Governance, Risk and Best Value Committee

10.00am, Tuesday 20 March 2018

Internal Audit: Overdue Recommendations and Late Management Responses

Item number	7.4
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Wards	
Council Commitments	

Executive Summary

This report sets out all overdue Internal Audit (IA) recommendations across the Council as at 19 January 2018, providing further status updates and likely implementation dates where they have been provided by Service Areas (Appendix 1).

There were 69 open Internal Audit recommendations across Service Areas as at 19 January (in comparison to 65 at 26 October 2017). Of these 47 (68%) are overdue in comparison to 31 (48%) as at 26 October. During the period, 6 overdue recommendations were closed and a further 22 are now reporting as overdue. Further detail is included at 3.5 to 3.11 below.

This report also highlights audit reports that have been issued in draft where final management responses have not been received within our two-week service standard. As at 19 January there were 2 draft reports where management responses were not received within the two-week requirement, and 1 report that has been delayed due to changes in the Internal Audit team. Further details are provided at 3.16.

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Report

Internal Audit: Overdue Recommendations and Late Management Responses

1. Recommendations

1.1 Members of the Governance, Risk and Best Value Committee are requested to note:

1.1.1 the status of the overdue Internal Audit recommendations as at 19 January 2018;

1.1.2 that there are were two reports issued in draft as at 19 January where management responses were not received within our two-week service standard, and that one of these has been delayed due to changes in the Internal Audit team; and

1.1.3 the proposals included at section 3.3 and 3.4 to address challenges associated with timing of audit responses received and quality of evidence provided to support closure of recommendations.

2. Background

2.1 Following concerns expressed by the Corporate Leadership Team (CLT) and elected members of the Governance, Risk, and Best Value Committee (GRBV) about the number of overdue Internal Audit recommendations being reported to the GRBV each quarter, CLT has requested a monthly update.

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 The revised Internal Audit Process to obtain updates from Service Areas on all open recommendations by the 15th of each month was implemented in September 2017. This has resulted in more proactive engagement on both open and overdue recommendations Service Areas, however, a number of updates continue to be received late.

3.2 Quality of evidence provided to support validation remains an ongoing challenge. Agreed actions are often confirmed as completed by Senior Management whilst subsequent Audit validation confirms that controls have not been fully and effectively implemented. This results in Audit providing further advice and often reperforming validation work to support final closure.

3.3 At CLT on 1 November 2017 it was agreed that each Service Area would nominate a representative who will be responsible for coordination of all audit updates and responses (including provision of evidence), and that IA would facilitate a workshop with all representatives to explain the validation process and expectations in relation to quality of evidence to support closure of recommendations.

3.4 Since then, IA has been exploring whether the TeamMate audit system could be reconfigured to support automation of the open and overdue recommendations reporting process. We have now confirmed that this is possible and are working with the system providers to make the relevant changes. These changes will enable:

3.4.1 generation of automatic reminders for Service Areas as in advance of completion dates;

3.4.2 nominated representatives from Service Areas to enter progress updates and attach evidence directly into the system;

3.4.3 automatic generation of monthly dashboards for each Service Area that illustrates their open and overdues position; and

3.4.4 automated reporting on the overall position across the Council to support both CLT and Governance, Risk, and Best Value Committee updates.

A further meeting with the system supplier took place on 7 February, and a pilot of the new process is planned for March and April, with a view to implementing the new process in July 2018.

These timeframes will enable completion of the pilot and implementation of the new process, supported by provision of training for service area representatives. The agreed actions noted at 3.3 will be incorporated within our system implementation plans.

3.5 There were 69 open Internal Audit recommendations across Service Areas as at 19 January 2018. Of these, 47 (68%) were overdue (5 High; 30 Medium; and 12 Low) in comparison to 31 (48%) as at 26 October. During the period, 6 overdue recommendations (2 High; 2 Medium; and 2 Low) were closed and a further 22 (3 High; 9 Medium; and 10 Low) are now reporting as overdue.

3.6 This increase in overdue recommendations is attributable to the high volume of recommendations that were due for closure in November and December, and also recommendations in relation to shadow IT (4 Medium) and service level agreements with outside entities (6 Low) that were allocated across all Service Areas (following agreement by CLT on 30 August 2017) that have not yet been fully concluded.

3.7 Evidence has been provided by Service Areas for 13 of the overdue recommendations (7 Health and Social Care (H&SC); 4 Resources; and 2 Safer and Stronger Communities (SSC)). IA has reviewed the evidence provided and is engaging with management, however, evidence provided is not yet sufficient to close these recommendations.

3.8 Six Medium overdue recommendations have been closed in the period across the following Service Areas:

- Health and Social Care (1 High)
- Resources (1 High; 1 Low)
- Place (1 Medium; 1 Low)
- Strategy and Insight (1 Medium)

3.9 22 recommendations (3 High; 9 Medium; and 10 Low) have now become overdue. These are:

- **Edinburgh Integrated Joint Board (EIJB) / H&SC (3)** – 1 High (**HSC1604ISS.1 – IJB Data Integration and Sharing); 1 Medium (CW1602ISS.1 – Disaster Recovery / Shadow IT) and 1 Low (HSC1715ISS.4 - EADP Contract Management);
- **Resources (7)** – 1 High (**RES1601ISS.1 – Supplier Management); 3 Medium (RES1615ISS.4 and ISS5 – Property Maintenance and **RES1712ISS.2 – Asset Management Strategy); and 3 Low (**RES1712ISS3 and 4 – Asset Management, RES1705ISS3 and RES1605ISS.1 – Service Level Agreements with Outside Entities);
- **Investment and Pensions (2)** – Low (RES1605ISS.1 – Service Level Agreements with Outside Entities and RES1705 – Information Governance);
- **Strategy and Insight (1)** – Low (RES1605ISS.1 – Service Level Agreements with Outside Entities);
- **Safer and Stronger Communities (4) –** 1 High (**SSC1701 – Short Term Homelessness); 2 Medium (SSC1701ISS.4 – Short Term Homelessness and CW1602ISS.1 – Disaster Recovery / Shadow IT); and 1 Low (RES1605ISS.1 – Service Level Agreements with Outside Entities); and
- **Communities and Families (3)** – 2 Medium (CF1621ISS.3 – GIRFEC Named Person and CW1602ISS.1 – Disaster Recovery / Shadow IT) and 1 Low (RES1605ISS.1 – Service Level Agreements with Outside Entities)
- **Place (2)** – 1 Medium (CW1602ISS.1 – Disaster Recovery / Shadow IT) and 1 Low (RES1605ISS.1 – Service Level Agreements with Outside Entities)

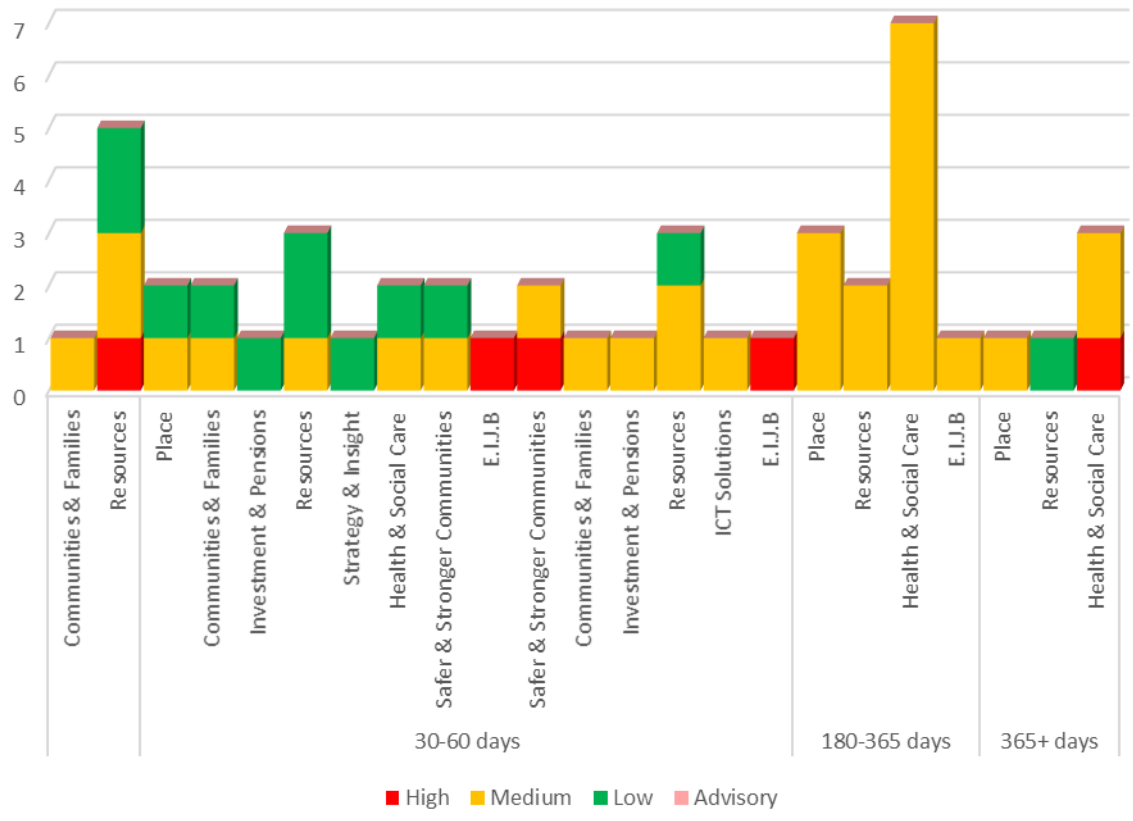
Where recommendations are noted as ** in the list above, initial evidence has been provided and IA is working with management to obtain sufficient additional evidence to support full closure.

3.10 One High rated recommendation owned by Health and Social Care was due for completion by 31 January 2018 (HSC1604ISS.2 – IJB Data Integration and Sharing). It is expected that this recommendation will be closed imminently following approval of a pan Lothian memorandum of understanding in relation to information sharing between relevant Councils and the NHS by the Health and Social Care's Chief Officer and the Council's Chief Executive on 14 February 2018.

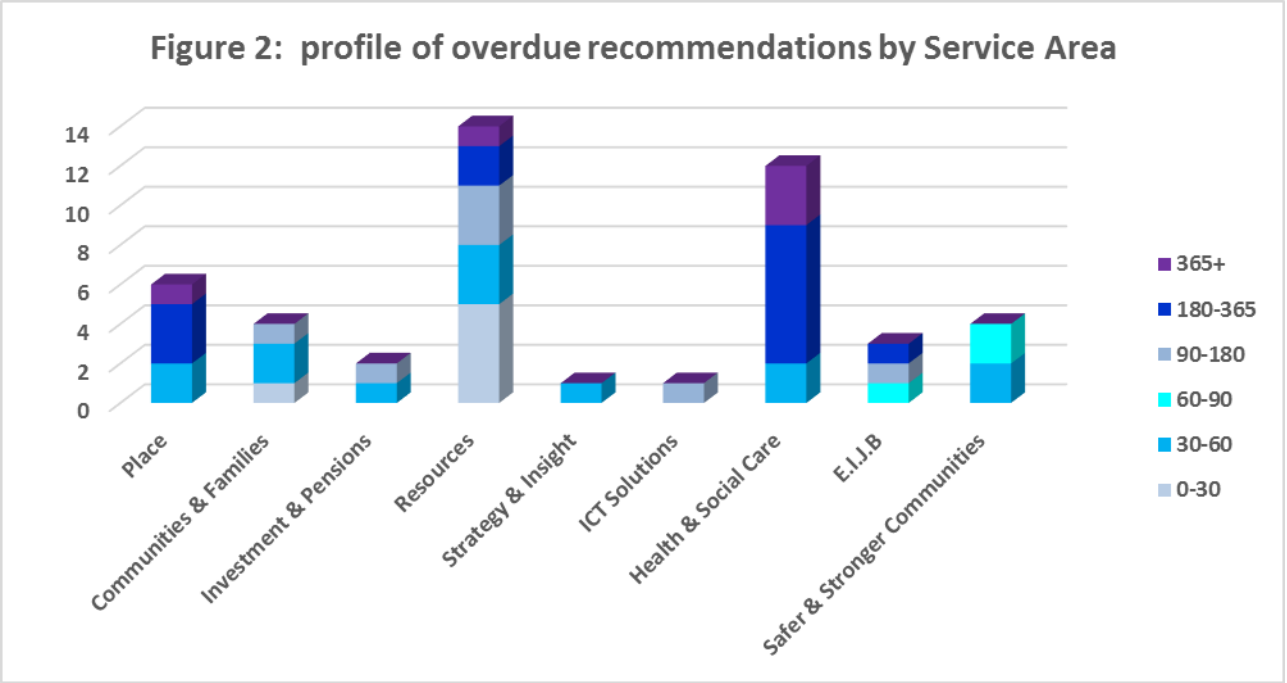
3.11 One Medium recommendation (Resources – Asset Management Strategy RES1712ISS.3) has been reduced to a Low based on evidence provided by management that confirms the risk has been partially addressed.

3.12 Figure 1 illustrates the ageing profile of all overdue recommendations by rating across Service Areas. Of the 47 overdue items, 18 are more than 180 days overdue (1 High; 16 Medium; and 1 Low) in comparison to 17 at the end of October, with 5 of the 18 (1 High, 3 Medium and 1 Low) more than 365 days overdue in comparison to 6 last month.

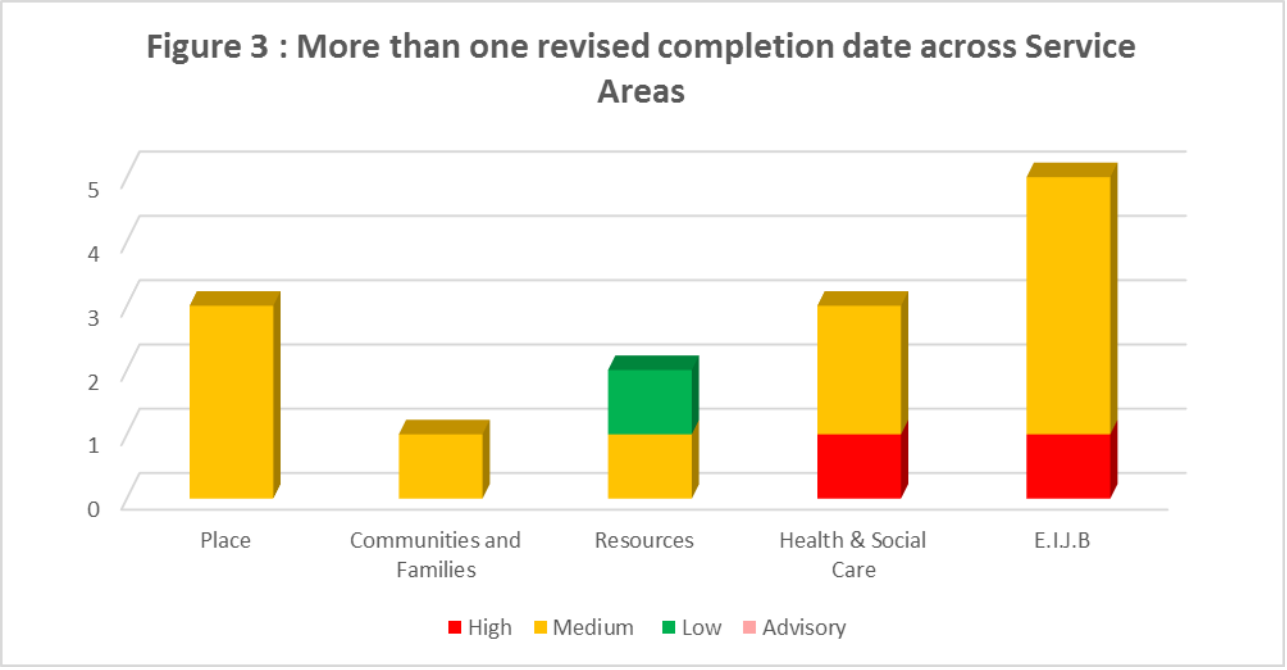
Figure 1: Aged profile of overdue recommendations by ratings across Service Areas



3.13 Figure 2 highlights the ageing profile of overdue Internal Audit recommendations for each Service Area.



3.14 Figure 3 illustrates that there are 14 overdue recommendations where completion dates have been revised more than once since the implementation dates agreed with Service Areas when finalising audit reports. This is a decrease of 6 in comparison to October. This decrease is driven by EIJB (+1); Health and Social Care (-1); Strategy and Insight (-2); Resources (-2); and Place (-2)



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

- Strategy and Insight - ICO Follow Up (RES1606ISS.2 – Medium);
- Strategy and Insight – Complaints Process (CF1619ISS.1 – Medium);
- Health and Social Care – IJB Data Integration and Sharing (HSC1604ISS.4 - Medium); and
- Resources – Asset Management Strategy (RES1712ISS.5 – Low).

3.16 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.

3.17 There were 2 Internal Audit reports issued in draft as at 19 January where management responses had not been received within our two-week service standard. These are:

3.17.1 Health and Social Care – Care Homes Assurance review. Draft report was issued mid-October for management responses. The Interim Chief Officer, Health and Social Care Partnership attended the Governance, Risk, and Best Value Committee on 16 January 2018 to provide an update on progress with this report. The final report was issued on 11 February 2018, and details of the High recommendations raised will be provided to GRBV as part of the June 2018 quarterly IA update report.

3.17.2 Resources – Customer Transformation Programme. Review was subject to handover from the Principal Audit Manager who left in August to the Chief Internal Auditor. Further work was required and has now been completed with a report out in draft for management comment. The Audit should have been completed by end August 2017, and has not yet been finalised.

4. Measures of success

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

4.2 An improvement in the time taken to receive management responses and finalise Internal Audit Reports

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.

Stephen S. Moir

Executive Director of Resources

Contact: Lesley Newdall, Chief Internal Auditor

E-mail: lesley.newdall@edinburgh.gov.uk | Tel: 0131 469 3216

11. Appendices

Appendix 1 – Status report: Overdue Recommendations Detailed Analysis

Unique No	Project Code	Project Name	Group	Issue Cor	Rating	Finding	Business Implication	Recommendation	Agreed Management Action	Status	Due Date	Revised Date	Revisions	Status Update	Owner
Communities & Families															
CW1602ISS.1	CW1602	Disaster Recovery	Communities & Families	ISS.1	Medium	Following the transition of IT managed services to CGI, a DR programme has been established which, it is anticipated, would allow the Council to recover critical services and data in the event of major disruption or loss of IT infrastructure. However, enhancements are required to allow confidence that the DR programme will meet the recovery requirements of the Council and its stakeholders. The weaknesses in the DR programme, set out below may adversely impact upon the ability of the Council to recover critical systems effectively: Robust testing in line with the CGI contractual requirement, of the Council 's recovery processes has not been performed to determine whether the recovery solution is fit for purpose and to validate the effectiveness of the current design of recovery provisions and processes. The approach to classifying critical systems, as either P1, P2 or P3 (High, Medium, Low), is not consistent and does not consider other prioritisations within the Council. The application of these ratings are determined by business owners and is a subjective process, which may result in systems being misclassified from a Council wide perspective . The inventory of system dependencies between critical Council systems is not regularly reviewed or maintained. Management review this on an ad hoc basis or when CGI identify any weaknesses in infrastructure. There is no mandatory requirement for, or oversight of, DR provisions or testing for IT systems that are procured, managed or maintained either outside the CGI contract or without oversight from ICT. Business owners and stakeholders for IT systems and services have not been updated, which may result in delays in implementing improvements and establishing business requirements.	Without an embedded DR programme in place that has been robustly tested and captures all Council critical services and systems, there is a risk that following significant ICT disruption (for example the loss of a datacentre or a major cyber security breach) the Council is unable to recover all critical data and resume business operations in a timely manner. The loss of critical ICT services for an extended period of time or the inability to successfully recover data could result in significant operational and reputational damage to the Council.	Management should ensure that ICT systems within the Council have been identified and classified appropriately. Disaster recovery processes should be vigorously tested to validate the ability of the Council to successfully recover systems and data within the defined timescales set by stakeholders. For systems that are identified which are not managed by central ICT (Shadow IT), Management should consider how they could work with the system owners in ensuring that that these systems are resilient and can recover following a major incident.	Service Areas will identify all shadow IT (systems, applications and websites historically procured and implemented by Services that are not managed corporately by ICT in conjunction with CGI) and provide details of these to the Head of ICT. Information to be provided will include: - Name of the application - Details of the application provider - Information on the Council service that the system supports - Details of any support agreements and licence arrangements in place with the system provider, including their expiry date - Information re any recent cyber or security attacks that impacted the operation of the system. - Any available information on how the system is backed up to ensure that source data held on the system can be recovered. - An initial assessment of the system's critically based on definitions provided by ICT.	Overdue	30/11/17			IA Note: This is a new recommendation allocated across all Directorates / Service areas as agreed at CLT in September. No update required for the current month. Please provide evidence that this has been prepared and submitted to ICT and we will close.	Alistair Gaw, Executive Director of Communities and Families
RES1605ISS.1	RES1605	Service Level Agreements with Outside Entities	Communities & Families	ISS.1	Low	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 Accountancy 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 reputational 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.	Directors will ensure that a service level agreement (SLA) has been established with all arms level organisations (ALEOs) that they support. The SLA should set out all services provided and received by the Council, key activities and deliverables, and the respective roles and responsibilities of the Council and the counterparty. The agreements should be for a one year period and refreshed annually to ensure that agreed services and charges remain appropriate.	Overdue	30/11/2017			IA Note: This is a new recommendation allocate across all Directorates / Service Areas as agreed at CLT in September. No update required in the current month. Can you please provide evidence that this has now been completed and we will close?	Alistair Gaw,Executive Director of Communities and Families
CF1621ISS.3	CF1621	GIRFEC Named Person	Communities & Families	ISS.3	Medium	Although the GIRFEC legislation does not require documentation of chronology in Wellbeing Concern (WC) files, this currently works well in Child Protection (CP) files to enable analysis of history and patterns of concern, and is to be promoted as good practice. There is no single repository for all Wellbeing Concern and Child Protection notes to enable data sharing between SCD and Named Persons. Testing identified relevant information being recorded in the following mediums: P aper files ; SEEMIS pastoral notes ; Off the shelf packages such as " on the button" ; and SWIFT Testing evidenced that the current GIRFEC Child Protection records management requirements are not being fully adhered to, resulting in breaches of the Council ' s data protection policy and General Data Protection Regulations (GDPR) (April 2017). The foll owing areas for concern were identified: Child Protection meeting notes retained in Pupil Progress Records (PPR files) Additional Child Protection files being sent to a feeder High School for pupils not transitioning on to their S1 role. There is currently no systematic process of review of compliance with records management requirements. Such a process would assist learning amongst professionals involved in Child Protection and allow Senior Management in School & Lifelong Learning area to identify and address any systematic weaknesses.	Lack of chronology in Wellbeing Concern files can result in difficulty analysing the history and patterns of concerns raised. Lack of a single repository to share data prevents professionals from being able to access the full picture for each child, and enhances the risk of inaccurate or in sufficient action being taken to ensure a child ' swellbeing is maintained. Data protection legislation and policy could be breached and not identified.	A standard chronology template should be prepared for WC files and supported with guidance on the analysis of data, trends and preparing planning meeting summaries. Whilst we understand that management accept the risk posed in relation to the current inability to share da ta , they should investigate the feasibility of using an established or introducing a new Data Management System DMS option by which the wellbeing chronology can be securely shared between relevant parties. Additionally, the SLL and SCD registers should be updated to reflect the risk that data cannot currently be shared and could result in th e risk of inaccurate or insufficient action being taken to support a child . Guidance on the application of Records Management policy and procedures should be prepared and appropriate training provided, drawing on existing good practice in special schools. A review process to assess compliance with data protection; record management; and GIRFEC policies should be introduced. The 'Self assessment framework currently being implemented within Communities and Families' could be used as a vehicle to provide this assurance.	Current seconded staff will develop a template for chronology. GIRFEC training will reinforce the need for named person in school to put in place a chronology of wellbeing concerns. Training will also specify that where the level of concern leads to a lead professional being appointed (e.g. social worker), that person then becomes respons ib le for the preparation of the single child plan including subsequent versions of the chronology. The risk of continuing to operate with separate electronic recording systems for schools and social care is accepted by senior management as no practicable solution currently e xists within any of the 32 Local Authorities in Scotland. SLL and SCD will update their risk registers to reflect this accepted risk. 3&4 There is good practice evident in special schools in relation to records management. The officers currently seconded to develop GIRFEC recording practice in schools will review the learning from this, issue guidance to schools about application of Records Management policy/procedures, and offer training as appropriate. They are also undertaking work to embed the use of the wellbeing app within SEEMIS which will standardise recording of child concerns within schools.	Overdue	29/12/17			Current Position 22/11/17 - Current Position: Partial evidence provided by Implementation Officer regarding the new Welbeing concerns chronology.	Alistair Gaw,Executive Director of Communities and Families
CF1619 ISS.3	CF1619	Complaints Process	C&F	ISS.3	Medium	The Chief Social Work Officer conducted a review of complaints handling for secondary schools in 2015, and surveyed the head teachers of the 18 secondary schools which had not recorded a complaint in the previous 2 years. 9 head teachers responded that they were unsure what type or level of complaint should be shared with the Advice and Complaints (Education) Service; and 4 acknowledged that they had not followed the complaints procedure. Perhaps as a result of increased a wareness of the complaints procedure following the Chief Social Work Officer ' s review, at least one Stage 1 complaint was recorded by each secondary school in 2015/16 or 2016/17. However, 29 primary schools have not recorded a Stage 1 complaint in 2015/16 or 2016/17. This represents 32% of the primary school estate. It seems unlikely that these schools did not receiv e any complaints in that period. This suggests that the Communities & Families complaints performance data is likely to be incomplete.	Performance information is inaccurate as it does not include all Stage 1 complaints; There is a risk that complaints are not being reported / handled approp riately by the schools, meaning problems are not addressed early on and may escalate; Communities and Families do not have complete management information on complaints, so can not identify and address common service issues.	We recommend the Advice & Complaints (Education) Service issues guidance to schools on what is considered a complaint, and how a complaint should be handled and recorded. This may be delivered most effectively through forums such as the Communities & Families Risk Group or Head Teachers Groups. We note that complaints recording is more difficult in schools as they cannot use Capture and complaints can only be recorded on Jadu once resolved. As noted in Finding 1 , the Council is procuring a new complaints handling system and will o verhaul the complaints handling process as part of this. We recommend that Communities & Families Advice & Complaints (Education) Service works with Strategy Insight to ensure that their complaints handling processes are aligned, and messages to head teach ers are consistent.	The current Jadu form will be reviewed, in consultation with the wider work ongoing within Strategy & Insight, to ensure that complaint information can be collected at an earlier stage in the process.	Overdue	31/08/17	31/07/18	31/08/17 31/07/18	October Update : The complaints action cannot progress in isolation as there is a Council wide complaints project underway which will determine the way our complaints are recorded. The update provided in September which is recorded in the spreadsheet provides the details. There is nothing further we can add at this time. September Update : 11/09/17 - The current Jadu form will be reviewed, in consultation with the wider work ongoing within Strategy & Insight, to ensure that complaint can be collected at an earlier stage in the process. As a result of the Corporate Review of Complaints, a Corporate Complaints Improvement Plan has been developed. The action for Education will be covered by the following workstream within the Improvement Plan: "Agree a strategy to minimise the number of databases currently being used across service areas to record, manage and report complaints" This will involve meeting with all services that do not use Capture or Confirm, research possible solutions, consult services affected by recommendations to agree future arrangements and to review training provided on alternative systems to ensure alignment with standardised complaints training. The timescale for this action is November 2017 – July 2018. Please note the procurement of a new CRM (customer relationship management) is currently on hold	Frances Smith, Advice & Complaints Officer (Education)
E.I.J.B and Health & Social Care															
CW1602ISS.1	CW1602	Disaster Recovery	Health & Social Care	ISS.1	Medium	Following the transition of IT managed services to CGI, a DR programme has been established which, it is anticipated, would allow the Council to recover critical services and data in the event of major disruption or loss of IT infrastructure. However, enhancements are required to allow confidence that the DR programme will meet the recovery requirements of the Council and its stakeholders. The w eaknesses in the DR programme , set out below may adversely impact upon the ability of the Council to recover critical systems effectively: Robust testing in line with the CGI contractual requirement, of the Council ' s recovery processes has not been performed to determine whether the recovery solution is fit for purpose and to validate the effectiveness of the current design of recovery provis ions and processes. The approach to classifying critical systems, as either P1, P2 or P3 (High, Medium, Low), is not consistent and does not consider other prioritisations within the Council . The application of these ratings are determined by business own ers and is a subjective process, which may result in systems being misclassified from a Council wide perspective . The inventory of system dependencies between critical Council systems is not regularly reviewed or maintained. Management review this on an ad hoc basis or when CGI identify any weaknesses in infrastructure. There is no mandatory requirement for, or oversight of, DR provisions or testing for IT systems that are procured, managed or maintained either outside the CGI contract or wit hout oversight from ICT. Business owners and stakeholders for IT systems and services have not been updated, which may result in delays in implementing improvements and establishing business requirements.	Without an embedded DR programme in place that has been robustly tested and captures all Council critical services and systems, there is a risk that following significant ICT disruption (for example the loss of a datacentre or a major cyber security breach) the Council is unable to recover all critical data and resume business operations in a timely manner. The loss of critical ICT services for an extended period of time or the inability to successfully recover data could result in significant operational and reputational damage to the Council.	Management should ensure that ICT systems within the Council have been identified and classified appropriately. Disaster recovery processes should be vigorously tested to validate the ability of the Council to successfully recover systems and data within the defined timescales set by stakeholders. For systems that are identified which are not managed by central ICT (Shadow IT), Management should consider how they could work with the system owners in ensuring that that these systems are resilient and can recover following a major incident.	Service Areas will identify all shadow IT (systems, applications and websites historically procured and implemented by Services that are not managed corporately by ICT in conjunction with CGI) and provide details of these to the Head of ICT. Information to be provided will include: - Name of the application - Details of the application provider - Information on the Council service that the system supports - Details of any support agreements and licence arrangements in place with the system provider, including their expiry date - Information re any recent cyber or security attacks that impacted the operation of the system. - Any available information on how the system is backed up to ensure that source data held on the system can be recovered. - An initial assessment of the system's critically based on definitions provided by ICT.	Overdue	30/11/17			IA Note: This is a new recommendation allocated across all Directorates / Service areas as agreed at CLT in September. No update required for the current month. Please provide evidence that this has been prepared and submitted to ICT and we will close.	Michelle Miller,Interim Chief Officer. EH&SCP
HSC1604ISS.1	HSC1604	IJB Data Integration & Sharing	E.I.J.B.	ISS.1	High	The governance processes in place are not sufficiently mature to support the vision of seamlessly sharing data between both parties to the IJB. We observed the following areas of weakness: Roles and responsibilities Roles and responsibilities are not well defined or communicated between CEC and NHS , in particular relating to : Management of access to critical systems; Reporting and escalation of issues; and Ensuring compliance with legal information governance regulations . Management structure A process is currently ongoing to establish and capture cross party system access requirements f or the NHS, CEC and external parties (e.g. GP practic es). While we recognise that th is exercise is now complete, at th e time of the review, a management structure to manage access has not been established, and there is no clear roadmap or timeline that details when and how access will be implemented. In the interim system access is being granted to individuals on an ad-hoc basis. Communication strategy During our review, it was observed that the communication strategy is not well defined. The IJB does not promote awareness of its remit or the benefits it can facilitate to staff within CEC and NHS. This has resulted in a lack of awareness on the types of data, not originating from their 'home' organisation, which is now available to staff.	There is a risk that without clear roles and responsibilities, legal requirements or regulations are not met or are addressed in isolation. There is a risk that IJB members and the executive board cannot monitor progress against strat egic objectives effectively. With no clear implementation roadmap, the IJB might experience resourcing issue or miss important dependencies between req uirements. If internal communication is not well defined , there is the risk that employees do not make best use of the available data with a knock on impact on patient/customer outcomes.	The IJB should ensure roles and responsibilities for the management of access to critical systems, reporting and escalation of issues and compliance with legal regulations are clearly defined and communicated.	Nominated officer to be identified in respect of ICT and Information Governance to take responsibility for ensuring that appropriate governance arrangements are in place for both the Edinburgh Integration Joint Board (EIJB) and the Edinburgh Health & Social Care Partnership (EHSCP).	Overdue - IA Validation in progress	30/08/17	31/12/17		Current Position 15.01.18 - - Overdue - IA Validation in Progress A new Operations Manager role has been created in the H&SC partnership for a 6 month period with funding provided by CEC. Role spec and job description has been provided by H&SC. IA has reviewed these and reverted with some follow up questions . Current status is ecommendation IA validation in progress, and evidence is included at E1.9 to E1.13 in the IA system. November update: an individual has now been appointed to the post. funded by Resources and will begin to develop a work plan. A hand over will be arranged with the existing action owner. Copy of offer of post and job role to be submitted by separate email. October Update: The Council's Executive Director for Resources has agreed to fund a temporary a post that will take on responsibility for coordinating core infrastructure activity, including information governance in the HSC Partnership.	Michelle Miller,Interim Chief Officer. EH&SCP

Unique No	Project Code	Project Name	Group	Issue Cor	Rating	Finding	Business Implication	Recommendation	Agreed Management Action	Status	Due Date	Revised Date	Revisions	Status Update	Owner
								The IJB should have a clear roadmap, detailing which requirements are to be implemented when, highlighting resources needs and eventual cross-dependencies.	Roadmap of ICT requirements to be developed based upon priorities for delivery of the IJB Strategic Plan.	Overdue - IA Validation in progress	30/09/17	31/03/18		Current Position 15.01.18 - Overdue - IA Validation in Progress A presentation detailing the range of work taking place that will lead to the identification of ICT requirements was discussed at the ICT and Information Governance Steering Group on 21/11/17 and the need to establish a clear, mechanism for recording ICT requirements for consideration by the Group agreed. A copy of the presentation has been issued to Internal Audit for Validation by separate email. November update: the HSCP ICT and Information Governance Steering Group will consider a paper on 21/11/17 setting out how the Statement of Intent being presented to the IJB on 17/11/17 provides a way forward in developing an ICT strategy/roadmap. Papers submitted by separate email. October update: The interim senior management team for the Health and Social Care Partnership is reviewing priorities and has agreed a new approach with the IJB. This approach will impact on the priorities for ICT. Agreement of priorities will be overseen by the Health and Social Care Partnership ICT and Information Governance Steering Group, which is chaired by the Interim Chief Officer. ICT support is being provided on an ad hoc basis to support specific projects, such as the establishment of the locality teams. Proposed revised completion date 31/3/18 to allow for work on reshaped priorities to be completed.	Wendy Dale,Strategic Commissioning Manager
								A clear prioritisation process should be implemented. Priorities should be revised each time a new requirement is gathered.	Prioritisation of requirements to be agreed through the EHSCP ICT and Information Governance Steering Group.	Overdue - IA Validation in progress	30/09/17	31/03/18	30/09/2017	Current Position 15.01.18 - Overdue - IA Validation in Progress A presentation detailing the range of work taking place that will lead to the identification of ICT requirements was discussed at the ICT and Information Governance Steering Group on 21/11/17 and the need to establish a clear ,mechanism for recording ICT requirements for consideration by the Group agreed. A copy of the notes from the ICT and Information Governance Steering Group will be sent by separate email. Revised completion date 31/3/2018. IA note: - notes from ICT and Information Governance Steering Group still to be received. November update: the HSCP ICT and Information Governance Steering Group will consider a paper on 21/11/17 setting out how the Statement of Intent being presented to the IJB on 17/11/17 provides a way forward in developing an ICT strategy/roadmap. Part of the discussion of this paper will include proposals for the identification, approval and prioritisation of ICT requirements. Papers submitted by separate email. October update: It is the role of the Health and Social Care Partnership ICT and Information Governance Steering Group to agree and prioritise requests for specific pieces of work from ICT outside business as usual. This Group has agreed to oversee the delivery of the recommendations within this audit report.	Wendy Dale,Strategic Commissioning Manager
								The IJB should ensure they communicate their visions and goals to the NHS and CEC staff.	Vision and goals in respect of ICT to be conveyed through the development and publication of an ICT Strategy for the EHSCP.	Overdue	31/10/17	31/10/18		Current Position 15.01.18 - Overdue A report on the outputs from the workshop held in November will be submitted to the Strategic Planning Group on 2/2/2018. November Update : a workshop to determine the information and communication needs of the IJB, staff working within the Health and Social Care Partnership and the public took place on 1/11/17. The outputs from that workshop are currently being analysed to determine the best way to move forward. October update: A workshop is taking place on 1 November 2017 to discuss the information and communication needs of the IJB, staff working within the Health and Social Care Partnership and the public. Following the workshop we will produce an evaluation of the needs identified, how these are currently met, any gaps and how they need to be addressed. Thios will be shared with staff, IJB members and other stakeholders.	Wendy Dale,Strategic Commissioning Manager
HSC1715ISS.4	HSC1715	Edinburgh Alcohol and Drug Partnership (EADP) – Contract Management	Health & Social Care	ISS.4	Low	On 2nd June 2017, the main provider contracted under the Adult Community Treatment Services Contract went into 'Administration'. The Joint Programme Manager advised that the provider contacted the EADP team towar ds the end of May to inform them of this and to advise that the contract terms and conditions were being transferred to another provider with immediate effect. It is understood at that point that the original providers' staff had already been ' TUPEd ' over to the new contract provider. The Joint Programme Manager noted that the Council was in the process of signing a Novation Agreement to transfer the terms and conditions over to the new contract provider. However, it is understood that the Novation Agreement is still unsigned (as at our audit closing meeting of 3rd October) although the provider has been providing service delivery under contract since the transfer of staff in June.	Risk of breach of contract which cannot be addressed as there is no signed contract between both parties.	The EADP Novation Contract Agreement should be signed by both parties immediately.	EADP Joint Commissioning Officer will follow up the novation agreement for the new contract and resolve by the end of November 2017.	Overdue	22/12/17				David Williams,EADP Joint Commissioning Officer
HSC1503 ISS.3	HSC1503	Personalisation SDS - Option 3	E.I.J.B.	ISS.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 Optio ns 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 accur ate 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 cha nges 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.	Overdue - IA Validation in progress	30/06/16	31/03/18	31/12/17 30/06/17	Current Position at 11/01/18 - Overdue - IA Validation in Progress Compliance and Data Quality Team Manager now in place, rest of the Team starts on 8/1/18. Draft project plan agreed by Assessment and Review Board (copy supplied to Internal Audit for validation). Position at 21/11/17 - Overdue - IA Validation in Progress The establishment of the Compliance and Data Quality Team has been agreed; the manager will take up post on 4/12/17 and the rest of the Team on 8/1/18. A prioritised work plan will be drawn up for the Team and include the development and implementation of a change management process. Delivery date to be extended to 31/3/18. Position at 25/10/17 - Overdue - IA Validation in Progress Updated following discussion with Internal Audit and Business Services Manager on 25/10/17. The development and implementation of the change management process will be part of the role of the proposed Compliance and Data Quality Team. Establishment of this Team is awaiting approval from CLT. Owner of action changed from Strategic Commissioning Manager to Business Services Manager. Current Position at 24/10/17 - Overdue - IA Validation in Progress Discussions are currently taking place to establish where responsibility for change management should sit within the Health and Social Care Partnership. August Update Chief Officer and Strategic Commissioning Manager provided an update at GRBV meeting of 01.08.17 that noted that a revised implantation 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	Mary McIntosh, Business Services Manager
HSC1503 ISS.6	HSC1503	Personalisation SDS - Option 3	E.I.J.B.	ISS.6	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 they have signed off the support plan. At present any edits made by the senior at 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	Overdue - IA Validation in progress	30/06/16	30/06/18	31/12/2017	Current Position at 11/01/18 - Overdue - IA Validation in Progress Compliance and Data Quality Team Manager now in place, rest of the Team starts on 8/1/18. Draft project plan agreed by Assessment and Review Board (copy supplied to Internal Audit for validation). Position at 21/11/17 - Overdue The establishment of the Compliance and Data Quality Team has been agreed; the manager will take up post on 4/12/17 and the rest of the Team on 8/1/18. A prioritised work plan will be drawn up for the Team and include the outstanding tasks in order to address this recommendation. Delivery date to be extended to 30/6/18. Position at 25/10/17 - Overdue - IA Validation in Progress: Updated following discussion with Internal Audit and Business Services Manager on 25/10/17 The running of data quality reports and ensuring compliance with processes will be part of the role of the proposed Compliance and Data Quality Team. Establishment of this Team is awaiting approval from CLT. Owner of action changed from Strategic Commissioning Manager to Business Services Manager. Current Position at 24/10/17 - Overdue - IA Validation in Progress: Work is actively taking place with colleagues in Internal Audit to agree what action now needs to take place in terms of evidence and verification. September Update : meeting arranged with Internal Audit to discuss how best to progress this issue. 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 monthly 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 June Update: 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.	Mary McIntosh, Business Services Manager
HSC1504 ISS.1	HSC1504	Care Sector Capacity	E.I.J.B.	ISS.1	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 ing is limited to percentage growth according to the N ational R ecords of S cotland 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.	Overdue - IA Validation in progress	30/04/17	31/12/17		November Update: - Ovedue - IA Validation in progress Further evidence supplied by Eleanor Cunningham for validation by Hugh Thomson Current Position at 24/10/17 - Overdue - IA Validation in Progress A meeting took place with Internal Audit on 17/10/17 to discuss the current approach to forecasting and what evidence is required for this recommendation to be closed. It was agreed that further evidence would be submitted for consideration by Internal Audit. September update : A meeting has been arranged for mid October with Internal audit to provide them with evidence of recent work undertaken in relation to demand forecasting in order to establish whether or not this addresses the concerns raised in the report. 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
HSC1601 ISS.6	HSC1601	Care Home Debt Management	E.I.J.B.	ISS.6	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 incident of apparent overcharging requires to be investigated and if substantiated, refunds provided to the individual residents affected.	The Team Manager – Social Care Finance – Transactions, will identify the clients who have been overcharged for 2015/16 by the Billing Team and make the appropriate refunds.	Closed - Verified					Elizabeth Davern, Team Manager: Social Care Finance - Transactions
								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.	Overdue	31/03/17	31/12/17	30/06/17 31/12/17	December Update: The recommendation changes the current policy and therefore will be presented for approval to the Corporate Policiy and Strategy Committeee on 28/02/18. November update: briefing paper for SMT drafted to be finalised following a meeting of key players on 20/11/17. Evidence of meeting and draft paper submitted by separate email. Current Position at 24/10/17 - Overdue - IA vaildation in Progress Meeting arranged for 18/10/17 to develop an agreed approach to annual uprates in respect of in-house care home fees for recommendation to the Health and Social Care Senior Management Team. September update: Meeting to be held with Finance to agree an annual process for uprating charges. Update requested July - finding owner on annual leave returning 17/7 A meeting is being arranged between the Strategic Planning and Quality Manager for Older People and collegues 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.	Katie McWilliam, Strategic Planning and Quality Manager for Older People

Unique No	Project Code	Project Name	Group	Issue Cor	Rating	Finding	Business Implication	Recommendation	Agreed Management Action	Status	Due Date	Revised Date	Revisions	Status Update	Owner
HSC1603 ISS.4	HSC1603	Management Information [EIJB]	E.I.J.B.	ISS.4	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.	Overdue	31/03/17	31/12/17	31/07/17 31/12/17	Current Position at 11/01/18 - Overdue No status update received for January - H&SC have been contacted for a response. October update: Resourcing issues in respect of performance management to be addressed as part of Phase 3 of the Health and Social Care transformation. Owner for this action to be changed to Michelle Miller September update; the Interim Chief Officer is currently exploring any key gaps in infrastructure support such as performance management and identifying how to address these. Implementation date extended: the support services part of the new structure has not progressed as quickly as anticipated.	Michelle Miller, Interim Chief Officer. EH&SCP
HSC1604 ISS.2	HSC1604	IJB Data Integration & Sharing	E.I.J.B.	ISS.2	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.	Overdue	31/07/17	31/01/18	31/10/17	December update : The Pan Lothian Agreement (final draft) has been circulated to respective Lothian Council legal teams for comment and CEO sign-off. CEC Legal Services have agreed document; other legal teams are holding up the process. Meeting has been arranged for mid-January to hopefully get agreement from all signatories and organisations involved. Suggested revised date: Jan 2018. November update: the memorandum of understanding is now in the final draft but is still with the Legal Teams in CEC and NHSL. At the EHSCP ICT and Information Governance Steering Group on 21/11/17 the Chief Officer will be asked to escalate this issue October update: Once the Memorandum of Understanding has been signed by all parties, a communication will be produced for distribution to all staff linked to the communication following the workshop to be held on 1/11/17. See response to the action above.	Kevin Wilbraham, Information Governance Manager, Corporate Governance.
								The processes for notifying system owners of staff changes should be well defined and communicated to stakeholders. Controls should be implemented to ensure access to CEC and NHS systems remain appropriate. This should include processes to ensure that changes are applied in a timely manner and access rights are regularly recertified. This would provide assurance to system owners over the operating eff e ctiveness of these controls.	The existing processes within the Council and NHS Lothian for notifying system owners of staff changes will be communicated to all managers of integrated teams. Establishing an integrated system setting out the systems access requirements for all posts and the mechanism for gaining access for new staff and notifying system owners of leavers and changes in role will be a priority for the nominated officer to be identified in respect of ICT and Information Governance.	Overdue	30/09/17	31/03/18	30/09/17	Current Position at 16/01/18 - Overdue Change of 'Issue' Owner'. A ' Handover meeting' was held between the Strategic Commissioning Manager and the Operations Manager on 08/01/18. IA Note: The Operations manager met with Internal Audit on 11/01/18 and it was agreed that the required update would be deferred to the following month. November update: an individual has now been appointed to the post. funded by Resources and will begin to develop a work plan. A hand over will be arranged with the existing action owner. October update: This recommendation will be progressed by the post funded by Resources. The post will have a range of responsibilities, inlcuding information governance, business continuity and resilience, health and safety and coordination of the HSC Partnership risk register. As it is anticipated that recruitment may not be completed before 31/12/17 a completion date of 31/3/18 is proposed	Wendy Dale, Strategic Commissioning Manager
HSC1604 ISS.3	HSC1604	IJB Data Integration & Sharing	E.I.J.B.	ISS.3	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.	Overdue	30/06/17	31/03/18	31/12/17	Current Position 17/01/18 - Overdue The ICT and Information Governance Steering Group tasked specific individuals to produce the Survey Monkey questions for agreement at the next meeting of the Group on 22/1/2018. Revised implementation date 31/3/2018. November update : following discussion with ICT colleagues in CEC and NHSL it will be recommended to the ICT and Information Steering Group on 21/11/17 that all staff in integrated teams where access to both CEC and NHSL systems are required are asked to take part in a survey (via Survey Monkey) to identify any issues relating to access to systems. October update: A formal request for the review to be undertaken will be lodged. September update : This action has been discussed at the EHSCP ICT and Information Governance Steering Group where it was agreed that the review required could not take place until the new integrated teams are in plce in the localities, this will be completed by the end of this month. Completion date extended to 31/12/17	Wendy Dale, Strategic Commissioning Manager
HSC1503 ISS.1	HSC1503	Personalisation SDS - Option 3	H&SC	ISS.1	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.	Overdue	31/10/16	31/03/18	31/12/17 30/06/17	Current Position at 10/01/18 - Overdue: Progress in delivering this action has been slower than anticipated. A revised completion date on 31/3/18 is requested. IA Note: - Revised completion date updated as requested; however, clarification of current implementation status has been requested from action owner. IA assistance to be provided if required. Progress made will be included within next months update. Position at 21/11/17 - Overdue: The working group is due to meet again to update on progress and agree next steps on 29/11/17. Position at 24/10/17 - Overdue: A working group has been established to take forward the revision/replacement of the existing Funding Allocation System that has been used to generate the indicative budget. The Group has held initial meeting on 19/10/17. September Update: Leaflet on independent advocacy for the public has been produced by the providers who have been awarded the contract and will shortly be published. Orb content advising staff about independent advocacy has also been prepared. Discussions are ongoing with the SWIFT team to establish the best way of identifying people who would benefit from advocacy and referring them to the appropriate service. August Update: Chief Officer and Strategic Commissioning Manager provided an update at GR8V meeting of 01.08.17 that noted that a revised implantation date of December was required. This was confirmed with the Strategic Commissioning Manager 22/08/17. Revised completion date of 31/12/2017 added. 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
SW1601 ISS.4	SW1601	Social Work: Pre-Employment Verification	H&SC	ISS.4	Medium	There was insufficientevidence 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 betwe en 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 fo r 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.	The "Recruitment and Selection Guidance for Managers Pre-Employment Checks for Nominated Candidates" should be updated to reflect the above change in procedure.	Employees should currently retain vetting information received as a result of a PVG disclosure check for regulated work. If an existing employee working in regulated work is the nominated candidate for another position within the Council which is also regulated work then that candidate should evidence the vetting information for the original PVG check. It should be noted that Disclosure Scotland have confirmed that Scheme Record updates now contain original vetting information. Employees who fail to evidence the original vetting information will result in the Council requiring to pay for a Scheme Record update. The cost of this update is £18, this will be an additional cost to the Council. The vetting information will continue to be destroyed by the People Support Recruitment Team as it is not deemed efficient to retain huge amounts of vetting information on a 'just in case basis'. The required documentation will be sought on a 'need' basis In the first instance the responsibility to provide information will be the employees. The requirement to evidence vetting information when recruiting staff internally will be included in the guidance at its next review.	Closed - Verified					Grant Craig, People Support Manager
								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.	Overdue- IA Validation in progress	31/03/17	30/11/17	30/11/2017	Current Position at 11/01/18 - Overdue IA Validation in Progress Stronger recruitment processes are currently in place following active improvement contributions between HSC Senior Management Team and Recruitment Coordination team. Reminder emails are sent as standard and embedded in the Partnership's new recruitment process to ensure that all nominated candidates pre-employment checks are made. Evidence submitted to Internal Audit for Validation. IA Note: - Meeting held with Operations Manager 11.01.18 Agreement reached on f urther evidence required. Position at 22/11/17 - Overdue November Update not received . Position at 26/10/17 - Overdue IA met with Executive Business Support Manager 25.10.17 and was advised that this work is still on-going. Action has a revised implementation date of 30.11.17. August Update - Required evidence to close off issue has been discussed and agreed with Executive Business Support Manager. Once evidence has been collated IA will carry out further review of evidence provided. Revised Implementation date of 30/11/2017 agreed. July Update - Meeting held with Health and Social Care early July to agree actions and evidence required. Finding owner curently on annual leave and will process on return. IA has been advised that H&SC awaiting evidence from Localities. 31.08.17 Update: - Required evidence to close off issue has been discussed and agreed with Executive Business Support Manager. Once evidence has been collated IA will carry out further review of evidence provided. Revised Implementation date of 30/11/2017 agreed.	Cathy Wilson, Executive Business Support Manager
SW1601 ISS.5	SW1601	Social Work: Pre-Employment Verification	H&SC	ISS.5	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'.	All relevant policies and procedures should be updated with the requirement to formally record the 'Recruiting Managers' decision on the "PVG / Disclosure Risk Assessment form" and "Record of Meeting on PVG / Disclosure Information" form in order to show clear evidence of the decision made. Once complete these procedures should be formally communicated to all relevant staff / Recruiting Managers. This should include the safe storage and retention periods of both forms.	The forms "PVG / Disclosure Risk Assessment form" and "Record of Meeting on PVG / Disclosure Information" should be forwarded to the Council Recruitment Team checked then retained as part of the employees personal file. This will evidence the decision of the recruiting manager to offer or rescind employment. A process review will be carried out and implemented by 31/12/2016 As part of the process review between the HSC Team and HR Recruitment the HSC Team have made a commitment to communicate to all relevant staff and recruiting managers.	Closed - Verified					Grant Craig, People Support Manager
								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.	Overdue - IA Validation in progress	31/03/17	30/11/17	30/11/17 31/5/17	Current Position at 11/01/18 - Overdue - IA Validation In Progress For every new candidate, standard email to all recruitment managers from HSC Recruitment Coordination Team now includes: 'Candidate needs to bring photographic identification on the first day at work. Candidate needs to be informed that failure to bring the appropriate identification may result in the candidate being refused to start work within the Council. This is a shared responsibility of the candidate, HR Recruitment Team and line manager to cross-check photographic identification. Candidate needs to bring PVG Certificate on the first day at work. Candidate needs to be informed that failure to bring the document may result in the candidate being refused to start work within the Council. FYI: Photographic identification and PVG certificate should have at least one piece of information matching: Current address and/or date of birth.' - Sample email evidence submitted to Internal Audit. Request to close this item. IA Note: - Meeting held with Operations Manager 11.01.18 Agreement reached on f urther evidence required. Position at 22/11/17 - Overdue November Update not received. Position at 26/10/17 - Overdue IA met with Executive Business Support Manager 25.10.17 and was advised that this work is still on-going. Action has a revised implementation date of 30.11.17. September Update: Further work required to support closure. Revised Implementation date of 30/11/2017 agreed. 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

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SW1601 ISS.7	SW1601	Social Work: Pre-Employment Verification	H&SC	ISS.7	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 che c k 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.	Overdue	31/03/17	30/11/17	30/11/17 31/5/17	Current Position at 11/01/18 - Overdue In addition to the Recruitment Coordination Team's emails (see previous audit item), it is recommended that Recruitment Manager's line management team carry out periodic staff file checks to ensure staff ID files are stored safely. Request to provide locality-wide evidence submission prior to 31/03/18. IA Note: - Meeting held with Operations Manager 11.01.18 Agreement reached on f urther evidence required. Position at 22/11/17 - Overdue November Update not received. Position at 27/10/17 - Overdue - IA Validation in Progress Communication has gone to all Locality Managers to ensure compliance with mandatory first day ID verification for new employees on first day. Work is still ongoing to ensure that this is being adhered to. Verification process to be completed throughout Novemeber. September Update: Further work required to support closure. Revised Implementation date of 30/11/2017 agreed. 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
SW1601 ISS.8	SW1601	Social Work: Pre-Employment Verification	H&SC	ISS.8	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.	Overdue- IA Validation in progress	31/05/17	30/11/17	30/11/2017	Current Position at 11/01/18 - Overdue IA Validation in progress. Updated iTrent list (produced by OD Team) submitted to Internal Audit confirming recruitment managers completion list. In addition, new recruitment process attached, signed off by Interim Chief Officer, that requires an additional burden of proof of recruitment selecton training completion prior to being allowed to advertise for a new post. Request to close this item. IA Note: - Meeting held with Operations Manager 11.01.18 Agreement reached on f urther evidence required. Position at 22/11/17 - Overdue November Update not received. Position at 26/10/17 - Overdue T he Interim Chief Officer has instructed and communicated to all HSC Partnership managers that the 'Recruitment and Selection' module on CeCil must be completed. Non-compliance will result in managers being unable to be part of the recruitment process. Control Following agreement at October SMT , there is now a new recruitment process for all HSC Partnership posts: - Managers must now submit a vacancy business case to the Chief Officer's generic mailbox (healthsocialcareintegration@edinburgh.gov.uk). - If the business case has been approved, managers must provide evidence that all members of the recruitment panel have successfully completed the Council recruitment and selection eLearning module before final approval will be given to advertise the post. - To verify this, a CeCil screenshot of the completion record for each panel member to an email addressed to healthsocialcareintegration@edinburgh.gov.uk. Once confirmed, only then will managers receive final approval to adverstise a vacancy. This also applies to NHS managers, where these are managing Council employees. IA Note: Partial evidence has been received 25.10.17 and is in the process of being validated. Further evidence has been requested. September Update : 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. Revised implementation date of 30/11/17. 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
								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 required 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.	Overdue- IA Validation in progress	31/05/17	30/11/17	30/11/17	Current Position at 11/01/18 - Overdue IA Validation in progress. New Recruitment process map ensures that Senior Managers, Locality Managers and Recruitment Coordination Team are adhering to mandatory training requirements. See previous item for evidence (circulation list and process map). Request to close this item. IA Note: - Meeting held with Operations Manager 11.01.18 Agreement reached on f urther evidence required. Position at 22/11/17 - Overdue November Update not received. Position at 22/10/17 - Overdue See above update. September Update: Interim Chief Officer – Edinburgh Health and Social Care Partnership issued email to managers which highlights the required actions to be taken in order to implement the recommendation. August Update: - Required evidence to close off issue has been discussed and agreed with Executive Business Support Manager. Once evidence has been collated IA will carry out further review of evidence provided. Revised Implementation date of 30/11/2017 agreed. 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															
CW1602ISS.1	CW1602	Disaster Recovery	Place	ISS.1	Medium	Following the transition of IT managed services to CGI, a DR programme has been established which, it is anticipated, would allow the Council to recover critical services and data in the event of major disruption or loss of IT infrastructure. However, enhancements are required to allow confidence that the DR programme will meet the recovery requirements of the Council and its stakeholders. The w eaknesses in the DR programme , set out below may adversely impact upon the ability of the Council to recover critical systems effectively: Robust testing in line with the CGI contractual requirement, of the Council ' s recovery processes has not been performed to determine whether the recovery solution is fit for purpose and to validate the effectiveness of the current design of recovery provis ions and processes. The approach to classifying critical systems, as either P1, P2 or P3 (High, Medium, Low), is not consistent and does not consider other prioritisations within the Council . The application of these ratings are determined by business own ers and is a subjective process, which may result in systems being misclassified from a Council wide perspective . The inventory of system dependencies between critical Council systems is not regularly reviewed or maintained. Management review this on an ad hoc basis or when CGI identify any weaknesses in infrastructure. There is no mandatory requirement for, or oversight of, DR provisions or testing for IT systems that are procured, managed or maintained either outside the CGI contract or wit hout oversight from ICT. Business owners and stakeholders for IT systems and services have not been updated, which may result in delays in implementing improvements and establishing business requirements.	Without an embedded DR programme in place that has been robustly tested and captures all Council critical services and systems, there is a risk that following significant ICT disruption (for example the loss of a datacentre or a major cyber security breach) the Council is unable to recover all critical data and resume business operations in a timely manner. The loss of critical ICT services for an extended period of time or the inability to successfully recover data could result in significant operational and reputational damage to the Council.	Management should ensure that ICT systems within the Council have been identified and classified appropriately. Disaster recovery processes should be vigorously tested to validate the ability of the Council to successfully recover systems and data within the defined timescales set by stakeholders. For systems that are identified which are not managed by central ICT (Shadow IT), Management should consider how they could work with the system owners in ensuring that that these systems are resilient and can recover following a major incident.	Service Areas will identify all shadow IT (systems, applications and websites historically procured and implemented by Services that are not managed corporately by ICT in conjunction with CGI) and provide details of these to the Head of ICT. Information to be provided will include: - Name of the application - Details of the application provider - Information on the Council service that the system supports - Details of any support agreements and licence arrangements in place with the system provider, including their expiry date - Information re any recent cyber or security attacks that impacted the operation of the system. - Any available information on how the system is backed up to ensure that source data held on the system can be recovered. - An initial assessment of the system's critically based on definitions provided by ICT.	Overdue	30/11/17			December Update: Overdue. ICT has confirmed that a n on-standard partial return was received in early December. Email requesting correct format was sent on 5/1/18. No response by deadline of COB 12/1/18. Chased up on 15/1/18. November Update: Information on Shadow IT system currently being gathered for Place and will be submitted before the end of November to fit with the December CLT report.	Paul Lawrence,Executive Director of Place and SRO
RES1605ISS.1	RES1605	Service Level Agreements with Outside Entities	Place	ISS.1	Low	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 Account ancy 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 a udit 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.	Directors will ensure that a service level agreement (SLA) has been established with all arms level organisations (ALEOs) that they support. The SLA should set out all services provided and received by the Council, key activities and deliverables, and the respective roles and responsibilities of the Council and the counterparty. The agreements should be for a one year period and refreshed annually to ensure that agreed services and charges remain appropriate.	Overdue	30/11/17			December Update: Overdue - no response received November Update: Information on SLAs is being gathered for Place and will be complete by 30/11/2017. IA Note: This is a new recommendation allocate across all Directorates / Service Areas as agreed at CLT in September. No update required in the current month.	Paul Lawrence,Executive Director of Place and SRO
PL1601 ISS.4	PL1601	Recycling Targets	Place	ISS.4	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.	Overdue	31/03/17	31/03/18	30/09/2017	Current Position at 18/12/17 - Overdue Waste and cleansing services have now been joined together. The strategy document has been redrafted following presentation to the new management team. The external waste services improvement plan will also be linked to this strategy. Aiming to have both approved by the internal management team by 31 st March 2018. Position at 25/10/17 An internal working draft will be circulated to management within the service by the end of this year (2017) with a view to sign off and approval by elected members by spring 2018. Thereafter we will carry out an approximately annual "light touch" review, with a more in depth review every 3-5 years, albeit this will be flexible in the event that we need to account for policy changes (e.g. resulting from a change of government). 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. 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 Draft new Waste and Recycling strategy is not yet finalised. Communication of this strategy will form part of a delivery plan for implementation.	Angus Murdoch, Strategy Officer

Unique No	Project Code	Project Name	Group	Issue Cor	Rating	Finding	Business Implication	Recommendation	Agreed Management Action	Status	Due Date	Revised Date	Revisions	Status Update	Owner
PL1601 ISS.5	PL1601	Recycling Targets	Place	ISS.5	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.	Overdue	30/09/16	31/12/17	30/04/17	Current Position at 18/12/17 - Overdue There is no one with formal responsibility for internal Council waste. A working group of stakeholders has been established and work is ongoing with corporate policy staff to ensure the policy / strategy re internal council waste is updated. A report was prepared for the Corporate Policy and Strategy Committee in April 2016 that was not presented. Following this, employees left, and Facilities Management was still undergoing transformation. Main progress has been targeting food waste in schools and recycling across the Council estates. Actions are ongoing to address. Position at 25/10/2017 No change from September Update. September 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. 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
PL1603 ISS.3	PL1603	Mortuary Services	Place	ISS.3	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 he 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.	Overdue	31/03/17	31/10/17		Current Position at 18/12/17 - Overdue A risk register has been provided to IA, however this is in a draft state. The risks are still to be rated based on their impact and likelihood and the controls section hasn't been finalised. September Update The Risk Register is being updated in collaboration with the Counil's Risk team this is anticipated to be complete by the end of September. Demand forecasts for future years have been made. Demand forecast(s) for seasonal variation within a year are to be completed by the end of October 2017. August Update: - Information was provided on the 22/8/17 and is currently being reviewed by Internal Audit. 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.	Robbie Beattie, Scientific, Bereavement & Registration Services SeniorManager
PL1603 ISS.5	PL1603	Mortuary Services	Place	ISS.5	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 c ontingency p lan 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 Arra ngements module, covering arrangements in response to intensive emergencies outlines the locations and number of body storage units within the Council and externally . Th is 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 Q ueen Elizabeth H ospital in Glasgow (the 300 quoted includes day to day usage and gives no indication of any potential capacity issues here). S ignificant 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 r eflect 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.	Overdue	31/03/17	31/12/17	30/4/17	Current Position at 20/11/2017 - Overdue A Business impact assessment (BIA) has been completed for the Mortuary Service and provided to IA. The Business Continuity Plan is being updated in coordination with the Resilience Team and is to be reviewed by the service manager. This is to be provided to IA when complete as well as the outcomes of any discussions with NHS Lothian. November update Work continuing on the update of contingency plans. Scottish Government continue to progress a national mortuary review to reassess the most suitable organisations to assume statutory responsibility. Arrangements with NHS Lothian for contingency provision are well progressed with a licence agreement drawn up. A trial of the use of the NHS facility was undertaken recently to allow for essential maintenance of the CEC mortuary. September Update: A stakeholder plan has been evidenced. A contingency plan for mass fatalities events (either intensive or extensive) an agreement is in place that the RIE would be the control centre with the support of the council's staff. A memorandum of understanding advising of this arrangement has been submitted to members of the EoS RRP group. The draft contingency plan at the time of the audit has been provided to the service area to deal with busy periods that are not designated as mass fatalities incidents, this is to be updated due to changes in the Council structure and is anticipated to be complete by December 2017. 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. Original implementation date 31/03/17	Robbie Beattie, Scientific, Bereavement & Registration Services SeniorManager
Resources, ICT Solutions and Investment & Pensions															
RES1605ISS.1	RES1605	Service Level Agreements with Outside Entities	Resources	ISS.1	Low	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 Account ancy 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 a udit 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.	Directors will ensure that a service level agreement (SLA) has been established with all arms level organisations (ALEOs) that they support. The SLA should set out all services provided and received by the Council, key activities and deliverables, and the respective roles and responsibilities of the Council and the counterparty. The agreements should be for a one year period and refreshed annually to ensure that agreed services and charges remain appropriate.	Overdue	30/11/17			December Update: IA Vaidation in progress. Schedule of SLA has been received from Resources, and copies of SLAs received from Finance and currently being reviewed. IA to select a sample of :SLAs to confirm existence and that the format is standard. Refer E1.7 and 1.8 for evidence. IA has engaged with Resources re potential completeness of the SLA register and progress with the wider L&R SLA refresh.	Stephen Moir,Executive Director of Resources
RES1605ISS.1	RES1605	Service Level Agreements with Outside Entities	Investments and Pensions	ISS.1	Low	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 Account ancy 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 a udit 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.	Directors will ensure that a service level agreement (SLA) has been established with all arms level organisations (ALEOs) that they support. The SLA should set out all services provided and received by the Council, key activities and deliverables, and the respective roles and responsibilities of the Council and the counterparty. The agreements should be for a one year period and refreshed annually to ensure that agreed services and charges remain appropriate.	Overdue	30/11/2017			December Update - overdue - no update received. IA Note: This is a new recommendation allocate across all Directorates / Service Areas as agreed at CLT in September. No update required in the current month. Can you please provide evidence that this has now been completed and we will close?	Clare Scott Chief Executive Officer LPF

Unique No	Project Code	Project Name	Group	Issue Cor	Rating	Finding	Business Implication	Recommendation	Agreed Management Action	Status	Due Date	Revised Date	Revisions	Status Update	Owner
RES1601ISS.1	RES1601	Health and Safety	Resources	ISS.1	High	While the Council has a number of standing orders in place to provide guidance on Contractor procurement, there is no overarching strategy and/or policy in place for the control and management of contractors/suppliers. The standing orders in existence have been developed to meet various needs that are being identified as the procurement process becomes more robust. There is a need for a Contractor Management Policy to give structure to the whole process. There are three particular areas of weakness, we have identified: Unclear r oles and responsibilities The lack of a structured c ontract or /supplier management process has led to a lack of clarity around roles and responsibilities with the majority of attention/responsibility reverting back to procurement. Procurement accept s that the initial phase of procuring contractors , is its responsibili ty but it do es not accept that the ongoing monitoring should lie with Procurement. Contract owners are named under each framework, but the individuals are not currently mandated to do anything in regards to H&S and , moreover, there is no guidance provided as to how they should discharge their duties. Contract owners are therefore unsure what is required of them which contributes to inconsistency across the Council with regards to how it manages contractors . For example, it is good practice to request health and safety documentation such as risk assessments, method statem ents and training certificates prior to commencing with safety critical works . However, all contract owners and contractors interviewed during the audit process reported that this is not currently taking place. Lack of c ontractor p erformance r eporting/ r eview process There is no quarterly or annual review of contractor performance , covering topics such as Safety but also financial and quality aspects of contract performance . The council is therefore missing potentially valuable management information whic h could provide benefits such as cost saving and performance feedback. In certain cases, KPIs are set for contractors but there is no evidence that this information is requested and followed through to check how contractors are performing against agreed ta rgets. Some contractors are providing this on a monthly basis but this is often being driven by the contractor rather than being specifically requested by the Council. Over-reliance on initial prequalification There is an over-reliance on the initial prequalification of contractors as a safety risk control measure. The prequalification process can only provide a snapshot in time and should be supplemented by ongoing monitoring of contractors. For example, Procurement may request a sample of risk assessments and method statements to review during the tendering stage but that does not mean that this review should be relied upon for all on-going activities by contractors. Further review should be undertaken by Contract Owners within the Council.	The Council has a responsibility to ensure that its contractors and subcontractors operate to acceptable standards in all aspects of their performance including quality of work, financial cost and risk management. Failure to satisfactorily monitor contractors could result in substandard performance by Contractors exposing the Council to financial, regulatory & reputational risk.	(a) Create a central team that has cross departmental oversight and is responsible for driving the different facets (Financial, Operational and Risk, plus Policy owners for H&S, data protection, resilience, etc.) of the control and management of contractors/suppliers. In the interest of consistency, we recommend that the current procurement team is augmented to be able to perform this additional oversight role. In order to effectively carry out this function, there would need to be an increase in resource and possible changes to responsibilities within CPS. b) (b) The monitoring of contractors and subcontractors will remain within the service areas as per the Contract Standing Orders. Where contractors are subcontracting work, a monitoring mechanism must be agreed to ensure that subcontractors are held to the council's performance standards.	It is proposed that the findings will be addressed through the implementation of a Council-wide approach to Contract Management. The establishment of a dedicated team to facilitate the development of an overarching strategy and architecture to define common processes, best practice and to support management and reporting on a tiered basis was previously approved by CLT and will support the delivery of some of the recommendations within the report. a.) Establish a team within CPS to w ork in partnership with service areas to facilitate the development of overarching processes , information, advice and guidance for Service Areas and Contract Owners. b.) Monitoring of Contractors and subcontractors remain s the responsibility of service areas as part of the Contract Standing Orders . A reminder will be sent to service areas in this regard . Contract owners need to ensure that Contractors and Suppliers operate to acceptable standards in all aspects of their performance including quality of work, financial cost and safety standards.	Closed - verified	31/12/17			December Update - Closed and Validated The new Contracts and Grant Management team within procurement was established in August 2017. IA has held one initial meeting with the team for introductions and discussed their roles and responsibilities on 18/10/17. Evidence attached at E1.11 provides details of the outcome of this meeting with the new CAGM team members and also an overview of CAGM team roles and responsibilities that have been shared across all Contract Managers of tier 1 (>£2M p.a.) contracts October Update- A dedicated Contract and Grants Management (CAGM) Team has been in operation since August 2017. The Team are drafting a Contract Management Guide with a full suite of supporting documents which will be circulated to service areas once it has been completed and approved. The documents produced will be part of a toolkit which will help to ensure formal and consistent Contract Management is embedded across all contracts and service areas. A contract tiering process has been developed to enable Service Areas to tier new / existing contracts which takes into consideration risk (reputational, economic, political, and health & safety) and complexity. Based on the contract tier allocated, the Contract Management Guide sets out the appropriate contract management activities required.	Hugh Dunn,Head of Finance
								Create a policy for the control and management of contractors and suppliers that aligns to recognised standards, leveraging sources of contractor management good practice. This policy should specify responsibilities for the different stakeholders involved in the contractor management process.	CPS will work closely with Service Areas and the H&S and other teams to create a policy for the control and management of contractors & suppliers that aligns to recognised standards and good practice. The policy will specify responsibilities for the different stakeholders involved in contract management process.	Overdue - IA Validation in Progress	31/12/17			December Update - IA Validation in progress Detaills of the Contract Management Guide has been provided to Internal Audit with suppoerting documentation. This has been reviewed and follow up conversation to address IA questions scheduled with the Head of Procurement. October Update: The CAGM Team are beginning to work with colleagues who specialise in the management of H&S, Risk, Resilience, Compliance and Data Protection to develop documentation and processes to allow for the proper management of suppliers aligned to recognised standards etc.	Tammy Gillies,Acting Head of Procurement
								Schedule and maintain regular reviews of contractor performance that consider the financial, operational, quality and H&S performance of the contractor. The frequency of these reviews should be determined by such factors as the significance of the safety risk, the amount of spend, etc.	CPS will work with Service Areas, CPS, Risk and Policy owners for key risks (incl H&S, data protection, resilience) to identify key measures and KPIs required to ensure consistency around contractors performance and review including guidance on good practice for Contract Owners and Service Areas. Using this appropriate measurement, a process on reporting, and escalation will be developed for use by Service Areas adopting a risk based approach.	Overdue - IA Validation in Progress	31/12/17			December Update - IA Validation in progress Detaills of the Contract Management Guide has been provided to Internal Audit with suppoerting documentation. This has been reviewed and follow up conversation to address IA questions scheduled with the Head of Procurement. IA Comment - The Contracts and Grant Management Team are beginning to work with colleagues who specialise in the management of H&S, Risk, Resilience, Compliance and Data Protection to develop documentation and processes to allow for the proper management of suppliers aligned to recognised standards etc.	Andrew Kerr,Chief Executive
								A communication plan for contractor management should also be determined by the Chief Procurement Officer, specifying the reporting arrangements to the central team in charge of contractor management .	Service Areas and CPS to develop a communication plan which will specify the escalation, reporting and feedback arrangements to the central Contract Management team and/or other relevant team on risks, poor performance or contract breaches.	Overdue - IA Validation in Progress	31/12/17			December Update - IA Validation in progress Detaills of the Contract Management Guide has been provided to Internal Audit with suppoerting documentation. This has been reviewed and follow up conversation to address IA questions scheduled with the Head of Procurement. October Update - The CAGM Team are beginning to work with colleagues who specialise in the management of H&S, Risk, Resilience, Compliance and Data Protection to develop communicatioj plan.	Tammy Gillies,Acting Head of Procurement
								Develop a training programme for those with responsibilities within the contractor management process, especially for Contract Owners and users. A contractor management 'roles and responsibilities' training plan should be developed with specific focus on Contract Owners, Contract Users, Contractors, as well as Managers and any other specific staff as agreed by the Council.	5. Chief Procurement Officer to determine generic principles of contract management with specific focus on Contract Owners, Contract Users, Contractors, as well as Managers and any other specific staff as agreed. Specific and relative skills training for contract owners will need to be assessed and implemented by Directors. Directors should ensure that suitably skilled staff are identified as Contract Owners. Head of HR will be responsible for the establishment of a Training Programme for those with responsibilities within the contractor management process.	Overdue - IA Validation in Progress	31/12/17			December Update - IA Validation in progress Detaills of the Contract Management Guide has been provided to Internal Audit with suppoerting documentation. This has been reviewed and follow up conversation to address IA questions scheduled with the Head of Procurement. October Update: The CAGM Team are developing high level principles of contract management roles and responsibilites.	Tammy Gillies,Acting Head of Procurement
RES1615ISS.4	RES1615	Property Maintenance	Resources	ISS.4	Medium	All works are now carried out by framework contractors, who work to a Service Level Agreement (for example 1 day for urgent works). The contractor is not required to report back to the Facilities Management helpdesk when work is completed. Facilities Management rely on building users to raise concerns if no action has been taken in response to reported issues. We note that technical officers now review contractor invoices before payment and quality check a sample of 10% of invoiced jobs. However, there is no monitoring of outstanding works orders (i.e. issues which have been reported, but not completed or invoiced).	Reported issues are not addressed within agreed timescales. Outstanding jobs may not be identified, with a risk that high risk issues are not resolved.	Contractors should confirm when jobs are completed. Outstanding jobs should be monitored.	The AS400 system does not allow recoding or reporting on completion until invoice stage. Contractors are already confirming when jobs complete to agreed SLAs (M&E in particular). This includes outstanding jobs. New contracts being procured will require all contracts to report on performance but th is is not anticipated to be complete until end 2017 by which time CAFM will also be in place . CAFM will support monitoring of outstanding works orders. In the meantime, as noted in Finding 2, an interim monitoring/tracking process has been developed for c ondition survey high risk/urgent items	Overdue	31/12/17	01/04/18		December Update - the use of CAFM to monitor and report on R&M work/expenditure is still expected to be operational in time for the start of the new FY 2018/19. Current position at 18/10/17 - Open - not yet due. The use of CAFM to monitor and report on R&M work / expenditure is still expected to be operational in time for the start of the new financial year 2018/19. Work is progressing to review, cleanse and align the FM cost centres with the new hub models as being implemented by the FM Transformation programme. Engagement with key stakeholders with regards to implementing CAFM for R&M works management is due to commence shortly. September Update As per audit action MIS1601a1SS.3 above, the full roll out of the CAFM solution, including the capturing of R&M costs at cost centre level, processing of supplier R&M invoices etc, will support the monitoring and close out of outstanding works orders going forward.	Murdo MacLeod,Maintenance Standards Officer
RES1615ISS.5	RES1615	Property Maintenance	Resources	ISS.5	Medium	All repairs and maintenance work is routed through the Facilities Management helpdesk. The helpdesk are a small, experienced team familiar with the Council's buildings and contractors, who are responsible for prioritising and procuring low value works, and escalating higher value works to the technical operations manager. There is no formal guidance available to F acilities M anagement helpdesk staff on how issues should be prioritised.	Risk of loss of corporate knowledge if members of the helpdesk team leave.	Formalise guidance on prioritising and commissioning works to ensure consistency and continuity if staff leave.	Helpdesk staffing does not report to P&FM but form part of the Business Support service. Business continuity and resilience are line management responsibility. However: An agreed list of H&S W&WT items has been developed and is issued and reviewed annually to all Helpdesk staff along with SLA times for actions/attendance.	Closed - verified					Mark Stenhouse,Facilities Management Senior Manager
								Formalise guidance on prioritising and commissioning works to ensure consistency and continuity if staff leave.	New Hard FM Services SLAs are being developed as part of the AMS Transformation workstream which will give clear guidance to helpdesk and customers on services delivered, prioritisation process and associated timescales. These are anticipated to be in place by April 2017 although the full supplier retender will not be complete to support until December 2017.	Overdue	31/12/17			December Update - overdue. Request for update has been sent to Service Area. November Update : t arget date to be met. October Update : New Hard FM SLA's currently being drafted by Arcadis and will include stakeholder engagement. It is anticipated that the new Hard FM SLA's will be in place by Q1 2018/19 and the retender exercise by December 2018. Previous Updates New Hard FM Services SLAs are being developed as part of the AMS Transformation workstream which will give clear guidance to helpdesk and customers on services delivered, prioritisation process and associated timescales. These are anticipated to be in place by April 2017 although the full supplier retender will not be complete to support until December 2017.	Mark Stenhouse,Facilities Management Senior Manager
RES1705ISS.3	RES1705	LPF - Information Governance	Investments and Pensions	ISS.3	Low	The Pensions website privacy policy & data protection section states that the City of Edinburgh Council is the data controller in terms of the Data Protection Act 1998. This is contrary to the Information Commissioners Office Data Protection Register entry which notes that the data controller is the Lothian Pension Fund. T he welcome letter to new scheme members references the website, however it does not specifically draw attention to the privacy policy and data protection content outlined in the website. The Pensions website privacy policy & data protection pages will require revision to comply with GDPR by May 2018, for example, opt outs should be opt ins.	There is a lack of clarity as to who the Data Controller is; LPF or CEC. There is a lack of transparency at the point of entry to the scheme as to how new members' data may be used.	Agreement regarding data controller responsibilities between LPF and CEC should be clarified and the ICO registration and Pensions website updated accordingly. The welcome letter should be updated to include a reference to the privacy policy and data protection content outlined in the website. Website privacy policy & data protection pages should be reviewed to ensure compliance with GDPR requirements by May 2018.	Recommendations accepted – all actions recommended by Internal Audit will be fully implemented.	Overdue	31/12/17			December Update - Overdue - no updates received.	Struan Fairbairn,Chief Risk Officer, LPF
RES1712ISS.2	RES1712	Asset Management Strategy	Resources	ISS.2	Medium	Our review of the controls established to support management of the investment property portfolio identified the following operational control gaps: • Signed leases requested for 2 investment properties could not be located. Additionally, records held on AIS are not fully up to date for all properties in the investment portfolio. • There is no centralised recording of inspections and repairs for investment property portfolio. Manual records of property inspections and repairs are held by surveyors. The Head of Service has advised that this due to resource constraints. • No monitoring is performed to confirm that necessary repairs have been performed, with reliance placed on receiving invoices to ensure that repairs have been completed. The Head of Service has advised that this is due to resource constraints. • The main key performance indicator (KPI) reported and monitored by the Investments team is the value of rental income received. No KPIs have been established to illustrate the percentage of the investment portfolio properties that are leased and those that are currently vacant. It is therefore not possible to determine whether rental or sales income generated across the portfolio has been optimised. • One Royal Institute of Chartered Surveyors (RICS) Registered Valuer currently completes rent renewals and negotiations with tenants. Negotiations can be verbal and are not always documented. Resources do not permit two officers to be involved in all negotiations, however all rent revaluations and new leases are approved by an independent Investments Manager in line with applicable Council standing orders.	Records management procedures should be reviewed and refreshed to ensure that all files can either be located or retrieved from storage upon request. The Investments team should ensure that the AIS system is updated to include all current property details. Current and accurate property details cannot be extracted from the AIS system for the Investment property portfolio. Information on investment property condition may not be easily accessible, especially where surveyors have left the Council or are on long term sickness absence. Risk that delayed completion of repairs is not identified where invoices are not received. Failure to record the need for essential repairs and ensure they are completed will increase the risk of occurrence of health and safety related incidents. Risk that a property could remain vacant for a significant period and that potential rental income is not optimised.	Monitoring of repairs across the Investment property portfolio should be implemented to confirm that essential repairs are completed in a timely manner.	Monitoring of repairs will now be routine and an inspection carried out when the invoice is received prior to payment. Tenants are generally on full repairing and insuring leases and therefore repairs etc will be identified during either interim or final dilapidation investigations. Structural survey exercise is also looking at investment portfolio.	Closed - verified					Graeme McGartland,Investments Senior Manager, Resources
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RES1712ISS.3	RES1712	Asset Management Strategy	Resources	ISS.3	Low	The Property and Asset Management strategy presented to the Finance and Resources Committee in September 2015 introduced the concept of the corporate landlord. The actions required to develop the concept are still in progress. These include development, finalisation and implementation of: Terms of reference for the recently established Asset Investment Groups. The content of management information packs to be provided to Localities Leadership teams. Finalisation of locality property requirements. The process supporting, and responsibilities for, preparation of business cases for all new property development requests for submission to Asset Investment Groups and the Property Board. Fully indexed property lifecycle costs across the portfolio. A process for receipt, assessment, and prioritisation of requests for property space from Service Areas. Whilst there is clear evidence of progress in each of these areas, there is no defined project plan or roadmap to support delivery and oversight of the remaining Operational Estate aspects of the wider property and asset management strategy.	Progress with implementation of the Operational Estate aspects of the property and asset management strategy cannot be formally monitored or tracked.	The plan will also record those areas where implementation is dependent on completion of actions by other Service Areas.	A project plan for the development of this information, bringing together the various on-going strands of work will be produced. This will set out dependencies (including other service areas) and risks, and will be incorporated within the Property Board governance with regular updates. It is also proposed to present this monthly to the Asset Management Strategy Board. This plan will reflect completion dates for the following: • The remit for the Asset Investment Groups has been drafted and is in the process of being approved at each departmental AIG meeting. • Base data and analysis for life cycle costing for the pipeline estate is nearing completion and the next step is to apply inflation. This information will be stored in a FAST model, developed with Finance, to allow scenario planning.• The identification of locality office accommodation requirements is mid-way through a two-month assessment, with requirements identify by the end of October and detailed models to be completed in November.• A change request process for property changes has been developed and will be implemented in tandem with the 'go-live' date of the FM review.• The first business cases for new property investment for the 2018/19 budget are currently being developed and are expected to be completed in December 2017.	Closed - verified	29/12/17			Current Status as at 19/01/17 - Closed Verified A FAST model has been produced to apply indexed lifecycle costs across the portfolio. Business cases have been produced for the projects within the portfolio as well as a process for pritorisiong requests. Guidelines have been added to the ORB for alterations to property and a RFMC from created (this is due to be implemented following the FM review).	Lindsay Glasgow,Asset Strategy Manager
								A project plan or roadmap detailing the remaining Operational Estate actions and timeframes for completion should be prepared.	A project plan for the development of this information, bringing together the various on-going strands of work will be produced. This will set out dependencies (including other service areas) and risks, and will be incorporated within the Property Board governance with regular updates. It is also proposed to present this monthly to the Asset Management Strategy Board. This plan will reflect completion dates for the following: • The remit for the Asset Investment Groups has been drafted and is in the process of being approved at each departmental AIG meeting. • Base data and analysis for life cycle costing for the pipeline estate is nearing completion and the next step is to apply inflation. This information will be stored in a FAST model, developed with Finance, to allow scenario planning.• The identification of locality office accommodation requirements is mid-way through a two-month assessment, with requirements identify by the end of October and detailed models to be completed in November.• A change request process for property changes has been developed and will be implemented in tandem with the 'go-live' date of the FM review.• The first business cases for new property investment for the 2018/19 budget are currently being developed and are expected to be completed in December 2017.	Overdue - IA Validation in Progress	29/12/17			Current status 19/01/18 - Overdue Project roadmap to be provided to IA.	Lindsay Glasgow,Asset Strategy Manager

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								Regular progress updates against plan will be provided at appropriate governance forums. This could include Senior Management meetings; Asset Management Strategy project meetings; or the Property Board.	A project plan for the development of this information, bringing together the various on-going strands of work will be produced. This will set out dependencies (including other service areas) and risks, and will be incorporated within the Property Board governance with regular updates. It is also proposed to present this monthly to the Asset Management Strategy Board. This plan will reflect completion dates for the following: • The remit for the Asset Investment Groups has been drafted and is in the process of being approved at each departmental AIG meeting. • Base data and analysis for life cycle costing for the pipeline estate is nearing completion and the next step is to apply inflation. This information will be stored in a FAST model, developed with Finance, to allow scenario planning.• The identification of locality office accommodation requirements is mid-way through a two-month assessment, with requirements identify by the end of October and detailed models to be completed in November.• A change request process for property changes has been developed and will be implemented in tandem with the 'go-live' date of the FM review.• The first business cases for new property investment for the 2018/19 budget are currently being developed and are expected to be completed in December 2017.	Overdue - IA Validation in Progress	29/12/17			Current status as at 19/01/18 - Overdue IA Validation AIG remits have been produced and discussed at each of the Asset investment groups, IA require conformation that these have been agreed by each of the AIGs.	Lindsay Glasgow,Asset Strategy Manager
RES1712ISS.4	RES1712	Asset Management Strategy	Resources	ISS.4	Low	The contractual agreement between the Council and Faithful and Gould specifies that a target of 10% of the condition surveys completed by Faithful and Gould's external surveyors are to be reviewed by the Council to confirm that the quality of surveys meets Council expectations. To date circa 5% of condition surveys completed by the external contractor have been reviewed. Although the surveys sampled and reviewed by the Council have found the surveys to be thorough and the reported costs realistic, issues have been noted regarding the categorisation of property condition findings. Condition surveys completed by the Council use a team of three fabric surveyors and two Mechanical and Electrical surveyors. The lead officer inputs the results into the Computer Aided Facility Management (CAFM) system. The quality of the survey details recorded and captured in the system is then independently verified by another surveyor. However, due to resource constraints, the officer performing the verification may be part of the original survey team.	Insufficient independent oversight of surveys performed by third parties and Council employees could result in failure to identify issues with quality or the estimated cost of repairs.	The volume of independent review of third party surveyors performed by the Council should be increased to meet the 10% target to ensure that any system issues with the quality of the surveys is identified and resolved. The review performed should ensure that survey grade applied (on a scale of A to D) accurately reflects the condition of the property and the costs associated with the repair.	Surveys were completed in mid-September 2017, with the quality assurance process well underway. Any surveys identified as inconsistent between identified costs and condition grade are being returned to the third party for further assessment. This has resulted in instances where the condition grade has been adjusted to reflect the level of spend required. A full 10% sample will be completed, along with scrutiny of any other obvious anomalies.	Overdue	22/12/17				Lindsay Glasgow,Asset Strategy Manager
CF1402 ISS.1	CF1402	School Meals	Resources	ISS.1	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.	Overdue	30/04/15	31/01/18	30/04/15 31/12/17	Dec 17 update from Gohar Khan - The Service Delivery Plan (schools), which outlines the structure, roles / responsibilities of staff and the overall strategic service plan for the catering service, is still with C&F for feedback / approval. It is anticipated that feedback will be received and approval granted mid January. Therefore, revised due date requested to 31/01/18. IA Note: A copy of the FM SLA has been provided to IA and this appears reasonable. FM are now waiting for final sign off from Schools (copy to be provided to IA) and this can then be signed off. Nov 17 Update – Service Delivery Plan with Communities and Families and waiting on feedback. Oct 17 Update from Gohar Khan: The Service Delivery Plan is with C&F for consultation and we are still awaiting feedback. It is, however, anticipated that the SDP will be signed off and in place by December 2017. Outwith the SDP, the catering service has a detailed strategic blueprint which outlines its aims, objectives and strategic goals going forward and it is anticipated that this blueprint will be shared and agreed with all relevant stakeholders. Sept Update from Gohar Khan: A Service Delivery Plan (SDP) that includes the catering service is currently out to consultation with key stakeholders and feedback is awaited. The SDP is designed to provide key stakeholders with an overview of the services that will be provided by the FM team to High Schools and includes clarity on staff roles and responsibilities. The overarching objective of the services is to provide the right resources at the right place at the right time, with the flexibility to respond to the requirements of each Directorate as and when required. It is envisaged that the SDP will be agreed by the key stakeholders by 31.12.17. 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. IA Note: PLease note that this recommendation was historically reported under Place and has now been transferred across to Resources.	Christopher Ross, Catering Manager
MIS1601a ISS.2	MIS1601a	Non Housing Invoices	Resources	ISS.2	Medium	A fixed-price quote is obtained from prospective contractors for repairs estimated to cost more than £1,000. Any variance between the quote and the invoice is challenged before the technical officer will approve payment. Estimates and quotes are not routinely requested for repairs likely to cost less than £1,000 (and we would not expect this). The technical officer is expected to be experienced enough to make a reasonably accurate assessment of the likely cost of a repair, and challenge or approve payment of the contractor's invoice accordingly. It is understood that a schedule of rates exists for the non-housing contract framework, but is not referred to. This means that: The authorising manager does not know the value of works that they are approving (see Section 2: variance between actual and estimate); The Council may not have access to commercially advanta geous rates for common repairs; and Elevated charges may not be identified by the technical officer as they have no benchmark.	There is a risk that the Council is not achieving best value on non-housing repairs and maintenance.	We recommend that a schedule of rates is built into the next non-housing contract framework.	The non-Housing contractor framework will be re-tendered during 2017. The inclusion of detailed best-value and due-diligence options will be considered as part of the process. This may include schedule of rates, gain share, penalties etc or a combination.	Overdue	31/08/17	31/12/18		December Update: Dec In order to mitigate the risk in the interim, a vouching / clearing regime is now in place to ensure all invoices are checked for value for money before being passed for payment. This has been agreed with Internal Audit. This is also tied into the potential increase in the R&M budget from 01.04.18 to ensure that we have the correct levels of governance and resource to manage the allocation. Furthermore, it is proposed that an interim supply chain will be in place from 01.0418 until the full retendering exercise is completed. IA Comment - Time to be arranged for walkthrough of revised process. November Update : Corporate procurement Plan has been revised and a new implementation date of dec 2018 agreed. October Update : Agreement reached with Corporate Procurement that due to the Procurement Plan being revised, the new implementation date will now be December 2018. However, in the meantime, in order to mitigate the risk from Medium to Low, a proposal is being worked on and will be reported at the next cycle. September Update: The non - Housing contractor framework will be re - tendered due to the value and EU regulations. This is being led by Corporate Procurement with a revised timescale.	Murdo MacLeod, Maintenance Standards Officer
MIS1601a ISS.3	MIS1601a	Non Housing Invoices	Resources	ISS.3	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 Co rporate 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 work s 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	Overdue	01/04/17	01/04/18		December Update : As per November with revised implementation date of 01/04/18. Whilst CAFM is due to be implemented in April 18 and is on track for implementation, a sufficient volume of invoices is required to be processed over a period of time before MI on repairs and maintenance work can be produced and used. November Update - the use of CAFM to monitor and report on R&M work/expenditure is still expected to be operational in time for the start of the new FY 2018/19. October Update: The use of CAFM to monitor and report on R&M work / expenditure is still expected to be operational in time for the start of the new financial year 2018/19. Work is progressing to review, cleanse and align the FM cost centres with the new hub models as being implemented by the FM Transformation programme. Engagement with key stakeholders with regards to implementing CAFM for R&M works management is due to commence shortly. September Update : The CAFM asset condition and helpdesk modules are now fully operational, however, the use of CAFM to monitor and report on R&M work / expenditure is now scheduled to be operational in time for the start of the new financial year 2018/19. This will include having the ability to produce MI reports on R&M activity at site level, which at this moment in time, only Frontier is able to produce this information 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, Head of Corporate Property
RES1603 ISS.5	RES1603	Leavers Process	Resources	ISS.5	Medium	We selected a sample of 45 employees who left the Council in August 2016. Security passes held by 18 of those employees (40%) had not been returned or disabled.	Security passes could be used to fraudulently gain access to Council buildings putting sensitive data and mobile assets at risk.	Security passes should be collected from payroll and non-payroll leavers and returned to the Facilities Management Hub. We recommend that Facilities Management are also provided with a daily or weekly list of leavers, so security passes can be deactivated.	An expiry date will be set for all cards issued to temporary staff, agency staff and contractors at 6 months unless otherwise specified by the line manager.	Closed - Verified					Mark Stenhouse, Facilities Management Senior Manager
									All security passes which have not been used for 3 weeks will be deactivated on 1 April. Cardholders will need to contact Security to reactivate them.	Closed - Verified					Mark Stenhouse, Facilities Management Senior Manager
									All temporary passes will be deactivated on 1 April. Cardholders will need to contact Security to reactivate them.	Overdue	30/04/17	31/03/18	31/10/17 30/06/17	Current Position at 18/12/17 - Overdue The terminal FM currently have functioning at WC is a SPOF and has no connectivity to the slave monitor at NPH. Once this connectivity issue is addressed, FES can sit with CGI and properly upgrade the terminal at WC which we have requested continually through ICT. New cards for contractors are for 3 months without exception. We receive weekly leaver reports and those cards are removed from system. We are now collating returned cards marrying up with leavers report whereas before they were destroyed. Main vulnerability is that contractors do not feature in leavers report therefore until we can audit there maybe some old cards in system Current Position at 18/10/17 - Overdue FM security team are liaising with contractors responsible for the system to ascertain if non CEC staff cards can be marked for future auditing and monitoring purposes. This will include all agency staff and contractors. Further amendments to the Orb forms will restrict all non-CEC cards to 90 days without exception. The practice of surrendering cards to the FM security HUB could be promoted by a formal comms via the Chief Executive. August Update: A walkthrough of the enhanced controls was completed on the 22/8/17. However it has been identified that the leavers lists provided by Strategy and Insight do not include agency staff, Facilities Management have agreed to deactivate all passes which have not been used in the preceding three months and new temporary passes will be end dated and deactivated if FM are not advised of a contract extension. Work is ongoing to liaise with HR to identify if agency leaver reports can be produced to allow FM to deactivate and remove security passes. New forms are to be uploaded to the Orb requiring an end date for temporary staff and a revised commentary will highlight the responsibilities of line managers. This issue can be closed once it can be evidenced that these controls are in place. Whilst undertaking this task it became apparent that there are data quality issues. A full cardholder report has been requested and will be analysed to ascertain actual breakdown of categories. Appropriate data cleansing and deactivations will then be carried out. Linked with action above- management actions are the same.	Mark Stenhouse, Facilities Management Senior Manager
									The Management Information team will provide Security with a list of leavers each week. Security will deactivate passes.	Closed - Verified					Edel McManus
RES1608 ISS.2	RES1608	Risk Management	Resources	ISS.2	Medium	The successful embedding of risk management throughout an organisation is achieved when staff of all levels are: aware of their risk management responsibilities; understand their responsibilities; and are motivated to act in accordance with their organisation's risk management framework. The Risk Function and CRO have delivered risk training to the CLT, their respective Senior Management Teams (' SMTs ') and to GRBV Councillors. Feedback indicates that this training has been effective in securi ng buy-in and understanding at the senior manager level and above. However, risk training has not recently been provided to middle management level s, nor have senior managers within directorates been trained to provide risk management training to their teams . This repr esent s a potential gap in the understanding and embedding of risk management below senior manager level . The Risk Function have designed CEC specific r isk m anagement training as well as an internal controls module which teaches staff how to manag e risks. T he se modules are available to everyone through CEC ' s interactive learning platform (' CECiL ') , however, there is no mandatory requirement for staff to complete this training . Within CECiL there is also a generic r isk m anagement training module , des igned by the external system	The risk management embedding gap below senior management level presents the risk that CEC may be exposed to a degree of undue risk: at times of significant change, people can unintentionally revert to behaviours that are not in keeping with expectations. If the generic risk management training module within CECiL is completed by staff, there is a risk that staff's understanding is inconsistent with CEC's risk management approach. If risk register templates are not used consistent ly across all Directorates, key information may be missed or reported incorrectly when consolidated by the Risk Function for CLT and GRBV. This undermines the quality of information present to CLT and GRBV. It makes management of risk and risk reporting less efficient and potentially less effective.	The Risk Function, supported by the new full-time CRO, should invest time and resource to embed risk management below senior management level. It is important to reflect on what contributed to the success of ' buy-in ' and education of the senior team. Additionally, there needs to be pragmatic consideration given to the large numbers of staff across the council. We recommend a training and communications plan is drafted reflecting the above and approved by the appropriate committee. This should involve input from HR and other relevant non-risk functions. Consideration should be given as to whether training senior management, to equip them to provide risk management training to their teams would held drive understanding and accountability below senior management level. Human Resources should include risk management and internal controls training modules as part of CEC's essential learning.	As identified, we are in an 'embedding' phase with respect to the journey to develop risk management. Prior to transformation a risk steering group was in place whereby risk 'champions' from each directorate could drive messaging the need for training and maintain momentum. With the substantial organisational changes this arrangement was suspended and we are currently re-establishing such ownership within the Service Area Risk Management Groups as indicated within the response to finding 3.3.	Closed - Verified					Rebecca Tatar, Principal Risk Manager
									For clarity two risk modules exist on the Council's eLearning site. One is generic and the other specific to CEC. We agree with the finding that the generic risk management module is not helpful from the perspective of specific messaging. Management will work with HR to ensure that only the single tailored solution is accessible.	Closed - Verified					Rebecca Tatar, Principal Risk Manager

Unique No	Project Code	Project Name	Group	Issue Cor	Rating	Finding	Business Implication	Recommendation	Agreed Management Action	Status	Due Date	Revised Date	Revisions	Status Update	Owner
						provider. This is not CEC specific and there is a risk that this may cause confusion amongst staff. From discussion s with the Head of HR, we understand that all staff will be required to complete ' essential learning ' when on-boarding and on an annual basis going forward . Good practice is achieved when HR have an important role in facilitating risk training so that it is considered alongside other key training and communications. More importantly , good practice is when HR have an active role in fully embedding responsibilities and accountabilities for risk across an organisation. T herefore, t o align with best practice, HR should play an active role in embedding risk, however there are currently no risk management modules within the essential learning suite. CEC ' s risk register template is available to all staff via the staff intranet. However, this document is not used consistently across all service areas. For example, t he Place Directorate uses a different style of risk register , and a s a result of the Transformation Project, some of the service areas which were previously part of Place have been moved to other Directorates , widening the inconsistent use of the template.		individual's score from the end of module assessments can be used to confirm staff's understanding of their responsibilities. The system provider's risk management module should be removed to avoid confusion. In keeping with policy, a ll service areas sh ould use the CEC risk register template, with any other versions removed to avoid inaccurate information being reported to CLT and GRBV and improve the efficiency of the aggregation and reporting process.	HR is currently reviewing the requirements of induction and essential learning throughout the Council. The latest timing for go-live is likely to be prior to the commencement of FY18. The plan with HR will be confirmed shortly.	Closed - Verified					Rebecca Tatar, Principal Risk Manager
									The 'different' risk register template was adopted as a temporary measure in Place as part of a learning exercise to prompt focus on cause and effect in the articulation of risks. This version is now being superseded.	Closed - Verified					Rebecca Tatar, Principal Risk Manager
									A training and communications plan involving input from HR and Communications teams was drafted within the last two years, however due to reorganisation of staff, teams and service delivery these plans had to be put on hold and will need to be reviewed once structures settle.	Overdue- IA Validation in Progress	30/09/17	30/04/18		December Update - work in progress and on schedule. November Update Work with technical staff to replace the current e-learning module on CeCiL with two new risk management modules, one aimed at all staff and the other at managers. Content to be relevant to roles and responsibilities as they relate to risk management. Modules to be available on the Orb by 27 April 2018. Encourage completion of module(s) as part of the Induction process and through the various risk management structures. Track attempt, completion, pass and failure rates, report metrics through Risk Management Groups and Risk Committees, and target any identified weaknesses. Note: the risk management modules may be included in CEC's essential learning suite, subject to CEC's essential learning policy refresh which is due around Spring/Summer 2018, and which is currently scheduled to be agreed by CLT by end Dec 2017. Include appropriate 'train the trainer'/risk education type items in Risk Committees, Risk Management Groups, annual risk refreshes, Leaders' Inductions and at Service Management Team (SMT) risk workshops on an ongoing-basis. Offer training to Heads of Service and above in how to provide appropriate risk management training within their Service. October Update from CRO - Ongoing discussions between CRO and CIA to clarify and reword Agreed Management Actions and revised due dates. September Update: Embedding risk management throughout the organisation is one of my key objectives. The current draft Annual Audit Report from Scott Moncrieff notes that: "Overall, we were satisfied that risk management arrangements appear to be embedded across the organisation" The following points describe some of the mechanisms which help embed risk management across CEC: Through the Risk Management Groups/Committees/Steering Group. Through 1-2-1 conversations between the CRO and several HoS/Directors. Individuals in the Corporate Risk Team and others have attended external training sessions on different aspects of risk management. Risk management workshops take place across the services, often at team locations away from Waverley Court. 'Risk Matters' newsletters highlight particular risk topics within schools. Risk management is one of the subjects covered at the Leaders' Induction events. Following the office move in Sep/Oct 2017 I intend installing a risk noticeboard to publicise information. I have created quarterly 'risk themes' to publicise the work of several areas. An internal comms and training plan can be developed and rolled out within an appropriate timescale to address this action but the measures described are having a greater effect	Rebecca Tatar, Principal Risk Manager
RES1608 ISS.4	RES1608	Risk Management	Resources	ISS.4	Low	CEC's risk management 'toolkit' represents the key documents and system available to staff via the orb (intranet) to support risk management. Key documents include risk management policy and procedures and the risk appetite statement. Upon review of these documents and following interviews with staff, a number of inconsistencies have been identified: The Covalent sy stem was introduced to support and encourage proactive and consistent management of performance, governance and risk. It offers the functionality to electronically consolidate information and make it simple and efficient for user to update and analyse dat a . This system is not used consistently throughout Directorates and CEC will be withdrawing Covalent in early 2017. Therefore, a manual and inconsistent approach to risk management is likely to ensue across Directorates upon withdrawal . The risk management policy and procedure documents are dated February 2015 and March 2014 respectively and do not reflect CEC ' s current operating structure . These documents are also inconsistent with CEC ' s risk appetite statement (dated February 2014) . For example, the categories of ' risk ' considered in th e risk appetite statement are not consistent with the categories of ' impact ' in the policy and procedure document . Indeed , CEC ' s risk appetite statement explicitly refers to reputational and development / regeneration r isks which are not included in the impact assessment .	Manual risk management processes are labour-intensive and require an increased reliance on interpretation and judgement if there is a need to consolidate information based on different assessment criteria of formats. When risk MI is collated on this basis, vital information may be missed and not escalated on a timely basis. Use of an enterprise risk management system should increase the efficiency of collating and reporting data, and increase capacity to focus on analysis of risk. Risk Management p olicies and procedures coupled with a consistent risk appetite statement form the foundation s f or a sound risk framework . I f a n organisation is going through strategic change, its risk environment is also continuously changing. Therefore, annual review and updating of this information is important to ensure staff are provided with guidance and direction to manage risks in accordance with CEC ' s expectations and requirements.	CEC should consider implementation of a replacement systemised risk management tool to drive efficiencies and consistency in risk management practices and provide the opportunity to generate risk MI without the need for manual intervention. The business case for an enterprise wide risk management system should be prepared and integrated with the wider IT change programme. In line with best p ractice, CEC risk documentation should be updated as soon as the new structure has been finalised, with updated versions communicated and circulated to staff.	CEC's Risk Management Policy is updated annually in December.	Closed - Verified					Rebecca Tatar, Principal Risk Manager
									The guidance set out in CEC's Risk Management Procedure is scheduled to be updated by January 2017 once the Council's new structure and associated risk escalation path has been clarified and confirmed. These will then be available to all staff on the CEC Intranet.	Closed - Verified					Rebecca Tatar, Principal Risk Manager
									The Risk Management team is currently reviewing options with regard to a 'GRC' (Governance Risk and Compliance) solution that is fit-for-purpose for the Council. The new CGI contract identifies the need to introduce such a solution by the Summer of 2017. As such a business case will be developed in line with this critical path. In the meantime, risk registers for SMT and CLT are updated quarterly on consistently formatted spreadsheets and stored on a shared drive for version control.	Closed - Verified					Rebecca Tatar, Principal Risk Manager
									Updating the Risk Appetite Statement is scheduled as part of a broader exercise on embedding improved understanding and consistency around risk appetite and tolerance levels once the new CRO is in place. It was always considered that the risk appetite would be further refined after two years once the risk management framework had been embedded and maturity of the organisation had developed with respect to risk management.	Overdue	30/09/17	30/06/18		December Update - Work in progress and on schedule November Update: Develop a risk appetite statement (RAS) which is fit for purpose for CEC. Due to a lack of standardised approach among local authorities a benchmarking exercise of selected Scottish and UK local authorities and other relevant private and public sector organisations will be carried out to help define what is fit for purpose for CEC. Guidance from the new international standard for risk management (ISO31000) which is due to be published in late 2017/early 2018 will be considered in the work. RAS to be approved by CLT and GRBV by 29 June 2018. October Update: Ongoing discussions between CRO and CIA to clarify and reword Agreed Management Actions and revised due dates September Update (CRO) Work has focused on maintaining quality output for new councillors and the new membership of the GRBV. The current risk appetite statement is fit for purpose, though this will be updated and included in the annual refresh of the risk management policy and procedure which is due around Jan 2018.	Rebecca Tatar, Principal Risk Manager
CW1603 ISS.5	CW1603	External Vulnerability Assessment	ICT Solutions	ISS.5	Medium	For projects that involve the implementation of new technologies or information management, the Council have implemented processes such as 'Security Assurance Statements' that ensure security considerations are acknowledged prior to project initiation and 'Privacy Impact Assessments' that assesses the use and management of sensitive data. However t here is currently no Design Authority or appr opriate governance forum in place within CGI to manage the introduction of new technologies and systems into the Council ' s existing infrastructure. As new projects and systems are being developed, there is not a suitable forum that would support the identi fication of IT security and technical considerations associated with the se technologies , or the suitability of integration with existing IT infrastructure. There is also a lack of consistency in the approach of project teams to the performance of security assessments on project deliverables, which results in project delays. This is symptomatic of not having an established design authority and embedded IT adoption processes in place, as well as sufficient awareness within the Council of the need to consider security requirements when implementing new technologies.	Without a Design Authority in place, there is a risk that issues with new technologies and systems are not identified in a timely manner leading to wasted resources, duplication of effort and project delays.	The Council, with the support of CGI, should implement a Design Authority that has appropriate oversight and governance to consider whether new technologies comply with the Council's security requirements, existing security architecture and aligns with the Council's strategic IT objectives.	The existence of a Design Authority is a contractual requirement in the CGI contract. The creation of this Authority will be progressed with CGI as a matter of priority.	Overdue	31/08/17	30/03/18		September Update: CGI have yet to deliver a cohesive Design Authority despite concerted effort and escalations by ICT Solutions management. Meeting with CGI Solution Architect on 14/09/2017 resulted in agreed approach and plan for the creation of an effective Design Authority. Revised implementation date is 30/03/2018.	Neil Dumbleton, ICT Enterprise Architect
RES1614 ISS.2	RES1614	Lothian Pension Fund Cyber Security	Investments and Pensions	ISS.2	Medium	We found that: ⍰ Security was not fully considered at time of procurement of third party systems; and ⍰ There is no formal, ongoing security governance for these third parties. Without effective oversight, LPF cannot gain assurance that controls in place at third parties are appropriate based on the services and data hosted. LPF outsources the provision of the Pension Administration System, the hosting of the infrastructure that it sits on, and at the time of review was in the project phase for contracting with another 3rd-party supplier – Civica – to provide the 'Employer Data Transfer Portal'. By formally reviewing security requirements and the provisions at third parties, LPF will understand if controls at the supplier mitigate risks to an acceptable level, taking into account compliance with the security objectives, requirements, regulations, and contractual obligations that are important to LPF. The companies that provide these services to LPF are all ISO 27001 certified, and as such can demonstrate that they have a framework for managing security. However, ISO 27001 certification does not provide a report on information security controls that are in place within the organization. It is therefore important that LPF is satisfied that the controls in place at third parties are proportionate to the risks faced and that these controls protect LPF member data adequately. Regulators are increasingly focusing on oversight of third parties and the FCA recently published Third Party Outsourcing Guidance that highlights areas that should be considered, including: ⍰ Firms should understand the risks of outsourcing and identify steps to mitigate them; and ⍰ Ensure contracts have appropriate provisions for breach notification and remediation. With regard to oversight, the FCA notes: "Firms retain full accountability for discharging all of their responsibilities and cannot delegate responsibility to the service provider." And: "Firms should carry out a security risk assessment that includes the service provider and the technology assets administered by the firm."	If LPF do not routinely consider the security of their suppliers, the impact and likelihood of a data breach, system compromise, or loss of service are increased. This may result, in adverse media coverage for LPF, loss of stakeholder confidence, an impact on financial results and could impact core services provided. Additional consequence can include increased vulnerability to litigation and the possibility of regulatory enforcement actions.	LPF should consider implementing a Supplier Risk Management Framework. Effective Supplier Risk Management will help LPF maintain consistency and visibility of the risks they face from the third parties that they contract with. It will also allow LPF to demonstrate to stakeholders, regulators and management that supplier risk is considered consistently LPF should review existing third party contracts to ensure that security provisions are appropriate.	LPF agrees to implement both recommendations. Existing third party contracts will be reviewed on a risk prioritised basis.	Overdue	30/09/17	30/03/18		December - no further updates received. November Update (IA) E mail received from the CRO. Implementation date change to 30/3/18. Supplier review: as part of our project to ensure ongoing compliance with the new data protection regulations (GDPR) we are already looking to review our core systems and external third parties to whom we send data. We are currently in the information gathering stage of that process and can provide evidence that this will involve our reviewing our third party relationships with data security and contractual protection in mind. This is an ongoing process and something which we are targeting to have completed by March 2018. Risk analysis: our ongoing and quarterly risk analysis monitors such matters as Failure of IT Systems, Business Continuity Issues, Data Protection Breaches, Regulatory Breach, Inadequate Contractual Protection for Services, Failure of IT Systems and Controls, Reliance on Core Service Providers. Over the quarters this process, whilst not being focused on supplier security issues, has established a framework on which the Fund's key risks are assessed and matters such as this identified and resolved. This process also picks up on the internal audits. We would propose to include an additional risk focused on this, along the lines of "Inadequate, or failure of, supplier and other third party systems (including IT and data security)" and assign this to all members of the management team and Bruce Howieson to monitor. This will be flagged in the December committee risk reporting and monitored thereafter in the usual way. Compliance checklist: equally, and in tandem with the risk process, LPF also has a process which monitors and checks our compliance with ongoing controls and we would also propose to include the monitoring and sign off of this into that process (done on a quarterly basis), with management and Bruce Howieson taking responsibility for the actions. Compliance email: Once the compliance checklist is signed off, it is then circulated to the LPF staff in a compliance email which highlights certain compliance aspects and reminders. We would also look to include in the next quarterly email a reminder to ensure that the compliance checklist now includes checking and ongoing monitoring of supplier's third party systems and that we should all bear this in mind when entering into new arrangements and in monitoring existing arrangements etc. We are of the view that it is important to consider this risk in proportion to other risks that the fund is required to manage. Therefore, rather than setting up a separate stand-alone framework which could be cumbersome and have resource implications which could distract from other material priorities and risks of the pension fund, we would prefer to integrate this issue within our existing risk and compliance controls and monitor it in the context of the fund's overall risks and responsibilities. We have also engaged with PwC on what is generally done in this regard, and have the sense that this perhaps does not warrant anything beyond what we are proposing above. October (IA) No evidence provided in relation to implementation of the supplier management framework whch is the main reason for recommendatio not closing. Evidence has been provided that review of security provisions in contracts has been performed.	Struan Fairbairn, Chief Risk Officer, LPF
Safer and Stronger Communities															