Governance, Risk and Best Value Committee

10.00am, Tuesday, 26 September 2017

Internal Audit: Overdue Recommendations and Late Management Responses

Item number	7.2
Report number	
Executive/routine	
Wards	

Executive summary

This report sets out all overdue Internal Audit recommendations across the Council providing further status updates and likely implementation dates where they have been provided by service Areas (Appendix 1).

There are currently 83 open Internal Audit recommendations across Service Areas as at 25 August 2017, of which 36 (43%) are overdue. This reflects a decrease of 5 overdue recommendations from the latest position (41) reported to the Governance, Risk and Best Value (GRBV) Committee on 1 August 2017 (as at 27 June 2017).

This report also identifies audit reports that have been issued in draft where final management responses have not been received within our two week service standard. There are currently no draft reports where management responses have not been received within the two week requirement.

Internal Audit: Overdue Recommendations and Late Management Recommendations

1. Recommendations

1.1 The Governance Risk and Best Value (GRBV) Committee is requested to note:

1.1.1 The current status of overdue Internal Audit recommendations as at 25 August 2017;

1.1.2 The revised approach proposed in relation to the 3 recommendations noted at section 3.12 below that was approved by the Corporate Leadership Team (CLT) at their meeting on 30 August 2017;

1.1.3 The revised Internal Audit (IA) monthly reporting timetable for updates on open and overdue recommendations detailed at section 3.13; and

1.1.4 That there are currently no reports issued in draft where management responses have not been received within our two week service standard.

2. Background

2.1 The GRBV Committee and CLT have both expressed concerns about the number of overdue Internal Audit recommendations. Currently, the status of overdue recommendations is reported monthly to CLT and quarterly to GRBV.

2.2 It is anticipated that the greater visibility that this monthly reporting provides will result in more Internal Audit recommendations being closed off in a timely manner.

2.3 At the CLT meeting on 10 July 2017, revised proposals for monitoring and reporting on overdue Internal Audit recommendations were approved. This paper provides an update on overdue recommendations in line with the revised approach.

2.4 The Internal Audit definition of an overdue recommendation is any recommendation where all agreed actions have not been implemented by the final date agreed and recorded in Internal Audit reports.

3.   Main report

3.1   There are currently 83 open Internal Audit recommendations across Service Areas within the Council as at 25 August 2017. Of these 36 (43%) are overdue (3 High; 30 Medium; and 3 Low). This reflects an overall decrease of 5 overdue recommendations from the latest position (41) reported at the GRBV Committee meeting on 1 August 2017 (as at 27 June). This movement is represented by an increase in overdue recommendations at the end of July (5), and the closure of 10 overdue recommendations across July and August.

3.2   The 5 recommendations that became overdue at the end of July were:

- Resources – 1 High (RES1603ISS.1 – Leavers Process)
- Resources (ICT) – 1 Medium (CW1603ISS.1 – External Vulnerability Assessment). This recommendation was subsequently closed in August.
- Strategy and Insight – 1 High (CSE1601ISS.2 – Review of Grant Management / Councillor Conflicts of Interest). Rating was downgraded from 'High' to 'Medium' in July based on evidence provided.
- Health and Social Care – 1 Medium (RES1604ISS.3 – IJB Data Integration and Sharing).
- Stronger and Safer Communities – 1 Medium (SSC1701ISS.3 – Short Term Homelessness Provision). This recommendation was subsequently closed in August

3.3   The 10 overdue recommendations that were closed between 27 June and 25th August comprised 2 High; 6 Medium; and 2 Advisory across the following Service Areas:

- Health and Social Care (1 High; 1 Medium; 1 Advisory)
- ICT (1 High; 1 Medium; 1 Advisory)
- Resources (2 Medium)
- Place (1 Medium); and
- Safer and Stronger Communities (1 Medium).

3.4   Whilst no new recommendations were overdue as at 25th August, 6 open recommendations are due for completion by 31 August 2017. These are:

- Communities and Families – 2 Medium (CF1619ISS.3 and CF1621ISS.1)
- Resources – 1 High (RES1704ISS.4) and 2 Medium (CW1603ISS.5 and MIS1601aISS.2).
- Strategy and Insight - 1 Medium (CF1619ISS.1)

3.5   Ratings were downgraded for 2 overdue recommendations in July based on implementation progress where the residual risk has been demonstrably reduced by control improvements:

- Strategy and Insight (CSE1601ISS.2 grant management / conflict of interest) - reduced from High to Medium.

- Health and Social Care (HSC1503ISS.6 – Self Directed Support) - reduced from Medium to Low.

3.6   Figure 1 illustrates the ageing profile of all 36 overdue recommendations by rating across Service Areas. Of these, 17 are more than 180 days' overdue (2 High; 12 Medium; and 3 Low), with 6 of the 17 (3 Medium and 3 Low) more than 365 days overdue.

Figure 1: Aged overdue Recommendations by Rating across Service Areas
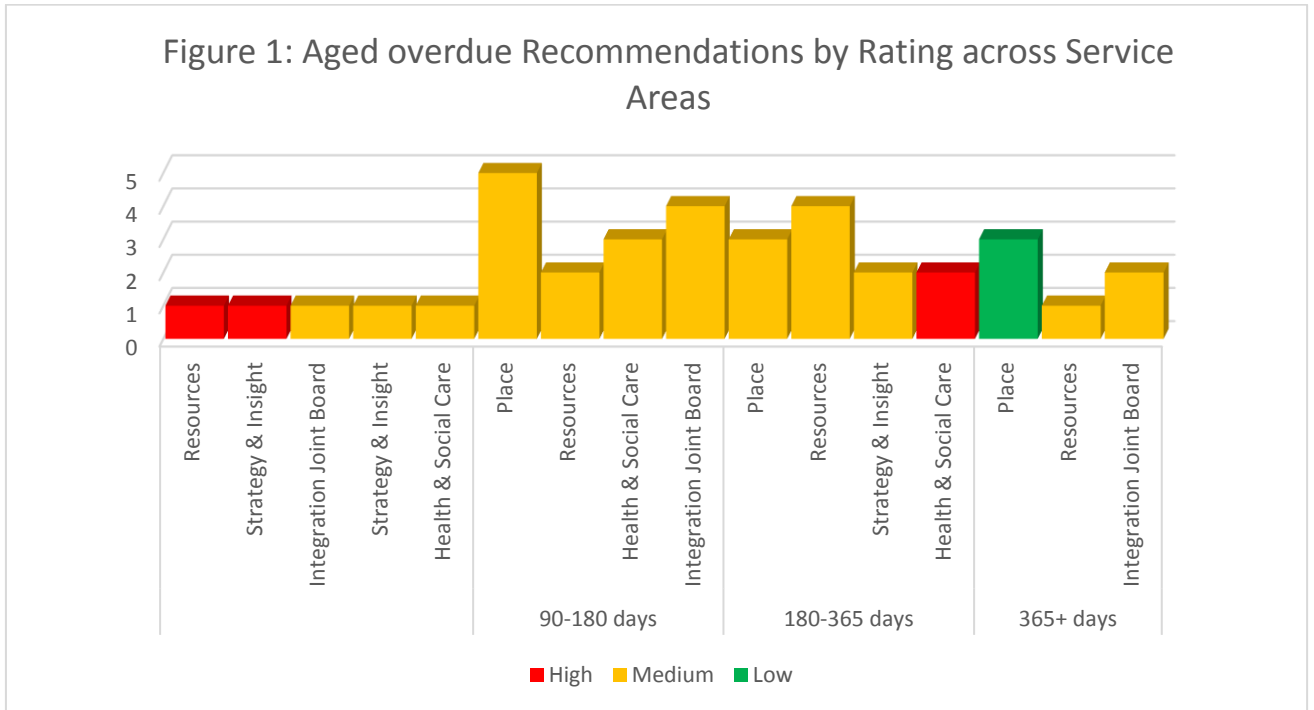
3.7   Figure 2 highlights the ageing profile of overdue Internal Audit Actions for each Service Area.

Figure 2: Aged Overdue Recommendations by Service Area
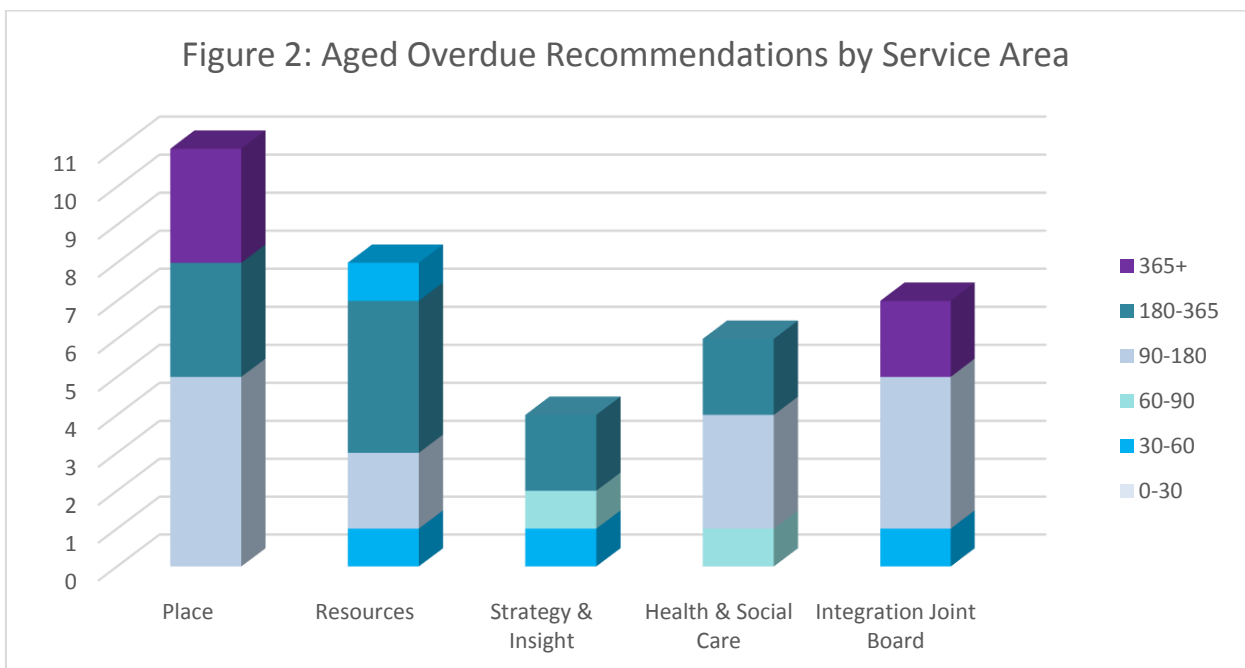
3.8   Figure 3 correlates the current top Corporate Leadership Team risks to the relevant overdue Internal Audit recommendations. Our primary risk exposures as a result of overdue recommendations are Health and Social Care and Internal Systems and Processes. Please note that these risks will be updated in October to reflect the revised CLT risk descriptions presented to the Governance, Risk and Best Value Committee in September.

Figure 3: Overdue Recommendations By CLT Risk
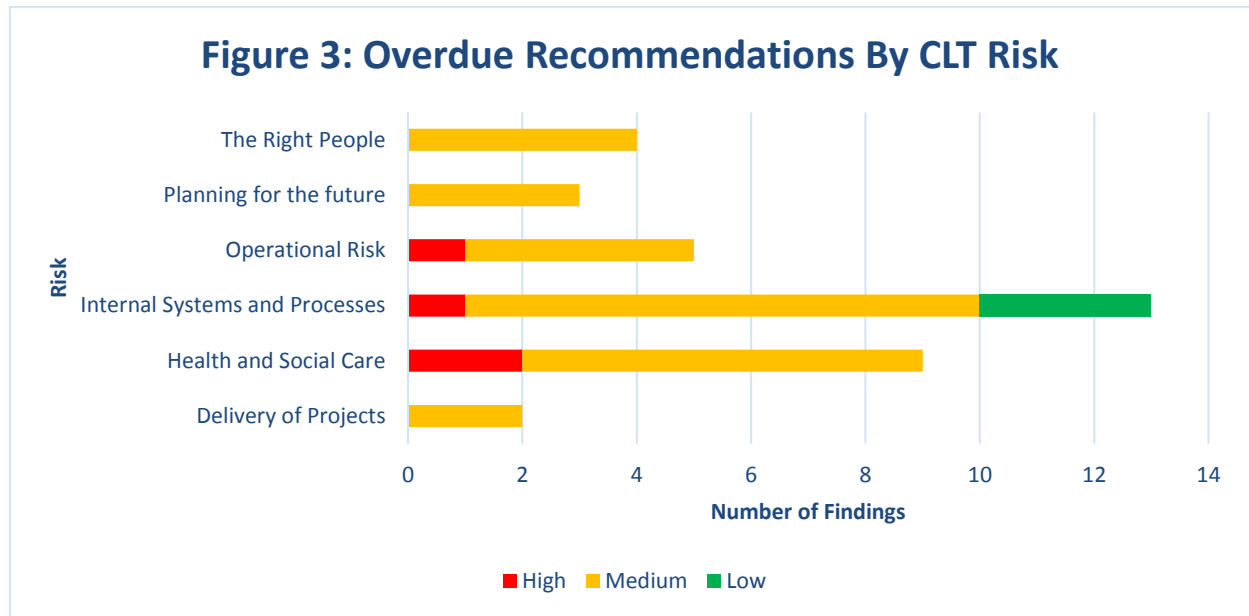
3.9   Figure 4 illustrates Service Areas who have revised completion dates for overdue recommendations more than once since the implementation dates agreed when finalising audit reports.

Figure 4: Overdue Recommendations With More Than One Revised Date
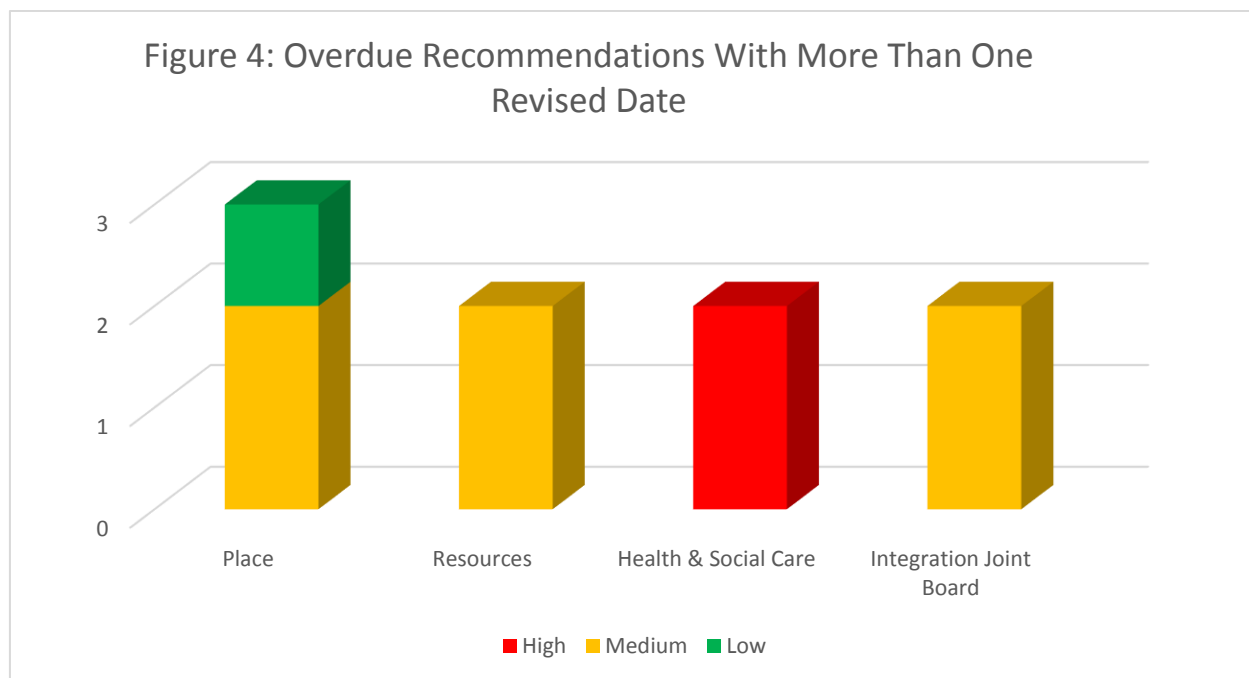
3.10   There are currently three remaining medium rated overdue recommendations in Resources where closure is dependent on implementation of the new Business World System. Internal Audit is working with the respective Management teams in Customer to enhance existing (manual) operational controls to ensure that these recommendations can be closed. We have also shared details of these recommendations with the Business World Programme and requested confirmation regarding their inclusion in the Business World system design.

3.11   There are two open (not overdue) recommendations where agreed dates for specific actions have been missed. These are:

- Strategy and Insight - ICO Follow Up (RES1606ISS.2 – Medium). Initial action date was 30 May. This action date has now been revised to 31 August, with the full recommendation due for closure by 31 March 2018.

- Safer and Stronger Communities – Short Term Homelessness Provision (SSC1701ISS.2 - High) – action date 30 June. The overdue action is currently being validated by IA, with closure of the full recommendation due by 31 October 2017.

3.12   There are currently 3 recommendations (2 open and 1 overdue) owned by the Head of ICT and the Head of Legal and Risk respectively, where support is required from all Service Areas to progress closure. To ensure that this is achieved, the following changes were approved by CLT at their meeting on 30th August 2017:

1. The Disaster Recovery and External Vulnerability Assessment Internal Audit reports concluded in May 2017 each include High findings that are open, but not overdue. A component part of each of these High findings relates to the need to identify 'shadow' IT systems and address the disaster recovery and security risks associated with them. 'Shadow IT' is defined as systems or applications historically procured and implemented by Service areas that are not managed centrally by ICT in conjunction with CGI. Responsibility for identification of the full population of shadow IT currently sits with the Head of ICT.

    As Heads of Service are best placed to review and identify any shadow IT systems or applications that they use, it is proposed that separate Medium rated findings are raised on each Head of Service to identify any shadow IT and provide their details to the Head of ICT by 30th March 2018.

    The original High findings will be amended to reflect that the Head of ICT will then be responsible for completion of a disaster recovery and security risk assessment for the shadow IT applications identified and implementation of appropriate controls to address these risks where the systems or applications are to be centrally managed going forward.

2. Our review of Service Level Agreements with Outside Entities (completed August 2016) included a Medium recommendation that reflects the need to

establish service level agreements (SLAs) with third party organisations that the Council provides services to. This was due for closure on 30th June 2017.

The Head of Legal and Risk has developed a pro forma SLA and shared with all Service Areas, however Service Areas have not yet provided information to confirm that SLAs have been implemented across the full population of third party organisations that they support.

It is proposed that the existing Medium recommendation is closed, with Low recommendations raised on each Service Area to ensure that these SLAs are implemented as required.

3.13 Since June 2017, Internal Audit has not consistently applied a cut off in the overdue recommendations reporting process in an effort to work with Service Areas and drive focus on validation and closure. With effect from September 2017, the following process will be applied:

- 10th of each month (or nearest Friday) – e mail sent to all recommendation owners with a list of all open and overdue recommendations that they own.
- The e mail will specify the requirement for receipt of progress updates, or provision of evidence to support IA validation by the 15th of each month (or nearest Friday).
- Any updates received after the 15th will not be included in the monthly CLT or quarterly GRBV reports due to be submitted in that month.

3.14 Internal Audit has categorised all overdue Internal Audit actions by Directorate showing the latest status updates where received. The detailed results of this categorisation are set out in Appendix 1.

3.15 There are currently no Internal Audit reports issued in draft where management responses have not been received within our two week service standard.

4. Measures of success

4.1 An increase in the implementation and closure of Internal Audit recommendations within their initial estimated closure date.

5. Financial impact

5.1 Not Applicable.

6. 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 effective risk management, compliance, and governance.

7. Equalities impact

7.1 Not Applicable.

8. Sustainability impact

8.1 Not Applicable.

9. Consultation and engagement

9.1 Not applicable.

10. Background reading/external references

10.1 Not Applicable.

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11. Appendices

Appendix 1 – Status report: Outstanding Recommendations Detailed Analysis

Appendix 1 - Overdue Internal Audit Recommendations as at 25 August 2017

Unique Ref	Project Name	Issue Type	Finding	Business Implication	Recommendation	Agreed Management Action	Estimated Implementation Date	Revised	Status Update	Owner
Health & Social Care										
HSC1503ISS.1	Personalisation SDS - Option 3	High	The Social Care (Self-directed Support) (Scotland) Act 2013 states that the authority must "inform the supported person of the amount that is the relevant amount for each of the options for self-directed support from which the authority is giving the person the opportunity to choose, and the period to which the amount relates." The "relevant amount" is defined as "the amount that the local authority considers is a reasonable estimate of the cost of securing the provision of support for the supported person". At present, the supported person is not informed of their assessed budget when they are asked to choose their option. They are only told of the resources available to them when they receive their personal support plan after they have selected their option.	There is a risk of non-compliance with The Social Care (Self-directed Support) (Scotland) Act 2013. The supported person may not have sufficient financial information to make an informed decision on the feasibility and affordability of arranging their own care under Option 1.	Management should seek clarification from Scottish Government on how the legislation should be applied where the supported person is allocated the same budget whichever option is chosen. Management must then ensure that the SDS assessment process is compliant with Scottish Government 's instructions . This may mean i nforming the supported person of their personal budget at an earlier stage of the assessment process.	Scottish Government have been approached on this issue through the Social Work Scotland SDS Sub-group and have indicated that they are prepared to consider issuing further guidance and in particular revisit the issue of whether local authorities need to notify individuals of the indicative budget for each of the four options or just provide a single indicative budget which is what most authorities seem to be doing in practice. These discussions will take place through the Social Work Scotland SDS Sub-group and Senior management will ensure that Edinburgh is involved in these discussions. The current processes and practice in relation to providing individuals with an indicative budget will be reviewed and updated and clear guidance issued to staff taking acc ount of any change in guidance from the Scottish Government. In either case, an indicative budget will be given to individuals before they are asked to select their preferred option.	31/10/16	30/06/2017 31/12/2017	**August Update:** Chief Officer and Strategic Commissioning Manager provided an update at GRBV meeting of 01.08.17 that noted that a revised implementation date of December was required. **June Update:** New assessment, personal care plan and budget process introduced in May 2017. Indicative budgets no longer calculated as part of assessment: calculated once personal care plan set. This means service users are not given an indicative budget to enable them to make an informed choice about their support: non-compliance with legislation remains. Finding remains open. Changes to be requested to SWIFT to allow recording and monitoring of compliance. Once these changes have been made an instruction will be issued to all staff reminding them of the need to inform service users of their "indicative budget". Planned completion date: to be confirmed by 24/2/17 following response from ICT Services.	Wendy Dale, Strategic Commissioning Manager
HSC1503ISS.2	Personalisation SDS - Option 3	High	The Social Care (Self-directed Support) (Scotland) Act 2013 states that the authority must give the person "in any case where the authority considers it appropriate to do so, information about persons who provide independent advocacy services (within the meaning of section 259(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13))." When researching advocacy services for people affected by SDS the only place we were able to find information was on the Council's Edinburgh Choices website which is an online directory of local care and support services, which includes details of independent advocacy services. However, we were unable to find links to the Edinburgh Choices website in key communications to service users and the general public about SDS. The Co uncil has produced d etailed pamphlets and leaflets which explain SDS to service users and carers but advocacy services are not covered, and readers are not directed to the Edinburgh Choices website. Practitioners we spoke to could not direct us to advocacy services.	There is a risk of non-compliance with the Social Care (Self-directed Support) (Scotland) Act 2013	The service should ensure that information about advocacy services is available to service users. Possible options may include: Providing practitioners with information about available advocacy service and what they do; Directions to Edinburgh Choices in guidance materials for service users; or N ames of advocacy services in pamphlets and leaflets for service users.	Existing leaflets and information materials to be reviewed to make reference to Edinburgh Choices Information to be produced for dissemination to practitioners regarding the duty to identify people who may benefit from advocacy and support them to access this services and the agencies that the Council has commissions to provide advocacy services.	31/08/16	31/08/2017 30/09/2017	August Update: Award of new contracts was agreed at Full Council at the end of June. Contracts formally signed at the end of July. Have agreed to work with the new providers to produce guidance for staff and leaflet for service users. Request revised completion date to end Sept 2017 New advocacy services contract will be agreed in June 2017. Changes to be requested to SWIFT to allow recording and monitoring of compliance. Once these changes have been made an instruction will be issued to all staff to identify those service users who may benefit from Advocacy Services and to support them to access these. Staff will be reminded that information about providers of independent advocacy services is available on Edinburgh Choices. Procedures and leaflets to be updated as part of the work to implement the new structure. Planned completion date: 31/08/2017	Wendy Dale, Strategic Commissioning Manager
SW1601ISS.4	Social Work: Pre-Employment Verification	Medium	There was insufficient evidence to support the PVG checks of three nominated candidates who were 'existing Council employees'. The original PVG certificate is destroyed at the initial point of employment. Therefore recruiting managers of nominated candidates, who are existing employees, may not be aware of the 'vetting information' included in the original PVG Check. This restricts managers' ability to make an informed decision to proceed with the employment. It should be noted that Scheme Record Updates (which carry out a check between the original PVG Certificated issued; to the date of the requested update) do not include details of any 'vetting information' held within the original certificate. The current "Recruitment and Selection Guidance for Managers Pre-Employment Checks for Nominated Candidates" states that "no further check is required if the individual is a PVG Scheme member in the Council for the same type of 'regulated work'. There is potential for staff to be recruited to a role which is not appropriate given their previous convictions. For example; a person with fraud convictions may properly be recruited to a care home if they are not handling cash but a future appointment to the homecare service; with access to vulnerable people's funds may be approved without due consideration of the risk. In October 2016 a carer in East Lothian was convicted of Fraud amounting to £46,000 from two clients.	Recruiting managers may have insufficient evidence of PVG 'vetting information' to allow them to make an informed decision over whether to proceed with employment. This may lead to recruitment of staff not appropriate to the role.	All nominated candidates should be requested to bring their copy of the PVG certificate to the pre-employment checks meeting; in order to allow mangers to make an informed decision as to whether to proceed with the recruitment process or to rescind the offer.	Locality Managers to obtain confirmation from their recruiting managers that nominated candidates are being requested to bring their PVG certificate to the pre-employment checks meeting. This requirement has been effectively communicated to all relevant managers / staff and a mechanism will be introduced to ensure that the requirement is being adhered too. This procedure will be embedded within the HSC and Safer & Stronger Communities protocol.	31/03/17	IA Validation in progress	August Update: Information has been provided and is being validated by Internal Audit. **July Update** - Meeting held with Health and Social Care early July to agree actions and evidence required. Finding owner currently on annual leave and will process on return. IA has been advised that H&SC awaiting evidence from Localities.	Cathy Wilson, Executive Business Support Manager

Ref	Area	Rating	Finding	Risk	Recommendation	Management Response	Target Date	Status	Update	Owner
SW1601ISS.5	Social Work: Pre-Employment Verification	Medium	Testing identified that working practices between recruiting managers, HSC Recruitment, and HR Recruitment are not fully documented and this has led to inconsistencies including: - bypassing the HSC Recruitment Co-ordination Team; - inadequate recording of Criminal Convictions form (CCF) and PVG information; - inappropriate record management; and - no clear formal procedure has been issued to Recruiting Managers to advice them of the requirement to formally document the decision to proceed with or recind the offer of employment; following receipt of 'vetting information' in respected of the nominated candidate.	Key information may not be retained. HSC Recruitment Staff and Recruiting Managers may not be aware of what is expected of them. Risk of non-compliance with Disclosure Scotland's 'Code of Practice'.	Procedures should be produced by the HSC Recruitment Co-ordination Team in conjunction with HR Recruitment Team and senior HSC Management to ensure the recruitment process is safe, consistent and compliant with appropriate legislation and CEC policies. This should include the requirement to complete the ' PVG/Disclosure Risk Assessment Form ' and ' Record Of Mee ting on PVG/Disclosure Form '.	HSC Recruitment Co-ordination Team will work with HR Recruitment Team to develop safe and consistent procedure including the requirement to update both of the PVG / Disclosure Forms noted. Procedures to be strengthened to ensure that we are up to date to reflect safe storage and retention procedures. HSC to formally communicate this to all relevant staff and recruiting managers, including the safe storage and retention periods of both forms. Confirmation of this to be sent to Locality Managers.	31/03/17 31/05/2017	IA Validation in progress	**August Update -** Audit validation in progress **July Update** - meeting held with Health and Social Care early July to agree actions and evidence required. Finding owner currently on annual leave and will progress on return.	Cathy Wilson, Executive Business Support Manager
SW1601ISS.7	Social Work: Pre-Employment Verification	Medium	The HSC Recruitment Co-ordination Team carry out 'Bulk Interviews' on a monthly basis for Care Home and Homecare posts where there are a number of different posts required at different locations around the city. This is due to a high volume of staff movement within these posts, which due to the nature of the posts are required to be filled timeously. However; it was established that the 'Location Manager' who the nominated candidate reports to on their first day of work is not necessarily the same manager who has interviewed the candidate or taken the candidate through the pre-employment checks to check their identification. It is acknowledged that this carries the risk that the person who turns up for work may not be the person that was interviewed.	Risk of identification fraud resulting in the Council employing a candidate who does not have the skills or experience required to fulfil the duties of the post. Risk of financial sanctions re Right to Work in UK Legislation	All nominated candidates be requested to bring photographic identification with them which should be checked and verified by the 'Location Manager' on the candidates first day of work. Failure to bring the appropriate identification should result in the candidate being refused to start work within the Council. This should be embedded within H&SC and Safer and Stronger Communities procedures and communicated to all relevant staff.	Locality Managers to seek confirmation from either recruiting managers and/or location managers to ensure that candidates are being requested to bring photographic ID on their first day of work. This process will also be embedded within the H&SC and Safer & Stronger Communities procedures and communicated to all relevant staff.	31/03/17 31/05/2017	IA Validation in progress	**August Update -** Audit validation in progress **July Update** - meeting held with Health and Social Care early July to agree actions and evidence required. Finding owner currently on annual leave and will progress on return. IA has been advised that HSC awaiting evidence from Localities	Cathy Wilson, Executive Business Support Manager
SW1601ISS.8	Social Work: Pre-Employment Verification	Medium	The Council's Recruitment and Selection Policy states that "all individuals in the recruitment and selection of potential candidates on behalf of the Council" must receive Council training in equality issues, Safer Selection, and the application of the policy". The CECIL Competency Based Recruitment and Selection module under "Safer Selection and Pre-employment Checks; notes the Council's approach to safer selection includes 'Mandatory training for all recruiters' and that if a manager recruits on a regular basis they should repeat the modules every 2 years. Checks were carried out on twenty individual managers who were involved in the recruitment of the nine nominated candidates whose PVG check had returned 'vetting information'. Testing highlighted that seven of the twenty managers have either not received the mandatory training or the fact that they have completed the training, has not been recorded on the iTrent system. Details of the seven managers noted above were subsequently provided to the HSC Business Manager.	Managers are not complying with Council Policy. Managers may be undertaking the recruitment process without having the required skills to make an informed decision as to whether the candidate is suitable for the post.	All managers identified through audit testing as not complying should be contacted to establish whether they have completed the mandatory training. The iTrent system should be updated with the date completed.	The HSC Business Manager will resolve this issue with the individual Locality Managers and ensure iTrent is updated on satisfactory completion.	31/05/17	IA Validation in progress	Managers have been reminded that mandatory training must be completed before undertaking any recruitment activity and to ensure that the iTrent system needs to be updated with the date training was completed. Awaiting evidence from the Locality Managers. **July Update** Meeting held with Health and Social Care early July to agree actions and evidence required. Finding owner currently on annual leave and will progress on return. Managers have been reminded that mandatory training must be completed before undertaking any recruitment activity and to ensure that the iTrent system needs to be updated with the date training was completed. Awaiting evidence from the Locality Managers."	Cathy Wilson, Executive Business Support Manager
			The Council's Recruitment and Selection Policy states that "all individuals in the recruitment and selection of potential candidates on behalf of the Council" must receive Council training in equality issues, Safer Selection, and the application of the policy". The CECIL Competency Based Recruitment and Selection module under "Safer Selection and Pre-employment Checks; notes the Council's approach to safer selection includes 'Mandatory training for all recruiters' and that if a manager recruits on a regular basis they should repeat the modules every 2 years. Checks were carried out on twenty individual managers who were involved in the recruitment of the nine nominated candidates whose PVG check had returned 'vetting information'. Testing highlighted that seven of the twenty managers have either not received the mandatory training or the fact that they have completed the training, has not been recorded on the iTrent system. Details of the seven managers noted above were subsequently provided to the HSC Business Manager.	Managers are not complying with Council Policy. Managers may be undertaking the recruitment process without having the required skills to make an informed decision as to whether the candidate is suitable for the post.	A review of the iTrent information held for each recruiting manager within Health and Social Care should be undertaken to establish any manager who has not completed the Recruitment and Selection training within the last 2 years. Any manager who is iden tified as not having complied with this training requirement should be requested to complete the training as soon as possible and not recruit staff until they have undertaken the training. A mechanism for monitoring the mandatory requirement should be in troduced. In the interim, Locality Managers and Safer and Stronger Communities Senior Managers should remind all recruiting managers that they are required to have completed the training before undertaking any further recruitment.	Locality Managers have been requested to remind all recruiting managers that they are required to have completed the training before undertaking any further recruitment and confirm that this has been completed. The H&SC Partnership has been going through an organisational re-design, with staff being appointed to posts within the new structure under Phase 1, 2 and 3. The organisational re-design of the team has inevitably meant changes to recruiting managers. It is envisaged that Phase 2 of the organisational re-design will be completed by January 2017. Under phase 2, new recruiting managers will be appointed. Once these appointments have been made, a review of their recruitment and selection training will be reviewed by the respective Locality Managers and the appropriate measures taken, to ensure full compliance.	31/05/17	IA Validation in progress	Awaiting evidence from the Locality Managers. **July Update** Meeting held with Health and Social Care early July to agree actions and evidence required. Finding owner currently on annual leave and will progress on return. IA has been advised that HSC awaiting evidence from Localities"	Cathy Wilson, Executive Business Support Manager

Place

Ref	Area	Rating	Finding	Risk	Recommendation	Management Response	Original Date	Revised Date	Update	Owner
CF1402ISS.1	School Meals	Low	For the school meals service delivered by SfC, the roles and responsibilities of key officers within SfC and C&F were not clearly defined in a formal document such as a service level agreement (SLA) or working protocol. Although processes have not been formalised, good cross departmental working was evidenced between the C&F Development Officer and SfC Catering Performance Officer. This collaboration was specifically noted within the menu planning process. Similarly Facilities Managers (FMs) and Kitchen Supervisors work closely with School Business Managers to resolve issues on site. It is understood that Corporate Facilities Management are producing SLAs for cleaning and janitorial services, however catering is not in scope at present. It is viewed differently as the end user of the service delivered is external, i.e., the pupils rather than Council staff.	In the absence of any documentation the service is reliant on the knowledge of key members of staff and staff changes may impact on the effectiveness of the service.	Consideration should be given to preparing an SLA to outline the respective responsibilities within key cross departmental processes in delivery of the school meals service.	As part of a wider Facilities Management Review for the clarity on roles and responsibilities of key offices within SfC who have responsibility for delivering the schools meals service it is proposed that an SLA between C&F and SfC be put in place to ensure a first class school meals service is delivered.	30/04/15	30/09/17	SLA completion is dependant on organisational reviews and expected completion date is Sept 2017 July Update SLA completion is dependent on organisational reviews. Initial expected completion date was Sept 2017 and this has now been revised to December 2017.	Victor Cruz, Interim Corporate Facilities Manager
SFC1403ISS.2	Community Recycling Centres	Low	The current CRC site policy appears very basic and inappropriate to adequately safeguard Council resources. Having such a basic policy exposes the CRCs to increased risk of commercial waste being passed off as household waste. The current policy may not be appropriate for modern CRC facilities and as a consequence, user guidance on the Council website is not sufficiently prescriptive or accurate to inform the CRC site user.	Loss of income to the Council Increased cost of disposal of commercial waste passed off as domestic waste Failure to meet residents expectation and reputational damage	CEC should consider a detailed and modern policy document to reflect the increased costs and environmental demands of providing this service. This should be considered at the same time as the chargeability of certain types of household items (i.e. reclassification of waste created from improvements, repairs and alterations to a household). Once the policy has been modernised and approved, an accompanying user guidance document and customer charter should be created and published. This should cover the following: Items accepted Permitted vehicles (including hired vehicles, trailers, vans) Household and commercial waste requirements When customers need to register with the Council to use the sites Charging policy and methods of payment Hazardous waste Charity waste Health and safety requirements General information (contact, opening times, etc.)	A policy and procedures document is to be drafted and consulted upon before being released.	31/03/15 31/07/2017	30/04/2018	**August Update:** CRC Improvement Plan being developed. Focus will be on improving signage and user information as well as developing more robust internal procedures. August update Details of the CRC Improvement plan have been provided to IA a revised date of April 2018 has been set for the CRC policy to be presented to the Transport and Environment Committee.	Bob Brown, Waste & Cleansing Operations (Waste) Manager
SFC1403ISS.3	Community Recycling Centres	Low	It was noted that physical security and enforcement measures for the CRC sites was not sufficiently robust. There is no number plate recognition technology in place, CCTV coverage is incomplete and it is possible for individuals to enter and remove items of value both during opening and closing hours. There are no CCTV cameras covering the weighbridge that would protect the integrity and safety of weighbridge staff and ensure that no cash transactions are taking place.	Safety of site officials compromised Risk that valuable items can be removed Abuse of Council service results in loss of income and/or increased costs	Security at each of the three CRC sites should be reviewed and strengthened. The use of CCTV and monitoring at each site should be carefully considered to ensure that coverage is adequate and covers the high risk areas (metal disposals, weighbridge and re-use cabin). Consideration should be given to using automatic number plate recognition (ANPR) technology in conjunction with CCTV to make sure that CRCs are used appropriately, safely & securely, to monitor vehicle usage (including detecting any patterns) and to assist with disputes & complaint procedures. As both a preventative and detective measure, use of a dedicated enforcement officer for a short period of time at each of the sites might highlight whether there is a wider issue of abuse of the system. A robust enforcement and site security infrastructure would be a vital requisite for any strengthening of site usage policy and charging structure.	Constant monitoring of site security is to be implemented. CCTV images re-directed to the main office at Powderhall with images also mirrored at the security office. The weighbridge software is being changed to accommodate ANPR piloting at Powderhall. This is to be rolled out to Sighthill and Seafield CRC sites and be operational by March 2015. Discussions with Community Safety regarding the implementation of an enforcement approach and associated support will be held.	31/03/15	31/12/17	Proposals for ANPR being built into site designs for the Seafield and Sighthill depot improvements. Liaison with security services has improved with new arrangements in place at Craigmillar CRC. **August Update** "Security arrangements have been reviewed at all CRC sites along with additional monitoring of each site by managers, supervisors and operatives. Environmental checks are carried out at the start and end of each shift. Seafield CRC site has recently (March 2017) had their CCTV equipment upgraded along with the rest of the newly developed depot. CCTV upgrades are being requested for Craigmillar and Sighthill sites. Each site now has overnight security personal in place. Conflict Management training has also been developed and is being rolled out to all CRC operatives, including supervisors, during Sep, Oct and November 2017." This finding can be closed when these actions have been evidenced.	Bob Brown, Waste & Cleansing Operations (Waste) Manager

Ref	Title	Rating	Finding	Risk	Recommendation	Management Response	Date	Updates	Owner
CW1502ISS.1	Governance Arrangements - Arms Length Companies	Medium	The Director responsible for each Arms Length Company within the Council appoints an Observer for each company from within the Directorate. The role is to scrutinise the activities and performance of the company and raise any concerns arising with the Directorate. The Observer attends company meetings on behalf of the Directorate but is not a company officer. We understand that all Arms Length Companies are different and that they will require different levels of intervention and interaction with their Observer. We would however, as a minimum expect the following from Observers: • Attendance as an observer at all Board and Audit Committee meetings; • Regular receipt and scrutiny of risk registers; • Regular receipt and scrutiny of management accounts and accompanying management information; and • Regular access to management. We identified the following instances where these minimum requirements were not met: • EICC: - the Observer attended 5 out of the 6 Board meetings tested but does not attend the Audit Committee meetings; and • EDI: - the Observer attended 2 out of the 4 Board meetings tested. We did not identify any process documentation for the observer roles within any of the Directorates. This results in the Council being subject to an element key man risk in the control of each of these entities, as the loss of the Observer would leave the Council with a limited understanding of the scrutiny processes in place for that particular company.	Observers may not carry out scrutiny to the required level when carrying out their governance roles of Council Companies on behalf of the Council. Financial and reputational risks may remain unidentified with the potential to adversely affect the Council. The controls in place are reliant on the knowledge, skills and experience of the senior staff involved. This knowledge may be lost if there is not sufficient succession planning.	Process documentation covering as a minimum the following points, should be prepared and maintained for each of the Arms Length Companies within Place. • Key management contacts; • Basic structure of the entity; • Key risks to the Council arising from the entity; • Nature/timing of meetings attended; • Key management information/reports received, their frequency and source; • Use made of/procedures undertaken on management information received including any early warning thresholds/KPI's; and • Reporting requirements for the relevant scrutinising Council Committee.	To produce process documentation covering the above points for Transport for Edinburgh, Edinburgh Trams, and Lothian Buses.	31/12/16 31/05/2017 15/09/17	August Update - revised date requested for implementation - ow 15/09/17 July Update: Action agreed to close in July were : Ensure all Board Observers are aware of their duties and responsibilities in relation to this role.	Paul Lawrence, Executive Director of Place and SRO
PL1601ISS.2	Recycling Targets	Medium	Contractors submit weighbridge tonnage data each month, which is used to calculate the recycling and landfill tonnage reported to the Transport and Environment Committee, and to prepare the annual SEPA submission. The current system for logging weighbridge tonnage submissions is manual as contractors provide their submissions in varying formats, some of which require further calculations to be made by Waste Services to establish the required figures. The data is entered manually into three separate databases, twice by the admin assistant and once by the Waste Collection Route Manager. The same data is entered into each database, with no significant differences in functionality between them.	Manual input could lead to errors in raw data used to calculate key performance measures; and Inefficient use of resources due to duplication of manual data input.	Automated data submission Contractors should be required to submit monthly weighbridge tonnage data in a prescribed format to support batch uploads of data to the tonnage database and reduce the need for manual data entry. Many contractors now have weighbridges which can produce tonnage data electronically and in real time. Management should investiga te whether it is feasible to obtain this data dir ectly. In the short term, a single database should be used for analysis and reporting. This will mean data only needs to be entered once.	There will be a review of the current process with the aim of implementing the recommendation of reducing the number of times data is inputted. This action will be taken forward on completion of the transformation process and once team structures are in place.	31/10/16	30/09/17 August Update : No further updates received by IA as LS has been on sickness leave. Further discussion required with ICT/CGI to identify software solutions to enable efficiencies. "July Update Meeting held 10/7/17 for update. 1) Date of end September is unrealistic for resolving multiple data input challenges. 2) Also need to ensure that data has been entered correctly. 3)IA to remain close to finding and monitor progress with September implementation date. 4) Weighbridge data flow return is to be looked at as a detective control to identify variability on a month by month basis. This information is to be provided to internal audit to ascertain its use as a detective control. 5) The service is to identify if it is feasible to sample high value invoices to identify possible mismatches with weighbridge information. "	Lesley Sugden, Waste Strategy Manager
			Contractors submit weighbridge tonnage data each month, which is used to calculate the recycling and landfill tonnage reported to the Transport and Environment Committee, and to prepare the annual SEPA submission. The current system for logging weighbridge tonnage submissions is manual as contractors provide their submissions in varying formats, some of which require further calculations to be made by Waste Services to establish the required figures. The data is entered manually into three separate databases, twice by the admin assistant and once by the Waste Collection Route Manager. The same data is entered into each database, with no significant differences in functionality between them.	Manual input could lead to errors in raw data used to calculate key performance measures; and Inefficient use of resources due to duplication of manual data input.	Automated data submission Contractors should be required to submit monthly weighbridge tonnage data in a prescribed format to support batch uploads of data to the tonnage database and reduce the need for manual data entry. Many contractors now have weighbridges which can produce tonnage data electronically and in real time. Management should investigate whether it is feasible to obtain this data directly. In the short term, a single database should be used for analysis and reporting. This will mean data only needs to be entered once.	Within all new procurement exercises going forward part of the technical specification will address the potential for direct access to contractors weighbridge systems. Where this is not possible the Council will provide an appropriate format for the return of weekly tonnage information to reduce any requirements for double handling data. In addition the Council will investigate the use of the E-doc system with contractors which requires upload of weighbridge tickets to a secure cloud based portal.	31/03/17 Revised date required	August Update : No further updates received by IA as LS has been on sickness leave Specification document has been updated and employed on the new dry mixed recycling contract. Weekly tonnage reports are also being provided by our Principal Contractors. [Closable on receipt of Evidence] "July Update Meeting held 10/7/17 for update. Specification document has been updated and employed on the new dry mixed; food waste and residual waste contracts, which cover circa 70 - 75% of the tonnage weighed by the weighbridge. Calibration clauses are included in all recycling contracts. Weekly tonnage reports are also being provided by our Principal Contractors. [Closable on receipt of Evidence]"	Lesley Sugden, Waste Strategy Manager
PL1601ISS.4	Recycling Targets	Medium	There are a number of Council service areas and divisions effected by the waste management strategy but are unaware of key issues, regulation changesand decisions. This appears to have been as a result of key stakeholders not having been appropriately identified and engaged in all areas of the process. The key stakeholders for the Council's overall waste management strategy are wide ranging, affecting related strategies and span both across the Council and externally.	☐ Key stakeholders not appropriately engaged leading to inefficiencies ☐ Lack of joined up working within the Council ☐ Regulation changes not appropriately communicated resulting in breaches ☐ Related strategies suffer from a lack of co-ordination.	A key stakeholder identification exercise should be performed to ensure all required individuals are included in the process. Key groups identified could include: Waste Services, Sustainability Team, Property Services and other external groups. In alignment with the creation of an internal waste management policy, stakeholders could be engaged through an overarching steering group with representation from each key group. This group would help ensure that relevant information is appropriately disseminated and that all stakeholders needs are considered. It would also enable stakeholders to monitor and challenge performance against the overall waste management strategy.	As outlined within the response to Action 2, it is our intention to refresh the existing strategy and to consult with both internal and external stakeholders to help shape the final strategy. A series of commitments/actions will be a key output from the strategy and progress against individual actions/commitments will form a key part of reporting progress to stakeholders.	31/03/17	30/09/17 August Update: Information has been provided to Internal Audit regarding the process of strategy review, this is unlikely to be ready for Committee before the revised September implementation date and a new date is to be provided. Draft new Waste and Recycling strategy is not yet finalised. Communication of this strategy will form part of a delivery plan for implementation. "July Update Work is continuing on the new Waste and Recycling strategy, this is not due to be presented to the Transport and Environment Committee until October at the earliest. A commitment to the date that the Waste and Recycling strategy is to be presented to committee, the committee papers and the outcome of the committee are to be provided to audit. The action can be reduced to low on the satisfactory receipt of this information. The strategy will then need to be communicated to stakeholders before the action can be closed "	Angus Murdoch, Strategy Officer

Ref	Title	Rating	Background	Risk	Recommendation	Management Action	Original Date	Revised Date	Update	Responsible Officer
PL1601ISS.5	Recycling Targets	Medium	Although there is considerable recycling internally within the council, there is currently no internal waste management policy.The Waste and Recycling Strategy 2010 - 2025 focuses on external, public waste but there is no supportingpolicy which specifically states how the Council itself as amajor local employer,plans on reducing waste arising from its own operations (e.g. schools, council offices) and increasingrecycling participation. The Council's strategic aim is to reduce overall waste being sent to landfill within the local authority by increasing recycling participation. Budgets h ave been set aside for schemes to increase public awareness and participation in an effort to achieve this strategic aim; however, a group of contributors to Edinburgh's overall waste (i.e. Council employees themselves) is being overlooked by not allocati n g sufficient resource to internal waste management schemes. In addition, there is a lack of data on how much waste is sent to landfill as a result of Council operations; therefore it cannot be accurately quantified how much the internally generated waste is costing the Council in landfill charges.	⯀ Lack of clarity over Council's own waste contribution that results in financial and environmental impact, ⯀ Risk of reputational damage due to lack of own strategy; and ⯀ Opportunity cost lost on not providing an overarching framework to support the Council's own recycling participation.	The Council should allocate sufficient resources to create and action an internal waste management or resource efficiency policy that embraces reducing, reusing and recycling. Many staff members will live in the City of Edinburgh Council, therefore generating waste at work and at home. Providing this awareness at work could realise additional benefits for the Council as a potential reduction for both internally generated waste and household generated waste within the local authority. With the continued future increases in landfill tax, it is advisable that the Council leads by example and gives consideration to monitoring its own waste data to ensure effective targeting of effort.	Our proposed management action is to approach the Sustainable Development Unit and Facilities Management to establish a working group to review any existing internal waste policy, the purpose being to incorporating this within, and consult on, a refreshed Waste Strategy Document (Ref Action 2). The inclusion of the Sustainable Development Unit is critical in moving forward this action as they hold responsibility for development of the Council's internal waste policy and recording data on internal waste arisings. Waste & Fleet Services will commit to taking the lead in establishment of the internal working group. Opportunities to improve the way in which the Council gathers and records data on its own waste arisings will be a key outcome of the working group. The Council ' s Trade Waste Service (part of the Waste & Fleet structure) has already met with Facilities Management to identify opportunities to increase the range of recycling opportunities across the Coun cil estate. New services such as food waste recycling will be available in major Council offices such as Waverley Court and is already available across a number of schools.	30/09/16	30/04/17 31/12/17	August Update - Information provided to IA regarding the Changeworks SLA requirement to "Develop awareness among staff of the correct procedures and contact points to improve and resolve waste management problems within schools." A revised date of the 31/12/17 to develop the internal waste management policy. Working group now established between Facilities Management and Waste and Cleansing Services. This group meets regularly. [Closable on receipt of evidence] July Update - meeting held 10/7/17 to discuss Recycling bins have been provided to corporate buildings. A Factsheet or Cecil leaning module could be provided and tracked to evidence that users know how to use the recycling bins. If it can be evidenced that 70% of buildings have recycling bins the action rating can potentially be reduced to low risk.	Karen Reeves, Technical Team Leader
PL1601ISS.6	Recycling Targets	Medium	There is no formal review plan in place for theCouncil'sWaste & Recycling Strategy 2010-2025.In addition, there is no clear action plan with assigned responsible individuals that stems directly from the strategy andassists for overall monitoring and review of the strategy. Instead, individual projects are created from the strategy that are monitored and reviewed individually on an ongoing basis. This is deemed sufficient for operational purposes, but there should still be an overarching review of the strategy as a whole on a regular basis to ensure that it remains relevant.	⯀ The strategy as a whole suffers a reduction in effectiveness at reaching set Council targets. ⯀ There is a risk that the strategy losses relevance to changing requirements. ⯀ Lack of awareness on how all projects feed into and complement the overall strategy.	The current Waste & Recycling 2010 - 2025 strategy should be reviewed and a clear action plan, with responsible individuals put in place as a direct result of the strategic goals/aims identified in the strategy. A formal review process should be implemented, which could form part of the remit for an overarching steering committee.	It is recognised within the service that the Strategy needs to remain as a 'living' document with appropriate points in its delivery for review. A number of the commitments within the existing document have been delivered and it the intention that the existing strategy undergoes a complete update/refresh. It is proposed that the refreshed strategy is consulted on with both key internal and external stakeholders to agree the contents and accompanying action plans. The key purpose is to develop a roadmap of commitments, projects and actions for the service. Waste & Fleet Serv ices are currently in the latter stages of an organisational review, a key part of which has been the establishment of the Service Support Unit (SSU). A Waste Strategy Manager has been recruited and joins the SSU in early January. A number of project deli v ery roles also exist within the strategy team. This increases and strengthens capacity within Waste & Fleet in order that the review and refresh of the existing Waste Strategy can commence in line with the proposed target date.	31/03/17	30/09/17	August Update: Waste and Cleansing Service Review complete. Responsibility for the drafting and delivery of the waste and recycling strategy has been recognised within the scope of the Technical Co-ordinator role. This will involve a review of the existing strategy. July Update - meeting 10/7/17 Responsibility for the drafting and delivery of the waste and recycling strategy has been recognised within the scope of the Technical Co-ordinator role. This will involve a review of the existing strategy. Waste and Recycling strategy review is ongoing. Evidence to be provided to IA of the ongoing workplan and ownership of the Waste and Recycling review as well as an agreed frequency for this to be reviewed.	Angus Murdoch, Strategy Officer
PL1602ISS.2	Licensing	Medium	Schemes of delegation covering licensing powers and responsibilities are in place for civic licences (the Council scheme), and for licences governed by the Licensing Board. For civic delegated decisions where an application is a renewal and non-contentious, the Authorised Officer can be a Licensing CSO (GR6). This level of authority is not formalised in writing within the section. Delegated authority for granting licences was reviewed for a sample of twenty five applications processed in 2015/16. The following issues were noted: Licences for 60 market stalls required at short notice over the festive period should have been subject to Councillor consultation. As none were available, a Senior Officer countersigned the grant sheet; Supporting papers could not be found for one application. As grant sheets are not scanned in to the APP system, no evidence could be obtained as to the level of authority required to grant this licence . 3. All applications categorised as 'new' require Councillor consultation, however one new application reviewed appears to have been incorrectly categorised as a renewal and the decision delegated to an Officer. It was noted that for changes in ownership of existing HMOs notified within 28 days of change, the application can be signed off as a renewal. In this case, actual date of ownership was difficult to determine from the supporting documents held.	There is a risk that delegated authority is used to grant applications that should be considered by elected members.	Delegated powers within the section require to be formalised. A guidance note should be produced to accompany the scheme of delegation, outlining the categories of application that can be signed off by Officers, and at what grade. Guidance should cover the requirement for segregation of duties between CSOs processing an application and granting the licence. Guidance should also cover the procedure and any retrospective validation required where Councillor consultation is not available within the required timescale. Copies of signed grant decision sheets should be held in APP to evidence the granting or refusal of the licence.	A guidance note accompanying the Councils Scheme of Delegation to Officers will be prepared for all licensing staff and discussed with elected members.All staff will be briefed on this guidance. The Team will be instructed that all grant/refusal decision sheets must be scanned and indexed in the relevant action diary within APP.	31/10/16	30/06/2017 Revised date requested - no response received	August Update: Draft letters of delegation are with legal for checking, hope to get them to the Director later today. IA has requested revised date - no response received SOD formalised, reviewed by legal. Guidance awaiting Senior Manager sign off. Need to initatiate wider review of this aspect of the scheme of delegation as the process risks legal challenge. Proposing to do this prior to local government elections and roll out new process as part of elected member training. New proposed completion date 30 June 2017. July Update Amendment to scheme of delegation was agreed at full Council on 29 June (para 3.6 of the operational governance framework report). \Paragraph 178 of the standing orders was amended to remove Councillors from role. A briefing note has been prepared explaining the change to the new Convenor. It was expected that this would take place in May but was delayed as the new administration was not in place. The existing deadline was agreed with an expected May completion date and has now been changed to end July. deadline was agreed when we expected a May report. Now that the change is agreed letters of delegation are being updated for Director approval. Once approval received, a staff briefing will be prepared reminding them all of the new procedure.	Andrew Mitchell, Regulatory Services Manager
PL1603ISS.3	Mortuary Services	Medium	The current Bereavement Services risk register, dated July 2015, outlines a range of controls in place as part of the mitigation strategy to manage the body holding capacity risk. The risk was escalated to the Place risk register, and as at April 2016 was in the top 10 Departmental residual risks, categorised as one of the most controlled risks due to the controls noted as being in place. The mitigation strategy includes the following: M ortuary plan in place ; and Staff training and participation in a Service quality action group. The Scientific , Bereavement and Registration Services Senior Manager noted that there are no formal mortuary plans in place covering arrangements to minimise storage times , and no such training is currently being delivered. In addition, n o Service KPIs or performance / service standards are currently produced. Q uality documents for the Mortuary covering forms, plans and procedures are being drafted . The mitigation strategy also notes that Funeral Directors are contacted to increase collection rates, but this does not recognise that Mortuary staff are limited i n the actions that they can take in this respect until the Funeral Director makes contact , as their service is assigned by the next of kin. The risk register does not reflect other issues outwith Council control, for example, T h e daily cap on the number of post mortems undertaken means there is always a backlog ; and T he uncertainty around service delivery post Crown Office contract expiry in 2020.	The lack of an accurate risk register and formal mortuary plan increases the risk that intended controls are not implemented in practice leading to inefficient use of resources and demand not being managed effectively.	The Bereavement Services risk register requires to be updated to reflect current controls in place. Issues currently outwith Council control should be added to facilitate wider discussion on ways to better manage these. A mortuary plan should be prepared covering the management of body holding capacity. The plan should include: An outline of current arrangements; An outline of all key stakeholders; Service standards expected of Mortuary staff to ensure an efficient, prompt and respectful service; Standards expected of key stakeholders, for example, processes to be followed by Police when storing a body out of hours, prompt notification from Funeral Directors when assigned, and prompt collection by Funeral Directors when notified that a body has been released for uplift; and A programme of regular staff training sessions to ensure that Mortuary staff are aware of their responsibilities to minimise storage. The plan should incorporate contingency arrangements for business as usual during periods of extended closure, for example, at Easter and Christmas.	Work with Environment Service and Place Directorate to update the risk register post transformation review. A mortuary plan is under development and should be completed before the end of December 2016. Implementation by 31/01/2017 is anticipated.	31/03/17	IA Validation in progress	July Update - meeting held 10/7 to discuss 1) A risk register is to be created. 2) Operational plan to be produced to track and forecast demand. This could be high risk as the Council is providing services to other local authorities and may not be able to meet the additional demand. 3) A contingency plan is to be produced to ease pressure on the council mortuary at times of high demand and it should be evidenced that this has been tested. 4) Potential for rating to be reduced to low if the risk register and operational plan can be evidenced. 5) Action can be closed on the receipt of evidence that that the risk register, operational plan and contingency plan have been implemented and tested. August Update - Information was provided on the 22/8/17 and is currently being reviewed by Internal Audit.	Robbie Beattie, Scientific, Bereavement & Registration Services SeniorManager

Ref	Title	Rating	Finding	Risk	Recommendation	Management Action	Date	Update	Owner
PL1603ISS.5	Mortuary Services	Medium	The City Mortuary is a key stakeholder in the following plans: City of Edinburgh Council (CEC) Emergency Plan; interim update Jul 2014; CEC Corporate Business Continuity Plan; Oct 2013; CEC Corporate Pandemic Influenza Business Continuity Plan; Jul 2009 (re-issue due Apr 2017); Emergency Mortuary Management Arrangements Module of CEC Emergency Plan; draft Apr 2015; Services for Communities Contingency Plan (Bereavement Services); draft Jul 2015; and Services for Communities Business Continuity Plans for Bereavement Services; Dec 2013. There are inconsistencies and gaps between the plans including: The Bereavement Services contingency plan includes no detailed action plan covering body storage arrangements in the event of an extensive emergency, such as a pandemic, where National / reciprocal body storage resources will not be available. This area is currently under review nationally via the Scottish Government Silver Swan exercise; and The Emergency Mortuary Management Arrangements module, covering arrangements in response to intensive emergencies outlines the locations and number of body storage units within the Council and externally. This does not reflect: The basic storage available at the Mortuary; The current location of the Council emergency units; Average spare capacity for NHS Lothian, as determined at Easter 2016; and Average spare capacity of the Queen Elizabeth Hospital in Glasgow (the 300 quoted includes day to day usage and gives no indication of any potential capacity issues here). Significant staff and organisational changes within Place and Bereavement Services over the past year have impacted on the preparation of, and key roles and responsibilities outlined within Place contingency documents. The Scientific, Bereavement and Registration Services Senior Manager recognises that all local plans need revised, with separate plans set up for Mortuary and Crematorium services.	If contingency plans in place are not comprehensive, with accurate and up to date capacity information, the required actions to be undertaken by Council staff may be unclear, increasing the risk of inappropriate treatment of fatalities.	All Mortuary Service contingency plans require to be reviewed and redrafted to ensure that they are up to date, comprehensive and reflect current government guidance. Capacity and location information within contingency documents should be corrected to reflect current arrangements. Following review and update of plans in place: Training should be rolled out to staff; and The Corporate Resilience Unit should be provided with updated extracts.	Work with Corporate Resilience Unit to update contingency plans drafted before transformation review. Work with NHS Lothian to support them taking on the role of host mortuary for mass fatalities, thus easing pressure on Council mortuary.	31/03/17	IA Validation in progress	**August Update** - Information was provided on the 22/8/17 and is currently being reviewed by Internal Audit. July Update - as per finding above, actions to resolve both are linked.	Robbie Beattie, Scientific, Bereavement & Registration Services Senior Manager
Resources									
RES1603ISS.1	Leavers Process	High	We selected a sample of 45 employees who left the Council in August 2016. 11 (25%) still had an open Active Directory account at the time of our audit in November 2016. An Active Directory account permits access to core Council IT systems including computer terminals, email and the intranet. User accounts for other Council systems such as Oracle (finance), Swift (social work), iTrent (HR and payroll) and Seemis (schools) are linked to the user's Active Directory account. Note that we did not review access to other Council systems, or systems hosted by third parties. However, we note that there is no record of which systems any one employee has access to. Leavers' accounts are therefore only closed if the leaver or their line manager contacts the relevant systems administrator.	Risk of a breach of data protection laws if sensitive data is accessed by staff who no longer work at the Council. Risk of inappropriate or fraudulent use of ICT systems access remaining active post employment, both by leavers accessing systems remotely, and by current employees with access to former colleagues' accounts. Once web-based Outlook and One Drive accounts are introduced in 2017, leavers with open Active Directory accounts will be able to access Council emails and shared sites with no need for access to a Council-managed device.	Active Directory accounts must be closed when a member of staff (whether payroll or non-payroll) leaves the Council. Access to other Council IT systems, including those hosted by third parties such as eIRD (which holds child protection records and is hosted by NHS Lothian), must be terminated when the member of staff leaves the Council, or moves to a role where access to that system is no longer required.	As Finding 1, a process review workshop will be held on 29 March when issues and improvements in the leavers process (including HR, Customer Services and ICT) will be mapped an identified. HR guidance will then be refreshed. This will include mechanisms to notify administrators of systems hosted by third parties.	30/06/17	30/09/17 **August Update:** Meeting held with HR and ICT for update. HR continuing to work through some actions. Position with ICG has bee escalated and IA are now engaged with them to validate new controls they will implement to support closure. Revised date has been agreed with Executive Director, Resources July Update Workshop sessions have been held on leavers process. We still have some work to do and a lot hinges on the work ICT & CGI are currently doing around asset management. CGI are reviewing best practice across all of the clients they work with to design the best process possible for CEC and we have set a date of 30 September 2017 for this to hopefully be completed.	Katy Miller, Head of Human Resources
CG1503ISS.1	Continuous Controls - One Time Payments	Medium	Finding The One Time Payment Form (OTP) is defined as being for 'one time' payments which do not relate to a contract for supplies and services. However, the audit review highlighted that the OTP system is being heavily used for multiple payments in the following categories: • System workarounds: ▢ Oracle payment system cannot make payments to non UK bank accounts; and • Historically suppliers such as the DVLA and Sheriff Clerk required individual cheques provided with each application for Vehicle Tax or Council Tax Summary Warrant. This practice remains when other more efficient debit or electronic payment options should be available. • Inefficient Channel: Due to either a lack of knowledge of options available; or lack of access to CEC systems; a large number of cheques are raised by CEC to CEC or to suppliers already on the database. Key examples of this are: ▢ Replenishment of Libraries Petty Cash Imprest; and ▢ Client account transfers in H&SC.	By their frequency and nature one time payments are subject to less rigorous verification controls on set up. The system also holds less data, for example supplier number and authoriser are not held. This increases the risk of: • fraud and error being undetected; • payments being made to inappropriate individuals or companies; • key vendor system controls being bypassed leading to increased costs; • incorrect financial figures being given in respect of FOI or other monitoring requests; and • inefficient use of resources.	Channel shift should be embraced to move regular multi-payments to a more efficient platform.	A total review of this area will be completed when the new UNIT 4 Business World system is implemented. Procurement note that any methods of making payments to DVLA and Post Office are a statutory requirement and will have to continue at present. OTP'S relating to vendors will only be accepted if payment is for a rebate only. [wef 18/1/16] Payment Services will request that these types of payments are set up in the new BW system as a sundry account and paid via BACS/Cheque. It should be noted that the new BW e-solution will not have the facility to convert currencies that are not British pounds.	31/10/16	01/10/17 These actions are intrinsically linked to the implementation of the new Business World system. As a result of delays to the programme, the original due date could not be met. Internal Audit have been kept informed of changes to the anticipated implementation date of the Business World system. These updates have been agreed with Internal Audit as the ICT implementation dates have become known. Ongoing focus in the short term to minimise one time payments, with OTPs now limited to rebates since Jan 2016. However as noted DVLA and Post Office payments are statutory. **July Update** Whilst these actions are intrinsically linked to the implementation of the new Business World system (now expected to deliver April 2018), management has confirmed that revised interim controls have been implemented to mitigate this risk. A walkthrough of the enhanced controls has been scheduled for week commencing 17 July 2017. If the revised controls are assessed as adequate and evidence of their operation provided, this finding will be closed. Ongoing focus in the short term has resulted in volumes of OTPs being minimised, with OTPs now limited to rebates since Jan 2016. However as noted DVLA and Post Office payments are statutory. **August Update** Whilst these actions are intrinsically linked to the implementation of the new Business World system (now expected to deliver April 2018), management has confirmed that revised interim controls have been implemented to mitigate this risk. A walkthrough of the enhanced controls was completed on the 17th July 2017. The new procedures were found to be adequate to prevent incorrectly completed cheques being sent out by the payments team. However, issues remain regarding the authorisation of payments. A new email based authorisation process is being implemented and a walkthrough of the procedure is to be conducted in September. If the revised controls are assessed as adequate and evidence of their operation provided, this finding will be closed.	Neil Jamieson, Customer Senior Manager

Ref	Area	Rating	Finding	Risk	Recommendation	Management Response	Orig Date	Rev Date	Update	Owner
CG1511ISS.2	Continuous Testing-Standby, On Call & Disturbance Payments	Medium	Guidance is published on the Orb for standby, on call and disturbance payments, setting out the rules and rates applicable. This guidance is supported by frequently asked questions. It is however a complex area with a range of common and less common situations, and in practice various combinations of allowances are claimed. The complexity of the process does not help scrutiny of claims and provides opportunity for inaccurate or inappropriate claims to be approved. Issues contributing to weakening the control framework, whether intended or otherwise are outlined below: 1. Lack of relevant detail in narrative fields preventing proper scrutiny of claim. Claims often just have "Call" and not enough information to identify separate or repeat incidents; 2. There are different claim forms for "Standby and Call-out", Overtime, "Non-Standby Call-out". The fact that these are separate and often input at different times makes robust scrutiny more difficult; 3. Core and standby periods used by areas often differ from the published times provided by the Service Area; and 4. Frequent failure to reset claim forms leading to conflicting dates appearing on forms.	Claims being made and authorised in excess of what is appropriate as claims are accepted at face value with insufficient data to validate them.	The claim process should be simplified where possible on the migration to the new payroll system.	Management are aware of the weaknesses of the current HR/Payroll solution and have retested the functionality to confirm the findings contained in the report. Configuration of the Business World solution will where possible include reduced complexity to prevent the recurrence of these issues going forward. Ongoing we will document specific system controls that have been configured within the new system to preclude recurrence of these issues. This will be shared with Internal Audit for the purposes of completeness and ensure we have in fact closed out the weaknesses identified.	31/10/16	01/04/18	These actions are intrinsically linked to the implementation of the new Business World system. As a result of delays to the programme, the original due date could not be met. Internal Audit have been kept informed of changes to the anticipated implementation date of the Business World system (2018). In the short term we are assessing the use of Robotics Process Automation (RPA) as an interim solution. This will cover both the form, process and transaction. Complete assessment by 31/8/17. July Update Whilst these actions are intrinsically linked to the implementation of the new Business World system (expected delivery date April 18), management has confirmed that they are implementing new controls into the existing process to mitigate the risk. It is expected that these will be in place by end of August 2017. Audit will arrange time to perform walkthroughs and obtain supporting evidence in early September. If the revised controls are assessed as adequate and evidence of their operation provided, this finding will be closed. August Update Whilst these actions are intrinsically linked to the implementation of the new Business World system (now expected to deliver April 2018). A walkthrough of the controls was completed on the 23/8/17, manual checking is completed by the payroll team to ensure the correct information is inputted into the iTrent system. Although there is segregation of duties it is the same team processing and checking the payments. Although some forms are rejected if completed inaccurately, there is no documented process regarding when a form should be rejected. Additional controls are being discussed with Internal Audit.	Grant Craig, People Support Manager
CG1511ISS.3	Continuous Testing-Standby, On Call & Disturbance Payments	Medium	The iTrent payroll system in its current configuration lacks basic automated input controls to validate the quality of information submitted. This leads to a high number of erroneous claims being accepted. A key example of this found during the review was a claim from 22:30 to 12:00 which led to a 1.5 hour claim being paid at 13.5hrs. This led to an overpayment of £316.80 which had not been identified. The money was recovered when we notified payroll. Lack of basic automated controls has led to the following types of errors being accepted, all identified during the course of this review: Conflicting standby header and week commencing dates, Incorrect mixture of 12 and 24 hour clock affecting claimed times, Invalid times accepted e.g. 2430, Future dates accepted, Historic dates from previous financial years accepted, Standby disturbance claims accepted when not on standby, and Mutually exclusive elements accepted at same time.	The lack of basic automated application controls increases the risk of invalid claims being made, approved and paid.	As part of the development of and migration to the new payroll system logical validation checks over input should be incorporated wherever possible.	Management are aware of the weaknesses of the current HR/Payroll solution and have retested the functionality to confirm the findings contained in the report. Configuration of the Business World solution will where possible include increased validation to prevent the recurrence of these issues going forward. Ongoing we will document specific system controls that have been configured within the new system to preclude recurrence of these issues. This will be shared with Internal Audit for the purposes of completeness and ensure we have in fact closed out the weakness e s identified.	31/10/16	01/04/18	These actions are intrinsically linked to the implementation of the new Business World system. As a result of delays to the programme, the original due date could not be met. Internal Audit have been kept informed of changes to the anticipated implementation date of the Business World system (2018). In the short term we are assessing the use of Robotics Process Automation (RPA) as an interim solution. This will cover both the form, process and transaction. Complete assessment by 31/8/17. July Update Whilst these actions are intrinsically linked to the implementation of the new Business World system (expected delivery date April 18),management is currently investigating the costs associated with upgrading the iTrent system input controls to mitigate this risk. If these costs are significant, then this Finding will remain open until the Business World implementation is complete.	Grant Craig, People Support Manager
CW1501ISS.1	Procurement Arrangements	Medium	Contract Register Updates It is the responsibility of Service Areas to provide complete, accurate and up to date contract information. Data is entered online via a contract register form in the Orb, downloaded to C&PS and used to update the register manually. This ensures that fields are updated in the same format as much as possible. The online form is being simplified to improve consistency of data provided. A sample of 12 contracts awarded by the Finance & Resource Committee in 2014/15 were selected to establish if details are reflected in the register. Most contracts had been updated, however in four cases contract end dates & values, and cross referencing between the live contract and live framework tabs required further validation. The Senior Commercial Operations Officer recognised the need for better validation of data provided online by Service Areas prior to updating the register. It is also recognised that a formal system to track activity within and improve the links between the contract and pipeline registers is required. Access to the Registers The registers are currently held in excel with shared open access within C&PS . There are plans to set up the pipeline register as a web application , with a link to an access database which will hold the contract register. Contract Register Overviews & Feedback Bi-monthly contract register overviews sent to each Directorate include lists of all contracts due to expire within 18 months, for example, details of 105 contracts were issued to Services for Communities (SfC) in March 2015. Service Areas are required to provide a note of actions being taken against each expiring contract. Feedback received by the Commercial Partners is forwarded to the Senior Commercial Operations Officer to update the contract and pipeline registers, and to the relevant Category Manager to note any new tendering requirements. It is recognised that data issued to Service Areas need to be more refined prior to issue; checks need to be made to the pipeline and contract registers to ensure that only contracts that C&PS require updates on are followed up.	Information inaccuracies on the contract register risk best value not being achieved and potential savings lost. Open access leaves the registers vulnerable to deliberate or accidental manipulation. The quantity of data provided creates additional work for both sides and may distract from the key information required.	Robust data validation checks are required to ensure the accuracy and completeness of contract register entries, including framework contract details. The Procurement Reform (Scotland) Act 2014 proposes a requirement for all Local Authorities to publish a register of contracts over £50,000, likely to come into effect within the next year. This pending wider scrutiny re-inforces the need to ensure that information is robust. Action should be taken to secure the pipeline and contract registers. This should include implementing password protection, restricting edit rights and creating an audit trail so that modifications can be tracked and monitored. Improvements need to be made to the process to ensure more targeted information in respect of expiring contracts is sent out focusing attention on areas where management feedback is required.	Validation checks are now in place. Each Category manager has reviewed the Register to validate entries aligned to their Category. The transfer of the pipeline to a Sharepoint database provides an audit trail reducing vulnerability to deliberate or accidental manipulation. In the short term we will introduce password protection for the contracts register or move the live version into a folder with restricted access, but in the medium term intend also to move the register to a database that provides an audit trail and provide wider access to staff to input their updates. Reporting of contracts approaching expiry is a recent development. The early reports have identified gaps in our procedures for capturing the current status of actions being taken against each expiring contract. We will address this by developing and documenting a clear process for recording status updates. In addition we will ensure that both Delivery Teams and Commercial Partners review reports before they are circulated to services.	31/03/16	30/04/17	**IA Updates requested July and August - no responses received potentially due to timing of annual leave.** (ii) Short-term - the pipeline register is now held on the Sharepoint database. The contract register is now password protected; only 4 members of the Commercial Operations Team now have access to update the master. Completed. The contract register and pipeline will be held within Business World 4 when this is implemented. As a consequence of delays to ERP programme the expected dates have not been met as CPS are reliant on Business World implementation. July Update Short-term - the pipeline register is now held on the Sharepoint database. The contract register is now password protected; only 4 members of the Commercial Operations Team now have access to update the master. Completed. The contract register and pipeline will be held within Business World 4 when this is implemented. As a consequence of delays to ERP programme the expected dates have not been met as CPS are reliant on Business World implementation. Whilst final implementation is dependent on Business World Implementation (expected April18), Audit are working with Procurement team to walkthrough the key controls (July) to establish whether the risk has been mitigated and the rating can be reduced.	Tammy Gillies, Acting Head of Procurement

Ref	Title	Rating	Finding	Risk	Recommendation	Management Response	Date	Revised Date	Latest Update	Owner
MIS1601aISS.3	Non Housing Invoices	Medium	The system used to manage repairs and maintenance to operational buildings, AS400, is due to be replaced in the Autumn/Winter 2016. The system is over 40 years old and is limited in its capabilities and links to other Council systems. This means it is difficult to obtain information about repairs carried out. Only one officer is able to use AS400 reporting functions, and none we spoke to in Corporate Property knew how to access information about EBS non-housing recharges through the Frontier financial reporting system. This limits the management information available to Corporate Property about the volume and value of repairs. It also delayed our audit fieldwork and restricted the scope of our audit. For example, the AS400 (works ordering), Total (billing) and Oracle (finance) systems do not use the same reference numbers. A manual log is kept to record the invoice number for each works order raised on AS400. This was not consistently updated, so, despite the help of the non-housing administration team and Accounts Payable, we were able to trace invoices for only 4 of the 60 charges reviewed. We also identified occasions where details of works orders charged to Corporate Property had not been transferred into the Oracle data warehouse. This means we (and Corporate Property) were unable to validate the accuracy of the charge for those periods. The total charge only was recorded.	Lack of management information about the volume and value of non-housing repairs.	Management will not have ready access to accurate and reliable information about the volume and cost of repairs and maintenance until AS400 is replaced by CAFM in Autumn/Winter 2016. We note that the introduction of CAFM has been delayed, and every effort should be made to meet the new target implementation date.	It is anticipated that CAFM will be in operational use (services being implemented on a rolling programme thereafter) in early 2017 with a non-Housing R&M implementation process in place for FY 2017/18	01/04/17	Revised Date required	**Latest Update:**This has progressed. However, following the PPP structural wall issue plus reports to CLT, the condition module has now been prioritised and, with assistance from external surveyors, this will be complete for the non-housing estate in autumn 2017. This will identify the backlog maintenance, both capital and revenue, and allow prioritisation and budget planning in detail going forward. The remaining property maintenance modules will be rolled out in 2017/18 and this is progressing. July Update This has progressed. However, following the PPP structural wall issue plus reports to CLT, the condition module has now been prioritised and, with assistance from external surveyors, this will be complete for the non-housing estate in autumn 2017. This will identify the backlog maintenance, both capital and revenue, and allow prioritisation and budget planning in detail going forward. The remaining property maintenance modules will be rolled out in 2017/18 and this is progressing.	Peter Watton, Acting Head of Corporate Property
RES1605ISS.1	Service Level Agreements with Outside Entities	Medium	We reviewed the arrangements in place with 5 organisations to which the Council provides professional services. Organisation Services provided 2015/16 Fees Lothian Valuation Joint Board Payroll services Accountancy services Internal Audit £ 20,100 SEStran Accountancy services Payments and procurement Insurance Treasury management Internal Audit Payroll services £ 23,350 Lothian & Borders Community Justice Authority A ccountancy services Payments Internal Audit £ 22,000 CEC Holdings Accountancy services £ 20,000 Royal Edinburgh Military Tattoo Payroll services Treasury management Internal Audit £ 1,500 There was a current Service Level Agreement (SLA) in place with only one of those 5 entities (SEStran). The agreement had been set up in June 2013 for a period of 12 months, and has been extended a further 3 times since then. There was a further SLA with the Lothian & Borders Community Justice Authority. This SLA expired in March 2010. The Council has continued to provide accounting support including accounts preparation to LBCJA at the rates agreed in 2009. Additional services including accounts payable and internal audit were not included in this SLA. There were no SLAs in place with the remaining 3 entities. Services provided and fees charged were understood to be historic arrangements.	If service levels are not formally agreed with the other organisation, there is a risk that: There is r eputational damage and increased resource pressure if the Council does not deliver services as expected by the counter party; The Council may not receive appropria te remuneration for services provided; and Arrangements in place may not be appropriate or may conflict with other Council duties.	Service Level Agreements with the organisations to which the Council provides professional services should be reviewed and/or established. These should set out services provided, key activities and deliverables, and the respective roles and responsibilities of the Council and the counterparty. Service Level Agreements should be for a defined period and refreshed regularly to ensure that agreed services and charges remain appropriate.	A service level agreement with the Edinburgh Integration Joint Board is currently being developed. This template will be rolled out to other third party organisations to which the Council provides services as a generic service level agreement, with the exact terms (fees, services, dates) appended as a delivery schedule. July Update The IJB SLA is signed and a generic SLA to be used as the basis for agreements with ALEOs as required has now been shared with all Service Areas. Directors / Heads of Service have been requested to confirm (for their areas) that service level agreements have been established to support all third party relationships where the Council provides services. If individual responses are not provided by end August 2017, individual actions will be raised allocated across all Service Areas to ensure that SLAs are implemented.	31/01/17	30/06/17	**August update:** Request in main paper for CLT to close this action and raise separate actions on all Heads of Service to identify all third party organisations and implement the SLAs. The SLA with the IJB has been agreed and is now a signed document. The next stage is to roll this template out to the other third party organisations that the Council provides services to. These have been identified and the task of implementing SLA's has been allocated to discrete individuals. The revised target for getting the SLAs in place is 30 June 2017.	Nick Smith, Head of Legal and Risk
RES1606ISS.2	ICO Follow Up	Medium	CEC agreed to the ICO that all employees would complete the e-learning module on Information Governance that was mandatory at the time (A16). Since the ICO review, frequent and consistent messages have been issued on information governance. Despite this, a number of council staff have still to complete the module. In addition, CEC agreed to undertake role-specific training for a number of higher-risk data security roles. In some cases (A6, C20, C27) these trai ning sessions have been planned, with materials provided for review. However, these sessions have not yet taken place, as many of the staff are relatively newly appointed and due to organisational restructur e and change across the Council. All role-specific training sessions agreed with the ICO are currently scheduled to be held by the end of Q2 2017.	Risk that staff do not properly understand the implications of data security within their role and the steps they can take to minimise risk to the Council.	All staff should complete the e-learning module and role-specific training courses should be conducted, as planned, by Q2 2017.	Existing Council employees who have not yet completed the IG eLearning module will be instructed/strongly encouraged to do so. Once the elearning module is complete, staff will be expected to update their knowledge of the Information Governance related policies on an annual basis as part of the annual policy refresher process. However, completion of the elearning module may be considered excessive for front line manual workers who have minimal or no information governance responsibilities and a briefing note, prepared by the Information Governance Manager, will be used as an alternative for these particular employee groups.	30/05/17	31/10/17	Several role specific training programmes have been established in relation to data protection compliance. The e-learning module for managers is being revised to include the latest guidance issued by the external regulator concerning the new General Data Protection Regulation which comes into force in May 2018.	Margaret-Ann Love, Learning & Development Manager

Strategy & Insight

Ref	Title	Rating	Finding	Risk	Recommendation	Status Update	Original Date	Revised Date	Latest Update	Owner
CSE1601ISS.2	Review of Grant Management	High	Conflicts of interest are difficult to define due to their inherent subjectivity and are often the subject of public scrutiny. The Culture and Sport Committee consists of 15 elected members. They approve grant funding to cultural organisations on an annual basis. A review of Companies House records and the Register of Interests found that ten of the elected members are current or recent directors of one or more of the funded organisations. This could result in the perception of conflicts of interest as in effect, elected members are awarding grants to organisations that they are connected to and have an interest in. The Councillors' Code of Conduct set by the Standards Commission for Scotland defines holding office in a company or voluntary organisation as a declarable non-financial interest (section 4.22). The Code states that an elected member must withdraw from the meeting room until any discussion or vote on an item where they have a declarable interest is concluded (section 5.7). The Code further advises that councillors should not accept a role or appointment if it would mean they frequently declare an interest at a particular committee on which they sit (section 5.22). There is an exemption within the code (section 5.18–d) where the appointment has been approved by the councillor's local authority and the company or voluntary organisation was: Established wholly or mainly for the purpose of providing services to the councillor's local authority; and Entered into as a contractual arrangement with that local authority for the supply of goods and/or services to that local authority In such a case, the councillor is not required to withdraw from discussion or voting, but must declare their interest. The Culture and Sport Committee approved grants to 36 cultural organisations on 8 March 2016. The 13 councillors present between them held 18 directorships on the boards of charities receiving grants. Only 9 interests in Directorships were declared at the meeting. No councillors withdrew from the meeting. It is not clear to Internal Audit that the 9 interests declared were in organisations that would qualify for the section 5.18-d exemption.	Risk that public confidence is damaged by perception that the Committee's decisions are influenced by factors other than the public interest; and Risk of Contravention of the Councillors' Code of Conduct	In accordance with the Councillors' Code of Conduct, Councillors must declare an interest where they are a member or director of a public body, company, or other organisation. Unless the exemption discussed above applies, councillors must withdraw from the meeting room until discussion or voting on an item where they have a declarable interest. This includes scrutiny or funding of charities of which they are a director. To meet best practice governance standards, we recommend that councillors do not sit on Committees which award grants to and scrutinise the activity of charities of which they are a director.	Mandatory induction training for new elected members in May 2017 on these areas will be in place. July Update Mandatory code of conduct training was scheduled as part of the new Councillor training programme with three scheduled sessions (9, 10 and 15 May) and two additional sessions delivered. . Strategy and Insight has provided evidence of the training packs, however 19 of the Councillors (16 returning and 3 new Councillors) have not yet completed this mandatory training. A training needs analysis will be carried out in August after recess, which will inform the Autumn training programme to be delivered in October/November. This will include training on the Code of Conduct. Based on the above, the rating has been reduced from High to Medium.	30/06/17	Revised date required		Kirsty-Louise Campbell, Strategy & Governance Manager
HSC1604ISS.2	IJB Data Integration & Sharing	High	During interviews conducted with NHS and CEC, it was noted that two processes (specifically access management and communication protocols for data sharing) do not fully support the objectives of the IJB. Responsibilities for ensuring that access rights to NHS and CEC systems remains appropriate have not been established. Currently, managers within NHS should notify CEC and vice versa of staff joiners, leavers or movers. This allows access rights to be updated in line with revised operational requirements. However, there is no formal documented process or guidance that sets out the requirement to notify the two bodies of staff changes , and interviewees reported that access control is inconsistently applied (for example not all managers notify their 'non-home' organisation ' of staff changes). Currently, communication protocols for data sharing are in place. However, we observed that these protocols were not fully established and not sufficiently mature enough on data protection to properly support the objectives of IJB.	There is a risk of managers not being aware of their responsibilities to notify their 'non-home' organisation of staff changes. This could lead to access rights not being updated for leavers or movers and result in confidentiality of sensitive citizen data being put at risk, leading to regulatory fines or censure. Immature data sharing protocols increase the risk of data being inappropriately handled or misused, putting the confidentiality of sensitive citizen data at risk, leading to regulatory fines or censure.	IJB should ensure the communication protocols for data sharing are fully established and mature on data protection.	A pan Lothian General Data Sharing Protocol that facilitates trust among all parties (NHS Lothian, Edinburgh, East, West and Mid Lothian Councils and IJBs) is now in place and the Memorandum of Understanding (MOU) defining the joint data controller responsibilities between the City of Edinburgh Council, NHS Lothian and the EIJB is in the final draft. It is envisaged that the MOU will be signed off by all parties by the end of June 2017. Once sign off has been achieved details will be shared with staff through the regular staff newsletter.	31/07/17	31/10/17	**August Update:** A final draft of the MOU has been circulated and we anticipate this to be agreed, in principle, by all parties and forwarded for signature shortly. Subsidiary documentation is currently being assessed by NHS, Lothian Councils, and CEC as part of this process.	Kevin Wilbraham, Information Governance Manager, Corporate Governance.
RES1605ISS.2	Service Level Agreements with Outside Entities	Medium	There is no complete record of professional services provided by the Council to outside entities.	Lack of a contract register makes it difficult to monitor services provided to other organisations and ensure that current contracts are in place. There is a risk that the resources required to provide professional services to other organisations are not fully understood and accommodated.	A contracts register should be created which includes: Counterparty Date of agreement Period of contract and expiry date S ervices provided Contract manager Key contact at organisation Contracted fees The contracts register should be reviewed periodically to ensure that all professional services provided to external organisations are captured, and that there is a current service level agreement in place for each one.	The findings of this audit review will be presented to the Corporate Leadership Team. Executive Directors will be asked to detail professional services provided to other organisations and to ensure that these are underpinned by Service Level Agreements. The Governance Unit within Strategy & Insight will maintain the Council's Register of Service Level Agreements and shall liaise with service areas to ensure that these are regularly reviewed.	31/10/16	Revised date required	All Service Area responses have now been received. Further clarity had been requested from 2 service areas. This has now been received and these submissions will be reviewed with a view to closing this action by the Outturn date of 30 April 2017.	Andy Nichol, Governance and Democratic Services Manager
RES1607ISS.1	Online Customer Services	Medium	Communication with the Head of Service and Service Manager for Licensing about the development and delivery of the HMO Licensing work stream has been irregular and limited to date. There was a 2-week consultation period in winter 2015 at the beginning of the project, but there has been limited communication since. There is no representative from the service area on the Project Board, and key programme documents have not been shared with the service area including: The Project Initiation Document (PID) ; The d esign document (which maps both the existing and the proposed processes) ; ICT and Transformatio n Service Level Agreements :, Risk registers (with no process of escalation of the risks from the Service Area to the programme) ; Agendas and minutes from Project Board and other key group meetings ; and Support available to the service area during and post-implementation. Ther e is no stakeholder engagement stage in corporated in the project plan. We note that the design document for the HMO licensing onlin e platform states that ' [the] Licensing Team [is] to own policy and guidance documents development to accommodate an online platform . ' It is unclear how they can do this effectively witho ut involvement in its design and implementation.	Stakeholder expectations are not adequately managed as critical stages of the project are not communicated; The Project Board may not have a full understanding of the service requirements for each work stream , meaning that it may not deliver the expected benefits ; The needs of users are not considered in the development of the system , meaning that it may not deliver expected benefits ; Barriers to implementation that the service area is able to identify from experience, but which may not be obvious to the programme team (for example, legislative requirements) are not captur ed; Service Area leads may not buy-in to the project which risks slowing project progress.	Stakeholder Engagement The Project Board should include representatives from the live Service Area projects to ensure all critical documentation is shared and service and legislative requirements are considered, managing stakeholder expectations at each stage of the project . The Project Board may decide that this is most effectively managed through the creation of working groups for key work streams.	As part of the Programme rest (detailed in the 'Current Status Update' above), the programme governance and model used for business engagement is being reviewed, clarified and improved. This will include standardised documentation. When the detailed pla n is received from CGI/Agilisys in April 2017 Working Groups for each " Dr op" will be convened to include Subject Matter Experts from each of the relevant service areas . Re-engagement across senior and frontline stakeholders is currently being planned to refresh the message and planned outcomes of the Programme to support buy-in across the organisation.	31/05/17	31/08/17	Governance structure was put in place before project was placed on hold. This will be adapted based on whatever the new development partner structure may be. 05/07/2017: Business Engagement Approach and Internal/External comms plans provided by Clare Mills (Project Manager). These set out the general principles of stakeholder engagement, with heads of service identified as key stakeholders to attend working group. However, no detail as yet on who those stakeholders are, frequency of meetings, nature of engagement etc. No workstream has progre July 2017 Business Engagement Approach and Internal/External comms plans provided by Clare Mills (Project Manager). These set out the general principles of stakeholder engagement, with heads of service identified as key stakeholders to attend working group. However, no detail as yet on who those stakeholders are, frequency of meetings, nature of engagement etc. No workstream has progressed far enough at this stage for active engagement with stakeholders: expect progress by end of August. Rating reduced to 'Medium' given Business Engagement Approach now developed.	Clare Mills, Project Manager

Ref	Title	Rating	Finding	Risk	Recommendation	Action Plan	Date	Source	Update	Owner
RES1616ISS.1	Facilities Management	Medium	The plans to transform the Facilities Management service are ambitious and rely on staff adopting significant changes to working practices, and building users understanding and accepting agreed service levels. During our review of the project plans and documentation, it was noted an implementation plan to embed the new service and minimise disruption during and immediately following the launch of the new operating structure has not yet been developed.	There is a risk of loss of stakeholder support if disruption occurs during the implementation phase which would result in the programme failing to deliver the expected benefits.	Formalise the project implementation plan to include mitigating controls which minimise disruption to service delivery.	The following action plan will be put in place: Hold a team workshop to discuss detailed Work Breakdown Structure for project preparation and implementation Develop programme including identifying critical path and key dependencies Finalise resource schedule for implementation and seek formal approval from CLT to implement any change within pre-agreed budget parameters Review governance for FM roll out and ensure it is sufficiently robust and in line with the wider AMS governance arrangements Continue to monitor progress and report in line with existing arrangements	30/01/17	Internal Audit currently validating	A team workshop was held and a detailed work break down structure and programme plan produced with key dependencies identified. All resource is now in place for programme delivery and it will be held within agreed budget parameters within AMS. The implementation team are currently re-programming the key millstones due to a decision taken by CLT to push the launch of consultation until after the Election and split the consultation into phases, launching with janitorial in mid May and cleaning and others after the summer holiday period. The FM implementation will continue to be monitored as part of the AMS governance arrangements and through the wider Change Board. 10/07/2017 - requested copy of programme plan, dependencies log, and latest project dashboard. July Update Awaiting full evidence from Service Area. Once received and reviewed, IA will close this action as appropriate. A team workshop was held and a detailed work break down structure and programme plan produced with key dependencies identified. All resource is now in place for programme delivery and it will be held within agreed budget parameters within AMS. The implementation team are currently re-programming the key millstones due to a decision taken by CLT to push the launch of consultation until after the Election and split the consultation into phases, launching with janitorial in mid May and cleaning and others after the summer holiday period. The FM implementation will continue to be monitored as part of the AMS governance arrangements and through the wider Change Board.	Emma Baker, Project Manager

EIJB

Ref	Title	Rating	Finding	Risk	Recommendation	Action Plan	Date	Source	Update	Owner
HSC1503ISS.3	Personalisation SDS - Option 3	Medium	Scottish Government collects data on SDS users through annual and quarterly statistical surveys of local authorities. The answers to survey questions are based on data held in Swift. The accuracy and completeness of data input is therefore essential. There have been several changes in the assessment process and data captured in the past year such as: - Eligibility for services (on which data is required by Scottish Government) has been recorded since January 2015; - 'Initial steps to support' assessments were in use for new contacts between August 2014 and May 2015 but are now used only for crisis care; -A new personal support plan was introduced in October 2015. Where a new personal support plan is used, 'Option 4' is now recorded as a combination of Options 1, 2 and 3. There was no cut-off date after which all assessments would be carried out using new templates. The full process of assessment and arranging care can be lengthy. This means that there are several different ways of recording assessments running concurrently, with different data captured in each one. It is therefore difficult to extract complete and accurate data for management information and for reporting to Scottish Government.	Data on Swift is used to provide internal and external reporting which is likely to be incorrect. Data quality is affected where several processes to capture the same information are in use. There are over 500 practitioners completing assessments on Swift: multiple process changes over a short period of time increase the likelihood of errors in data input.	Further changes to the assessment process are expected over the next year as a result of the Transformation Programme and integration with the NHS. A change management process should be in place to minimise the number of process and recording changes through the year, implement clear cut-off dates, and to ensure changes are communicated to staff clearly. In the meantime, Research and Information should be aware of the likely inconsistencies in data recorded and ensure th at reports are thoroughly reviewed before issue.	A change management process will be established and overseen by the SDS Infrastructure Steering Group. The inconsistencies in data recording are as a result of numerous changes to processes and trying to reduce the recording burden of implementing these on frontline practitioners. The Research and Information Team are aware of all changes to recording practice and take these into account. A summary of all changes and the impact on data extraction has also been produced.	30/06/16 31/12/2017	30/06/2017	August Update Chief Officer and Strategic Commissioning Manager provided an update at GRBV meeting of 01.08.17 that noted that a revised implentation date of December was required. Existing change management processes will be formalised as part of the revised governance being put in place for the Health and Social Care Transformation Programme. Planned completion date: 31 March 2017	Wendy Dale, Strategic Commissioning Manager
HSC1503ISS.6	Personalisation SDS - Option 3	Medium	Since October 2015, all personal care plans must be signed off by a senior. This is a measure introduced to improve the quality of personal support plans. We obtained a report of all personal support plans completed between October 2015 and January 2016. We identified 44 cases out of 811 (5.4%) where the system recorded that the assessor who prepared the personal support plan also signed it off. This was reflected in the variable quality of the 25 personal care plans we reviewed as part of our audit work.	The quality of personal support plans is a vital aspect of delivering SDS and ensuring that people receive the care that they choose and need. A lack of review may affect the quality of care received.	All personal care plans should be signed off by a senior, as required by HSC policy. 'Workarounds' on Swift should be deactivated to prevent this breach of segregation of duties recurring.	Ensure that there is a mechanism in place on SWIFT for the senior to record that the time of the review will show that the senior has both prepared and reviewed the plan. Data quality reports will be set up to identify any support plan signed off by the assessor who produced the plan. Sector Managers and seniors to ensure appropriate oversight and sign off by senior for the personal care plans	30/06/16 31/12/2017	30/06/2017	An instruction will be issued to all staff that Support Plans must be signed off by a senior social worker, who cannot be the same person who created the plan. Reports will be set up to ensure compliance as part of regular quality monitoring. Planned completion date: to be confirmed by 24/2/17 following response from Strategy and Insight . 20/06 Assessments are no longer signed off, but costed Personal Support Plans up to the value of £650 p.w. are signed off by a senior. To close these findings, we need to confirm that sign off is being monitored through exception reporting to identify Plans which haven't been signed off, or that have been prepared and signed off by the same person. **August Update**: Report has now been set up so it will automatically identify cases where the support plan was created and signed off by the same person. Evidence of this has been supplied to Internal Audit. Business Support Teams will be asked to run these reports on a monthly basis initially. The outstanding issue here relates to support plans that have not been signed off. We had asked if an additional category of "closed before completion" could be created in SWIFT but have been advised that this is not possible. Strategic Commissioning Manager will arrange to have a discussion as to how we resolve this with Senior Strategy and Planning Officer and Internal Audit. Suggest revised date to end December to allow time for Audit to check this is working. **July Update** Preparer and approver of live Personal Care Plans compared manually on 19/07/2017: no cases identified where a Personal Care Plan had been signed off by the assessor who produced it. This manual comparison will be repeated monthly for al new care plans. Risk rating reduced from 'medium' to 'low'. Changes to system requested to allow electronic exception reporting, and to record status ('in progress'/'terminated') and 'go live' date to identify any care packages which have not been authorised. This is already checked manually by the Service Matching Unit each time a new care package is allocated to a care provider. Revised date 31/08/2017	Wendy Dale, Strategic Commissioning Manager

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HSC1504ISS.1	Care Sector Capacity	Medium	A Joint Strategic Needs Assessment (JSNA) has been drafted by the Research and Information team in preparation for health and social care integration. This analyses demographics across the city and the attendant pressures on social care provision such as life expectancy, morbidity, deprivation, prevalence of unpaid carers and employment levels (affecting both need for social care and the availability of carers). While the JSNA gives a sophisticated analysis of the current demographic and economic profile of the city, it is a snapshot based on historic statistics. Forecast is limited to percentage growth according to the National Records of Scotland population projections by age group. The demographic trends and pressures on social care provision identified in the JSNA have not been translated into the likely effect they will have on demand for services in the medium- to long- term. This means that the Council does not have a robust forecasting model of demand for social care in the City to inform its strategic planning.	Lack of robust forecasting models impedes informed strategic planning of future service provision; New service structures and initiatives may be c reated in an attempt to address current problems which are not suitable for changing demands caused by foreseeable mov ements and trends in the population.	Forecasting The JSNA should be developed into a robust forecasting m odel for demand for social care in the City. This should involve an appropriate level of scrutiny of t he reliability of the data used and the assumptions used in the model. We recommend that an officer from Health and Social Care is involved in the development of the JSNA in order to assess the assumptions used. The forecasting model should include a sensitivity analysis to assess the likely impact of variation in forecast trends. This is particularly important given the recognised breadth and complexity of social and economic factors affecting demand for care. Gap Analysis Once demand for homecare services has been forecasted, the Service should identify the gap between current and required capacity. If the forecast is sufficiently nuanced, the Service will be able to identify the gap between available resources and need fo r different groups, types of care, and localities. Implementation To date, population projections have generally been used to illustrate the need for service reform. The forecasting model and gap analysis should be used to inform strategic planning of Health and Social Care services.	Forecasting The Edinburgh Health and Social Care Partnership ' s Strategic Plan includes as a priority the improvement of our understanding of the strengths and needs of the local population through the ongoing development of the JSNA . A working group has been established to carry out this work. Members include colleagues from Public Health in NHS Lothian as well as from the Health and Social Care Partnership . One of the work streams which ha ve been identified for the group is to further investigate methods of forecasting needs among specific groups , and our P ublic Health colleagues are supporting this work. Sensitivity analyses will be built into forecasting models. Gap Analysis Existi ng methods enable the gap to be identified between demand and supply in broad terms. Further work will be done in conjunction with Strategic Planning and Contracting colleagues to provide analyses in relation to specific service models. Implementation Improved understanding of the strengths and needs of local populations, and the gap between demand and supply, will be used to develop service models and will inform strategic planning.	30/04/17 Revised date required.	This action is being taken forward through the ongoing development of the JSNA and the development of the Capacity and Demand Plan for Older People	Wendy Dale, Strategic Commissioning Manager
HSC1601ISS.6	Care Home Debt Management	Medium	Section 22(2) of the National Assistance Act 1948 states that "the payment (which a person is liable to make) for any such accommodation shall be in accordance with a standard rate fixed for that accommodation by the council managing the premises in which it is provided (and that standard rate shall be represent the full cost to the authority of providing the accommodation)." Historically the Council have not charged the full cost of accommodation provision and provided the accommodation at a discount to the full unit cost. The Chief Officer of the Edinburgh Health and Social Care Partnership is responsible for reviewing charges on an annual basis. Unit costs are updated regularly by Finance and are available to Health and Social Care senior management to inform decisions on charges. Rates charged to residents for Care Homes are currently based on a historic costs exercise thought to have been completed in approximately 2005, then updated by "inflationary" increases in subsequent years. These uplifts were not linked to the actual cost increases in delivering accommodation and in 2015/16 a cohort of 9 residents receiving specialist dementia care at the North Merchiston Care Home appear to have been charged £9.80 per week in excess of the Home's unit cost of care provision for all or part of the year (total over-charge: £3,059), an apparent breach of the National Assistance Act 1948. This situation did not recur in 2016/17 due to the contract changes with the company running the care home on behalf of the Council. The unit cost of care increased by 3.9% in 2016/17 while the rate charged to residents remained constant, resulting in the unit cost of care being greater than the unit cost for patients in this category at the North Merchiston Care Home.	The Council appears to have charged this cohort of residents a sum in excess of what is permitted under the National Assistance Act 1948. The rates charged to residents in all Council provided accommodation needs to be reviewed for 2017/18 to ensure that they better reflect the actual cost of the care provided and prevent a similar recurrence.	The rates charged to residents in all Council provided accommodation needs to be reviewed for 2017/18 to ensure that they better reflect the actual cost of the care provided and prevent a similar recurrence.	The rates charged to residents in all Council provided accommodation will be reviewed for 2017/18 to ensure that they better reflect the actual cost. Finance will update unit costs to inform this review.	31/03/17 30/06/2017 Revised date required	A meeting is being arranged between the Strategic Planning and Quality Manager for Older People and colleagues in Finance to progress this action. NB: no changes have been made to care home charges for 2017/18, work to review their appropriateness in light of actual costs incurred will start once the revised staffing structures following the conclusion of the organisational review are in place. Suggest dependency be pushed implementation back to the end of June. Update requested July - finding owner on annual leave returning 17/7 - no further updates have been provided.	Katie McWilliam, Strategic Planning and Quality Manager for Older People
HSC1603ISS.3	Management Information [EIJB]	Medium	Monthly 'waiting for assessment' reports are generated by the Council Performance and Information team for locality managers, which identify the length of time service users have been waiting for an assessment by locality and by sector team. At 1 September 2016 there were 1,638 assessments on the waiting list, with 1,320 overdue (on the waiting list for more than 2 weeks). Delays in assessments in the community have an impact across the health and social care system and are likely to contribute to higher admissions to hospital. This information is not reported to the EIJB or its Executive Board. The number of patients remaining in hospital because their assessment is overdue is reported to the EIJB bi-monthly as part of the 'delayed discharges' report. At 1 September 2016 this number stood at 33, just 2% of the total number on the waiting list for assessments. Only 9 of those were overdue (0.7% total overdue). In comparison, 78 delayed discharges recorded in July were caused by delays in arranging domiciliary care.	Risk that attention is focussed on effect rather than cause: a relatively small (though high impact) number of delayed discharge, with poor visibility of delays across the health & social care system.	Reporting on delays Management should consider including reporting delays in waiting times for assessments as part of bi-monthly delayed discharge reporting to the EIJB, to help members consider and address delays across the health and social care system (which may be contri b uting to higher admissions to hospital and delayed discharge rates). Lessons learned In developing the Performance Management Framework, management should consider the measures they report to ensure they give EIJB and Executive Bo ard Members a full and ba lanced view of performance across the health and social care system, covering areas which are under the remit of both the legacy NHS and legacy Council teams.	Reports on delays across the whole system from point of referral to receipt of service are being developed and will be reported to the Performance Board on a monthly basis. The whole system approach to reporting that is being developed under the auspices of the Flow Programme Board chaired by an IJB member will provide greater transparency in terms of delays across the whole system. This report will also inform future reporting to the IJB.	08/03/17 31/07/2017 IA validation	22/08/17: The Annual Performance report is a sub set of indicators including 23 core indicators and 6 Integration Indicators together with some key local indicators including waiting times for assessment and packages of care which will be reported to and scrutinised by the IJB Performance and Quality Sub group. A performance report based on the Annual Performance report will be submitted to the IJB every 6 months. If the Performance and Quality Group have any concerns these will be escalated to the IJB. The Annual Performance Report was issued to the EIJB on 14/07/2017 where it was agreed that "the report would be circulated to members for comments and additions prior to sign-off by the Chair and Vice Chair, and publication" IA has requested further evidence of IJB Performance and Quality Sub Group minutes from the Strategic Commissioning Manager for the last 3 months to evidence scrutiny undertaken by the sub-groupImplementation date extended to 31/07/2017. Whole system reporting has been developed through the Flow Programme e. W e will be in a better position to confirm the regular reporting arrangements to the IJB Performance and Quality Group and through them to the IJB once the Annual Performance Report has been completed.	Wendy Dale, Strategic Commissioning Manager

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HSC1603ISS.4	Management Information [EIJB]	Medium	There is one member of the NHS Data Set Team responsible for pulling together and circulating delayed discharge reports to locality managers each week. We selected a sample of 5 weeks and confirmed that the report had been generated and circulated. We identified: - One week where no delayed discharge report was circulated as the officer responsible was on annual leave; - One week where additional information was missing as the officer responsible did not have time to complete it.	Locality managers do not have sight of delays if the staff member responsible for preparing management information is absent. There is a risk that this means resources cannot be targeted effectively, and the number of delays increases. There is a reliance on existing NHS and Council professional support arrangements which may not meet the needs of the EIJB.	Delayed Discharge At least one other member of the NHS or Council Data Set Teams should be trained in preparing delayed discharge reports to provide cover in the event of staff absence. Lessons Learned In developing the Performance Management Framework, the Edinburgh Health and Social Care Partnership should identify re sources required to collect and analyse performance data and maintain a consistent quality of reporting to locality managers, the Executive Board, and the EIJB.	The resource requirements to meet the performance management requirements of the IJB will be identified as part of the development and implementation of the new operating structure in Health and Social Care.	31/03/17 31/07/2017 Revised date required	Implementation date extended: the support services part of the new structure has not progressed as quickly as anticipated.		Rob McCulloch-Graham, Chief Officer: Edinburgh Health & Social Care Partnership
HSC1604ISS.3	IJB Data Integration & Sharing	Medium	During our audit procedures, we observed there are compatibility and connectivity issues when using CEC hardware at NHS locations or to access NHS owned systems and vice versa. CEC staff have experienced difficulties in connecting through Wi-Fi at NHS sites (and vice versa) in order to access their emails, and some systems cannot be accessed using specific hardware such as mobile devices (i.e. tablets, mobile phones).	There is a risk of the operational efficiency and effectiveness being impacted by an inability to access system in a timely manner.	The IJB should ask for a review of connectivity and hardware compatibility to be conducted in NHS and CEC sites, to ensure all staff can be fully operational wherever they are located.	The ICT and Information Governance Steering Group will request a review of connectivity and hardware compatibility to be conducted across all sites housing integrated teams and consider any recommendations arising from that review.	30/06/17 Revised date required.	Update requested 14/07/17		Wendy Dale, Strategic Commissioning Manager