Governance, Risk and Best Value Committee

10.00am, Thursday 3 March 2016

Internal Audit follow-up arrangements: status report from 1 October 2015 to 31 December 2015

Item number	7.2
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 31 December 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 October 2015 to 31 December 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 Team (CLT) 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 4 high recommendations and 18 medium recommendations that remain open past their due date at 31 December 2015. These are split as follows:

Grading	***Reported to GRBV in December 2015***	***Closed***	***Management now tolerating risk***	***Newly overdue***	***Total***
High	5	(2)	-	1	4
Medium	14	(8)	-	12	18
Total	***19***	***(10)***	***-***	***13***	***22***

The details of these recommendations are shown in Appendix 1, with the 10 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***	***Reported to GRBV in March 2016***
High	1	3	3	5	4
Medium	8	10	12	14	18
Total	***9***	***13***	***15***	***19***	***22***

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
Communities and Families					
1	Anti-Fraud Arrangements CG 1507 ISS.2 Medium	The Council's Policy on Fraud Prevention, Anti-Bribery Policy and Procedure, and Employee Code of Conduct demonstrate a clear culture against bribery, fraud and corruption. Mandatory induction and annual refresher training is in place and communicated widely to ensure Corporate compliance with relevant laws including the Bribery Act 2010. Completion of this training must be recorded on myPeople, the HR system. At the time of the audit, seven weeks after the deadline for completion of annual mandatory policy awareness training, only 37% of employees are recorded in myPeople as compliant. Economic Development were 92% compliant and the other service areas ranged from 14% - 64% It is noted that escalation has been cascaded by HR Business partners, and a cross-departmental working group is being set up to tighten controls although this has not yet met ***Action should be taken by the Director and Senior Management Team to evidence compliance with this mandatory training.***	Children & Families will promote the completion and recording of the Mandatory Annual Refresher and sign off through specific management communication channels (Heads of Service), the use of the CPD Directory, reference to the Mandatory Annual Refresher at Leaders Induction and the use of Risk Matters to achieve the compliance required by the end of the year.	Director of Children & Families 31 December 2015	Senior Officers were sent a reminder to follow up with managers to ensure all staff complete the training as a matter of urgency. In addition revised guidance was circulated to CF managers on recording this information on Trent as current guidance does not match the upgraded functionality in Trent. Update Completion statistics have been requested to evaluate the impact of the latest circular. Heads of Service will be reporting back on progress to the Executive Director on 16.02.16
Health & Social Care					
2*	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	Update 3/02/2016: This work is being taken forward through the Health and Social Care Transformation Project (Governance, Devolved Budgets and Budget Management), which will identify and oversee all the workstreams required to implement delegated budget management. The SWIFT element of this work is expected to be complete by September 2016 and is being overseen by the SWIFT Governance Group. However, the Organisational Review of ICT has led to a reduction in capacity in the SWIFT Team and discussions are now underway to ensure that the necessary skills and resources remain available to the project. Further considerationof any additional risks that the implementation of a new threshold & decision making process has the potential of introducing further delay to the decision making process.

No	Review and Risk Level	Initial Finding & ***Recommendation***	Initially Agreed Management Action	Owner & Initially Expected Implementation Date	Last Status Update
3*	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	Update 3/02/2016: Work to identify essential data and means of ensuring data accuracy, via reports or SWIFT functionality was addressed through the review of SWIFT overseen by the SWIFT Governance Board. The key action was to produce and implement a data quality strategy and implementation plan. The Data Quality Strategy was approved by the SWIFT Governance Board in December 2015; a draft data quality scorecard has been developed to address the 7 priority data quality items (which includes inaccurate open services) and work is underway to monitor and address these. The scorecard will be issued during the week beginning 8 February 2016.

No	Review and Risk Level	Initial Finding & ***Recommendation***	Initially Agreed Management Action	Owner & Initially Expected Implementation Date	Last Status Update
4*	Integration - Health and Social Care HSC1501 ISS. 1 High	It has been agreed that during the transition year (1 April 2015 to 1 April 2016), once the EIJB is fully established and ready to have functions delegated to it, the leadership group will stand down in its current form. However, there is not yet clarity around what will replace the leadership group, what the format will be and which stakeholders will be included. The CEC Finance and Resources Committee, NHS Lothian and members of the shadow EIJB have supported and approved an outline structure of a future group "in principle" however the detailed structure remains to be agreed. The elements of the arrangements where agreement remains to be reached includes the extent of which administrative, technical and professional services will be delegated (or provided via a Service Level Agreement) to the EIJB. ***A clear remit for the group to replace the current leadership group and how this will interact with the EIJB should be agreed. This should include the composition of the membership, as well as how the reporting structure will operate.***	**Management Response** The remit of the current Leadership Group is to establish a fully functioning EIJB in readiness for formal delegation of functions to it. It will not be stood down until this work is completed, which will not be before December 2015. Plans are underway to establish relevant groups to function after 1 April 2016. **Management Action** The role and membership of the replacement joint stakeholder group will be developed by December 2015. Work has started on this in relation to a 'Risk Sharing' stakeholder arrangement. This timeline fits with that for developing and approving the statutory Strategic Plan which is the pre-requisite for the delegation of functions to the EIJB.	Integration Project Manager 31 December 2015	Update 3/02/16: The December Joint Leadership Group meeting at which this should have been discussed was cancelled. The item was carried forward to January meeting. The revised draft is currently with the Chief Officer along with the proposed tripartite agreement between NHS Lothian, Council and Edinburgh IJB. The Joint Leadership Group is on the 23rd February where it will be signed off – following inclusions of comments received on 18 January. **The delay on the deadline for this item does not create a gap or any risk at the moment because:** From 1 April 2016, the EIJB will be the formal joint governance body for integrated budget and functions and the existing Joint Leadership Group is scheduled to stand down at the end of March. Everything is on track for the major elements of this to be delivered. The replacement group will be an informal key stakeholder arrangement that will meet in line with quarterly reporting as identified in the Integration Scheme. While the deadline in the Audit report was the 31st December, an early deadline to ensure that it was sorted by 1 April 16. This gave 3 months tolerance ahead of the actual need for the arrangements - to handle the inevitable complexities in the integration work and as it turns out we have needed it.
5*	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	Update 3/02/2016: This work is being taken forward through the Health and Social Care Transformation Project (Governance, Devolved Budgets and Budget Management), which will identify and oversee all the workstreams required to implement delegated budget management. Interim reports are being enhanced to include financial information for budget managers to inform their decision making in relation to purchasing care. Training on these reports has been given (by Corporate Finance colleagues).

No	Review and Risk Level	Initial Finding & ***Recommendation***	Initially Agreed Management Action	Owner & Initially Expected Implementation Date	Last Status Update
6*	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	Update 3/02/2016: This work is being taken forward through the Health and Social Care Transformation Project (Governance, Devolved Budgets and Budget Management), which will identify and oversee all the workstreams required to implement delegated budget management.
7	Business Objects Management Information HSC 1401 ISS. 2 Medium	There is currently no formal suite of BO procedures giving guidance over the following; - Preparation and amendment of data mining reports and queries; - Dealing with data anomalies including the escalation of concerns to Senior Managers; or · Documenting roles and responsibilities including role specific requirements. At present there is no requirement to retain an audit trail to support requests for reports and secure folders, in the H&SC G\drive partition, to be produced/opened, amended, moved or deleted. As a result information retained to modification requests is inconsistent. There is no documentary evidence showing the controls in place over the issue and removal of the limited developer licences. ***Procedures should be formally documented setting out the process from the initial request and its authorisation, through to the issue of the final report/ report data.*** ***Once prepared the procedures should be communicated to all staff using BO or BO reports, and evidence should be retained to show they have been received and understood. These procedures should be review regularly to ensure that they remain current.*** ***The procedures should include guidance on the documentation to be retained to support report creation, activity and deletion.*** ***Procedural and documentary evidence should be prepared and retained showing control over the issue and removal of developer licences.***	We will create a Reports Review Panel that will be tasked with taking forward the recommendations of this report along with the ongoing governance of the reporting mechanisms for Health and Social Care: A comprehensive work stream scoping this strand of the work has been provided.	Research & Information Manager 31 December 2015	Update 3/02/2016 : this work was led by the SWIFT Implementation Manager. A meeting has been arranged with Internal Audit colleagues (11/02/2016) to discuss progress and remaining actions.

No	Review and Risk Level	Initial Finding & ***Recommendation***	Initially Agreed Management Action	Owner & Initially Expected Implementation Date	Last Status Update
8	Business Objects Management Information HSC 1401 ISS. 8 Medium	The Research and Information team were the only development team to have a contingency plan in place for accessing BO reports should Waverley Court become inaccessible. However this was not written in a formal document nor communicated to key officers. Neither the Business Services team nor Swift Implementation and Development team had any continuity plans in place for accessing reports in the event of the closure of Waverley Court. ***There should be a contingency plan put in place to prevent critical reporting data being inaccessible in the event of the closure of Waverly Court, leading to delays in work or breach of legislation requirements.***	As part of the procedures production reference will be made in relation to the business continuity processes in the event of a closure at Waverley Court. This will be done in consultation with the Resilience and ICT teams. This part of the process will provide clarity on who has responsibility for running essential reports, confirmation of what the essential reports are and who will need them and how this information will be provided to those who need it. This will provide written clarity and manage expectations in relation to what happens if there is a closure of Waverley Court.	Research & Information Manager 31 December 2015	Update 3/02/2016 by Research & Information Manager: this work was led by the SWIFT Implementation Manager. A meeting has been arranged with Internal Audit colleagues (11/02/2016) to discuss progress and remaining actions.
9	SWIFT - Access Controls HSC1502 ISS1 Medium	There is no regular review of an individual's user access rights to check their access remains appropriate. ***A regular revalidation of all users should be performed. Line managers should check each individual's access to Swift and that the type of access they have is appropriate.***	On a six monthly basis, managers will be sent a report detailing all active end user accounts listed against the teams they manage, requesting active confirmation that access rights for all these individuals is correct. This will have a confirmation turnaround date of 2 weeks. Failure to comply will be escalated to Swift Governance Board. These reports will be circulated in November and May.	Swift Programme Manager 31 December 2015	Update 3/02/2016: A report is being prepared for the SWIFT Governance Board on 22 February to provide options to the group so that they can decide on the approach to be taken to manage and monitor the risk of inappropriate access to individual levels.
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 and that 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.***	The actions to be taken to clarify the business processes, roles and responsibilities in relation to Option 2 are set out in response to Finding ISS.1. 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.	Research & Information Manager 31 December 2015	Update 3/02/2016: Business services have drafted, tested and reviewed processes as part of the ongoing work to review all SDS processes. Revised processes have now been published on the Orb. Further process review will take place as part of the Health and Social Care Transformation Project (Governance, Devolved Budgets and Budget Management) which is underway. The move to locality working will also require a full review of current processes and process redesign.

No	Review and Risk Level	Initial Finding & ***Recommendation***	Initially Agreed Management Action	Owner & Initially Expected Implementation Date	Last Status Update
Place					
11*	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	There are designated staff both within Roads and Fleet Services who have responsibility for monitoring fuel stocks and ensuring that they are kept at or above the recommended minimum levels. The Road Services fuel depot will be brought under the management of fleet Services as part of the Environment Service Review. A single integrated fuel management system for all council fuel depots is also to be procured this year. Council fuel stocks have been increased at Russell Road and Bankhead, and Council wide are in excess of the minimum levels recommended by existing national guidance. Existing national guidelines have not changed and the Council's existing protocols are still applicable and being worked to by Fleet Services. Scottish Government are planning a revision later this year this is dependent on the UK government updating UK wide arrangements.
12	Anti-Fraud Arrangements CG 1507 ISS.2 Medium	The Council's Policy on Fraud Prevention, Anti-Bribery Policy and Procedure, and Employee Code of Conduct demonstrate a clear culture against bribery, fraud and corruption. Mandatory induction and annual refresher training is in place and communicated widely to ensure Corporate compliance with relevant laws including the Bribery Act 2010. Completion of this training must be recorded on myPeople, the HR system. At the time of the audit, seven weeks after the deadline for completion of annual mandatory policy awareness training, only 37% of employees are recorded in myPeople as compliant. Economic Development were 92% compliant and the other service areas ranged from 14% - 64%. It is noted that escalation has been cascaded by HR Business partners, and a cross-departmental working group is being set up to tighten controls although this has not yet met ***Action should be taken by the Director and Senior Management Team to evidence compliance with this mandatory training.***	Low levels of compliance has been added to the SfC Risk Register. Actions to address this include reminding service managers of their requirement to ensure their staff complete mandatory training and that this is appropriately recorded on myPeople. Where access to online resources is an issue or there are other access challenges, SfC's Learning and Development staff will support service managers and staff teams.	Executive Director of Place 31 December 2015	The Mandatory Training Review team (cross directorate working group) have collated requirements from each service and are in the process of establishing mechanism for notification, recording and monitoring of compliance requirements. The Review team will report the progress to CLT

No	Review and Risk Level	Initial Finding & ***Recommendation***	Initially Agreed Management Action	Owner & Initially Expected Implementation Date	Last Status Update
ICT Function					
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	An examination was carried out on what functions on Northgate were not auditable. Whilst it was found that the viewing of records was not audited or recorded, all significant updates of records were, with the exception of system configuration changes including the creation and amendments of user accounts. BT were asked as to what was necessary to theoretically address either of those issues. They said that the logging of "read" activity on the database could be enabled via Apex Oracle database releases, but it was felt that this would cause performance issues, would involve a change request at an unspecified cost, and could not be guaranteed to be incorporated into BT's pre handover work programme. The enabling of auditing functionality with regards to system configuration changes would require paid consultancy from Northgate. It is currently intended to progress this once the transfer to CGI is complete.
Resources					
14*	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.***	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	It is anticipated that Phase 1 of the CAFM implementation will be completed by the 31 March 2016 at which point this outstanding action can be closed off. It is anticipated that performance reporting based on specific agreed PI's for CP will commence when Phase is implemented. Estimated implementation date for PI reporting 30.06.16.

No	Review and Risk Level	Initial Finding & ***Recommendation***	Initially Agreed Management Action	Owner & Initially Expected Implementation Date	Last Status Update
15*	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	It is anticipated that Phase 1 of the CAFM implementation will be completed by 31 March 2016 at which point this outstanding action can be closed off.
16*	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	A training programme for the rollout of the full CAFM solution will be developed internally with the assistance of our software supplier TF Cloud Estimated Implementation Date 30.06.16.

No	Review and Risk Level	Initial Finding & ***Recommendation***	Initially Agreed Management Action	Owner & Initially Expected Implementation Date	Last Status Update
17	Occupational Health / Sickness Absence CG1415 ISS4 Medium	The effectiveness of the Council's Absence Management Process is reliant on line managers recording key information. Testing focused on absences between a three to nine month period as HR review casework is currently focusing on longer term absences. Some shorter term absence was also included for review to establish that actions are also taken when short term trigger points are reached. Unacceptable levels of noncompliance were found, for example: 1. Completion of self-certification forms was not recorded in myPeople in ten of thirteen cases; 77% 2. Submission of fit notes was not recorded in myPeople at all for four of fifteen cases (for 37 weeks absence in one case) with details for a further four not covering the full period of absence; 53% 3. Return to work interviews were not recorded in myPeople in 16 of 21 cases; 76% . 4. Evidence of trigger point reviews via completion of key myPeople fields within Managing Attendance user defined fields (UDF) was not found in seven of nineteen cases; 37%. **Given the high levels of non compliance found the importance of completion of key managing attendance fields in the myPeople system needs to be communicated to Managers. System prompts should be added to MyPeople to flag instances where not all required fields have been completed and exception reports should be produced monthly to detect where not all required fields have been completed. Follow up action to then be initiated to ensure that the omissions are corrected.**	The Workforce Controls Project is supported by Corporate Communications in delivering an ongoing Communication plan which uses the 'Managers' News communication channel. A communication was sent to managers on 5 May 2015 regarding changes to the way managers' record absence management meetings. Further communication to managers on recording sickness absence and return to work interviews will be scheduled between now and October 2015. The People & Organisation and Customer Services Divisions will work together to design and deliver appropriate management information to Senior Management Teams on a monthly basis to allow them to take appropriate action to ensure compliance with mandatory procedures. The Interim Head of People & Organisation will report the results to the Corporate Leadership Group on a periodic basis.	Head of Human Resources and Organisational Development 31 December 2015	The recording of self certificates and fit notes cannot be attached to individual absences on Itrent. In light of this, and the fact that recording of those on the system is not mandatory in relation to the Managing Attendance Procedure, the focus has been on reporting on Return to Work Interview (RTWIs) and trigger points. Communication has gone out to managers to raise awareness of the procedure they have to follow and data on RTWIs and trigger points are shared monthly with SMTs and SHRBPs. SHRBPs are working with management teams to support managers to actively manage sickness absence.

No	Review and Risk Level	Initial Finding & ***Recommendation***	Initially Agreed Management Action	Owner & Initially Expected Implementation Date	Last Status Update
18	Occupational Health / Sickness Absence CG1415 ISS7 Medium	Employees appointed as Managers or promoted into a managing role are required to undertake mandatory induction training. Details of all new Managers appointed in the last year was provided, and evidence of induction training was not recorded in myPeople for ten of forty seven employees (one recent appointment not included); 21%. Mandatory annual refreshers are undertaken by existing Managers for key policy awareness and understanding. Details of all Reporting Managers were obtained and compared to the evidence of completion of mandatory training from April 2014 - March 2015. Of 1,796 Managers, evidence was not found that training had been completed in 1,036 cases; 58% . **Given the high levels of non compliance found the importance of completion of key induction and training fields in the myPeople system needs to be communicated to Managers. A protocol should be prepared for following up instances of induction not being completed where they are identified by the exception report run by the Business hub. Corporate management information is required to improve the visibility and allow Senior Management Teams to enforce compliance with mandatory procedures.**	A series of communication is ongoing using the Managers News communication channel. A communication was sent to managers on 13 May 2015 regarding the mandatory annual policy refresher. The aim is for all staff (except teachers) to complete this by 31 July 2015. Due to school holidays teachers have until 30 September 2015. Ongoing communication will be made to managers' and all staff as the deadline gets closer. The need to complete induction will also be communicated in this way. Senior HR Business Partner advises SMT's on remedial action required on a range of workforce controls including the above. Senior Management Teams are then responsible for cascading necessary action in their service area. The People & Organisation and Customer Services Divisions will work together to design and deliver appropriate management information to Senior Management Teams on a monthly basis to allow them to take appropriate action to ensure compliance with mandatory procedures . The Interim Head of People & Organisation will report the results to the Corporate Leadership Group on a periodic basis.	Head of Human Resources and Organisational Development 31 December 2015	As described in the agreed action column awareness has been raised on this matter and completion of mandatory training and monitoring of it are carried out on an annual cycle. Monthly monitoring is carried out and SHRBPs discuss with the relevant SMTs. Data is also provided monthly to Business Intelligence who report on performance monthly to CLT. Completion rates remain poor. A OD working party has been set up to review the content of induction and mandatory training for job categories. This working party will also review reporting and monitoring arrangements and will make final recommendations by 31 March 2016.

No	Review and Risk Level	Initial Finding & ***Recommendation***	Initially Agreed Management Action	Owner & Initially Expected Implementation Date	Last Status Update
19	Review of Carbon Reduction Commitment Scheme Compliance CG1501 ISS.1 Medium	There is no clear ownership, roles, responsibilities or internal reporting requirements for the CRC scheme. ***An updated handbook and supporting process maps should clearly define;*** ***An individual officer with management ownership for the CRC Scheme; requirements of the scheme around the roles, responsibilities and internal pre-submission and post-submission reporting requirements within CEC;*** ***The membership of a CRC group to have responsibility for oversight and monitoring of the data collation and annual report submission for the scheme;*** ***Process map of CRC requirements supported by procedure notes for each role in the scheme;*** ***Segregation of duties between those collating the data and the submission of the final report;*** ***Independent audit of the data reported and allowances purchased; and Monitoring of the effectiveness of the scheme in connection with carbon usage reduction projects.*** ***The handbook should be presented to the relevant committee for approval and communicated to the key officers with involvement in the Scheme. The handbook requires to be reviewed and updated on a regular basis to ensure it is in line with current legislation.***	The need to document formally respective scheme roles and responsibilities is acknowledged. A named senior officer with overall responsibility will be identified and will be further supported in discharging this role by the planned appointment of a dedicated CRC Officer. The draft handbook will be updated with the new CRC Registry contact officer details and will detail the key items as identified above; Subject to Committee scheduling, the handbook will be presented to the Finance and Resources Committee for approval and thereafter an Annual Report will be considered by the Committee by the end of September following each compliance year; and the handbook will be circulated to appropriate Service Managers for involvement of key staff. Assurance will be sought from managers that key staff will be afforded sufficient time to discharge their responsibilities. A dedicated officer group including representation from all relevant service areas (including Housing, Street Lighting and Traffic Signals), the Energy Management Unit and the Corporate Policy and Strategy and Finance teams will also be established and meet on an at-least twice-yearly basis to implement an agreed action plan.	Corporate Finance Manager 31 December 2015	The Corporate Finance Manager has been designated the senior officer with overall responsibility for the scheme. The content of the scheme operating handbook is also currently being finalised and will be presented to the F&R Committee on 17 March 2016.
20	Review of Carbon Reduction Commitment Scheme Compliance CG1501 ISS.2 Medium	Due to the lack of defined roles and responsibilities there has been no training for officers involved in preparing the data and annual report submission and there is no resilience plan in place. ***In line with the definition of roles and responsibilities all key officers involved in the CRC scheme should receive sufficient training for their duties. There should be a clear note on delegated authorities for scheme in the event of key officers being unable to fulfil their duties. These should be reviewed and updated on a regular basis.***	Agreed; the handbook referred to in Recommendation ISS.1 will include a resilience plan, setting out clearly continuity arrangements in the event of absence of key officers. Internal and external training opportunities for relevant officers will also be identified.	Energy and Water Officer 31 December 2015	Procedures for roles and responsibilities will be clarified in the handbook which will be presented to F&R Committee on 17 March 2016.

No	Review and Risk Level	Initial Finding & ***Recommendation***	Initially Agreed Management Action	Owner & Initially Expected Implementation Date	Last Status Update
21	Review of Carbon Reduction Commitment Scheme Compliance CG1501 ISS.3 Medium	There is no independent monitoring of the evidence pack to ensure that it is updated timeously and complete. At the time of the audit the evidence pack is collated retrospectively once the end of the financial year had completed. This resulted in there being no evidence to audit during this review or the recording of special events which require to be reported in the final report. The evidence pack does not give clarity over the process for budgeting, purchasing and spending carbon allowances. The previous evidence packs were still live and sitting in the shared drive. These could be updated and amended by anyone with access to the shared drive. ***The Evidence pack for each financial year should be set up at the beginning of the financial year and populated throughout the year up to the cut off point set by the reporting requirement. This should be monitored and verified as being carried out by the Independent responsible officer. The evidence pack should contain a separate section which shows the allowance purchase process from budgeting, collation of actual purchase requirement, and purchase to final use this will ensure transparency over the financial element of the scheme.*** ***All previous evidence packs should be removed from the general access drive and placed in a secure folder with limited access passwords. This will protect the integrity of the data collated for that year's report submission.***	Agreed; arrangements will be put in place to ensure collation of relevant evidence on a timely basis, with this process verified by an appropriate officer. Security of previous years' submissions will be improved through the introduction of suitable password protection.	Energy and Water Officer 31 December 2015	Procedures for roles and responsibilities will be clarified in the handbook which will be presented to F&R Committee on 17 March 2016.
22	Anti-Fraud Arrangements CG 1507 ISS.2 Medium	The Council's Policy on Fraud Prevention, Anti-Bribery Policy and Procedure, and Employee Code of Conduct demonstrate a clear culture against bribery, fraud and corruption. Mandatory induction and annual refresher training is in place and communicated widely to ensure Corporate compliance with relevant laws including the Bribery Act 2010. Completion of this training must be recorded on myPeople, the HR system. At the time of the audit, seven weeks after the deadline for completion of annual mandatory policy awareness training, only 37% of employees are recorded in myPeople as compliant. Economic Development were 92% compliant and the other service areas ranged from 14% - 64%. It is noted that escalation has been cascaded by HR Business partners, and a cross-departmental working group is being set up to tighten controls although this has not yet met ***Action should be taken by the Director and Senior Management Team to evidence compliance with this mandatory training.***	Communication's campaign championed by the Deputy Chief Executive to managers to ensure that all staff have completed the mandatory policy awareness training and that it is recorded on the MyPeople system. HR Business Partner and Representatives for cross-departmental working group to escalate and monitor progress with Heads of Service.	Acting Executive Director of Resources 30 November 2015	As described in the agreed action column awareness has been raised on this matter and completion of mandatory training and monitoring of it are carried out on an annual cycle. Monthly monitoring is carried out and SHRBPs discuss with the relevant SMTs. Data is also provided monthly to Business Intelligence who report on performance monthly to CLT. Completion rates remain poor. A OD working party has been set up to review the content of induction and mandatory training for job categories. This working party will also review reporting and monitoring arrangements and will make final recommendations by 31 March 2016.
* Previously reported to GRBV as outstanding					