Governance, Risk and Best Value Committee

10.00am, Tuesday 5 June 2018

Internal Audit: Overdue Findings; Late Management Responses; and 2017/18 plan completion

Item number	7.1
Report number	
Executive/routine	
Wards	
Council Commitments	

Executive Summary

This report sets out details of overdue Internal Audit (IA) findings, and audit reports issued in draft where management responses have not been received within the agreed service standard timeframes as at 23 March 2018; and progress with delivery of the 2017/18 IA plan as at 11 May 2018.

As at 23 March 2018 there were 86 open IA findings across the Council. This excludes the 30 IA historic findings reported to Committee on 8 May 2018 that will be reopened and tracked as overdue.

Appendix 1 contains details of the overdue findings and management updates as at 23 March 2018. Some of the actions will have progressed significantly since that date and progress is set out in set out in the report on this agenda responding to the Motion approved at this Committee on 8 May 2018.

The overdue findings ageing profile confirms that 45% are more than six months old and 10% more than one year old. Of the open (not yet overdue) findings, 45% include management actions where agreed implementation dates have not been achieved.

The management responses for one audit was not received on time.

A total of 18 audits are in the process of being finalised to support completion of the 2017/18 plan and IA annual opinion. Early indications are that these will include number of High findings. These requirements are likely to have a significant resource impact on service areas.

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Report

Internal Audit: Overdue Findings; Late Management Responses; and 2017/18 plan completion

1 Recommendations

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

1.1.1 the status of the overdue Internal Audit findings as at 23 March 2018;

1.1.2 IA progress towards implementation of an automated open and overdue findings monitoring and reporting process;

1.1.3 that a further 30 historic IA findings dating back to 1 April 2015 that have not been implemented, or implemented but not sustained, will be reopened as overdue (based on the original implementation date) with effect from 15 May, as reported to Committee on 8 May 2018;

1.1.4 that there was one report issued in draft where management responses have not been received within the agreed two-week service standard (Lothian Pension Fund Pensions Tax). This report has now been finalised;

1.1.5 that the proposals in relation to shadow IT set out below have been approved by the Corporate Leadership Team (CLT) with an 18-month timeframe agreed to address shadow IT risk; and,

1.1.6 progress with the 18 audits to be completed to support the 2017/18 IA annual opinion.

2 Background

2.1 IA overdue findings and late management responses are reported monthly to the CLT and quarterly to the GRBV.

2.2 It is expected that the greater visibility that monthly CLT reporting to improve direct ownership of actions at an executive level will result in more IA findings being closed off in a timely manner.

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

2.4 The IA Charter includes the requirement for receipt of management responses to draft IA findings within 10 working days. Where management responses are not received on time, details are included in this report

3 Main report

Historic findings

3.1 This report reflects the current population of known overdue IA findings as at 23 March 2018, but does not yet include the 30 historic IA findings dating back to 1 April 2015 that have not been implemented, or were implemented but not sustained, as reported to the Committee on 8 May 2018. These will be reopened as overdue (based on original implementation dates) and recorded through the monthly IA follow up process from 15 May 2018.

Quality of Evidence and Management Responses

3.2 Quality of evidence provided to support follow-up and closure of IA findings remains an ongoing challenge. Agreed actions are, at times, confirmed as completed by senior management whilst subsequent IA review confirms that controls have not been fully and effectively implemented. This has resulted in IA providing further advice and often having to reperform follow-up work to support final closure. This is having a sustained and adverse impact on resourcing within IA.

3.3 Quality and agreement of management responses is a new challenge emerging when finalising IA reports. Whilst management responses are generally received on time, the quality of responses provided often do not always fully address the findings raised and require rework to ensure that they can be included in the final report prior to presentation to GRBV.

3.4 It should be noted that Appendix 1 contains details of the overdue findings and management updates **as at 23 March 2018**. Some of these actions will have progressed significantly since that date and progress is set out in set out in the separate report responding to the Motion approved by GRBV on 8 May 2018.

IA Solutions to Address Quality of Evidence and Management Responses

3.5 Representatives from service areas are currently supporting the pilot of the automated open and overdue findings reporting process in May and June. Training delivered to pilot users in April and early May has been well received and full launch of the system is across the Council is scheduled for July 2018.

3.6 The full launch will be supported by training for all owners of IA findings and executive support. This training will include an explanation of IA follow-up expectations and the quality of evidence required to support closure of findings.

3.7 IA is also planning a rebrand. This will involve production of a video where members of the GRBV, the Chief Executive, and the Executive Director of Resources will reinforce the importance of implementing agreed management actions to close IA findings effectively and on time. In addition, there will be a launch of new IA pages on the Council's intranet, the Orb, that will include guidance on working with IA to finalise reports and close findings.

Overdue Findings as at 23 March 2018

3.8 There were 86 open Internal Audit findings across Service Areas as at 23 March 2018 (70 as at 20 February 2018). Of these, 39 (45%) are overdue (3 High; 24 Medium; and 9 Low) in comparison to 36 (46%) as at 20 February. During the period, 5 overdue findings (3 Medium; and 2 Low) were closed, with 7 new findings reporting as overdue.

3.9 The 5 overdue findings were closed by the following Directorates:

3.9.1 Health and Social Care / EIJB (4) – 3 Medium; 1 Low

3.9.2 Resources (1) – 1 Low

3.10 The 7 open findings that have become overdue in the period are:

3.10.1 Health and Social Care (4) – 1 High; 1 Medium; 2 Low

3.10.2 Investments and Pensions (1) – Medium

3.10.3 Resources (2) – 1 Low; 1 Advisory

3.11 The 4 Health and Social Care overdue findings relate to the Care Homes review that was completed in January 2018. Whilst Health and Social Care are the owners of these findings, support was required from Resources (Finance and Customer Services and IT) to ensure that they could be closed on time.

Shadow IT

3.12 Customer Services and IT owns a High rated audit finding requiring review of all critical shadow IT (systems and applications used by services areas that are provided by third parties) to ensure that appropriate disaster recovery arrangements either exist or are established and implemented. This finding is due for closure by 31 May 2018.

3.12.2 The full population of returns from Service Areas was received in January 2018, and confirmed that a large number of shadow IT systems were in use across the Council. Service areas have confirmed that around a quarter of these would have a critical or major adverse impact on service delivery if they were unavailable. Given the scale of the critical shadow IT systems identified, both the agreed management action and May implementation date were considered unrealistic in terms of delivery capacity requirements. IA recommends that:

- a paper is presented to CLT to discuss the risks associated with critical shadow IT resilience and security;
- a revised approach and implementation date is agreed at CLT;
- delivery of the revised approach is raised and tracked as IA findings; and
- Shadow IT risk is captured on both Directorate and CLT risk registers.

3.13 A low recommendation in relation to service level agreements with outside entities was also reallocated to all Service Areas Directorates; Service Areas; and Lothian Pension Fund in August, with an implementation date of 30 November. Only three

service areas have completed their actions, with Communities and Families; Place; Resources and Strategy and Insight actions overdue.

3.14 Service Areas have provided evidence to IA for 9 overdue findings (5 H&SC and EIJB; 4 Resources). IA is reviewing the evidence provided and engaging with management to confirm whether the findings have been sufficiently addressed and can now be closed.

3.15 No overdue finding ratings have been reduced in the period.

3.16 Our next open and overdues report to CLT will reflect the position as at **23 April 2018**. Evidence is required for 17 open findings to ensure they are not reported as overdue in our next report. These are

3.16.1 Health and Social Care (9) – Social work: Pre-employment verification (SW1601ISS.5); IJB Data Integration and Sharing (HSC1604ISS.4); Care Homes (HSC1701 issues 3, 4, 6 and 15); Edinburgh Alcohol and Drug Partnership (HSC1715 issues 1, 2 and 3);

3.16.2 Communities and Families (1) – GIRFEC named person (CF1621ISS.2);

3.16.3 Place (3) – Local Development Plan (PL1705 issues 1, 2 and 3);

3.16.4 Lothian Pension Fund (2) – Review of IT Business Resilience and Disaster Recovery (RES1706ISS.2); and Pensions Payroll Outsourcing (RES1708ISS.1); and

3.16.5 Strategy and Insight (2) - ICO Follow up (RES1606 issues 2 and 4)

3.17 A further 4 overdue Medium findings are due for closure by 30 April 2018. Action is required from Resources (Risk Management RES1608) and Health and Social Care (Social Work Pre-Employment Verification SW1601).

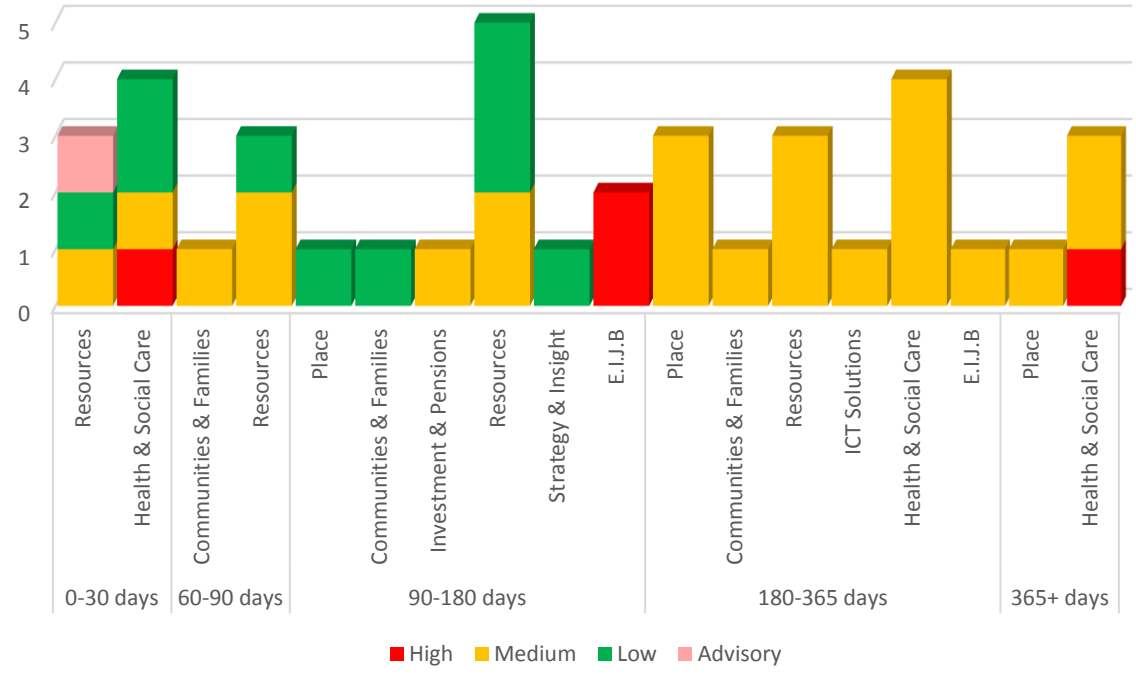
3.18 16 overdue findings (2 High; 7 Medium; 6 Low; and 1 Advisory) currently have no revised implementation dates. Action is required from Communities and Families (1 Medium and 1 Low); Place (3 Medium and 1 Low); Resources (1 Medium and 2 Low; 1 Advisory); Health and Social Care and EIJB (2 High; 1 Medium 2 Low); and Strategy and Insight (1 Low). Findings where revised dates are required have been highlighted in Appendix 1.

3.19 Figure 1 illustrates the ageing profile of all overdue findings by rating across Service Areas. Whilst the total number of 17 findings more than 180 days old remains the same as the position as at 20 February (17) the following movement is evident:

3.19.2 Resources +1 (Medium)
3.19.3 Health and Social Care +2 (Medium)
3.19.3 Communities and Families +1 (Medium)
3.19.4 EIJB -4 (Medium)

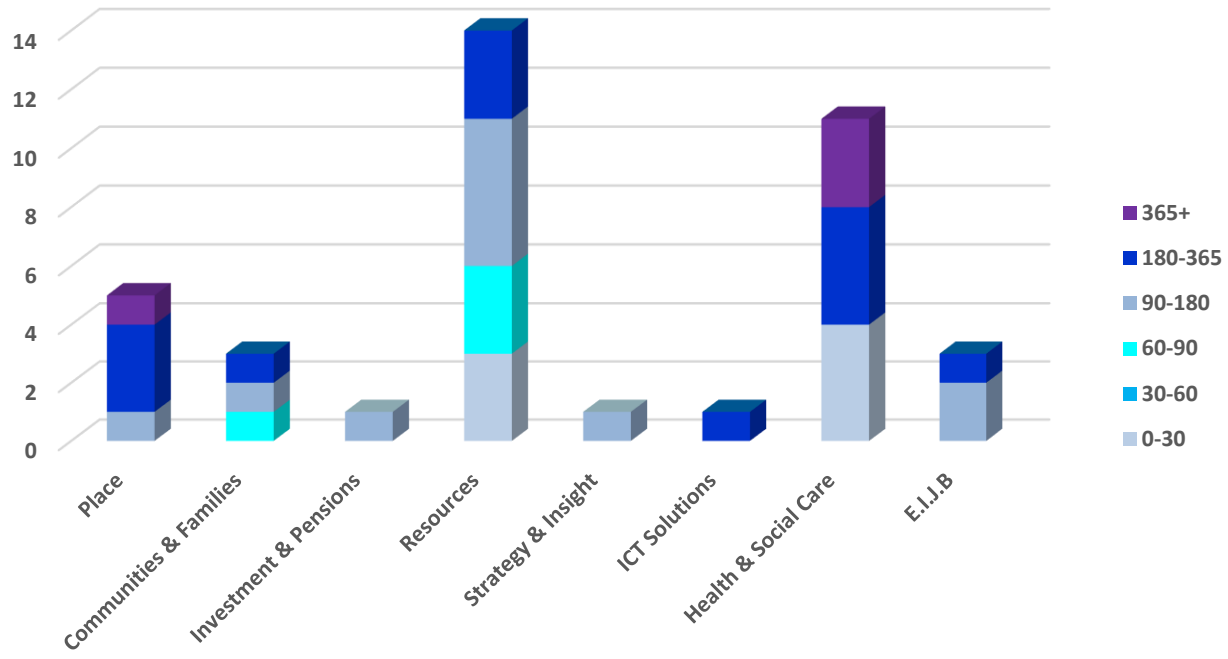
3.20 4 Findings remain more than 365 days old – 1 High and 2 Medium in Health and Social Care; and 1 Medium in Place

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



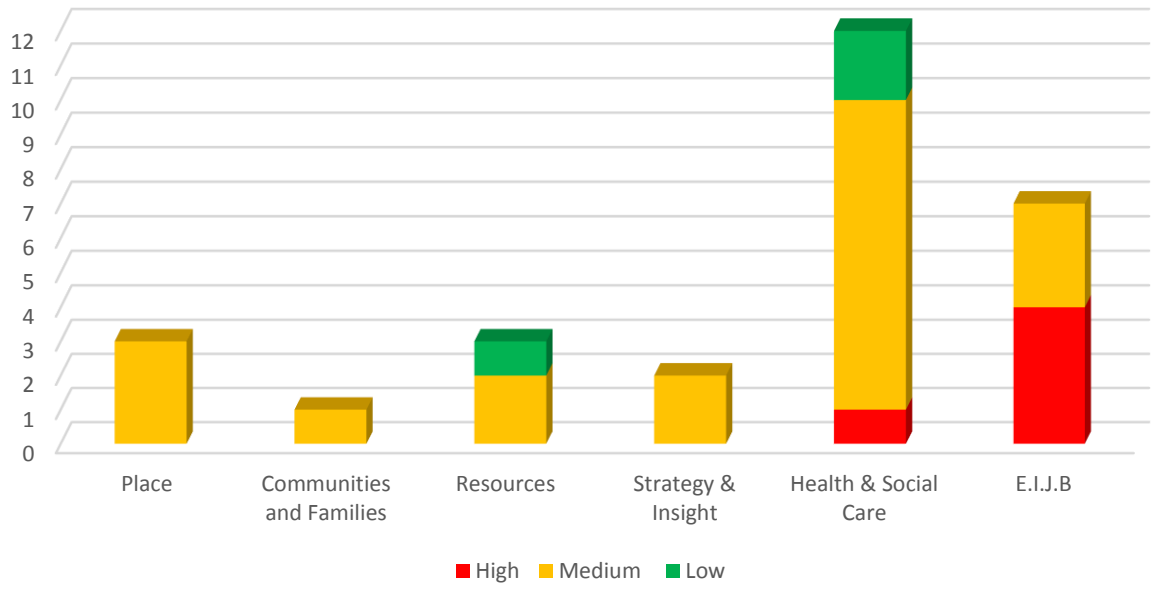
3.21 Figure 2 highlights the ageing profile of overdue IA findings for each Service Area. Place and Health and Social Care are the owners of the most historic overdue findings.

Figure 2: profile of overdue findings by Service Area



3.22 Figure 3 illustrates that there are 28 overdue findings (15 as at 20 February 2018) where completion dates have been revised more than once since the implementation dates agreed with Service Areas when finalising audit reports. This is an increase of 13 and reflects changes in 2 dates for EIJB; 9 for Health and Social Care; 1 for Strategy and Insight; and 1 for Resources.

Figure 3: Overdues with more than one revised completion date



3.23 There are also 21 open (not overdue) findings where agreed dates for specific actions have been missed. These are:

3.23.1 Health and Social Care (13) – Care Homes Assurance Review (HSC1715 issue 18 (High); issues 6, 7, 10, 11, 12, 14 and 15 (Medium); issues 7 and 9 (Low)); EADP Contract Management (HSC1715 issue 3 (High) and issues 1 and 2 (Medium));

3.23.2 EIJB (1) – Data Integration and Sharing (HSC1604ISS4 – Medium);

3.23.3 Resources (2) – External Vulnerability Assessment (CW1603ISS.3 – High); Asset Management Strategy (RES1712ISS.5 – Low);

3.23.4 LPF (2) - IT Business Resilience and Disaster Recovery (RES1706 issue 2 (High) and issue 1 (Medium);

3.23.5 Strategy and Insight (2) – ICO Follow Up (RES1606ISS.2 – Medium); Complaints Process (CF1619ISS.1 – Medium); and

3.23.6 Safer and Stronger (1) – Short Term Homelessness Provision (SSC1701ISS5 – Medium).

3.24 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.

IA 2017/18 annual plan completion progress as at 11 May 2018

3.25 As at 31 December 2017, IA had a total of 29 audits to complete to support the 2017/18 annual opinion. 11 Audits have now been finalised, and of the remaining 18:

3.25.1 1 review (St Katherine's Records Management) will continue into 2018/19;

3.25.2 5 reports are with IA to review management comments, provide feedback and finalise;

3.25.3 3 reports are with service areas awaiting management comments;

3.25.4 7 draft reports are being prepared by IA; and

3.25.5 2 reviews are in fieldwork (Care Inspectorate and Fleet). As these audits require to be completed in time to support the 2017/18 IA opinion, management will require to support IA in finalising the reports by 14 June to ensure the annual opinion can be prepared for the GRBV meeting on 31 July 2018.

3.27 2 reviews are in fieldwork (Care Inspectorate and Fleet). Management responses for one report (LPF Pension Tax) were not finalised within our specified two-week timeframe but have now been agreed.

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 agreed management actions supporting closure of Internal Audit findings are not implemented, the Council will be exposed to the risks set out in the relevant Internal Audit reports. Internal Audit findings 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 If agreed management actions supporting IA findings are implemented, but not sustained, this could result in increased and unnecessary exposure to service delivery risk.

9 Consultation and engagement

9.1 Not Applicable.

10 Background reading/external references

10.1 Internal Audit report - Historic Internal Audit Findings - Item 7.3

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Appendices

Appendix 1 - Audits in Progress to be finalised to support the 2017/18 IA annual opinion as at 11 May 2018

Appendix 2 - Status report: Overdue Findings Detailed Analysis as at 23 March 2018

Appendix 1 - Audits in progress to be finalised to support the 2017/18 IA annual opinion – status as at 11 May 2018

Audit Title	**Status**	**Comments**
Health and Social Care		
1. Care Inspectorate Report	Fieldwork	Ongoing discussions with Health and Social Care Partnership Chief Officer regarding the scope of this review.
IJB		
2. Purchasing Budget Management	Draft Report preparation	Initial findings discussed with new Partnership Chief Officer. Draft report to be issued w/c 14 May.
3. Community Care Capacity and Access	Draft Report preparation	Initial findings discussed with new Partnership Chief Officer. Draft report to be issued w/c 14 May.
Resources		
4. Customer Transformation	Draft Report with IA	Draft report with IA for finalisation.
5. HR and Payroll - Drivers	Draft Report preparation	Progress has been delayed due to delays in receiving information from Service Areas.
6. CGI Contract Management and Cyber Maturity (PwC)	Draft Report preparation	PwC specialist review. Initial draft has been received from PwC. Initial outcomes discussed with for Chief Information Officer; the Executive Director, Resources; and the Head of Customer Services and Information Technology
Place		
7. Port Authority Security	Draft report with Place	Awaiting final sign off by service area
8. St James project	Draft report with IA	Draft report with IA to finalise..
9. Zero Waste project	Draft report with IA	Draft report with IA to finalise.
10. Structures and Flood Prevention	Draft report preparation	Fieldwork now completed. IA preparing draft report.

11. Fleet Project	Fieldwork	This Audit is ongoing.
12. Edinburgh Building Services	Draft report with Place	Awaiting final sign off by the service area
13. Health and Safety – Waste and Recycling (PwC)	Draft report preparation	PwC specialist review. Initial outcomes have been discussed with Waste and Recycling. Draft report will be issued to Place w/c 23 April.
Strategy and Insight		
14. Resilience	Draft report with IA	Management comments have now been received from Strategy and Insight. IA to update and reissue draft report.
Council Wide		
15. Phishing	Draft report with ICT / Resources	ICT currently working through management comments and will revert to IA.
16. Records Management – St Katherine's	Will complete in 2018/19 - currently in fieldwork	Completion date to be determined. A project has now been established within Strategy and Insight to support completion. Likely that this review will continue into the 2018/19 plan year.
17. GDPR Readiness (PwC)	Draft report preparation	PwC specialist review.
Other		
18. Lothian Valuation Joint Board	Draft report with IA	Meeting held with LVJB 23 April. IA now require to finalise and issue report.

Appendix 2 - Internal Audit Overdue Recommendations as at 23rd March 2018

Project Code	Project Name	Group	Issue Code	Rating	Finding	Business Implication	Recommendation	Agreed Management Action	Status	Due Date	Revised Date	Revisions	Status Update	Owner
Communities and Families														
CF1619ISS.3 CF1619	Complaints Process	Communities & Families	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	Februatr Update - Jadu recording format has been reviewed, however dependant on a council wide platform for electronically monitoring progress with complaints handling and an earlier stage.	Frances Smith,Advice & Complaints Officer (Education)
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. L ack of a single repository to share data , they should 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 ' s wellbeing is maintained. D ata 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	##########	Date required		Current Status 22/2/18 - progress is being made but actions not yet fully implemented - see extracts from response from Jane Sadler: Schools issued with Wellbeing chronology template in June 2017 and guidance issued about the storage of Wellbeing Concerns. GIRFEC training has focussed on changes to legislation, record management and Information Governance. Concerns from schools have been expressed about their significant gaps in knowledge of information compliance/records management and the increased work load involved in reaching compliance. A first draft has been produced of GIRFEC in Edinburgh – Practitioners Guide, a document for schools and nurseries, to reinforce key messages of GIRFEC practice including Child Protection, information governance and records management. Action required : SEEMIS Wellbeing Application (WB Application) Identify who will be Head Quarters contact. Identify who will be leading the WB roll out post March and who would lead training sessions to support roll out. Identify key staff to attend the SEEMIS WB training sessions (4 days) to become accredited and allow for roll out. Decision to be made as to whether access to the Wellbeing Application should be extended to EWS and EAL and nursery schools. Transition process for pupils into/out of Wellbeing Application. Guidance needs to be issued to schools and workload concern addressed. Agree use of Wellbeing Virtual Centre. Cannot get download link to open to validate	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 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 LBCIA 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	##########	Date required		IA Note: no response received or evidence provided. 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
Place														
PL1601ISS.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	##########	##########	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.	Angus Murdoch,Strategy Officer
PL1601ISS.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	##########	31/12/2017 Date required	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.	Karen Reeves,Technical Team Leader
PL1603ISS.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: Mortuary plan in place; and Staff training and participation in a Service quality action group. The Scientific, Bereavement and Registration Service 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, no Service KPIs orperformance / service standards are currently produced. Quality 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 in 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, The daily cap on the number of post mortems undertaken means there is always a backlog; and The 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	##########	31/10/2017 Date required	0	Current Position at 20/02/18 - Overdue Service standards are to be communicated with external stakeholders through meetings with COPFS/Pathologists/Police and FDs. Internally the service standards will be emailed to mortuary staff. This action can be closed when evidence of the updated risk register and communication of the service standards are provided to Internal Audit.	Robbie Beattie,Scientific, Bereavement & Registration Services SeniorManager
PL1603ISS.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; Service 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	##########	31/12/2017 Date required	30/4/17	Current Position at 20/02/2018 - Overdue The Business Continuity Plan is being updated in coordination with the Resilience Team. This action can be closed when evidence of the updated Business Continuity Plan is provided to Internal Audit.	Robbie Beattie,Scientific, Bereavement & Registration Services SeniorManager
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 LBCIA 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	##########	Date required		February Update - some information has been provided, but this does not fully address the recommendation. IA are currently working with Place on what is required. 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
Investments														

RES1614ISS.2	RES1614	Lothian Pension Fund Cyber Security	xx Investment & 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	##########	##########	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	Struan Fairbairn,Chief Risk Officer, LPF
RES1705ISS.1		LPF - Information Governance			Medium	The Fund's records management framework and supporting processes require improvement to ensure that Fund records are effectively managed in line with Data Protection Act requirements. Our review identified the following control weaknesses: There is currently no formal records management plan and supporting processes; Retention schedules and disposal logs are not used to record and action pre-determined disposal dates of Fund records; Regular clear out days are not held to ensure that electronic and paper records are archived or scheduled for disposal;Some records are duplicated between Pensions Web and the Fund's shared drive.No documents have been archived in Pensions Web since its installation in 2013; andThe pensions mailbox is used to store correspondence that has not been attached to the Altair pensions administration system.	Lack of formal governance supporting records management breaches the requirements of the Council's records management policy (sections 4.5 – 4.8)The lack of a records retention schedule, records management process and disposal log means that decisions are not being maderegarding records, files and folders containing sensitive data that no longer requires to be held, or is being held in more than one location.	It is recommended that a records management plan is prepared that sets out the proper arrangements for the management of the Lothian Pension Funds records that include personal data. A model records management plan developed by National Records of Scotland includes 14 elements for effective records management. Whilst there is no statutory requirement for this plan to be applied, it would be good practice to incorporate as many of these elements as possible into existing records management processes where they are not already applied by LPF. The 14 elements of the plan are noted below and further information can be found at:https://www.nrscotland.gov.uk/record-keeping/public-records-scotland-act-2011/resources/model-records-management-plan Senior management responsibility - An individual at senior level who has overall strategic accountability for records management. Records manager responsibility - An individual within the Fund to have day-to-day operational responsibility for records management. Records management policy statement - To underpin the effective management of the Fund's records and information. Business Classification Scheme to organise records - A scheme describing what business activities the Fund undertakes.Retention schedules - A list of pensions records for which pre-determined disposal dates have been established. Destruction arrangements - Disposal arrangements must ensure that all copies of a record – wherever stored – are identified and destroyed. Archiving and transfer arrangements - Mechanism by which an authority transfers records of enduring value to an appropriate archive repository, specifying the timing of transfers and other terms and conditions. Information Security - Process by which records are protected and ensures they remain available.Data Protection - High level statement of public responsibility and fair processing.Business continuity and vital records plans; - A business continuity and vital records plan serves as the main resource for the preparation for, response to, and recovery from, an emergency that might affect any number of crucial functions in an authority.Audit trail - Sequence of steps documenting the movement and/or editing of a record resulting from activities by individuals, systems or other entities. Competency framework for records management staff - lists the core competencies and the key knowledge and skills required by a records manager. Assessment and review - To ensure that records management practices conform to the Records Management Plan.Shared information- Reference to information sharing protocols in place that govern how the Fund exchanges information with others. When implementing these additional actions, reference should be made to governing legislation and advice available from	Recommendations accepted – all actions recommended by Internal Audit will be fully implemented.	Overdue	##########		March - no updates received.	Struan Fairbairn,Chief Risk Officer, LPF
Resources															
CW1603ISS.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.	IA Validation in Progress	##########	##########	IA Note: Evidence has been provided by ICT and is currently being reviewed by IA. 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
MIS1601aISS.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	##########	##########	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.	Murdo MacLeod,Maintenance Standards Officer
MIS1601aISS.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	IA Validation in Progress	##########	##########	February Update: It appears this was in relation to PO's going direct to EBS, this was stopped about 2 years ago and now reports can be run to trace all invoices.	Peter Watton,Head of Corporate Property
RES1603ISS.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.	All temporary passes will be deactivated on 1 April. Cardholders will need to contact Security to reactivate them.	Overdue	##########	##########	31/10/17 30/06/17	Current Position at 27/02/2018 - Overdue The terminal is now functioning, the proposed next step to assist us in maintaining the database is to have the contractor audit the database for inactive cards over 90 days. The contractor will travel through the database and start the process of removing inactive cards. 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	Mark Stenhouse,Facilities Management Senior Manager
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	##########	Date required	February Update : Overdue - further action required to confirm completeness of the list of SLAs provided. IA has shared detailes of action required with Resources.	Stephen Moir,Executive Director of Resources

RES1608ISS.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 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.	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. Individual's scores 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.	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	########## ##########			Duncan Harwood,Chief Risk Officer
								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. Individual's scores 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.	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	##########			Duncan Harwood,Chief Risk Officer
								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. Individual's scores 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, all service areas should 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	########## ##########			Duncan Harwood,Chief Risk Officer
								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. Individual's scores 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, all service areas should 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.	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	########## ##########			Duncan Harwood,Chief Risk Officer
								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. Individual's scores 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, all service areas should 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.	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	########## ##########	Feruary Update - Work in progress and on schedule 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.	Duncan Harwood,Chief Risk Officer
RES1608ISS.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.	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	########## ##########			Duncan Harwood,Chief Risk Officer
								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	########## ##########			Duncan Harwood,Chief Risk Officer
								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 practice, CEC risk documentation should be updated as soon as the new structure has been finalised, with updated versions communicated and circulated to staff.	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	########## ##########			Duncan Harwood,Chief Risk Officer
								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 practice, CEC risk documentation should be updated as soon as the new structure has been finalised, with updated versions communicated and circulated to staff.	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	########## ##########	February Update - Work in progress and on schedule 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.	Duncan Harwood,Chief Risk Officer
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	########## ##########	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.	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 action/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	Overdue	##########	Date required	February Update - Discussion required with Service Area December Update - overdue. Request for update has been sent to Service Area.	Mark Stenhouse,Facilities Management Senior Manager
	RES1701		Resources	ISS.2										March - no update received since December.	
RES1701ISS.2		Edinburgh Shared Repairs Service			Low	The Service aspires to become a paperless office with a single, trusted repository for all documentation relating to a case or property. Idox DMS will be introduced as an Enterprise Content Management system which will also enable the Service to share content with external stakeholders and allow remote working through mobile devices. However, the implementation of Idox DMS has been delayed and there is no 'go live' date for the new system. This is connected to wider delays in the ICT Transformation project, and is outwith the control of the Service. In the meantime, project documentation is held on the shared drive and in paper files. We found this affects the Service in two ways:Availability of documentationTwo documents requested during the audit could not be found. The documents were of minor relevance to the audit, but this indicates that current records management arrangements do not allow project documentation to be retained and retrieved reliably and efficiently. Duplication of recordsThe Gateway and Compliance Checklist is used to record review and authorisation at key stages of a project. It is currently maintained as both a digital Word file and as a physical paper document. The Word document is not secure, so paper documents are held to record authorisation and provide an audit trail. It is not clear whether Idox DMS will enable the Service to record project sign-offs electronically.	Risk that project documentation is inaccurate where duplicate records are held.Risk that core project documentation cannot be retrieved.	Develop records management procedures with a clear file structure and naming conventions.Assess whether Idox DMS will allow authorisation to be recorded electronically.As an interim measure, assess whether a digital signature on a PDF would provide an adequate record of authorisation at key stages of a project.	ESRS has a Records Manager from Information Governance working on historical paper files and part of this project is to implement a new electronic records management system. This project is underway and due to be complete by December 2017. Due to the ERP project with CGI being delayed ESRS has had authorisation to implement a DMS system linked to the system already in use, Uniform. This will be implemented by early 2018.	Overdue	##########	##########	December Update - Although not yet overdue, ICT has proactively advised that this date will not be achieved due to delays by CGI in the Uniform software upgrade). Revised implementation date of 31/7/18 notes. November update - target date to be met. October Update : As per September September UpdateDue to the corporate wide Enterprise Content Management project with CGI being delayed ESRS has had authorisation to implement a Document Management System (DMS) that is provided by the supplier of our Case Management System, Uniform. This DMS is already in use by Planning and Building Standards however there is a reliance on a wider upgrade of Uniform before we can go-live as we will need additional storage to cope with the volume of records ESRS needs to migrate. The upgrade is due to complete in prior to March 2018 as there are dependencies from Scottish Government to have these wider upgrades complete by then for the purpose of e-planning changes. Once the upgrade is complete, there will be a month lead-time after the go-live to migrate the documents from shared drives over to the DMS. Therefore, the earliest implementation would be April 2018.The records management programme has been amended to complete the 'governance' stage of the project (i.e. documentation of retention rules and processes around managing records) first before the ESRS electronic records are organised to be completed in line with the DMS project i.e. by end April 2018.We would therefore advise that we wish to amend the date for completion of the outstanding action to 30/04/18.	Jackie Timmons,ESRS - Manager
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.	Property inspections and repairs for investment properties should be recorded centrally to allow this information to be accessed when required.	All property inspections will now be recorded and placed on file with immediate effect. Notes of repairs and inspection notes for properties will be added to AIS system.	Closed - Verified	##########		Current position at 20/02/18 - Closed verified Evidence provided to show property inspections are cross referenced in AIS. December Update A walkthrough was completed on the 15/01/2018, a process has been implemented to record property inspections, the recording of inspections is to be cross referenced in the AMS system before closure. December update Walkthrough arranged for the 12/01/2018	Graeme McGartland,Investments Senior Manager, Resources
								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	##########		Current position at 19/01/2018 - Closed Validated A process has been implemented to record and monitor repairs to vacant properties. December update Walkthrough arranged for the 12/01/2018	Graeme McGartland,Investments Senior Manager, Resources
								Guidance should be produced on the acceptable timelines for agreeing new leases on rental properties.	A guidance good practice note will be prepared on timeline for dealing with the reletting and negotiation of new leases, this will include process for an options appraisal of properties that have been vacant for more than 6 months.	Closed - Verified	##########		Current position at 20/02/18 - Closed Verified A revised procedure note highlighting key timeframes has been provided to Internal Audit. January Update Internal audit awating revised procedure note highlting key timeframes. December update Internal Audit have been provided with a procedure note regarding agreeing leases for rental properties, it has been requested that this is changed to highlight key time frames.	Graeme McGartland,Investments Senior Manager, Resources
								The KPIs reported by the Investment Team should be reviewed to include a specific KPI in relation to the percentage of the portfolio that has been leased.	Void rates on commercial property has been introduced as one of eleven KPI by Strategy and Insight and reported to RMT monthly.	Closed - Verified	##########		Current position at 19/01/17 - Closed Verified Corporate property KPIs are reported to the directorate. Current position at 22/12/17 - IA validation Emails have been provided to IA including the KPIs reported the Resources Management Team (RMT), IA to request the RMT minutes to ensure these were reported and discussed.	Graeme McGartland,Investments Senior Manager, Resources
								Investment properties which have been vacant for more than six months should be reviewed to ascertain if other options would maximise returns.	A guidance good practice note will be prepared on timeline for dealing with the reletting and negotiation of new leases, this will include process for an options appraisal of properties that have been vacant for more than 6 months.	Closed - Verified	##########		Current position at 20/02/18 - Closed Verified A revised procedure note highlighting key timeframes has been provided to Internal Audit. January Update Internal audit awating revised procedure note highlting key timeframes. December update Internal Audit have been provided with a procedure note regarding agreeing leases for rental properties, it has been requested that this is changed to highlight key time frames.	Graeme McGartland,Investments Senior Manager, Resources
								Records in the AIS system should be reviewed to ensure the information recorded for each property is up to date, complete and accurate.	All property inspections will now be recorded and placed on file with immediate effect. Notes of repairs and inspection notes for properties will be added to AIS system.	IA Validation in Progress	##########		Current postion as at 20/02/18 - IA validation The service area has confirmed that the management action has been implemented, Internal Audit will complete a walkthrough before the action can be closed. January Update The Senior Investments Manager has asked all staff to review their files on AIS this is a work in progress and will require IA to conduct testing to ensure this has been completed.	Graeme McGartland,Investments Senior Manager, Resources
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	##########		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 prioritising 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
								Progress with implementation of the Operational Estate aspects of the property and asset management strategy cannot be formally monitored or tracked.	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.	Closed - Verified	##########		Current status as at 20/02/18 - Closed Verified Minutes has been provided to IA confirming agreement of the AIG terms of reference. January Update 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
								Progress with implementation of the Operational Estate aspects of the property and asset management strategy cannot be formally monitored or tracked.	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	##########	Date required	Current status 20/02/18 - Overdue The service area has indicated that a project roadmap may not be their preferred method of addressing the finding, an alternative is to be discussed with Internal Audit. January Update Project roadmap to be provided to IA.	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.	IA Validation in Progress	##########		Current Status as at 20/02/2018 - IA Validation Reports reviewing the condition surveys completed by external contractors have been provided to Internal Audit. Internal Audit have requested additional information regarding how the issues identified have been remedied.	Lindsay Glasgow,Asset Strategy Manager
RES1712ISS.7		Asset Management Strategy			Advisory	It has been identified that there may be a lack of oversight regarding security arrangements supporting the let of Council property for out of hours' leases (for example, hire of school halls for evening community lets). It is understood that a draft Facilities Management Service Level Agreement is currently being prepared that will include provision of security and janitorial services.	If Council properties do not have appropriate internal security arrangements in place, the Council's assets and records could be compromised due to out of hours letting arrangements.	The Facilities Management SLA should specify the minimum security arrangements required to support out of hours lets of Council properties and protect Council assets and records.	The SLA – and accompanying Services Portfolio Matrix (SPM) – will detail the requirement for security staff to have a thorough understanding of the layout, working and management knowledge of each building and its functionality. These will be managed and monitored through the static patrols or through the key holding alarm response mobile unit. Where applicable CCTV will also relay back to the control room.	Overdue	##########		No updates provided.	Andrew Field,Interim Operations Manager

Health and Social Care and EIJB

HSC1503ISS.1	HSC1503	Personalisation SDS - Option 3	Health & Social Care	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	##########	##########	31/03/18 31/12/17 30/06/17	Current Position at 22/02/18 - Overdue: Discussions have been taking place to consider the options for the replacement of the Funding Allocation System informed by the developments that have been taking place around the support planning and brokerage pilot. A further meeting has been arranged for 26/2/18 to come up with more concrete proposals.	Wendy Dale,Strategic Commissioning Manager
												IA Validation in Progress	##########			Current Position as at 26/03/18 - IA Validation in Progress March 2018 Update: This piece of work has been completed. Now done more regularly. Evidence already submitted to close in November - can this please be followed up by IA. IA Update: Meeting held on 09/04/18 and supporting evidence requested for a sample of Care Homes; CS.	Kenny Raebum,Senior Accountant
HSC1701ISS.5	HSC1701	H&SC Care Homes - Corporate Report	Health & Social Care	ISS.5	High	At the time of our final visit in July 2017, four months into the new financial year, none of the care homes 2017/18 budgets had been finalised and no financial monitoring reports had been provided since March 2017. 9 out of 10 care homes significantly overspent staffing budgets in 2016/17 due to high sickness absence rates, unfilled vacancies & lack of budget for holiday cover for non-care roles necessitating increased expenditure on agency staff. Care home managers previously met with Finance (Service Accounting) monthly. These meetings no longer happen regularly resulting in a lack of oversight and challenge of care home expenditure. Consequently, care home managers no longer have a regular forum where they can seek advice on financial matters or raise operational issues (such as long-term sickness absence or new residents with high care needs) which may impact on their ability to meet their budget.Additionally, changes in the care home management structure implemented in January 2017 has resulted in limited contact between care centre managers and their line managers, and limited oversight of budgets within Health and Social Care.	Care home budgets should be reviewed and rebased to align them with current operational service models and expected operating costs.											
								All care home managers should be provided with monthly budget reports or given access to the Frontier system to enable review of performance against budget and communication of any issues.	Frontier reports sent out monthly	IA Validation in Progress	##########			Current Position as at 26/03/18 - IA Validation in Progress March 2018 Update: This piece of work has been completed. Frontier reports are now sent to Care Home Managers monthly. Evidence already submitted to close in November - can this please be followed up by IA? IA Update: Meeting held on 09/04/18 and supporting evidence requested for a sample of Care Homes; CS.	Kenny Raebum,Senior Accountant
								Care home managers should be supported with budget management by re-establishing regular meetings with Finance and their line managers (cluster managers).	All care home managers will have a budget meeting once a year with finance and on an ad hoc basis when required. Budget meetings started in Sept 2017.	IA Validation in Progress	##########			Current Position as at 26/03/18 - IA Validation in Progress March 2018 Update: This is done. Evidence already submitted - Can this please be followed up by IA? IA Update: Meeting held on 09/04/18 and supporting evidence requested for a sample of Care Homes; CS.	Kenny Raebum,Senior Accountant
HSC1701ISS.17	HSC1701	H&SC Care Homes - Corporate Report	Health & Social Care	ISS.17	Low	Whilst no concerns were identified at any of the care homes in relation to employees accepting gifts from residents or family members, no formal gifts and hospitality registers are maintained at individual care homes. Social Care finance maintain a central gifts and hospitality register for care homes, however there is no established guidance or procedures to ensure that details of gifts and hospitality received are provided by care homes to the Social Care finance team to support maintenance of the centralised register.		Gifts and hospitality registers should be maintained in each care home to record all gifts and hospitality received by employees.	This will be included as part of a new monthly controls process to be implemented and monitored via completion of a monthly spreadsheet. A working group has been established to document all processes to be included. The new process will specify that anything in excess of £10 in value should be included in the gifts and hospitality register	Overdue	##########	30/06/18		Current Position at 12/04/18 - Overdue March 2018 update: Gift and Hospitality register work stream to be created. Revised due date requested: June 2018.	Mary McIntosh,Business Services Manager
								Gifts and hospitality details should be provided quarterly to the Health and Social team (including provision of a nil return where applicable) to ensure that the central register is regularly updated and maintained.	This will be included as part of a new monthly controls process to be implemented and monitored via completion of a monthly spreadsheet. A working group has been established to document all processes to be included. The new process will specify that anything in excess of £10 in value should be included in the gifts and hospitality register and that the central hospitality register should be updated quarterly.	Overdue	##########	30/06/18		Current Position at 12/04/18 - Gift and Hospitality register work stream to be created. Revised due date requested: June 2018.	Mary McIntosh,Business Services Manager
HSC1701ISS.19	HSC1701	H&SC Care Homes - Corporate Report	Health & Social Care	ISS.19	Medium	In seven of the ten care homes, employees who had left the Council were still listed on the Global Address List and had live active directory account enabling them to access Council systems, including e mail.		Care home managers should ensure that the Council's procedures for leavers are consistently applied, with requests to remove access directory accounts submitted in advance of the leaving date with a request for this to be actioned by ICT the day after the agreed termination date.	This will be part of the revamped Starters/Leavers process.	Overdue	##########			Current Position 12/04/18 - IA Update 12.04.18 - One piece of evidence received for validation. Meeting held between IA, Business Support Manager and H&SCP Operations Manager12.04.18 to discuss further evidence required. Business Support Manager to advise of date for validation of relevant evidence to IA.	Mary McIntosh,Business Services Manager
HSC1701ISS.20	HSC1701	H&SC Care Homes - Corporate Report	Health & Social Care	ISS.20	Low	Five care homes did not have an asset register in place at the time of our audit visit, with three of those indicating that they had no high value assets to record. The nature of items recorded on the 5 asset registers varied and usually only included Council issued desktops and mobile phones. Other assets including artwork, TVs, computers for service users and rented items were often excluded.		Clear guidance should be provided by Finance and ICT regarding the value and nature of items that should be recorded in an asset register.	The asset registers currently used in Social Work centres has been copied and e mailed to all business support teams and unit managers in care homes for completion.	Past due date - please provide an update	##########			IA Update 12.04.18 - Meeting held between IA, Business Support Manager and H&SCP Operations Manager12.04.18 to discuss evidence required. Business Support Manager to advise of date for validation of relevant evidence to IA.	Mary McIntosh,Business Services Manager
SW1601ISS.4	SW1601	Social Work: Pre-Employment Verification	Health & Social Care	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	##########	##########		Closed and 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.	IA Validation in Progress	##########	##########	30/04/2018 30/11/2017 31/03/2017	Current Position at 22/02/18 - Overdue IA Validation in progress. Februrary Update: Draft checklist has now been produced. Proposed pre-employment process map has now been developed. Meeting to discuss with Internal Audit on 21 February. This will also be included in the Care Home Assurance Framework. Agreed revised date for April 2018 in January with Internal Audit. IA note: Observed proposed process 21/02/18. Further evidence requested prior to consideration for this issue to be closed off and verifified.	Cathy Wilson,Operations Manager
SW1601ISS.5	SW1601	Social Work: Pre-Employment Verification	Health & Social Care	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 advise 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.	IA Validation in Progress	##########	##########	30/04/2018 30/11/17 31/5/17	Current Position at 22/02/18 - Overdue IA Validation in progress. Februrary Update: Draft checklist has now been produced. Proposed pre-employment process map has now been developed. Meeting to discuss with Internal Audit on 21 February. This will also be included in the Care Home Assurance Framework. Agreed revised date for April 2018 in January with Internal Audit. IA note: The above process map does not fully cover the original finding, recommendation and management action made within the audit report. A further meeting will be requested with the Operations Manager and the HSC Recruitment Team leader to agree a way forward.	Cathy Wilson,Operations Manager
SW1601ISS.7	SW1601	Social Work: Pre-Employment Verification	Health & Social Care	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.	IA Validation in Progress	##########	##########	30/04/2018 30/11/17 31/5/17	Current Position at 22/02/18 - Overdue IA Validation in progress. Februrary Update: Draft checklist has now been produced. Proposed pre-employment process map has now been developed. Meeting to discuss with Internal Audit on 21 February. This will also be included in the Care Home Assurance Framework. Agreed revised date for April 2018 in January with Internal Audit. IA note: Observed proposed process 21/02/18. Further evidence requested prior to consideration for this issue to be closed off and verifified.	Cathy Wilson,Operations Manager
HSC1503ISS.3	HSC1503	Personalisation SDS - Option 3	xx Integration Joint Board	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	##########	##########	31/3/18 31/12/17 30/06/17	Current Position at 28/02/18 - Overdue IA Note: Request for further clarification / evidence issued 17/01/18. 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).	Mary McIntosh,Business Services Manager

HSC1503ISS.6	HSC1503	Personalisation SDS - Option 3	xx Integration Joint Board	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	##########	##########	30/06/18 31/12/17	Current Position at 28/02/18 - Overdue IA Note: Request for further clarification / evidence issued 17/01/18 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).	Mary McIntosh,Business Services Manager
HSC1504ISS.1	HSC1504	Care Sector Capacity	xx Integration Joint Board	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. Forecasting is limited to percentage growth according to the National Records of Scotland population projections by age group. The demographic trends and pressures on social care provision identified in the JSNA have not been translated into the likely effect they will have on demand for services in the medium- to long- term. This means that the Council does not have a robust forecasting model of demand for social care in the City to inform its strategic planning.	Lack of robust forecasting models impedes informed strategic planning of future service provision; New service structures and initiatives may be created in an attempt to address current problems which are not suitable for changing demands caused by foreseeable movements and trends in the population.	Forecasting The JSNA should be developed into a robust forecasting model for demand for social care in the City. This should involve an appropriate level of scrutiny of the 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 for 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 has been identified for the group is to further investigate methods of forecasting needs among specific groups, and our Public Health colleagues are supporting this work. Sensitivity analyses will be built into forecasting models. Gap Analysis Existing 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.	IA Validation in Progress	##########	31/12/2017 Date required	31/12/17	November Update: - Overdue - IA Validation in progress Further evidence supplied by Eleanor Cunningham for validation by Hugh Thomson	Wendy Dale,Strategic Commissioning Manager
HSC1604ISS.1	HSC1604	IJB Data Integration & Sharing	xx Integration Joint Board	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 for the NHS, CEC and external parties (e.g. GP practices). While we recognise that this exercise is now complete, at the 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 strategic objectives effectively. With no clear implementation roadmap, the IJB might experience resourcing issue or miss important dependencies between requirements. 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	##########	31/12/2017 Date required	0	Current Position 23/02/18 - Overdue February Update: Operations Manager has been in post from 1 December 2017. Handover appointments for ICT and Information Governance with Strategic Commissioning Manager completed in January/Feb 2018. The post holder is currently leading on the information governance/GDPR for the Partnership and has held meetings with both NHS Lothian and Council Information Governance officers and has assisted in the recent delivery of the Memorandum of Understanding among CEC, the EIJB and the NHS in relation to information sharing. For ICT, the Operations Manager will be leading on the systems access requirements workstream for the Partnership	Michelle Miller,Interim Chief Officer. EH&SCP
								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	##########	##########	31/03/18 31/10/17 30/09/17	Current Position Overdue February 2018 update - a copy of the outputs from the workshop on 1/11/2017 presented to the ICT and Information Governance Steering Group on 13/2/18 will be submitted as evidence by separate email. IA note - separate email not received	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	##########	##########	30/09/2017	Current Position 26.02.18 - Overdue February 2018 update - following discussion at the ICT and Information Governance Steering Group on 13/2/18 it has been agreed that four short life working groups will be established to take this work forward. Once requirements have been identified they can be prioritised.	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	##########	##########	0	Current Position 26.02.18 - Overdue February 2018 update - a copy of the outputs from the workshop on 1/11/2017 presented to the ICT and Information Governance Steering Group on 13/2/18 will be submitted as evidence by separate email. IA note - separate email not received.	Wendy Dale,Strategic Commissioning Manager
HSC1604ISS.2	HSC1604	IJB Data Integration & Sharing	xx Integration Joint Board	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	##########	31/01/2018 Date required	31/10/17	Current Position at 27/02/18 - Overdue Memorandum of Understanding has been signed off by Chief Officer and the Council's Chief Executive on 14 February 2018. HSC Comms officer has been contacted to prepare a staff message that will be sent from the Chief Officer to all HSC. Copy of Comms to be sent to Internal Audit for evidence. IA Note: Noted evidence has not been received.	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 effectiveness 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	Current Position at 27/02/18 - Overdue February 2018: Operations Manager has now been given a copy of a spreadsheet made in 2016, detailing staff access and training requirements. Extensive work to validate this data via consultation with Locality Managers needs to take place.	Cathy Wilson,Operations Manager
HSC1604ISS.3	HSC1604	IJB Data Integration & Sharing	xx Integration Joint Board	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	##########	##########	31/12/17	Current Position at 27/02/18 - Overdue No status update received this month. 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.	Wendy Dale,Strategic Commissioning Manager
Strategy and Insight															
RES1605ISS.1	RES1605	Service Level Agreements with Outside Entities	Strategy & Insight	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 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 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 appropriate 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	##########	Date required	0	December Update: Overdue - no response received	Lawrence Rockey,Head of Strategy & Insight