Dundee City Council
Corporate Services
CHANGING FOR THE FUTURE

City Chambers
DUNDEE
DD1 3BY

27th January, 2026

Membership

Bailie Kevin Keenan
Bailie Helen Wright
Bailie Fraser Macpherson
Bailie Derek Scott
Depute Lord Provost Nadia El-Nakla
Councillor Jimmy Black
Councillor Lynne Short

Dear Colleague

You are requested to attend a MEETING of the **SCRUTINY AND AUDIT COMMITTEE** to be held remotely on Wednesday, 4th February, 2026 at 2.00 pm. Substitute members are allowed.

Members of the Press or Public wishing to join the meeting should contact Committee Services on telephone (01382) 434228 or by email at committee.services@dundeecity.gov.uk by 5.00 pm on Monday, 2nd February, 2026

Yours faithfully

GREGORY COLGAN

Chief Executive

1 DECLARATION OF INTEREST

Members are reminded that, in terms of The Councillors Code, it is their responsibility to make decisions about whether to declare an interest in any item on this agenda and whether to take part in any discussions or voting.

This will include all interests, whether or not entered on your Register of Interests, which would reasonably be regarded as so significant that they are likely to prejudice your discussion or decision-making.

(A) SCRUTINY REPORT ITEMS

2 EDUCATION SCOTLAND (HMI) RETURN VISIT – BALDRAGON ACADEMY - Page 1

(Report No 32-2026 by the Executive Director of Children and Families Service, copy attached).

(B) AUDIT REPORT ITEMS

3 INTERNAL AUDIT REPORTS - Page 11

(Report No 25-2026 by the Chief Internal Auditor, copy attached).

4 INTERNAL AUDIT PLAN AND PROGRESS REPORT - Page 31

(Report No 26-2026 by the Chief Internal Auditor, copy attached).

5 INTERNAL AUDIT PERFORMANCE MEASURES AND INDICATORS - Page 59

(Report No 27-2026 by the Chief Internal Auditor, copy attached).

ITEM No …2……..

REPORT TO: **SCRUTINY AND AUDIT COMMITTEE – 4 FEBRUARY 2026**

REPORT ON: **EDUCATION SCOTLAND (HMI) RETURN VISIT – BALDRAGON ACADEMY**

REPORT BY: **EXECUTIVE DIRECTOR OF CHILDREN AND FAMILIES SERVICE**

REPORT NO: **32– 2026**

1.0 PURPOSE OF REPORT

1.1 The purpose of this paper is to report on the findings of the Education Scotland, His Majesty's Inspectors of Education (HMI), follow up inspection visit to Baldragon Academy in June 2025.

2.0 RECOMMENDATION

2.1 It is recommended that the Scrutiny Committee:

a notes the contents of this report; and

b instructs the Chief Education Officer to monitor progress towards meeting the areas for improvement outlined in the report.

3.0 FINANCIAL IMPLICATIONS

3.1 None

4.0 BACKGROUND

4.1 Education Scotland undertook a follow up inspection visit by His Majesty's Inspectors of Education (HMI) in June 2025 in relation to the original inspection of January 2023, and subsequent follow up inspection visits in December 2023 and June 2024. They published a report of their findings on 11 November 2025.

4.2 The School Improvement Plan 2024/25 included a continued focus on the identified areas for improvement from the original inspection and follow up inspection visits. This is regularly reviewed, monitored and evaluated in line with both the school and the local authority's quality improvement procedures. The letter published by Education Scotland in relation to this return visit is attached in Appendix 1.

5.0 KEY RETURN VISIT FINDINGS

Key areas of progress

5.1 The school has made steady progress in improving young people's attendance, attitudes to learning and behaviour.

- School senior leaders have continued to strengthen the school's approaches to improving young people's regular attendance at school, including late coming to school and to class. This has been achieved through a revision of policy, implementation of robust systems of staged intervention and through more effective tracking and monitoring of attendance data.

- Appropriate school and multi-agency supports are helping to identify and address barriers to attendance at school, including for those young people who are more at risk of poor attendance.

- The school ethos continues to improve, and young people's behaviour is improving. The school's revised Relationships for Learning policy is having a positive impact on the culture and climate for learning across the school. The policy sets out clear expectations for all young people, and staff, who now understand better their roles and responsibilities in classrooms and corridors. The Relationships for Learning policy is supporting greater consistency in how behaviour issues are being addressed, and resolved, by staff.

- Young people respond better to adult instructions and interactions. This is resulting in a significantly calmer learning environment and is showing a decrease in behaviour referrals and school exclusions.

5.2 The school has made positive progress to plan tasks and activities that are relevant, motivating and set at the right level of difficulty for young people.

- Senior leaders have actively involved young people and all staff in developing The Baldragon Standard Classroom Approach. This approach is being used effectively to support improvements in the consistency and routines of learning and is having a positive impact on the motivation and engagement of young people.

- School staff work well together to share and discuss good practice in learning, teaching and assessment. This professional learning has influenced and improved their practice.

- Almost all staff demonstrate an improved understanding of the needs of young people requiring additional support in their learning. Staff have an improved access to information about learners, are using a wider range of inclusive classroom materials and are using evidence-based approaches to better support their learners.

5.3 The school has made sound progress to improving attainment across the school.

- Senior leaders and staff work well together to improve approaches to tracking and monitoring of learning, achievement and attainment through the Broad General Education and the Senior Phase. This includes a specific focus on different groups of learners and their needs. Learning data is analysed more rigorously through regular attainment meetings which are focused on young people's progress, next steps in learning and identification of interventions to improve attainment.

- There are clear signs of improvement in young people's attainment in literacy and numeracy which represents steady improvement from recent years.

- A new and more robust school presentation policy provides a clear framework for staff to support young people to undertake qualifications more aligned to their needs. This approach is supported by the progression pathways document which helps young people and parents to better plan their learning journey from S3-S6.

- Senior leaders and teachers are increasing the number of young people presented for National Qualifications. Senior leaders demonstrate positive indicators in improvement in attainment over time. Senior Phase data suggests that the approaches being used to raise attainment are having a positive impact on attainment outcome for pupils in S4 and S5. The significant improvement in attainment at National 5 and Higher in S4 and S5 from 2023-2025 is shown in Appendix 2.

- S4 breadth and depth attainment continues to improve across all key performance indicators. Notably and since the original inspection, the number of pupils achieving five or more National 5 (or equivalent) qualifications has increased by 150%.

- S5 breadth and depth attainment continues to improve across all key performance indicators. Overall, the number of pupils gaining one or more Higher (or equivalent) qualifications has increased by over 30% and pupils achieving three or more Higher (or equivalent) qualifications has increased by over 60%. Pupils achieving five or more Higher (or equivalent) qualifications has also increased by over 60%.

- S6 pupils achieving one or more Higher (or equivalent) qualifications continues to improve. In particular, the number of pupils in S6 achieving five or more Higher (or equivalent) qualifications has improved by over 50% when compared to recent years.

<u>Areas for Improvement</u>

Key areas for improvement include:

5.4 Continue to prioritise improvements to attendance to bring school data in line with national averages.

5.5 Continue to use the positive relationships that are developed with young people to promote consistently high expectations and to encourage young people to be ambitious in their learning.

5.6 Continue to focus on delivering, and evaluating, consistently high-quality, well-paced and inclusive learning experiences, designed to motivate young people.

5.7 Continue to review the presentation policy regularly to ensure it reflects the changing context of the school and needs of all young people and to maintain a relentless focus on ensuring young people achieve and attain to the best of their abilities.

6.0 NEXT STEPS

6.1 Following the June 2025 follow up inspection, HM Inspectors wrote to parents and carers in November 2025 to report their view that the school has made good progress since the original inspection. As a result, they are confident that Baldragon Academy has the capacity to continue to improve so will make no more visits in connection with this inspection.

6.4 The School Improvement Plan 2025/26 Includes a continued focus on the identified areas for improvement from the follow up inspection visits. This is regularly reviewed, monitored and evaluated in line with both the school and the local authority's quality improvement procedures.

7.0 POLICY IMPLICATIONS

7.1 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.

8.0 CONSULTATIONS

8.1 The Council Leadership Team have been consulted in the preparation of this report.

9.0 BACKGROUND PAPERS

9.1 None.

Audrey May
Executive Director

Paul Fleming
Head of Education, Learning and Inclusion

APPENDIX 1

Education Scotland
Foghlam Alba

11 November 2025

Dear Parent/Carer

In June 2023, HM Inspectors published a letter on Baldragon Academy. The letter set out a number of areas for improvement which we agreed with the school and Dundee City Council. We subsequently returned to the school to look at how it had continued to improve its work, and published another letter in March 2024 and September 2024. Recently, as you may know, we visited the school again. During our visit, we talked to young people and worked closely with the headteacher and staff. We heard from the headteacher and other staff about the steps the school has taken to improve. We looked at particular areas that had been identified in the original inspection. As a result, we were able to find out about the progress the school has made and how well this is supporting young people's learning and achievements. This letter sets out what we found.

Senior leaders, with staff, should improve young people's attendance, attitudes to learning and behaviour.

The school has made steady progress in this area of development.

Senior leaders have continued to strengthen the school's approach to improving attendance through the introduction of a helpful attendance policy. In addition, a robust system is now in place to identify, track and support young people who are at risk of poor attendance. Support staff work well with young people and their families to help to improve attendance. The school's attendance data is steadily improving, as a result of well-consider support and interventions. Senior leaders recognise the importance on maintaining this area of focus to support further improvements.

Staff have also focused on reducing young people's late coming to school and class. Positively, there has been a reduction in late coming. Staff work with young people to identify and address barriers to arriving in school on time, and consequences for persistent late coming are working well. A few young people do not regularly attend all of their classes but are present in the school building. Staff work together effectively to redirect these young people back to classes. Staff should work closely with young people and continue to sustain their work to ensure all young people attend their designated classes.

The school's Relationships for Learning policy is having a positive impact on the culture and climate for learning across the school. Young people and staff now better understand their roles and responsibilities in classrooms and corridors. Senior leaders and staff are now developing a whole school approach to addressing the use of mobile phones.

The school ethos at Baldragon Academy continues to improve. Young people's behaviour is improving and, as a result, they arrive at class better ready to engage in their learning. Teachers should now focus on delivering consistently high-quality learning experiences, designed to motivate young people. They should ensure learning is well-paced and meets the needs of all learners. Staff should continue to use the positive relationships that they develop with young people to promote consistently high expectations and to encourage young people to be ambitious in their learning.

Staff should work within their departments to plan tasks and activities that are relevant, motivating and set at the right level of difficulty for young people.

The school has made positive progress with this area of development.

Senior leaders have actively involved young people and all staff in developing The Baldragon Standard Classroom Approach. This approach is being used well in most lessons. It is supporting improvements in the consistency and routines of learning experiences. Young people and teachers speak confidently about the whole school approach and report that it is having a positive impact on the motivation and engagement of learners. Young people appreciate the clear and consistent structure to their lessons.

Teachers are now working together well to share and discuss good practice in relation to learning, teaching and assessment. They value opportunities to work together with other teachers, and to access support from the local authority. The local authority has supported teachers by developing a wide range of helpful digital resources to support and enhance learning. Teachers would benefit from further professional learning focusing on meeting the needs of all learners.

Senior leaders correctly identified the need to improve how teachers plan learning, teaching and assessment. Staff adopted a consistent approach to planning learning as a result. It is important that senior and middle leaders monitor and evaluate the impact of approaches to planning. They should focus on ensuring it is improving the quality of learning experiences for all young people.

Senior and middle leaders should continue to develop how they monitor the quality of learning, teaching and assessment. This will help them to identify best practice and promote it widely across the school. They should also encourage teachers to continue to learn from practice happening in other schools, in the local authority and beyond.

Work with staff from the local authority to improve attainment as an immediate priority across the school, especially in S4, by S5 and by S6.

The school has made sound progress in this area for development.

Senior leaders and staff work together well to improve their approaches to monitoring the progress of young people. All staff are now using an agreed whole-school tracking system capturing information across all curricular areas from S1-S3. Staff review young people's progress and next steps in learning through regular attainment meetings with senior leaders. They also identify young people who are not on track in their learning and the approaches to be used to support their progress.

There are clear signs of improvement in young people's attainment in literacy and numeracy in S1-S3. Teachers with responsibility for literacy and numeracy are working closely with primary colleagues to improve the quality of the information provided at the point of transition to secondary school. They recognise that developing shared approaches to how they assess and plan will improve the accuracy of data provided, but also support teachers to accelerate the progress of young people in their learning.

Senior leaders have introduced a helpful course choice document. This helps young people and parents to plan their learning journey from S3-S6. A new school presentation policy ensures young people are being presented for an appropriate and challenging level of study. Staff should review the policy regularly to ensure it reflects the changing context of the school and needs of all young people.

Staff are offering young people a greater range of awards and courses, beyond National Qualifications. These provide young people with opportunities to develop skills for learning, life and work, and improve their attainment. As well as this, senior leaders and teachers are increasing the number of young people presented for National Qualifications. This is a positive indication that teachers are being more aspirational and ambitious in the outcomes sought for young people.

Senior leaders demonstrate positive indicators in improvements in attainment over time. Data shows that the approaches used to raise attainment are having a positive impact on attainment outcomes, particularly for young people in S4 and S5.

What happens next?

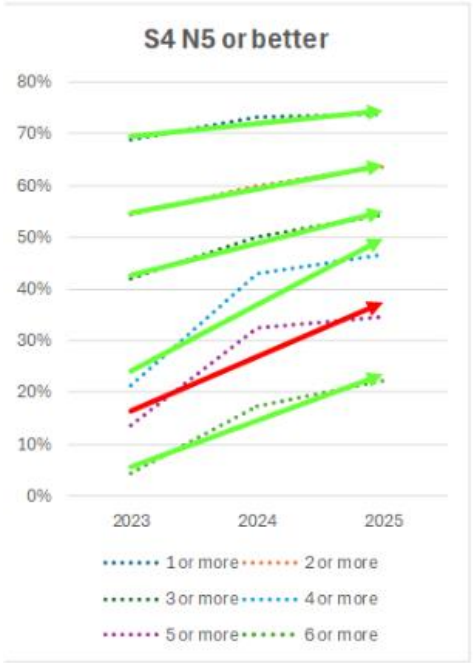
The school has made good progress since the original inspection. We are confident that the school has the capacity to continue to improve and so we will make no more visits in connection with this inspection. Dundee City Council will inform parents about the school's progress as part of its arrangements for reporting on the quality of its schools.

Teri McIntosh
HM Inspector

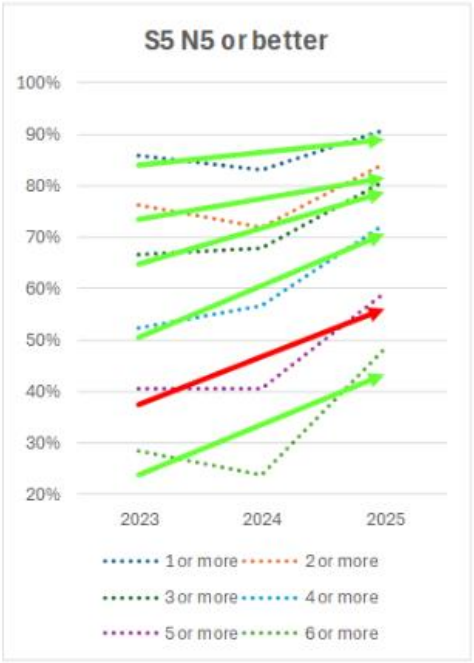
APPENDIX 2

Source: SEEMiS BI SQA Analysis, accessed 13/01/26

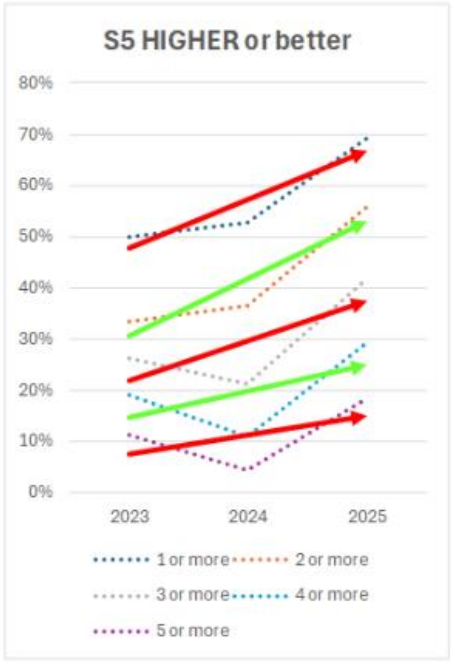
Green	= year to year increase
Yellow	= 2% tolerance (lower)
Red	= KPI Measure



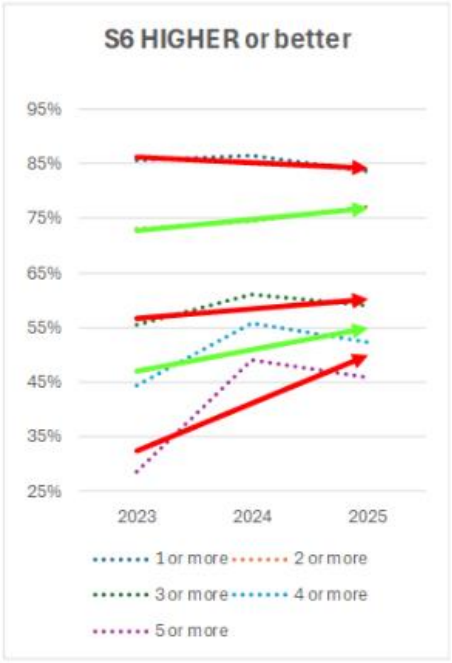
Awards at A-D	2023	2024	2025
1 or more	69%	73%	74%
2 or more	54%	60%	64%
3 or more	42%	50%	54%
4 or more	21%	43%	47%
5 or more	14%	33%	35%
6 or more	4%	17%	22%



Awards at A-D	2023	2024	2025
1 or more	86%	83%	91%
2 or more	76%	72%	84%
3 or more	67%	68%	81%
4 or more	52%	57%	73%
5 or more	40%	41%	59%
6 or more	29%	24%	48%



Awards at A-D	2023	2024	2025
1 or more	50%	53%	69%
2 or more	33%	36%	56%
3 or more	26%	21%	42%
4 or more	19%	11%	29%
5 or more	11%	4%	18%



Awards at A-D	2023	2024	2025
1 or more	86%	86%	84%
2 or more	73%	75%	77%
3 or more	56%	61%	59%
4 or more	44%	56%	52%
5 or more	29%	49%	46%

ITEM No …3……..

REPORT TO: **SCRUTINY AND AUDIT COMMITTEE – 04 FEBRUARY 2026**

REPORT ON: **INTERNAL AUDIT REPORTS**

REPORT BY: **CHIEF INTERNAL AUDITOR**

REPORT NO: **25-2026**

1.0 PURPOSE OF REPORT

To submit to Members of the Scrutiny and Audit Committee a summary of the Internal Audit Reports finalised since the last Scrutiny and Audit Committee.

2.0 RECOMMENDATIONS

Members of the Committee are asked to note the information contained within this report.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1. The day-to-day activity of the Internal Audit Service is primarily driven by the reviews included within the Internal Audit Plan. On completion of a specific review, a report which details the audit findings and recommendations is prepared and issued to management for a formal response and submission of management's proposed action plan to take the recommendations forward. Any follow-up work subsequently undertaken will examine the implementation of the action plan submitted by management.

4.2. In arriving at the overall assurance level for each audit, the assurance levels within the individual objectives do not always carry equal weighting. Findings from the audit are considered in total against the scope and risk levels to arrive at the overall assurance opinion.

4.3. Executive Summaries for the reviews which have been finalised in terms of paragraph 4.1 above since the last Scrutiny meeting are provided at Appendix A. The full reports are available to Elected Members on request. Reporting in Appendix A covers:

Audit	**Assurance level**
Parking Meter Procurement	Advisory
Multi Agency Screening Hub (MASH) Intake Process	Substantial
Fleet Purchasing	Limited
MOSAIC Payments	Limited

4.4. Internal audit recommendations are categorised as either relating to the design of the control system (Design) or compliance with the operation of the controls (Operational).

5.0 POLICY IMPLICATIONS

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 CONSULTATIONS

The Council Leadership Team have been consulted in the preparation of this report.

7.0 BACKGROUND PAPERS

None.

CATHIE WYLLIE, CHIEF INTERNAL AUDITOR **07JANUARY 2026**

(i) INTERNAL AUDIT REPORT 2024/21

Client	**Corporate Services**
Subject	**Parking Meter Procurement**

Executive Summary

Conclusion

Advisory Report
The review found that while the procurement exercise generally followed the form required by statutory guidance, and some good practice was identified, processes were not fully adhered to in the early stages. This resulted in issues in the published tender which were not identified and addressed as the procurement moved forward. These ultimately undermined the integrity of the procurement outcome, leading to the collapse of the tender. The review identified seven recommendations which, if implemented, would reduce the risk of similar process breakdowns. The findings show that robust checking and verification procedures are essential at key decision points to maintain public confidence in the Council's procurement activities.

Background

Dundee City Council advertised a tender opportunity to secure a 5-year contract for parking meter maintenance and upgrade services. The sourcing strategy was presented to the 22 April 2024 meeting of the Fair Work, Economic Growth, and Infrastructure Committee (Report 100-2024 refers). The Head of Sustainable Transport and Roads subsequently recommended to the 6 January 2025 meeting of the same committee that a tender received at a total cost of £410,900 be accepted (Report 7-2025 refers)

Following objections from an unsuccessful bidder the tender was collapsed, and it was decided that the service specification would be reviewed and the tender process restarted.

Management requested that Internal Audit review the process by which the procurement for parking meter maintenance and upgrade services was conducted, with the aim of determining whether this adhered to the Council's procurement procedures and the requirements of the tender specification.

Scope

Review of the procurement process for the tender with Project Number DCC/CD/111/24, to confirm that the procurement process followed was consistent with Council procurement procedures and the requirements of the published tender specification.

Objectives

This review was carried out with the aim of making determinations in relation to specific procurement risks and controls identified in consultation with Council Senior Management.

The review:

- Documented the process followed for the pre-tender market appraisal process and the conduct of the procurement exercise for parking meter maintenance and upgrade services.

- Evaluated the consistency of this process with the requirements of the Council's procurement policies and procedures, and other relevant guidance.
- Determined the root causes which resulted in the decision to collapse the tender.

Approach

The audit process undertaken consisted of:

- Acquisition of procurement process documentation, to determine the extent to which an audit trail of key decisions existed
- Documentation by walkthrough of the process followed in carrying out the procurement exercise, which included discussions with relevant staff
- Evaluation of the consistency of the process used with Council procedures and guidance
- Determination of an opinion on the compliance of the procurement exercise with statutory regulations and guidance

Procurement Framework and Guidance

The Council's procurement activities are guided by the Corporate Procurement Strategy 2024-27, The Procurement Journey (the main source of procurement best practice guidance for the Scottish public sector), and statutory guidance including the guidance accompanying the Procurement Reform (Scotland) Act 2014 and the Scottish Procurement Policy Handbook. This procurement for parking meters followed Route 3 in The Procurement Journey, as advised by the Procurement Category Officer, as it was above the GPA (The Agreement on Government Procurement of the World Trade Organisation) procurement threshold.

Compliance Assessment and Recommendations

In carrying out our assessment of compliance, we have considered the procurement process as consisting of four main phases, which reflect the progress of a tender exercise from initiation to award. These align with the principal phases described in The Procurement Journey, although we have separated the Tender Publication and Evaluation processes, for clarity.

		Action Priority			
		C	H	M	L
Pre-Tender Market Appraisal and Strategy Development	Advisory	-	1	1	-
Tender Publication and Management of Queries	Advisory	-	1	-	-
Evaluation Process	Advisory	-	2	-	-
Award Process	Advisory	-	1	1	-
TOTAL		-	5	2	-

Nature of Recommendations

Two of the seven recommendations relate to the operation of existing controls, and these both arose in the Pre-Tender Market Appraisal and Strategy Development stage of the Procurement exercise. The remaining five recommendations relate to the design of controls which take place in later stages.

Key Findings

We have documented the main events and key decisions of the procurement exercise. We confirmed that the Parking Meter procurement generally followed the procurement process stages required by the Procurement Regulations.

Throughout the review we made a number of observations regarding adherence to processes, recommended practice, and statutory guidance. However, not all of these contributed to the decision to collapse the tender. We have reported our findings and conclusions to management under the following categories:

- issues which directly led to the collapse of the tender;
- issues which represent non-compliance with processes or statutory requirements.
- other areas in which there is scope to strengthen processes.

Impact on risk register

The Corporate Finance and Sustainable Transport and Roads risk registers included, at time of audit, the following risks:

- CDRT006 Finance (inherent risk 5x5, residual risk 3x3)
- CSCF008 Compliance (inherent risk 5x5, residual risk 5x3)
- CSCF007 Procurement - General (inherent risk 5x5, residual risk 5x3)

Specific hazards documented within the Service assessments of these risks, which were considered in this advisory review are as follows:

- Poor decision making
- Failure to comply with procedures and statutory guidelines
- Reputational damage
- Potential legal challenge
- Financial loss through procurement collapse and re-tendering costs

The review identified that several of these risks materialised during the procurement process. The risk registers include various internal controls to mitigate these risks. Key controls include the centralised procurement function (rated as partially effective), while tender procedures following the Scottish Government Procurement Journey toolkit, use of qualified procurement staff, and management supervision and checking processes are all rated as fully effective.

The review findings suggest that some control effectiveness ratings may require reassessment. Despite tender procedures being rated as fully effective, multiple procedural breaches occurred. Similarly, management supervision and checking processes are rated fully effective but failed to identify compliance issues and documentation errors.

Risk owners should consider whether current effectiveness ratings accurately reflect the control environment, particularly for tender procedures and management checking processes, and assess whether residual risk scores remain appropriate given the vulnerabilities identified through this review.

(ii) INTERNAL AUDIT REPORT 2024/14

Client	**Children and Families**
Subject	**Multi Agency Screening Hub (MASH) Intake Process**

Executive Summary

Conclusion

Substantial Assurance
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.

Background

The Children (Scotland) Act 1995 establishes a framework for the welfare and rights of children in Scotland, emphasizing parental responsibilities and the role of public authorities in child protection. Under the Act the local authorities are required to create plans for services that benefit children and to cooperate with other agencies to promote the welfare of children in need. Further, the Children and Young People (Scotland) Act 2014 introduced significant changes that impact on every aspect of children's services and on all stages of a child's life, from birth well into adulthood which guides the local authority's responsibility in ‘Getting It Right for Every Child’ (GIRFEC).

The Multi-Agency Screening Hub (MASH) is implemented as a "Front Door" arrangement, to effectively and safely manage the demand for referrals and assessments in safeguarding children and young people in the local population. The hub is designed to promote information-sharing and collaborative decision-making across multiple agencies, involving co-located staff from local authorities, health services, and the police.

The MASH environment enables practitioners to efficiently and swiftly collect and analyse information to assess risk. Through this multi-agency collaboration and coordination, professionals are in a stronger position to make accurate, appropriate, and proportionate decisions regarding child safety.

It's important that MASH takes timely, effective action on referrals in collaboration with Council Service areas and partner bodies. It functions as the initial screening process, where a decision-maker determines the next steps for the case. As a general guideline, urgent referrals are expected to be screened within a few hours, while non-urgent referrals should be completed within three days.

Scope

Review of the administrative processes to support the Multi-Agency Screening hub in taking timely, effective action on referrals in collaboration with Council Service areas and partner bodies.

Objectives

		Action Priority			
		C	H	M	L
The Council has established an administrative process that effectively supports taking timely, effective action on referrals.	**Substantial Assurance**	-	-	1	1
The process allows for coordination and effective communication between Children's and Adult's services	**Comprehensive Assurance**	-	-	-	1
Arrangements are in place which will assist in ensuring that a consistent approach to decision making is adopted	**Substantial Assurance**	-	-	1	-
Appropriate monitoring information is compiled and reported to provide assurance to management that these processes are working effectively, and to identify any trends or areas of unmanaged risk.	**Substantial Assurance**	-	-	-	-
TOTAL		-	-	2	2

Nature of Recommendations

Two (one medium and one low) recommendations made relate to issues identified with the design of existing controls and two (one medium and one low) recommendations on operation of existing controls, represent instances in which the control framework requires revision to adequately address risks.

Key Findings

We identified a number of areas of good practice:

- Although there is no formal training programme for staff on the MASH intake process, we observed that processes are in place to ensure staff gain and retain relevant knowledge and skills.
- There is a process to ensure adequate staff are available to monitor incoming referrals.
- The MASH intake process provides clear guidelines on handling referrals, including appropriate routes for escalation and communication with partners.

- Responsibility for individual referrals is clearly allocated, and referral information is stored in defined and accessible location.

We have identified the following areas for improvement:

- The MASH process is clearly and comprehensively documented; however, we observed that the Memorandum of Understanding (MOU) setting out the responsibilities of the participating agencies is not available to MASH Management.
- Referral logs are maintained to ensure all the referrals are recorded, attended and actions taken; However, the time taken to action referrals is not tracked and monitored.
- There is no formal process to handle referrals which involve families already known to Social Work as a single referral. However, the existing process provides opportunities for staff to coordinate with Adult Services, where appropriate.
- There are standard formats used to document the information collated on a referral, however these do not explicitly record which information sources have and have not been checked.
- Reporting to Committee includes statistics summarising volumes of referrals handled and outcomes, however the Steering Group, for monitoring the MASH performance is in the process of relaunching.

Impact on risk register

- DCC002 Effectiveness of Partnerships (inherent risk 5x3, residual risk 4x2)
- DCC009 Statutory & Legislative Compliance (inherent risk 5x4, residual risk 4x4, Target 5x2)
- CFCJ004 Harm (inherent risk 5x5, residual risk 5x3)

The internal controls identified against these risks in the Corporate and Service risk registers consist of:

- Good case recording.
- Information Sharing.
- Mandatory regular training for staff to ensure statutory responsibilities are understood.
- Potentially violent persons database.
- Regular supervision and quality assurance by line management.
- Staff are trained and supported in defensible assessment and decision making.
- Workforce professionally qualified for all roles which require it.

We have identified areas for improvement in relation to the maintenance of referral logs, documentation of MASH screening process and formalising the existing process to handle referrals related to families. Risk owners should consider whether risks remain accurately scored in the light of the findings of this review.

(iii) INTERNAL AUDIT REPORT 2024/19

Client	**City Development**
Subject	**Fleet Purchasing**

Executive Summary

Conclusion

Limited Assurance
The purchasing workflows integrated into the Tranman system include the majority of controls expected of a purchasing system, including the purchasing controls which Executive Directors are required to implement by the Standing Orders and Financial Regulations. However, we found that the configuration of the system as it is presently implemented potentially permits some of these controls to be bypassed. The complexity of the process by which invoice information is recorded presents obstacles to gaining strong assurance over the coherence and integrity of the transaction audit trail. This complexity is heightened by the reliance on manual activities, including the manual entry of invoices and the manual matching of invoices to purchase orders, which increase the risk of error and inconsistency.

Background

Dundee City Council uses Civica Purchase to Pay systems for the majority of purchasing activity. However, in certain areas of the organisation alternative or special purpose systems are used to administer purchasing processes such as approval of orders and authorisation of invoices. Where these are in place, the level of integration with the Council's core financial systems varies.

The Fleet function uses the Civica Tranman (Tranman) system to administer purchasing activity, on the basis that this supports the high order volume and just in time procurement required to minimise stock holding and vehicle and plant downtime. An internal audit review carried out in 2021/22 made a number of recommendations with the aim of strengthening purchasing controls. These included:

- Establishing conventional purchasing controls over the ordering process within Fleet, including maintaining records of orders placed and their approval, establishing approval limits for ordering, and segregation of duties between ordering, receipting, and invoice approval.
- Reviewing purchasing processes to address delays in invoice processing.

Putting in place processes to facilitate reconciliation of purchasing records held within Tranman and financial information transferred to financial ledger system.

Management has reported that these have been implemented through the implementation of the Tranman ordering system, which should provide a direct interface with financial systems, and through the creation of a compliance officer post.

Management have requested that a review is carried out of the purchasing controls currently in place within Fleet, to determine their fitness for purpose and their adequacy in relation to the control processes which apply across the majority of Council functions.

Scope

Review processes which are specific to the Fleet function for placing and approving orders, receipting, and approval of payments.

Objectives

This review is carried out with the aim of making specific determinations in relation to financial and procurement risks and controls identified in consultation with Council Senior Management. The review will:

- Document the process which operates within the Fleet function, for those purchases which fall outside the scope of conventional purchases through Civica Purchasing.
- Evaluate the controls within that process, identify where these differ from controls which were recommended in the 2021/22 audit, or are applied to conventional purchasing activity.
- Conclude upon the extent to which these controls are adequate to support the discharge of relevant responsibilities set out within the Council's Standing Orders and other financial guidelines.
- Examine records of purchases, through a sampling approach or otherwise, to determine the extent to which those controls are operating.

Approach

The audit procedures to be undertaken consist of:

- Identification and examination of relevant process and procedure documents, if these are in place.
- Formal walkthrough of the purchasing process in order to document its operation.
- Acquisition of listings of purchase transactions from relevant systems to identify specific transactions for audit testing.
- Examination of underlying records in relation to identified transactions.

		Action Priority			
		C	H	M	L
Evaluate the controls within that process, identify where these differ from controls which are applied to conventional purchasing activity.	**Limited Assurance**	-	2	2	1
TOTAL		-	2	2	1

Nature of Recommendations

Four of the five recommendations made relate to issues identified with the design of existing controls and represent instances in which the control framework requires revision to adequately address risks.

Key Findings

We identified a number of areas of good practice:

- The purchasing process designed into the Tranman system adheres to basic good practice in that it requires “three way matching” between the purchase order, invoice, and goods received note prior to the release of any payment.
- Where purchasing processes operate as intended, there are adequate controls to ensure payments are matched with an authorised Purchase Order prior to payment.

We have identified the following areas for improvement:

- The Standing Orders and Financial Regulations require segregation of duties for approval of purchases, but this is not enforced by the Fleet purchasing system as it is currently configured. While this is a part of the system functionality, some users are able to override this requirement through the use of system administrative permissions. We identified a small number of transactions where this had occurred, or we were unable to assess if it had occurred due to generic log-ins being used.
- Access to the system is not actively managed, and records of users and their permissions held by the Service were out of date. Carrying out periodic review of user access would provide greater assurance that purchasing controls are effective, and identify instances where users hold system administrative privileges unnecessarily.
- Individual users have the ability to delete orders entered into Tranman, provided those transactions have not been invoiced, resulting in gaps in the audit trail. Even though this practice has been discontinued, the user permissions for deletion has not been revoked. It is recommended that this practice is discontinued.
- There is no formal training program in place for staff on the use of the Tranman system. However, training is provided informally on-the-job and annual quality conversations are held to identify any specific training requirements of the staff. Management should assess the adequacy of existing knowledge of the staff and consider if any ongoing programme of training or refresher training is required.

Impact on Risk Register

The (Service) risk register included, at time of audit, the following risks:

- CDRT006 Financial (inherent risk 5x5, residual risk 3x3)
- CSCF008 Compliance (inherent risk 5x5, residual risk 5x3)
- CSCF007 Procurement – General (inherent risk 5x5, residual risk 5x3)

The internal controls identified against these risks in the Corporate and Service risk registers consist of:

- "No Purchase Order, No Pay" policy
- Centralised procurement function.
- Segregation of duties
- General monitoring and reporting controls

- Procurement / Supplier controls

We have identified areas for improvement in relation to the access controls and segregation of duties in Fleet Purchasing process.

Risk owners should consider whether risks remain accurately scored in the light of the findings of this review

(iv) INTERNAL AUDIT REPORT 2024/18

Client	**Children and Families Service**
Subject	**MOSAIC Payments**

Executive Summary

Conclusion

Limited Assurance
Processes for the administration of payments to Fostering Agencies are not well defined. The controls which are 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.

Management Response

The Service operates a system and associated processes involving multiple Social Work, Admin, Contracts, and Finance staff with roles at different stages. The complexity has been compounded by some staff leaving posts and new staff starting without clear transfer of responsibilities. While the MOSAIC system calculates payments automatically, this is based on the placement information entered and updated by staff. Currently, this information should be input by the case holding Social Worker with oversight from a Team Manager. However, other updates are input separately by Admin Officers and the system therefore lacks some cohesion.

Concerns about this initiated the management request for the audit and it is agreed that a simple, manageable process needs to be developed and implemented with operational, Finance and Contracts officers.

As an initial response to the findings of the review, Managers have issued instructions to teams reiterating that they must keep MOSAIC records up to date, and promptly note when a placement has ended, so payments do not continue to be made. The functionality of MOSAIC will be utilised to place a maximum duration on payment arrangements, after which further payments will require renewed authorisation.

Responsibility for administration of this and other MOSAIC payment processes are being transferred from Dundee Health and Social Care Partnership to Corporate Business Support Services, part of Dundee City Council Corporate Services, as part of a broader review of responsibility for clerical processes.

Background

MOSAIC is an electronic system used within the Children and Families Service and Dundee Health and Social Care Partnership. The system holds electronic case files relating to Children's and Community Justice Social Work. The functionality of MOSAIC includes provision for creation and authorisation of payments which are processed via an interface with the Council's main financial systems.

An internal exercise reviewing payments to providers of fostering, adoption and related activities has identified a number of instances in which payments have continued to be made to providers after provision of the service has ended. As a consequence, the Council has been required to engage with care providers to recover these overpayments.

This review has been added to the internal audit plan in-year, at the request of management, for the purpose of establishing the effectiveness of the control framework surrounding payments of this type.

The review was carried out in the context of work that had already commenced within the Children and Families Service to identify the causes of errors in payments for placements to providers of Fostering, Kinship Care, and Adoption services.

The Service investigation approach was based on investigation of payments generated by the system but excluded from the payment run submitted for processing, termed "rejections" or rejected payments, as opposed to being a broad-based review intended to identify erroneous payments in general.

MOSAIC calculates payments automatically based on the placement information which is recorded in the system. The most prevalent source of error found in the Service Investigation, in terms of the number of errors and their financial value, was a failure to record placement end dates on a timely basis, meaning that MOSAIC continued to automatically generate payments for services which were no longer being provided. Investigation into these errors and engagement with fostering agencies revealed other errors arising from different issues.

The Service Investigation was ongoing at the point when audit work commenced and has continued throughout. At commencement of the audit, the Service investigation had provisionally identified:

- 43 payment arrangements with errors resulting in overpayment
- 14 payment arrangements with errors resulting in underpayment
- Overpayments to providers totalling £382,625
- Underpayments due to providers totalling £115,523

It has not been possible to quantify errors identified during the audit in a way that is comparable with these figures, as investigation is required beyond the data obtained for testing. Most of the errors identified during the audit related to unapplied discounts, which depend on the specifics of the provider contract and the length of the arrangement. Further work will be required to determine the extent of any error, and the relevant data has been provided to Service staff.

Scope

Review of the processes by which payments to third party providers for fostering, adoption and third sector spot purchased activities are arranged, approved, and monitored.

Data Set and Testing Population

We obtained data from MOSAIC for all Children's services payment arrangements against which a payment had been raised in the last 24 months. As we were able to obtain reliable, structured data, audit testing was performed by analysis over the complete population of interest, as opposed to on a sample basis. The focus of our testing was payment arrangements relating to the following MOSAIC "Service Types":

- Independent Fostering Agency
- Internal Fostering
- Kinship Carer
- Kinship Carer (Pre-approved)

This provided a population for testing of 500 service users, for whom payment arrangements of the above Service Types had been in place, and against which payments had been raised, in the 24 month period between 1 December 2022 and 1 December 2024.

Objectives

		Action Priority			
		C	H	M	L
There is a process for instigating regular payments to providers through the MOSAIC system, which is subject to adequate controls	No Assurance	1	4	-	-
Regular payments are brought to an end when the related service ceases	Limited Assurance	-	1	2	-
Monitoring and oversight arrangements are adequate to identify instances in which payments are raised for services which are no longer required	Limited Assurance	-	-	2	-
TOTAL		1	5	4	-

Nature of Recommendations

All but one of the recommendations raised relate to the design of controls, as opposed to their operation. To a large extent this reflects that the controls which presently exist are not fully effective at mitigating risk, with an absence of control in some areas. In particular, the absence of a systematic means of ensuring that placement end dates are promptly recorded, and payments stopped, gives rise to a Critical recommendation.

Key Findings

We considered that the existing arrangements in some areas represented good practice:

- MOSAIC holds details of provider contract rates centrally, such that these are automatically applied for new payment arrangements and updated for existing payment arrangements when they change.

- Transfer of information between MOSAIC and Civica Financials is semi-automated, and reconciliation controls are applied to ensure accuracy and completeness.

We have identified the following areas for improvement:

- The processes by which payment arrangements are created and approved within the MOSAIC system are undocumented. Although the process followed in practice includes a number of checks, authorisations, and approvals, the criteria to be applied by the individuals carrying out those checks are not clear. This gives rise to the risk that approval controls may not operate as intended as a result of confusion as to the responsibility for identifying particular errors.
- The lack of defined approval criteria means that these controls do not detect and correct instances in which the documented Individual Payment Agreement and other administrative information relevant to payment arrangements is not added to, or recorded within, MOSAIC. This limits opportunities for staff other than the Social Worker to identify errors by removing the ability to verify information entered into the MOSAIC system against source documentation.
- Individual Payment Agreements (IPAs) which set out the service to be provided by, and the rates to be paid to, providers are not routinely provided to the Contracts team for checking, resulting in arrangements being put in place at incorrect or out of date rates.
- Levels of financial approval authority in MOSAIC include some individuals whose responsibilities do not appear to align with this authority. These should be reviewed and considered in line with the existing Council approval limit guidance set out in the Short Guide to Payments and Purchasing once the relevant processes and approval responsibilities have been clarified.
- Payment arrangements can remain active for long periods of time, in some cases for the entire duration of an individual service user's childhood, however there are no controls which periodically verify whether payment arrangements should still be active. This can result in instances in which payments continue to be raised for placements which have ended.
- The process by which payment runs are instigated and approved is largely undocumented. The absence of payment process documentation means that key controls are not defined, with the result that there is limited assurance that checking processes have the intended effect or consistently take place.
- The most common issue giving rise to overpayments is a failure to update placement dates in the MOSAIC system when placements come to an end. Social Workers are responsible for ensuring this information is up to date, and opportunities for other staff performing administrative or finance functions to identify instances where this has not occurred are limited. There is a need to establish a suitable process and set of controls to identify these instances which is proportionate to the financial risk.
- The MOSAIC system has the capacity for configurable reports; however this is not in use for exception reporting. Some of the issues identified throughout the Service's investigation and internal audit testing could have been detected through regular review of automated exception reports.
- The payment calculation used by MOSAIC means that there is significant scope for error, particularly where workflows are instigated but not completed. MOSAIC is configured to calculate the difference between the total expected payment for a given placement since its start date, and the sum of payments already made. This has the result that in certain circumstances the system may automatically generate large, one-off "correcting"

payments. Limiting the scope of the automated payment calculation may provide a means to mitigate the potential size of individual payment errors.

- The Contract Monitoring Process captures information about placement end dates, however there is no mechanism to feed this back to Social Workers or Social Work Admin. Introducing a process to review any placement identified as ended in the course of contract monitoring would mitigate the potential duration for which automated payments can continue for placements which have ended.
- Changes in role mean that, for the period under review, contract monitoring meetings were not well attended by Social Work representatives. This means that a potential avenue by which payment issues could be fed back to social workers was not in place.
- Placements are subject to regular monitoring in fulfilment of the Council's statutory obligations towards children in the Care system, however these are generally not designed to identify potential payment error. Including some basic checks as part of these reviews which confirm that key information recorded in MOSAIC is complete and current would provide an additional opportunity to identify errors.
- The Social Work management structure includes a committee named the Resource Management Group, whose remit appears to include oversight of payment arrangements. However, this group does not currently receive the necessary information to fulfil this function. Reviewing the group's purpose and putting in place arrangements to provide better quality management information would enhance oversight.

Impact on risk register

The Service risk register included, at time of audit, the following risks:

- DCC001 Financial Sustainability (inherent risk 5x4, residual risk 5x5)
- DCC013 (inherent risk 4x5, residual risk 4x3), CFCJ015 (inherent risk 5x5, residual risk 4x2) Fraud & Corruption
- CFCJ002 Funding (inherent risk 5x5, residual risk 4x3)
- CFCJ007 Partnerships / External Providers (inherent risk 5x5, residual risk 3x3)

As this review is primarily concerned with a payment process, the principal risks arising from its findings are risks to financial resources. This is reflected in the findings of the Service's own investigations which identified a significant volume of overpayments.

A secondary risk arises from the fact that these processes concern payment for services which are provided by agencies and providers with which the Council has ongoing relationships. Poorly managed processes for ensuring accurate and timely payments are made carries a risk of harm to these relationships, impacting upon the Council's ability to meet its obligations to individuals in the care system.

Risk owners should consider the implementation of the controls recommended throughout this report from the perspective of ensuring that both the financial risk and the potential for adverse outcomes in the event of non-payment is tolerable assuming the normal operation of controls. This provides a framework within which to assess whether the commitment of resources such as staff time is proportionate to the level of risk which would otherwise arise.

Definitions of Levels of Assurance

Comprehensive Assurance	The system of controls is essentially sound and supports the achievement of objectives and management of risk. Controls are consistently applied. Some improvement in relatively minor areas may be identified.
Substantial Assurance	Systems of control are generally sound, however there are instances in which controls can be strengthened, or where controls have not been effectively applied giving rise to increased risk.
Limited Assurance	Some satisfactory elements of control are present; however, weaknesses exist in the system of control, and / or their application, which give rise to significant risk.
No Assurance	Minimal or no satisfactory elements of control are present. Major weaknesses or gaps exist in the system of control, and / or the implementation of established controls, resulting in areas of unmanaged risk.

Definitions of Action Priorities

Critical	**Very High-risk exposure to potentially major negative impact** on resources, security, records, compliance, or reputation from absence of or failure of a fundamental control. Immediate attention is required.
High	**High risk exposure to potentially significant negative impact** on resources, security, records, compliance, or reputation from absence of or non-compliance with a key control. Prompt attention is required.
Medium	**Moderate risk exposure to potentially medium negative impact** on resources, security, records, compliance or reputation from absence or non-compliance with an important supporting control, or isolated non-compliance with a key control. Attention is required within a reasonable timescale.
Low	**Low risk exposure to potentially minor negative impact** on resources, security, records, compliance, or reputation from absence of or non-compliance with a lower-level control**, or areas without risk exposure but which are inefficient, or inconsistent with best practice.** Attention is required within a reasonable timescale.

ITEM No …4……..

REPORT TO: **SCRUTINY AND AUDIT COMMITTEE – 4 FEBRUARY 2026**

REPORT ON: **INTERNAL AUDIT PLAN UPDATE AND PROGRESS REPORT**

REPORT BY: **CHIEF INTERNAL AUDITOR**

REPORT NO: **26-2026**

1.0 PURPOSE OF REPORT

To submit to Members of the Scrutiny Committee an update on the progress towards delivering the 2025/2026 Internal Audit Plan; the audit from previous years' plans that were not complete in June 2025, and information about the number of open internal audit recommendations.

2.0 RECOMMENDATIONS

It is recommended that the Committee note progress with:

(i) the Internal Audit Plan; and

(ii) the implementation of agreed internal audit recommendations.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 AUDIT PROGRESS

4.1 Appendix 1 notes the current stage of progress with implementing the 2025/2026 Internal Audit plan and the outstanding items brought forward from previous plans (the plan). It also includes the current position regarding previous years' internal audits with remaining open actions at 13 January 2026.

4.2 Appendix 2 shows the total open internal audit recommendations by service, audit year and risk priority. Limited progress has been made to implement and close open actions, with 9 actions closed since this was last reported in November 2025. New target dates have also been set for a number of actions, with 30 still requiring a new target date to be set by the services, compared to 17 at November 2025.

5.0 POLICY IMPLICATIONS

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 CONSULTATIONS

The Council Leadership Team have been consulted in the preparation of this report.

7.0 BACKGROUND PAPERS

No background papers, as detailed by Section 50D of the Local Government (Scotland) Act 1973 (other than containing confidential or exempt information) were relied on to a material extent in preparing the above report.

Appendix 1 - Internal Audit Plan update 2025/26 plus previous years' not reported by June 2025.

Appendix 2 - Outstanding Internal Audit Agreed Actions.

CATHIE WYLLIE, CHIEF INTERNAL AUDITOR **07 JANUARY 2026**

Appendix 1 - Internal Audit Plan update 2025/26 plus previous years' not reported by June 2025

The tables below show the progress stage of each audit, and the overall assurance level provided from completed audit work. They also include the numbers of remaining open actions for each report to allow members to assess if risks identified during the audit are now mitigated, or where risk remains outstanding.

Progress with previous years' audits not complete at June 2025

2022/23 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Final Status / Update	Assurance Level	Open Actions at 13 January 2026				Closed Actions
					C	H	M	L	
Procurement / Contract Reviews									
Social Work Contracts and Payments	Review of contract management and commissioning arrangements, including payments, within Dundee Health and Social Care Partnership to assess their adequacy and effectiveness.	February 2025 Revised to April 2026	Draft Report Issued 6/01/26						

2023/24 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level	Open Actions at 13 January 2026				Closed Actions
					C	H	M	L	
Procurement / Contract Reviews									
SLAs with External Bodies	Assess the extent to which the Council has adequate service level agreements in place where Council responsibilities are delivered by external bodies. To include an assessment of arrangements to ensure satisfactory service delivery and value for money.	April 2025 Revised to December 2025	Complete	Limited	-	2	3	-	None
System Reviews									
Section 75 Planning Obligations (Contractor)	Review of the arrangements in place for the recording, receipt, and monitoring of Section 75 payments/planning obligations from Developers.	February 2025 Revised to December 2025	Complete	Substantial	-	1	5	1	None
Young People in Residential Care - Missing Persons Processes	Review of the arrangements for risk assessment, planning for, and prevention of young people going missing from Residential Care. To include review of processes for identifying, recording, and responding to such instances.	April 2025 Revised to September 2025	Complete	Substantial	-	-	5	2	None

2024/25 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level	Open Actions at 13 January 2026				Closed actions
					C	H	M	L	
Governance Reviews									
Partnership Working - Dundee Alcohol and Drugs Partnership	Review of the arrangements which underpin the Council's delivery responsibilities under the Alcohol and Drugs Partnership's Strategic Framework, including delivery plans, progress monitoring, and engagement with other members of the Partnership.	April 2025 Revised to September 2025	Complete	Comprehensive	-	-	-	-	-
ICT Reviews									
Service Cyber Incident Readiness (contractor)	Review the adequacy of design, and operating effectiveness of key controls, established in services to ensure delivery of their key activities to a minimum agreed level, during a cyber incident.	September 2025 Revised to April 2026	Draft report in review						
Financial Reviews									
Capital Planning and Monitoring	Review of the procedures to oversee the implementation of Capital Plans, in line with the Council's Capital Investment Strategy, and monitor and scrutinise Capital expenditure.	February 2025 Revised to September 2025	Complete	Limited	-	1	1	-	-

2024/25 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level	Open Actions at 13 January 2026				Closed actions
					C	H	M	L	
MOSAIC system payments	Review of payment processes added mid-year at Service's request.	April 2025 Revised to February 2026	Complete	Limited	1	5	4	-	None
Systems Reviews									
Multi Agency Safeguarding Hub (MASH) Intake processes	Review of the administrative processes to support the Multi-Agency Safeguarding hub in taking timely, effective action on referrals in collaboration with Council Services and partner bodies.	April 2025 Revised to February 2026	Complete	Substantial	-	-	2	2	None
Climate Strategy and Delivery Plans	Review to be conducted using a scope and audit programme being developed by SLACIAG for use across local authorities in Scotland.	June 2025 Revised to Sept 2025	Complete	Substantial	-	-	3	1	None
DHSCP Lead Partner Governance and Assurance Arrangements	To consider the governance arrangements in place to manage service planning and information sharing for Lead Partner Services	June 2025 Revised to April 2026	In Progress						

2024/25 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level	Open Actions at 13 January 2026				Closed actions
					C	H	M	L	
Other Work									
Housing Stock (External Wall Insultation)	Review the processes, procedures and programmes relating to the implementation of the works identified as required after August 2021 by the report from the Design and Property Service.	June 2025 Revised to April 2026	Draft Report being finalised						
External Quality Assessment Process	As part of the peer review process developed to ensure conformance with the PSIAS, complete External Quality Assessment (EQA) of the Council's Internal Audit Service. Self-assessment provided to reviewer November 2023. Review delayed during 2024, re-started in October 2024, but further delay by reviewer. These actions are not included in the tables about open audit actions	December 2024 Revised to December 2025	Complete	Generally conforms 2 Sections Fully conforms 12 sections	1	-	-	9	1 H and 1 L

2025/2026 Internal Audit Plan - Progress Report

The following table includes the 2025/26 plan.

2025/26 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level	Open Actions at 13 January 2026				Closed Actions
					C	H	M	L	
Finance Reviews									
Cash Handling	Review of the arrangements in place within the Council for the management and handling of cash.	December 2025 Revised to April 2026	In review						
Treasury Management (Large Value Transactions)	Review of procedures for processing and authorisation of large value transactions involving Council funds.	February 2026 Revised to April 2026	In progress						
HRA Budgetary Control	Review of budget management and monitoring processes in relation to Housing Revenue Account funds.	December 2025 Revised to April 2026	In progress						

2025/26 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level	Open Actions at 13 January 2026				Closed Actions
					C	H	M	L	
ICT Reviews									
Artificial Intelligence (AI) adoption	Review of ethics and governance in this area, potentially as an advisory review rather than an assurance audit	April 2026	In progress						
Cyber Security supply chain management	Review of arrangements for management of cyber security within supply chains. This will cut across IT, Information Governance and procurement.	April 2026	In progress						
Governance Reviews									
Performance Reporting	Assessment of organisational performance monitoring arrangements within Services, and their consistency with key operational plans.	February 2026 Revised to June 2026	Planning						
Information Governance (progress of GDPR Action Plan)	Review of Information Governance arrangements across the Council, including the progress of previous action plans.	December 2025 Revised to April 2026	Planning						

2025/26 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level	Open Actions at 13 January 2026				Closed Actions
					C	H	M	L	
Dundee IJB - Implementation and Monitoring of Directions	Review of the governance and operational arrangements for the implementation and monitoring of Directions from Dundee IJB to the Council.	June 2026	Not started						

2025/26 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level	Open Actions at 13 January 2026				Closed Actions
					C	H	M	L	
Systems Reviews									
Asset Management	Review of the processes which ensure that the Council's asset management databases are complete, accurate, and kept up to date. To include processes for condition assessment.	Originally Feb 2026	Removed from plan						
Employability Services	Review of the efficiency and effectiveness of the Employability pathway, and arrangements to implement the Scottish Government's *No one left behind* policy.	Originally December 2025	Postpone till 2026/27 plan						
Energy Management and Billing	Evaluation of the processes in place for energy metering and billing, including an assessment of value for money.	April 2026 Revised to June 2026	Not started						
Business Continuity Planning	Review of the extent to which Business Continuity Plans are in place, up to date, and consistent with Council policies and guidance, considering emergency planning and Service incident readiness plans.	April 2026 Revised to June 2026	Planning						

2025/26 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level	Open Actions at 13 January 2026				Closed Actions
					C	H	M	L	
Council Tax and Non-Domestic Rates refunds	Review of the processes and controls for managing Council Tax and Non-Domestic Rates refunds, taking cognisance of work already carried out within Digital and Customer Services on Council Tax Refunds.	April 2026	Planning						
DWP Appointeeships	Review of the arrangements in place within the Council for the management of DWP Appointeeship clients who are deemed incapable of managing their own affairs.	February 2026 Revised to June 2026	Not started						
Homelessness	Review of the development and progress of the Council's plans to address Homelessness.	February 2026 Revised to June 2026	In progress						
Immigration Sponsorship and Visas	Review of the processes by which the Council considers and manages recruitment applications from individuals overseas and/or requiring visa sponsorship, including the update of these policies and procedures in line with changing legislation.	December 2025 Revised to April 2026	Draft report issued 17/12/25						

2025/26 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level	Open Actions at 13 January 2026				Closed Actions
					C	H	M	L	
Payroll	Review of a payroll sub-process, to be selected in conjunction with Service management.	April 2026	Not started						
Schools Administrative Support	Review of the arrangements to provide administrative and office support to schools, including arrangements for backfill in the event of absence.	February 2026 Revised to June 2026	In progress						
Self-Directed Support	Review of the arrangements for the uptake of and management of self-directed support within Children Services.	April 2026	Planning						
Other Work									
Parking Meter Procurement	Review of the procurement process for the tender with Project Number DCC/CD/111/24, to confirm that the procurement process used is consistent with Council procurement procedures and the requirements of the tender specification.	September 2025 revised to February 2026	Complete	Advisory	-	5	2	-	

2025/26 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level	Open Actions at 13 January 2026				Closed Actions
					C	H	M	L	
Purchasing outwith Civica - Fleet Purchasing (Tranman)	Review processes which are specific to the Fleet function for placing and approving orders, receipting, and approval of payments.	September 2025 revised to February 2026	Complete	Limited	-	2	2	1	-
Purchasing outwith Civica - GVA	Review processes in relation to the ordering, approval, and payment for repair work to Council buildings which are administered through the GVA system and related processes.	September 2025 revised to December 2025	Complete	Limited	-	2	3	1	
Follow-Up	Review of progress with the implementation of prior internal audit actions agreed by the Council, for the purpose of providing assurance to Elected Members that identified issues are addressed on a timely basis, and that management attention is appropriately directed towards issues which expose the Council to higher degrees of risk.	Each meeting	Ongoing	N/A	-	-	-	-	
Technical Development	Review and update of the Council's Internal Audit Methodology following the	On-going	In Progress	N/A	-	-	-	-	

2025/26 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level	Open Actions at 13 January 2026				Closed Actions
					C	H	M	L	
	implementation of Global Internal Audit Standards. Further refinement of the Council Audit Universe in consultation with Services. Development and implementation of a Data Analytics strategy and capability.								
Advice and Guidance	Provision of ad-hoc support to assist services in respect of specific queries and contribute to the delivery of improvements in the Council's framework of governance, risk management and control. This will include the ongoing provision of advice and guidance surrounding the development of newly implemented systems and processes, or the revision and update of those processes.	N/A	Ongoing	N/A	-	-	-	-	
GIAS (UK Public Sector) Quality Self-Assessment Process	Annual self-assessment for conformance with GIAS (UK Public Sector).	June 2026	Ongoing						
Specific Investigations	To respond to requests for advice and assistance as required in respect of	As required							

2025/26 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level	Open Actions at 13 January 2026				Closed Actions
					C	H	M	L	
	cases of suspected fraud, corruption or malpractice.								

Previous Years Internal Audit Plan - Progress Report (Audits with audit actions remaining open at 13 January 2026)

The following table shows the audits from previous years that still have outstanding actions, or where the final actions have been closed since we last reported. Once all actions are closed the report will be removed at the following reporting cycle. There are four reports in that position.

Revised dates have been agreed where actions have past their original agreed completion date, however a small number of these are also now in the past and require a new target date to be set.

Previous Year's Audit	Open actions	Report Number	Reported to Scrutiny Committee	Report Assurance level	Open Actions at 13 January 2026			
					C	H	M	L
Lone Working	3 Warning Alerts	2017/07	During 2017/18 audit year	2 closed actions	-	1	-	-
Follow-up Review of General Data Protection Regulations (GDPR)	7 Subject Access Requests ("SAR")	2020/19	April 2021	7 closed actions	-	1	-	-
Payroll	1 Salary Additional Payments/Deductions	2021/01	June 2022	2 actions closed	-	-	-	1
Stocks and Inventories - 2020/21 Year End	2 Construction Services Stock	2021/03	Sept 2021	0 closed actions	-	1	-	-
Fire Risk Assessments	3 Procedures and Controls for ensuring all Relevant Properties are Fire Risk Assessed - Housing Division as Part of Neighbourhood Services	2021/22	June 2023	3 closed actions	-	1	-	-
Tay Cities Region Deal	1 Securing Business Case Approval	2022/08	Sept 2023	3 closed actions	-	1	-	-

Previous Year's Audit	Open actions	Report Number	Reported to Scrutiny Committee	Report Assurance level	Open Actions at 13 January 2026			
					C	H	M	L
LACD Financial Sustainability	1 Service Agreement 2 Monitoring 3 Service Level Agreements 4 Management Fee Plus 4 LACD actions	2022/09	June 2024	0 closed actions	2	2	-	-
General Ledger	2 Documentation of Controls 3 Cost Centre Structure 4 Monitoring Timetable	2022/17	Sept 2023	4 closed actions	-	1	1	1
Cyber Security	2 Documentation of Processes 7 Testing Response and Recovery Processes	2022/20	City Governance Feb 2024	5 closed actions	-	-	1	1
Procurement	2 Contract and Supplier Management 5 Waivers	2022/21	June 2024	3 closed actions	-	1	-	1
Health and Safety - Incident Reports	1 Conduct regular audits and quality checks on the incident reporting and recording 2 Improve the storing and filing of incident information 4 Promote management involvement in investigations	2022/23	Sept 2024	1 closed action	-	1	1	1
Service Design and Business Improvement		2023/01	June 2024	4 closed actions	-	-	-	-
Recruitment (Contractor)	1 Formalising service areas' succession plans	2023/08	Dec 2024	0 closed actions	-	1	-	-

Previous Year's Audit	Open actions	Report Number	Reported to Scrutiny Committee	Report Assurance level	Open Actions at 13 January 2026			
					C	H	M	L
Permanence	1 Improve Document Storage and Accessibility 2 Enhance Meeting Documentation 3 Improve Communication about Legal Processes 4 Implement and Evaluate New Date Recording Form in MOSAIC	2023/10	April 2025	0 closed actions	-	-	4	-
Community Justice Liaison with COPFS and the Courts	1 Process Documentation	2023/12	2024	5 closed actions	-	-	-	1
Civica CX - Rent Accounting Module	1 Post Implementation Review Framework	2023/17	Feb 2025	0 closed actions	-	1	-	-
Corporate Governance	3 Guidance for Respondents 5 Business Continuity Plan Testing 6 Approval of Responses - Record Keeping 7 Responding Services	2023/20	Dec 2024	3 closed actions	-	-	1	3
Corporate Debt Recovery Arrangements		2023/21	Feb 2024	4 closed actions	-	-	-	-
Health and Safety Risk Assessments and Incident Management in Schools	1 Mandatory Health and Safety Training Programme	2023/24	April 2025	2 closed actions	-	-	1	-
Safety Alarm Response Centre	2 Implement a Performance Measurement and Reporting Framework for SARC Operations	2023/25	Dec 2024	4 closed actions	-	-	1	-

Previous Year's Audit	Open actions	Report Number	Reported to Scrutiny Committee	Report Assurance level	Open Actions at 13 January 2026			
					C	H	M	L
Microsoft Office 365 (Contractor)	1 Access Management Review 3 Application Restrictions 5 Administrator Account Access 6 Update and Introduction of Policies 7 Data Loss Prevention Assessment	2023/28	June 2025	2 closed actions	-	5	-	-
User Access Management (Contractor)	5 Civica Monitoring	2023/29	Feb 2024	4 closed actions	-	1	-	-
Tay Cities Region Deal		2024/03	April 2024	1 closed action	-	-	-	-
Purchase to Pay		2024/09	April 2025	4 closed actions	-	-	-	-
Risk Management (Contractor)	2 Update and Enhance the Risk Management Procedures 3 Develop and Maintain a Risk Appetite Framework 4 Strengthen Risk Identification Process and Refresh the Risk Register to reflect Current and Emerging risks 5 Ensure Risk Description is completed, and Proper Risk Ownership is assigned 6 Review and Cleanse Risk Records Across Pentana 7 Strengthening the Consistency of the Prioritisation Practices 8 Strengthening Risk Mitigation 9 Strengthening Monitoring to Drive Effective Risk Reduction	2024/04	June 2025	1 closed action	-	-	6	2

Previous Year's Audit	Open actions	Report Number	Reported to Scrutiny Committee	Report Assurance level	Open Actions at 13 January 2026			
					C	H	M	L
User Access Management Northgate	2B CAR User Access Review 3B System Monitoring	2024/06	June 2025	3 closed actions	-	-	2	-
Payroll - Changes in Circumstances	2 Development of Payroll processing guidance 4 Calculation Tool Integration 7 Risk Management Framework	2024/08	June 2025	4 closed actions	-	-	2	1
Insurance (Contractor)	1 Creation of a Comprehensive Claims Management Handbook	2024/16	June 2025	3 closed actions	-	-	1	-

Definitions of Levels of Assurance

Comprehensive Assurance	The system of controls is essentially sound and supports the achievement of objectives and management of risk. Controls are consistently applied. Some improvement in relatively minor areas may be identified.
Substantial Assurance	Systems of control are generally sound, however there are instances in which controls can be strengthened, or where controls have not been effectively applied giving rise to increased risk.
Limited Assurance	Some satisfactory elements of control are present; however, weaknesses exist in the system of control, and / or their application, which give rise to significant risk.
No Assurance	Minimal or no satisfactory elements of control are present. Major weaknesses or gaps exist in the system of control, and/or the implementation of established controls, resulting in areas of unmanaged risk.

EQA definitions

Fully conforms - The assessment team concludes that the internal audit activity fully complies with all aspects of the PSIAS and the Application Note. All tests have been concluded as satisfactory and areas of good practice are likely to have been identified.

Generally conforms - The assessment team concludes that the internal audit activity has the relevant structures, policies, and procedures in place and these are applied in practice in all material respects. The majority of tests have been concluded as satisfactory and there is at least partial conformance in others. General conformance does not require complete / perfect conformance. Some areas of good practice and some minor areas of improvement may have been identified.

Partially conforms - The assessment team concludes that the internal audit activity is making efforts to comply with the requirements, is aware of the areas for development but falls short in some material respects. Some tests will have identified material areas for improvement.

Does not conform - The assessment team concludes that the internal audit activity is not aware of and is not making efforts to comply with the requirements. The majority of tests will have identified significant opportunities for improvement. The deficiencies will usually have a significant negative impact on the activity's effectiveness and its potential to add value to the organisation. Some deficiencies may be beyond the control of the activity and may result in recommendations to senior management and the Board of the authority being assessed.

OUTSTANDING INTERNAL AUDIT AGREED ACTIONS

Agreed actions from Internal Audit recommendations are recorded in Pentana and implementation is monitored by Services and the Risk and Assurance Board. Implementation of the agreed action is the responsibility of the service area, and the risk exposure identified in the audit remains in place until the action has been completed. New dates should be agreed for actions that were not complete by their original due date.

The numbers of outstanding actions in Pentana for each Service, by audit year, on 13 January 2026 are noted above against individual reports and summarised in the following tables.

- Table 1 - shows actions that have not yet reached their original agreed due date.
- Table 2 - shows actions that have had their due dates extended but are still not completed.
- Table 3 - shows actions overdue from their agreed due date, and which require a new date to be agreed.

At 13 January 2026 there were 84 open actions in Pentana, compared to 76 at 11 November 2025, 2 of which are critical and relate to on-going work in relation to LACD. There has been limited progress in closing actions, with 9 actions closed. 17 new actions have been added. Actions from reports presented to the February committee were not yet in Pentana as at 13 January 2026.

Table 1 - Actions not yet reached original agreed due date

Service	Audit Year	Critical	High	Medium	Low	Total
		No	No	No	No	No
City Development	2024/25	-	2	6	2	10
Corporate Services	2024/25	-	-	2	1	3
Corporate	2023/24	-	1	4	-	5
Neighbourhood Services	2024/25	-	1	-	-	1
Totals		**0**	**4**	**12**	**3**	**19**
11 November 2025 Totals		**0**	**4**	**12**	**4**	**20**

Table 2 - Actions with due date extended from original due date

Service	Audit Year	Critical	High	Medium	Low	Total
		No	No	No	No	No
City Development	2022/23		1			1
Chief Executive's Service	2022/23	2	-	-	-	2
Corporate Services	2020/21	-	1	-	-	1
	2021/22	-	1	-	1	2
	2022/23	-	4	2	3	9
	2023/24	-	6	2	3	11
	2024/25	-	-	3	-	3
Neighbourhood Services	2017/18	-	1	-	-	1
	2021/22		1	-	-	1
	2022/23	-	1	1	1	3
	2023/24	-	1	-	-	1
Totals		**2**	**17**	**8**	**8**	**35**
11 November 2025 Totals		**2**	**15**	**12**	**10**	**39**

Table 3 - Actions overdue from agreed due date

Service	Audit Year	Critical	High	Medium	Low	Total
		No	No	No	No	No
City Development	2023/24	-	-	3	1	4
Children and Families	2023/24	-	-	9	3	12
Corporate Services	2023/24	-	2	1	-	3
	2024/25	-	-	7	2	9
Neighbourhood Services	2022/23	-	1	-	-	1
	2023/24	-	1	-	-	1
Totals		**-**	**4**	**20**	**6**	**30**
11 November 2025 Totals		**-**	**3**	**11**	**3**	**17**

Definitions of Action Priority

Critical	**Very high-risk exposure to potentially major negative impact** on resources, security, records, compliance, or reputation from absence of or failure of a fundamental control. Immediate attention is required.
High	**High risk exposure to potentially significant negative impact** on resources, security, records, compliance, or reputation from absence of or non-compliance with a key control. Prompt attention is required.
Medium	**Moderate risk exposure to potentially medium negative impact** on resources, security, records, compliance or reputation from absence or non-compliance with an important supporting control, or isolated non-compliance with a key control. Attention is required within a reasonable timescale.
Low	**Low risk exposure to potentially minor negative impact** on resources, security, records, compliance, or reputation from absence of or non-compliance with a lower-level control**, or areas without risk exposure but which are inefficient, or inconsistent with best practice.** Attention is required within a reasonable timescale.

EQA action definitions

Critical Equivalent of High
Significant Equivalent of Medium
Routine Equivalent of Low

Critical	Equivalent of Critical above.
Significant	Equivalent of High above.
Routine	Equivalent of Medium or Low above - shown in table as Low.

REPORT TO: SCRUTINY AND AUDIT COMMITTEE – 04 FEBRUARY 2026

REPORT ON: INTERNAL AUDIT PERFORMANCE MEASURES AND INDICATORS

REPORT BY: CHIEF INTERNAL AUDITOR

REPORT NO: 27-2026

1. PURPOSE OF REPORT

This report seeks input and approval from the committee regarding published Internal Audit performance measures and indicators (KPIs) and provides an update regarding committee review of internal audit performance.

2. RECOMMENDATIONS

Members of the committee are asked to

(i) review the proposed measures and indicators of Internal Audit performance to be published in the Annual Internal Audit Report and agree them, or propose any required changes,
(ii) note that a review of other councils' published KPIs will be undertaken after the publication of Annual Reports in June 2026 to identify any other relevant KPIs that should be considered for adoption, and
(iii) note the proposal to obtain feedback about Internal Audit's performance from the Scrutiny & Audit Committee members when the annual self-assessment of the Committee is undertaken with members.

3. FINANCIAL IMPLICATIONS

None

4. MAIN TEXT

4.1. The new Global Internal Audit Standards applicable from 1 April 2025 in the UK public sector and Local Government (GIAS (UK Public Sector)) are more specific about KPIs than the previous standards. The following is an extract from the new Standards.

Standard 12.2 Performance Measurement

Requirements

The chief audit executive must develop objectives to evaluate the internal audit function's performance. The chief audit executive must consider the input and expectations of the board and senior management when developing the performance objectives.

The chief audit executive must develop a performance measurement methodology to assess progress toward achieving the function's objectives and to promote the continuous improvement of the internal audit function.

When assessing the internal audit function's performance, the chief audit executive must solicit feedback from the board and senior management as appropriate.

The chief audit executive must develop an action plan to address issues and opportunities for improvement.

5. CURRENT POSITION

5.1. In addition to reporting progress in implementing the Annual Internal Audit Plan to each Scrutiny and Audit Committee, key performance indicators and measures (KPIs) are published in the Annual Internal Audit Report that comes to the committee in June each year. The KPIs from the June 2025 Performance and Quality Assurance section in the report are noted in detail in Appendix 1 below.

These are:

- PSIAS Conformance and Quality Assurance and Improvement Programme
- Internal Feedback and Indicators
- Management agreed to implement xx% of the recommendations made
- Results from service user satisfaction questionnaires
- Other External Assessment

Review and proposed KPIs

5.2. The Internal Audit Strategy notes our key objective as delivering risk-based and objective assurance and advisory internal audit services. The proposed published KPIs are therefore related to demonstrating how well this is being achieved.

5.3. The Internal Audit team members in both Dundee and Angus were involved in the review of the KPIs. In addition to the published KPIs the internal performance management processes for managing audits were also discussed by the teams and will continue as they are and be kept under review.

5.4. CLT considered the proposed KPIs on 9 December 2025.

5.5. It is proposed to retain the current annual published KPIs noted in Appendix 1 with one exception and add the KPIs noted in Appendix 2 to the Annual Report for 2026 or from 2027 where data for the current year is not available. The exception is that the indicator “Management agreed to implement xx% of the recommendations made” will be removed because the way in which recommendations are made and agreed with services means that their acceptance is not a measure of internal audit performance.

5.6. Information considered in setting the proposed published KPIs:

- Review of the requirements of Standard 12.2 and consideration of the suggested measures included in the Standard (Appendix 3). Some of the suggested measures are for internal management purposes. Some others have not been included as Internal Audit does not have control over the timing of service input to audits and therefore these are not felt to be useful measures of internal audit performance.
- Benchmark information from June 2025 reported KPIs from other councils.
- The measures included in our current Internal Audit Strategy. Progress will be reported in the Annual Report.
- The Mandate and Charter identifies conformance with Standards as a KPI. This is already reported. There are a few internal measures that will be adopted relating to training compliance.
- Our current KPIs (Appendix 1). Information is currently also published about the planned work delivery and completion of actions, but not specifically as performance measures.
    - It is proposed to expand planned work delivery information and include this as new performance measures as per the table in Appendix 2.
    - Targets set are similar to those in benchmarked Councils
    - It is not proposed to change the reporting of action delivery to make it a performance measure since implementation is not internal audit’s responsibility. Information published will be reviewed for the 2025/26 report.

Elected Members feedback

5.7. The Standard requires feedback on Internal Audit performance from the Board/Audit Committee. A progress report is presented to every Scrutiny and Audit Committee meeting providing an opportunity for members to give comment.

5.8. It is proposed to obtain feedback on Internal Audit performance from the Scrutiny and Audit Committee members when the annual self-assessment of the Committee is uncertaken with the members, usually in April each year. The process for this is currently being developed. The results will be noted in the Committee's Annual Report and cross referenced in the Internal Audit Annual Report.

6. POLICY IMPLICATIONS

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.

7. CONSULTATIONS

The Council Leadership Team have been consulted in the preparation of this report.

8. BACKGROUND PAPERS

None.

Appendix 1 Performance Indicators reported in Internal Audit Annual Report 2024-2025
Appendix 2 Proposed new KPIs for inclusion in the Annual Report
Appendix 3 Measures suggested by Standards

CATHIE WYLLIE, CHIEF INTERNAL AUDITOR **07JANUARY 2026**

Performance Indicators reported in Report 179-2025 - 2024/25 Internal Audit Annual Report – extract

10. PERFORMANCE INDICATORS

PSIAS Conformance and Quality Assurance and Improvement Programme (QAIP)

1. The self-assessment of the Internal Audit Service undertaken in November 2023 for the EQA, and reviewed in April 2025, confirmed that the service operated in conformance with the PSIAS throughout 2024/25 with one minor non-conformance that is outwith our control. The non-conformance relates to the timing of the external review that PSIAS requires to be undertaken at least every five years. The EQA was initially scheduled to take place in 2022/23 within a compliant timeframe through the peer review process agreed by the Scottish Local Authority Chief Internal Auditors Group (SLACIAG). The reviewer delayed the review making it later than five years since the last review. Our self-assessment was provided in November 2023. The review has progressed since then but is not complete at June 2025 due to other commitments of the reviewer.

2. The last EQA performed for Dundee City Council, also undertaken using the SLACIAG peer review process reported in May 2018. The report concluded that "the Internal Audit activity within Dundee City Council fully conforms with 11 standards and generally conforms with the remaining 2 standards."

3. PSIAS requires the Chief Audit Executive to develop and maintains a QAIP covering all aspects of the Internal Audit Service. During 2024/25 the key elements of the QAIP were work to prepare for the implementations of the new Global Internal Audit Standards as they apply to the UK Public Sector.

4. A copy of the QAIP Action Plan, including progress updates against the actions outstanding at June 2024 is at Appendix C. It should be noted that the actions do not represent significant deviations from the PSIAS and are related to continuous improvements to keep up to date with good practice and make best use of available technology.

Internal Feedback and Indicators

5. As part of the continuous improvement process within the Internal Audit Service, client feedback questionnaires are issued at the conclusion of each planned audit review. Feedback from this process is used, where appropriate, to improve the quality of the Internal Audit Service going forward. During 2024/25, 10 (2023/24 five) completed client feedback questionnaires were received. Responses were very positive across four feedback categories. 98% (2024/25 100%) of responses agreed or strongly agreed with statements that the Audit Approach, Communication and Conduct, Timing and Audit Report were satisfactory. All of the returned questionnaires indicated that the review was beneficial to the client's area of responsibility.

6. Management agreed to implement 100% of the recommendations made (2023/24 100%).

Other External Assessment

7. The internal audit arrangements are assessed on an annual basis by the Council's External Auditor, which is a team from Audit Scotland. As part of this assessment, the External Auditor considers the activities of internal audit, principally to obtain an understanding of the work carried out and determine the extent to which assurance can be placed on its work. This approach helps to minimise duplication of audit coverage.

Appendix 2 Proposed new KPIs for inclusion in the Annual Report

Audit Plan Delivery

	Audits in plan	Audits B/F in June	Audits postponed or deleted	Audits added	**Total audits as adjusted in year**	Audits C/F at June	**Audits reported in year**	**Audits in draft at June**	**%age of adjusted plan delivered to final stage**	**%age of adjusted plan delivered at least to draft report stage**	**B/F complete or removed at June**	B/f but then c/f	**%age B/F completed in the year**
2023/24	21	14	7	0	**28**	17	**11**	**4**	39.3	53.6	**14**	0	**100**
2024/25	15	17	5	3	**30**	11	**19**	**4**	63.3	76.7	**13**	4	76.5
2025/26	22	11											
Target									65%	80%			100%

A narrative explanation for the figures will be provided.

The number of advisory (previously called consultancy) projects included in the plan will be noted

Compliance with Cipfa's statement on the role of the Head of Internal Audit in public service organisations.
This is currently published in Angus. It is proposed to self-assess against the guidance for Dundee City between now and April and publish the results in June. Governance elements of this statement have been replaced by the new Cipfa Code on Governance of Internal Audit, published in February 2025 and applicable from 1 April 2025. Other elements have requirements for both the Head of Internal Audit and the Council. From informal consideration of this to date a strong level of compliance, with only minor, if any, non-compliance, is anticipated.

CIPFA Directors of Finance section efficiency indicator shows the %age of productive hours discharged in comparison to planned productive hours. The number of days actually spent is currently published in another section of the Annual Report and will continue to be published for 2025/26. In order to change this in future planned hours will need to be allocated to the plan in April each year, beginning with April 2026 so that this can be calculated in June 2027. It is not time efficient to go back and do this for 2025/26.

The number of instances of additional advice sought will be reported. This will not be possible until 2027 as this has not been recorded fully in the period from 1 April to now and cannot be reliably re-created. This indicator will demonstrate the extent of internal audit's advisory activity with services beyond assurances and advice included in the formal reports.

Scrutiny and Audit Committee review of Internal Audit
The format and process for undertaking this has still to be agreed

Update on Internal Audit Strategy measures

Short-term by June 2026

- Full compliance with GIAS (UKPS) assessed in annual self-assessments and external Quality Assessments every 5 years, where resources make this level of compliance possible, or general compliance where resources make full compliance unreasonable.
- Joint working activity between Dundee and Angus internal audit teams
- Plan in place for provision of Chief Audit Executive post prior to end of current arrangement with Dundee and smooth transition to new arrangement

Medium term - over next 2 to 3 years

- Number of areas where digital/continuous audit is applied and reported regularly to management and audit committee
- All team members achieve Continuous Professional Development (CPD) requirements, Exam pass and career grade progression where applicable, and Support contract work integrated with annual internal audit plan where required
- Number of joint audits (with Angus) performed compared to the number of aligned and shared services assessed as high-risk areas

Measures suggested by Standard

Some of these are already reported or are internal management information. Some would be disproportionately time consuming to collect

Measure suggested by Standard	Current Position / proposed change	Published or Internal?
1. Coverage of engagement objectives expected to be reviewed according to the internal audit mandate	Publishing the extent to which the plan has been delivered through the new proposed table for item 6 below will address this	Published
2. The extent to which the internal audit conclusions at the level of the business unit or organisation address significant objectives of the organisation	The annual plan is linked to risk registers and Council objectives but given the size of the organisation the link to objectives is tenuous in some cases. Risk Impact is already discussed in reports and considered in individual audit planning, and then in the reporting of each audit as required. No meaningful KPI that can be measured, therefore no change.	N/A
3. The %age of recommendations or action plans completed by management that result in desired outcomes, as monitored by the internal audit function. Standard recognises this isn't only a measure of IA as management have responsibility to implement	We already publish data on total numbers of actions agreed and open actions in progress to each S&A committee and in the Annual Report. This is not an IA performance measure - the information currently reported is sufficient for information but not a KPI No change proposed.	N/A
4. %age of the organisations key risks and controls reviewed	The annual audit plan already notes the risks that are covered but not controls - these will be picked up in the audit testing programme. All corporate risks are usually covered in each annual plan. It is impractical for us to quantify the total number of controls in the council. No change is proposed.	N/A
5. Stakeholder satisfaction regarding understanding of engagement objectives, timeliness of engagement work, and clarity of engagement conclusions	Stakeholder satisfaction is already included in the annual report. It has been confirmed that the current questionnaire covers the areas suggested by the standards. No change needed.	Already published
6. Percentage of internal audit plan (as adjusted and approved) completed on time	The Annual Report currently provides information that could easily be used to calculate %ages. See Appendix 2 suggestion for additional information to be published	Published

7. Balance of assurance and advisory engagements in the internal audit plan relative to the internal audit strategy	The Strategy does not provide a target for each because the risk based annual planning will identify the optimal split for any given year. The number of advisory projects included in each annual plan will be noted.	Published
8. EQA reviews confirming internal audit conformance with the Standards	We already report this in Annual Report. No change required	Already published
9. Quality Assurance reviews confirming that adequate competencies are in place to perform the scheduled internal audit engagements	This is part of the audit file review process already in place. No change required	Internal
10. Internal auditor learning and development plans linked to the Internal Audit Strategy and the organisation's developing risks	This is being developed through application of the IIA competency framework and linking it with annual appraisal reviews - work in progress at the moment through the GIAS (UK Public Sector) implementation action plan.	Internal
11. Staff holding at least one recognisable certification relevant to internal auditing	Service leader and Manager/Team Leader posts require CCAB or IIA qualifications. Auditor posts have a career grade structure and CCAB or IIA is encouraged. This isn't a true KPI but will be included in enhanced resources information to be included in the 2026/27 Annual Plan and 2025/26 Annual Report	Published (with resource information, not as a KPI)