Governance, Risk and Best Value Committee

10.00am, Tuesday 15 December 2015

Internal Audit follow-up arrangements: status report from 1 July 2015 to 30 September 2015

Item number	7.1
Report number	
Executive/routine	
Wards	None

Executive summary

This report provides an overview of the process adopted by Internal Audit for following up the status of audit recommendations. It also identifies all the open audit recommendations at 30 September 2015 that are past their initial estimated closure date.

Links

Coalition pledges	
Council outcomes	
Single Outcome Agreement	

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

Report

Internal Audit follow-up arrangements: status report from 1 July 2015 to 30 September 2015

Recommendations

1.1 It is recommended that the Committee notes the status of follow-up actions and determine with which, if any, officers they want to discuss the status.

Background

2.1 Where follow-up actions in response to Internal Audit recommendations have not been taken by management in relation to critical, high and medium risks, escalation is to the Corporate Leadership Group (CLG) and GRBV.

Main report

3.1 At the end of each calendar quarter, Internal Audit prepares a complete listing of all open recommendations and shares these with Management on a divisional or line of service basis. Internal Audit then invites management to identify which recommendations they consider to have been addressed or which are no longer relevant.

3.2 Internal Audit will review Management's supporting evidence for recommendations that Management consider to be closed and feedback their view on whether this is the case. Recommendations that are agreed as closed; have their status updated in Internal Audit's records.

3.3 There are 5 high recommendations and 14 medium recommendations that remain open past their due date at 30 September 2015. These are split as follows:

Grading	***Reported to GRBV in Sept 2015***	***Closed***	***Management now tolerating risk***	***Newly overdue***	***Total***
High	3	-	-	2	5
Medium	12	(2)	-	4	14
Total	***15***	***(2)***	***-***	***6***	***19***

The details of these recommendations are shown in Appendix 1, with the 13 items previously reported to GRBV separately identified.

We have also tracked the number of overdue recommendations each quarter since we moved to the current approach of tracking overdue recommendations.

Grading	***Reported to GRBV in March 2015***	***Reported to GRBV in June 2015***	***Reported to GRBV in Sept 2015***	***Reported to GRBV in Dec 2015***
High	1	3	3	5
Medium	8	10	12	14
Total	***9***	***13***	***15***	***19***

Measures of success

4.1 The implementation and closure of Internal Audit recommendations within their initial estimated closure date. Where recommendations are not closed within this time period, the Committee can determine whether action to date is acceptable or if further action is required.

Financial impact

5.1 Not applicable.

Risk, policy, compliance and governance impact

6.1 If Internal Audit recommendations are not implemented, the Council will be exposed to the risks set out in the relevant detailed Internal Audit reports. Internal Audit recommendations are raised as a result of control gaps or deficiencies identified during reviews therefore overdue items inherently impact upon compliance and governance.

6.2 To mitigate the associated risks, the Committee should review the status of overdue recommendations presented and challenge responsible officers where there is concern that limited or no action has been taken.

Equalities impact

7.1 Not applicable.

Sustainability impact

8.1 Not applicable.

Consultation and engagement

9.1 An overview was provided at the Corporate Leadership Group (CLG) and each Director was made aware of responsibilities to implement and agreed internal audit recommendations.

Background reading/external references

Not applicable.

Magnus Aitken

Chief Internal Auditor

Links

Coalition pledges	PO30 - Continue to maintain a sound financial position including long-term financial planning
Council outcomes	CO25 - The Council has efficient and effective services that deliver on objectives
Single Outcome Agreement	
Appendices	Appendix 1 – Status report: Outstanding Recommendations Detailed Analysis

No	Review and Risk Level	Initial Finding & ***Recommendation***	Initially Agreed Management Action	Owner & Initially Expected Implementation Date	Last Status Update
Children and Families					
1	Access Controls for SEEMIS CF1406 ISS.1 Medium	There is no check performed to ensure that Children & Families staff who have access to the HQ unit are appropriate. ***A regular revalidation process should be created for all users in the HQ unit.***	We will put in place an annual audit of all HQ users and their profiles. We propose to carry this out near the end of August or beginning of September, to tie in with receiving the list of leavers from HR .	ICT Development Manager 30 August 2015	An exercise has been carried out to record HQ Area profile against HQ Users record. all 420 HQ users with the "HQ Area" profile. We have 27 different HQ areas that have access to SEEMIS. There will be an exercise conducted to contact the Manager/Lead Officer in each of these 27 areas and to confirm that the staff are correct and the staff profiles are appropriate. However, before that exercise is undertaken, it would be appropriate to complete the planned leavers exercise as it will also identify any HQ leavers. Revised Implementation date 31/12/15
2*	Access Controls for SEEMIS CF1406 ISS.3 (1) Medium	38 out of the 604 members of staff at schools who left in 2014 have not been removed from SEEMiS. This equates to 6% of all leavers covering a total of 24 schools. ***Training should be given on the importance of ensuring that users have appropriate access and changes to access rights are made in a timely manner. It should also be ensured that the appropriate individuals know how to generate a listing of users and can remove their access.***	The audit has identified that the 6% of staff leavers not marked as such on SEEMiS comes from just 24 schools. To address this we will contact those schools individually, remind them of the process required to remove staff leavers and the importance of so doing. In addition, we will make guidance available for all schools on the Orb. We don't consider a training course as such is required or appropriate – the information needed on marking staff leavers is minimal and can be communicated specifically to offending schools and in general by placing guidance on the Orb and within relevant other mailings (for example ScotXed).	ICT Development Manager 30 June 2015	As a result of the 2015 SEEMiS audit recommendations and our subsequent investigations into how schools record staff in SEEMiS, a number of unexpected scenarios have come to light. For example, some schools are creating generic staff accounts – they can only do this if they create made up NI numbers. Also, there are some staff records that are clearly non-CEC staff – Police Officers (presumably school based community police officers), nuns (in RC schools), duplicate staff records for the same person (with the same name, date of birth, postal address etc.) but with two different NI numbers recorded against each. We need to consider these anomalies and develop policy guidance for schools. Also, there are a number of SEEMIS records where the employee number does not match that contained in their HR records. There are a number of possible reasons for such mismatches and some work is needed to correct them. Revised Implementation Date 31/3/16

No	Review and Risk Level	Initial Finding & ***Recommendation***	Initially Agreed Management Action	Owner & Initially Expected Implementation Date	Last Status Update
3	Access Controls for SEEMIS CF1406 ISS.3 (2) Medium	38 out of the 604 members of staff at schools who left in 2014 have not been removed from SEEMiS. This equates to 6% of all leavers covering a total of 24 schools. ***A regular reconciliation of leavers per HR records (iTrent) to SEEMiS users should be performed to ensure that all leavers have had their access rights to SEEMiS revoked. This would not eliminate the need for the schools to perform a regular revalidation of users but would become an additional monitoring control. Schools would continue to be responsible for ensuring that the access rights of staff are appropriate and that access is removed when staff leave.***	It would be possible to arrange with HR (if they agree) to send a list of leavers for the September staff census, around the end of August or beginning of September, to our central SEEMiS systems administrator. For users based centrally who have left or changed role, our SEEMiS admin could simply mark them as leavers in SEEMiS. For school based leavers the list for this year would be a one-way list from HR to C&F , not a bi-directional list facilitating SEEMIS data being given to back to HR.	ICT Development Manager 30 August 2015	Leavers information has been received from Business Intelligence and Reports are being developed to match these records against SEEMIS. Employee reference is not mandatory on SEEMIS so lack of unique identifier makes this an onerous task. The data is currently being analysed to identify the best solution. Revised Implementation Date 31/3/16
Health & Social Care					
4*	Personalisation & SDS - Stage 2 RS1245 ISS.2 High	The Swift system has the capability to support authorisation controls, however, the cost threshold is currently set at £20K per week, potentially equating to £1.04M a year. This is such a high level that in effect, there is no authorisation process operating within the Swift system to prevent a service being attached to a client without approval. ***A control mechanism be introduced within the Swift system (or the new Adult Integration System) which ensures that no package of care service can proceed to conclusion within the Swift system without the appropriate approval being met.*** ***Exception Reports should be produced which highlight any services that have been attached to the system, which do not have the appropriate approval.***	A new Financial Approval Procedure will be produced which will ensure that all requests for care and support are approved before progressing to Business Services to be input to SWIFT. The Procedure will detail: 1 who can authorise what placement/ service/budget and their level of authorisation; 2 the mechanism through which authorisation will take place; 3 the monitoring and quality assurance measures to be put in place to ensure compliance with the procedure; and 4 Reports will be developed and tested to ensure staff comply with the procedure. 4-weekly automated payment reports will also be updated to include details of the Budget that has been approved on SWIFT and who authorised the spend along with the payment amount.	Research & Information Manager 30 June 2015	A review of the business requirements for the SWIFT system has been undertaken; following which it has been agreed that full use should be made of the budget management facilities within SWIFT. This work is being taken forward through the transformation programme put in place as a result of the work undertaken with KPMG. The SWIFT element of this work is expected to be complete by June 2016 and is being overseen by the SWIFT Governance Group which was established in July 2015. Business Services to update the End to End Business Processes to reflect any changes and produce a new Financial Approval Procedure to accompany the SWIFT process for all HSC staff.

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5*	Personalisation & SDS - Stage 2 RS1245 ISS.4 High	Our audit testing sample was extracted from the report titled "Services 1 – All Open Services (AB) 19.09.13". Analysis of this report highlighted that a number of the fields within a number of client records were either noted as 'Not recorded' or had the following entered ", ()". Additional analysis of the 'Service Actual Start Date' showed that: - 1 The earliest 'Service Actual Start Date' entered was 26 April 1963. This particular service was classified as 'Older People with Support Needs', however the client's date of birth is 12-Apr-1947 suggesting that the client was 16 when the service commenced; and 2 The latest 'Service Actual Start Date' noted was 16 April 2016, roughly two years seven months from the date of the 'open services' report. ***Data should be classified in order to establish information which is 'critical' to each stage of the process. All essential data should be cleansed. Data quality control checks should be established and undertaken on a regular basis. Highlighted issues should be incorporated into the service area's training and awareness programme.***	The need to identify critical data items and agree how these will be recorded has already been identified. A key part of this work will also be determining the quality assurance measures required in relation to key data. As part of this exercise the wide range of data quality reports that already exist will be reviewed with a view to removing reports that are no longer required, developing new reports if necessary and amending others. At the completion of this exercise a document will be produced detailing all data quality reports available and in respect of each report: 1 the purpose of the report; 2 where the report is located; 3 how the report is accessed; 4 who is responsible for maintaining the report; 5 who is responsible for running the report and at what frequency; 6 who is responsible for actioning the report and at what frequency; and 7 quality assurance arrangements in terms of monitoring that the report has been actioned and escalation arrangements if it has not.	Research & Information Manager 30 June 2015	Work to identify essential data and means of ensuring data accuracy, via reports or SWIFT functionality, is being taken forward through the review of SWIFT overseen by the SWIFT Governance Group. The key action is to produce and implement a data quality strategy and implementation plan. The Data Quality Strategy is expected to be complete by December 2015; development of supporting procedures re identification and resolution of data anomalies is expected to be complete by January 2016.
6	Personalisation & SDS - Stage 3 HSC1402 ISS.1 High	The roles and responsibilities of the 'Option 2' process have not been clearly defined. There is a lack of understanding of the roles within the process that the following teams are responsible for: - Contracts and Commissioning Teams - Sector Services - Business Services In addition, there is no overall owner of the 'Option 2' process. ***Roles and responsibilities are clearly defined and communicated to all relevant staff and management in order that they can obtain an understanding of what is expected of them.***	Responsibility will sit with the person nominated as the 'Owner of the Option 2 process. The owner will be agreed at the Personalisation Programme Board meeting to be held on 4 June 2015. It is envisaged that the actions taken would include a workshop involving key staff from the teams identified to agree a clear and coherent business process detailing specific roles and responsibilities. The agreed process will be documented for approval via the Health and Social Care Performance Improvement Meeting .T he agreed process will be communicated to all staff through the existing Health and Social Care Procedures Process .	Contracts Manager 31 July 2015	Final roles and responsibilities within contracts, commissioning and business support services to be determined by future structure as affected by the H&SC Infrastructure Review, Health and Social Care Integration, Council-wide Transformation agenda. Individual Service Fund Procedure is being developed by Business Services and input is required from the Contracts Team. On completion, this will be communicated to all staff in H&SC. Target October 2015. The procedure has now been edited by the Contracts Team and is with a group looking at 'guidance for practitioners' so they can provide feedback

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7	Personalisation & SDS - Stage 3 HSC1402 ISS.3 High	To comply with "Statutory Guidance" accompanying the Social Care (Self-Directed Support) (Scotland) Act 2013" it is essential that the two forms of monitoring - welfare and financial - are co-ordinated to ensure that the person's outcomes are being met and the authority's funding is being used in line with those outcomes. In respect of 'Option 2' the process spans over a number of areas including contracts and Commissioning Teams, Sector Services and Business Services, Service Accounting and Social Work Quality Assurance and Standards Section It is acknowledged that there are a number of monitoring processes in place, but the audit review has highlighted that there are key control areas within the monitoring process which have still to be fully determined. ***The monitoring requirements of the 'Option 2' process require to be fully ascertained for each of the service areas. A mechanism be introduced to ensure that a co-ordinated approach is developed between each of the services areas to ensure that the monitoring requirements of the ' Option 2 ' process (both through the SDS legislation and the Individual Services Fund Agreements) are met.***	Operational monitoring takes place through the social work review process. Any issues identified in relation to the standard of care or financial probity are referred back to Business Services and/or the Contract and Commissioning Teams as appropriate. Probity issues or concerns identified by the Contracts, Commissioning and/or Business Services Teams would be referred to the relevant Head of Ser vice and an agreement on how these concerns were to be managed, including communication to operational staff agreed and documented. Existing procedures will be amended to explicitly include the appropriateness and operation of the SDS option in place and include controls to ensure:- - Providers are meeting the requirements of the ISF agreement. -Personal plans agreed between the provider and Supported Person reflect the needs and outcomes agreed through the assessment process. - Care manager agreement to the Personal Plan is made within the 14 day time limit. - The Individual Service Fund does not commence until the criteria within clause 25.3 of the agreement has been met. - Individual Service Funds are appropriately managed by the Provider on behalf of the Supported Person'.	Contracts Manager 31 July 2015	Effective Monitoring will be the joint responsibility of Business Services Manager and the Contracts team with Business Services as the lead. The Contracts team will be responsible for monitoring the quality of services provided: Business Services will be responsible for ensuring finances and the budget are managed Target December 2015 The audit process has been up and running for several months. A meeting is being arranged with the three current providers to discuss the process and any possible improvements.
8*	Personalisation & SDS - Stage 2 RS1245 ISS.5 Medium	The audit review highlighted a lack of awareness of the type of management information and / or exception reports which are available to 'operational managers'. It was also established that there is no management information for some types of care packages which are 'spot' purchased. In addition, there is an inconsistency in approach for a number of the Swift reports which are produced in respect of the type and frequency of checks being carried out. ***Management Information / exception reports held within the Swift and Business Object systems are reviewed to ensure that the right people are receiving the right information at the right time to allow managers to make informed decisions over key controls / processes such as the monitoring of care package costs.***	Management information requirements will be reviewed in the light of the implementation of self-directed support and reporting requirements identified. As part of this exercise existing reports will be reviewed and a decision made in each case as to whether they should be retained, amended or dropped; any requirement for new reports to be developed will also be identified. At the completion of this exercise a document will be produced detailing all management information reports available.	Business Services Manager 30 June 2015	The lack of data in relation to spot purchased care will be addressed through budget management via the SWIFT workstream detailed in the response to action 4 above. As an interim measure, Finance colleagues have developed a suite of reports, which combine data from SWIFT with Oracle budget data which is provided to sector managers on a weekly basis, to support them in budget management. Training has been provided to relevant managers in how to interpret these reports.

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9*	Personalisation & SDS - Stage 2 RS1245 ISS.6 Medium	Packages of care are currently not checked against the relevant financial budgets during the approval process. ***Financial budgets should be considered at authorisation stage for packages of care. Any costs which will exceed approved budget levels should be agreed by senior management prior to approval.***	A new budget structure is currently being developed in response to the changes required by the Self-directed Support Legislation. Work around the implementation of this structure will include a review of authorisation levels, responsibilities and process.	Head of Older People & Disability Services 30 June 2015	A review of the business requirements for the SWIFT system has been undertaken. Following which it has been agreed that full use should be made of the budget management facilities within SWIFT, including budget authorisation with the ability to view impact on overall budget. This work is being taken forward through the transformation programme put in place as a result of the work undertaken with KPMG. The SWIFT element of this work is being overseen by the SWIFT Governance Group established in July 2015 and is expected to be complete by April 2016. As an interim measure, Finance colleagues have developed a suite of reports, which combine data from SWIFT with Oracle budget data which is provided to sector managers on a weekly basis, to support them in budget management. Training has been provided to relevant managers in how to interpret these reports.
10	Personalisation & SDS - Stage 3 HSC1402 ISS.2 Medium	The following process, procedure documents and guidance notes which encompass the 'Option 2' process have been produced: -End to End Process which was approved by Head of Service in February 2015 -Contract Management Framework Document - Reviewed July 2014 -Business Services: Individual Service Fund Procedure (Draft) -Swift Payments Administration Process: Individual Service Fund -Swift Community Care Finance: Recording Services for Individual Service Fund Payments The audit review has highlighted that there is no overall ownership of the documentation with a group 'Lead' still to be determined. There are a number of processes which have either changed or are still to be determined in each stage of the process, resulting in these procedures requiring to be updated. Within the governance arrangements for the 'Phase 2' of the Personalisation and SDS programme it is noted that the Business Process Review Group purpose is to "Progress the collaborative approach taken to defining the 'As Is' processes and identify opportunities for improvement". ***All business processes should be brought up to date; control issues addressed where indicated and rolled out to the appropriate responsible officers.***	Responsibility will sit with the person nominated as the 'Owner of the Option 2 process. The owner will be agreed at the Personalisation Programme Board meeting to be held on 4 June 2015. The Business Services Manager will ensure that all control issues are addressed and once the business processes for Option 2 have been documented, the Business Services Manager will ensure that current processes are updated and circulated to reflect these.	Business Services Manager 31 August 2015	Business services will be the lead. Processes have been drafted and tested and will reviewed as part of the ongoing work to review all SDS processes. This will be complete by December 2015.

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11*	Care Plan Reviews HSC1302 ISS.8 Medium	The service start date, assessment date, review date, and future reviews should be documented on Swift, along with client and care details. We tested a sample of 30 case files with a service start date of June 2013. We found that records were variously recorded on Swift, the G: drive and e-Assess. We understand further case notes may also be stored in hard copy. Due to incomplete and inaccurate data on Swift, we were unable to complete our planned testing of case review documentation. ***All care events should be documented accurately and completely on Swift.***	The implementation of the AIS assessment tool should bring about standard recording of reviews on SWIFT. It is also planned that all clients will only have one assessment recorded on SWIFT with all subsequent re-assessments being recorded as reviews.	Business Development Manager (Sector Services) 31 March 2015	The AIS assessment tool has now been implemented. Part of the implementation was creating a new assessment type called My Steps to Support Review, which is used to record a request for an assessment when a client has previously had an assessment. This means that any subsequent assessments will be recorded as reviews.
12*	Procurement RS1225 ISS.1 Medium	The relationship between the Contracts Team and Planning & Commissioning teams for monitoring is not formally defined. While the Contracts team and Planning & Commissioning teams work in conjunction to monitor service provision, separate responsibilities with regard specifically to the monitoring process are not clear. ***The roles and relationships between the separate teams covering contract monitoring and service provision monitoring should be clearly defined and communicated to all key staff.***	Scheduled for discussion/response at December 2013 Senior Management Team	Contracts Manager 30 June 15	This action point remains 'Ongoing' as the roles and the responsibilities will be defined as part of the current infrastructure review. The report on the Infrastructure review proposals have not yet been made available and require approval. It is expected that he proposals will be available by the end of August 2015
Services for Communities					
13*	Key IT Systems Access Control CG1307 ISS.16 High	It is understood from the auditees, and initial contact with BT, that no logging is carried out of system access or activity. Whilst it is possible to establish if a specific record has been access it is not possible to determine if any updates/changes have been made or by whom. This applies to both user and non standard user activity. The system privileges afforded non standard users make this of particular concern for these users. ***"1. Clarification is sought from the system vendor (Northgate) on what logging functionality is available.*** ***2. Clarification is sought from BT as to what logging functionality is currently enabled and if any review thereof is carried out.*** ***3. A risk based assessment of Northgate system access and activity be conducted and aligned with the logging functionality required to address the identified risks. With the resulting logs requiring to be appropriately reviewed."***	1. 2. & 3. Agreed. The above will be carried out as part of the SfC Transformation Programme Security Review workstream, with appropriate liaison and alignment with Corporate Governance.	Operational ICT Programme Manager, Business Improvement Team, 30 June 2015	SfC 2/6/15 Clarification is currently being sought from BT and Northgate as to what activities are logged and auditable. [Revised Target Date – July 2015]

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14*	School Meals CF1402 ISS.4 Medium	For the in-house service, the full cost of provision of all meal types is agreed between Services for Communities (SfC) and Children & Families (C&F). Historically, an annual inflationary increase has been applied based on RPI, however for 2013/14 and 2014/15, no agreement has been reached, therefore current costs recharged are still per charges in place as at April 2012. ***Senior Management within SfC and C&F need to formalise the budget and recharge arrangements going forward to allow future planning.***	The Head of Corporate Property, Finance Managers from SfC and C&F will seek to formalise the recharge process going forward.	Acting Head of Corporate Property 30 April 2015	This action remains open.
15*	Review of Controls Around Fuel Storage at Depots RS1246 ISS.5 Medium	City Fleet and Road Services do not have clearly defined roles and responsibilities for Council fuel resilience. Roads Services and Fleet Maintenance are not aware of any policy, procedure or strategy documentation in relation to fuel resilience. The Roads Manager stated that the fuel storage level which triggers the ordering of fuel has been significantly increased since the last fuel crisis. Fleet Maintenance are currently undergoing a rationalisation review which will consider fuel supplies and are working on a new Fleet Strategy which will include the provision of fuel supplies. ***A fuel resilience procedure should be drawn up by the division in liaison with the Corporate Resilience Unit.***	City Fleet and Roads Services will seek to work with the Corporate Resilience Unit to develop a central approach to fuel resilience.	Fleet Services Admin & Finance Controller 31 March 2015	Work has concluded to incorporate the fuel management system in Bankhead Roads Depot, into Fleet Services existing system and then the Fleet inspection regimes. Work is still ongoing between Fleet services, Business Continuity and the Emergency Planning Officer on the development of a policy to ensure resilience of fuel stocks. This workstream is currently still outstanding and will not be fully resolved until September 2016 when the Council fuel management system is renewed and upgraded. In the meantime, however, work is ongoing to have firm business continuity plans in place to ensure there is fuel resilience. This will include the researching of the potential for use of corporate fuel cards for external fuel suppliers (e.g. petrol stations) Expected Completion 30 September 2016
16*	Property Rationalisation SFC1306 ISS.2 Medium	From a review of the IPD report and controls discussions, it was noted that the quality of information which is presented to the Property Rationalisation Unit is not always adequate to make informed decisions about property rationalisation. The data from each asset varies in quality, meaning that the council cannot fully assess the expenditure and income from revenue streams operating within each property. The reports which are received require further work before information is of sufficient quality for decision making. This makes it hard to track performance and to get reliable data for all assets held by the council. ***We recommend that the method of reporting on asset usage be updated to ensure that a clear Property Rationalisation Strategy can be developed. This will support better data sharing and more efficient performance reporting on buildings.*** ***Where required, the systems should be updated or reporting methods changed to ensure that the same information can be presented for all properties to allow direct comparisons to be made, ensuring that the strategic plan is correct and making best use of the Council's properties.***	The Council's new Computer Aided Facilities Management (CAFM) system for property data is currently being introduced to improve access to data at individual property level. This will enable us to capture all data required to report real time for all KPI's. The CAFM solution will also provide asset management, asset tracking and trend analysis functionality and the ability to report on historical data	Asset Strategy Manager 31 October 2014	Phase 1 of CAFM is now expected to be completed by 31 August 2015.

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17*	CAFM - Corporate Property SFC1406 ISS.2 Medium	There are only two buildings from the Council's estate currently using CAFM meaning that for majority of the buildings within the Council, the AS400 system is still being use. The intention is to migrate the remaining property assets into the CAFM system as part of Phase 2 along with the implementation of new modules. The delivery of the CAFM solution is behind schedule, however, the implementation team anticipate that given the correct resource requirements and investment, the CAFM will progress and be delivered within the revised timelines ***The Council should ensure that Phase 1 of the CAFM project is completed within the revised timetable.***	We will close out all outstanding issues relating to Phase 1 and ensure Head of Service signs off phase 1 as complete.	Management Information Officer 31 March 2015	The timetable has slipped further and it is now expected that phase 1 will be completed by 31 August 2015
18*	CAFM - Corporate Property SFC1406 ISS.3 Medium	Although the Facilities Management (FM) Managers have been trained to use CAFM, update training is required before CAFM is implemented for all buildings managed by FM. This update training has been prepared, but does not include any specific written guidance on areas where there are likely risks of errors, or specifically what the FM manager is to look at when reviewing a works order. ***FM managers training should include information on risky areas and common errors, as well as giving them guidance on what they should look for when approving a works order. Some form of checklist or lessons learned document should be used to advise them on likely errors.***	We will produce an agreed training plan for all Corporate Property staff and ensure that the correct resource is made available to roll out the training, including areas of risk, governance and reporting.	Management Information Officer 30 May 2015	Systems Administration training has been provided. The Training plan for the overall roll out has still to be drafted.
19	Property Disposals SFC1503 ISS.1 Medium	To ensure that conditions of sale are properly tracked and monitored, the Capital Receipt Programme database used by Estates Services to monitor the Council's Capital Receipt Programme has been expanded to record details of any sale conditions that require monitoring. Out of a total of 111 properties entered since April 2010, there were 21 entries with missing/incomplete information. ***The estates team should investigate the 21 properties to determine if there are any outstanding conditions of sale and update the Capital Receipt Programme database accordingly*** .	The estates team has made significant progress since the audit fieldwork and has reduced the number of entries with incomplete information to 2 properties (1 of which has 2 entries for phased payment structure). It is expected that the status of these properties will be determined and the Capital Receipt Programme database updated by the end of July 2015. .	Acting Estates manager (Disposals) 31 July 2015	No update received.
* Previously reported to GRBV as outstanding					