# Governance, Risk and Best Value Committee

**10.00am, Tuesday 18 August 2020**

# Internal Audit Annual Opinion for the year ended 31 March 2020

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| **Item number** | |
| **Executive/routine** | **Executive** |
| **Wards** | |
| **Council Commitments** | |

## 1. Recommendations

1.1 It is recommended that the Committee notes the limited Internal Audit (IA) annual opinion for the year ended 31 March 2020.

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# Report

## Internal Audit Annual Opinion for the year ended 31 March 2020

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| **Significant improvement required** | Significant and / or numerous control weaknesses were identified, in the design and / or effectiveness of the control environment and / or governance and risk management frameworks. Consequently, only limited assurance can be provided that risks are being managed and that the Council's objectives should be achieved. |

## 2. Executive Summary

2.1 This report details IA's annual opinion for the City of Edinburgh Council (the Council) for the year ended 31 March 2020. Our opinion is based on the outcomes of the audits carried out as part of the Council's 2019/20 IA annual plan, and the status of open IA findings as at 31 March 2020.

2.2 IA paused delivery of the 2019/20 annual plan recognising the need for the Council to focus on immediate implementation of its Covid-19 resilience arrangements. As a result, only 72% of the 2019/20 IA annual plan has been completed to support the 2019/20 IA annual opinion. The impact of this reduced level of assurance is outlined at paragraph 4.3 in the main report.

2.3 Consequently, the 2019/20 opinion is a 'limited' opinion, recognising that the plan has not been substantially completed, and that it is not possible to pre-empt the potential outcomes of the remaining audits that comprise the remaining 28% of the plan. It is also important to note that completion of the remaining audits could potentially have resulted in a different annual opinion outcome. This approach is aligned with guidance from relevant professional bodies, and was also discussed and agreed at the June 2020 Governance Risk and Best Value Committee meeting.

2.4 IA's independent and professional opinion (based on limited completion of the 2019/20 annual plan) is that significant and / or numerous control weaknesses were identified in the design and / or effectiveness of the Council's control environment and / or governance and risk management frameworks. Consequently, only limited assurance can be provided that risks are being identified and effectively managed, and that the Council's objectives should be achieved.

2.5 IA is therefore reporting a ‘red’ rated (significant enhancements required) limited opinion with our assessment towards the lower end of this category. This outcome has improved slightly when compared with the 2018/19 IA opinion, which included an assessment towards the middle of significant enhancements required category,

2.6 Whilst only 72% of the 2019/20 IA annual plan has been completed, the number of audits completed remains aligned with prior years, enabling comparison with prior year IA assurance outcomes as detailed at paragraphs 4.26 and 4.27 in the main report.

2.7 No ‘Critical’ IA findings have been raised during the year and the total number of findings raised remains generally aligned with prior years, with a positive improvement evident in the proportion of High rated findings raised in comparison to prior years. Some improvement is also evident in the percentage of overdue IA findings and their ageing profile, although this is mainly attributable to closure of the majority of the historic IA findings reopened in June 2018.

2.8 However, a number of new significant and thematic weaknesses have been identified in the Council’s control environment, and further work is required to ensure that the Council consistently addresses the risks associated with open IA findings by implementing agreed management actions to address these risks within agreed timeframes.

2.9 This report is a key component of the overall annual assurance provided to the Council and there are a number of additional assurance sources that the Committee should consider when forming their own view on the design and effectiveness of the control environment, governance, and risk management arrangements across the Council.

2.10 This report has been prepared fully in line with Public Sector Internal Audit Standards (PSIAS) requirements, and IA has fully conformed with PSIAS requirements during the 2019/20 financial year.

## 3. Background

3.1 The objective of IA is to provide high quality independent audit assurance over the control environment established to manage the Council’s most significant risks, and their overall governance and risk management arrangements in accordance with PSIAS requirements.

3.2 The PSIAS provide a coherent and consistent IA framework for public sector organisations. Adoption of the PSIAS is mandatory for IA teams within UK public sector organisations, and PSIAS require annual reporting on conformance with their requirements.

3.3 It is the responsibility of the Council’s Chief Internal Auditor to provide an independent and objective annual opinion on the adequacy and effectiveness of the Council’s control environment and governance and risk management frameworks in line with PSIAS requirements. The opinion is provided to the Governance, Risk, and

Best Value Committee and should be used to inform the Council's Annual Governance Statement.

3.4 Where control weaknesses are identified, IA findings are raised, and management agree actions and timescales by which they will address the gaps identified.

3.5 It is the responsibility of management to address and rectify the weaknesses identified via timely implementation of these agreed management actions.

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

3.7 A total of 30 historic findings were reopened in June 2018 across both the Council (26) and the Edinburgh Integration Joint Board (4), where management actions agreed to address the risks associated with historic IA findings (dating back to 1 April 2016) had either not been implemented or had been implemented but not sustained.

3.8 Internal Audit is not the only source of assurance provided to the Council as there are a number of additional assurance sources including: external audit, regulators and inspectorates, that the Committee should equally consider when forming their view on the design and effectiveness of the Council's control environment, governance and risk management arrangements.

3.9 The Institute of Internal Auditors 'Three Lines Model' defines the first line in an organisation as those teams responsible for provision of products/services to clients, and managing risk; the second line as teams that provide expertise, support, monitoring and challenge on risk-related matters; and the third line as teams that provide independent and objective assurance and advice on all matters related to the achievement of objectives. This model can be translated across the structure and operations of the Council with first line teams those responsible for ongoing service delivery and risk management; the second line those teams providing frameworks, policies and guidance (for example, the Information Governance Unit; Legal Services; Corporate Health and Safety; and Corporate Risk Management); and the third line, Internal Audit.

## 4. Main report

**Impact of a Limited 2019/20 Internal Audit Annual Opinion**

4.1 The 2019/20 IA annual opinion is a 'limited' opinion based on 72% completion (31 of a total of 43 planned audits) of the 2019/20 annual plan, which is directly attributable to the impacts of the Covid-19 pandemic. The limited opinion recognises that it is not possible to pre-empt the potential outcomes of the remaining audits that comprise the 28% balance of the plan, and that completion of the remaining audits could potentially have resulted in a different annual opinion outcome.

4.2 This approach is aligned with Institute of Internal Audit (IIA) Covid-19 guidance; and the Chartered Institute of Public Finance and Accountancy (CIPFA) and the Internal Audit Standards Advisory Board (IASAB) joint guidance in relation to conformance with the PSIAS during the Covid-19 pandemic. The approach was also discussed and agreed at the June 2020 Governance Risk and Best Value Committee meeting.

4.3 The overall impact of the 28% reduction in completion of the 2019/20 annual plan is reduced assurance on Health and Social Care; Digital Services; and ongoing management of Council properties. These areas are all currently included in the Corporate Leadership Team risk register as red (original) and amber (current) risks. There has also been a reduced level of coverage across the Communities and Families Directorate in comparison to the planned coverage included in the 2019/20 annual plan.

4.4 Whilst only 72% of the 2019/20 IA annual plan has been completed, the total number of audits completed remains aligned with prior years (34 in 2019/20; 37 in 2018/19; and 34 in 2017/18), enabling comparison with prior year IA assurance outcomes as detailed at paragraphs 4.26 and 4.27 below.

**Basis of Internal Audi Annual Opinion**

4.5 Our limited opinion is based on the outcome of the 34 audits completed across the Council in the year to 31 March 2020, and the status of open IA findings as at 31 March 2020.

4.6 As the Council is the administering authority for the Lothian Pension Fund (LPF), our opinion also includes the outcomes of the three audit reviews (100% plan completion) performed for LPF and the status of their open audit findings as at 31 March 2020.

4.6.1 A separate IA opinion for the LPF was prepared and presented at the Pensions Audit Committee on 24 June 2020. This was an 'amber' rated opinion (generally adequate but with enhancements required), with our assessment towards the middle of this category, and remained unchanged from the 2018/19 annual opinion. The opinion reflected the outcomes of three completed audits with one assessed as 'Effective' (green); one as 'Some Improvement Required' (amber); and one as 'Significant Improvement Required' (red), and the status of overdue LPF IA findings (1 High; 1 Medium) which were 18 months and 1 month overdue respectively as at 31 March 2020.

4.7 No audits have been referred by the Edinburgh Integration Joint Board (EIJB) Audit and Risk Committee for inclusion in the 2019/20 IA annual opinion as the 3 reviews completed in the 2019/20 plan year had no direct impact on the services delivered by the Council as part of the Health and Social Care Partnership.

4.8 This opinion does not include audit reviews performed for the Lothian Valuation Joint Board (LVJB) and the other arms-length external organisations that currently receive assurance from the Council's IA team.

**Internal Audit 2019/20 Annual Opinion**

4.9 Based on limited (72%) completion of the 2019/20 annual plan, IA considers that significant improvements are required across the Council's control environment, governance and risk management arrangements to ensure that the Council's most significant risks are effectively identified, mitigated, and managed, and is raising a 'red' rated 'significant improvement required' opinion (see Appendix 1 category 3), with our assessment towards the lower end of this category.

4.10 This opinion is slightly improved in comparison to the outcome reported for the 2018/19 financial year, reflecting a movement from the middle towards the lower end of this category, and is subject to the inherent limitations of IA (covering both the control environment and the assurance provided over controls) as set out in Appendix 2.

4.11 No 'Critical' IA findings have been raised, and the total number of findings raised in 2019/20 remains generally aligned with the number of findings raised in prior years, with a positive improvement in the proportion of High rated findings raised.

4.12 Some improvement is also evident in the percentage of overdue IA findings and their ageing profile, although this is mainly attributable to closure of the majority of the historic IA findings reopened in June 2018.

4.13 A number of new, significant, and thematic weaknesses have been identified in the Council's control environment, and further work is required to ensure that the Council consistently addresses the risks associated with open IA findings by implementing management actions to address these risks within agreed timeframes.

4.14 Consequently, we believe that the whilst some progress is evident, the Council's established control environment; governance; and risk management frameworks have not yet matured and adapted sufficiently to support effective management of the rapidly changing risk environment and the Council's most significant risks, putting achievement of the Council's objectives at risk.

4.15 It is IA's view that the weaknesses identified and highlighted in IA reports supporting the 2019/20 annual opinion are predominantly attributable to lack of capacity and skills within first line divisions and directorates to ensure that key controls; governance; and risk management processes are consistently and effectively applied to support effective ongoing management of service delivery and projects. This point was also raised in the 2018/19 IA annual opinion (refer paragraph 4.4.1) and it is essential that appropriate action is taken by management to ensure that this is addressed. The Council's Corporate Leadership Team has advised that these concerns will be considered within the scope of the Adaptation and Renewal Programme.

**Areas where improvement is required**

4.16 The Council should endeavour to improve its control environment and governance and risk management frameworks to ensure that all significant risks are effectively recognised, managed, and mitigated, particularly across the areas highlighted below.

4.16.1 **Governance** – the Assurance Actions and Annual Governance Statements and Policy Management Framework audits highlighted the need to ensure that appropriate second line frameworks are designed and implemented to support completion of annual governance statements by first line divisions and directorates that accurately reflect the outcomes of all open first line assurance findings, and support the completeness and accuracy of the Council's overarching annual governance statement; and to support effective ongoing development, review, and management of Council policies. Once these frameworks have been designed and implemented, it will be important to ensure that they are consistently and effectively applied by all first line directorates and divisions.

4.16.2 **Risk Management** – the independent Risk Management audit performed by Scott Moncrieff confirmed that the Council is still on its risk management journey, and that whilst an appropriate overarching risk management framework has been developed and implemented by the second line Corporate Risk Management team, it is not yet being consistently applied across the Council by first line teams. The report also highlights the need to ensure that risk registers are developed and consistently maintained by all divisions and directorates; that there is sufficient first line capacity to support ongoing risk management activities; and that risk management training is developed and delivered for all relevant employees.

4.16.3 **Health and Safety** – A number of significant and thematic health and safety concerns have been identified in the outcomes in the Life Safety, Lone Working (Health and Social Care), and Drivers audits. These highlight the need to confirm the existence and quality of fire risk assessments across circa two thirds of the Council's operational property estate; establish a holistic life safety performance and reporting framework; clarify both the Council and NHS Lothian's respective legal responsibilities in relation to ongoing compliance with statutory employer health and safety requirements; review Health and Social Care Partnership lone working policies and procedures (including incident reporting) and ensure that they are consistently applied; and confirm that circa 1,500 Council drivers are legally eligible to drive.

4.16.4 **Technology** – the Council has no current overview of the extent of third party cloud based technology (shadow IT) systems used by first line divisions and directorates to support the delivery of Council services. This is an areas of significant concern especially where these systems have been procured historically, as limited assurance is currently obtained from system suppliers in relation to the adequacy and effectiveness of the security and information management controls supporting these systems. Consequently, the Council is unable to confirm whether the requirements of its externally hosted ICT service protocol is consistently applied, and the extend of its exposure to security and information management risks associated with the ongoing use of these systems.

4.16.5 **Brexit** – whilst the Brexit Impacts – Supply Chain Management audit had an overall amber (some improvement required) outcome, this reflects the fact that the UK is currently in the midst of the Brexit transition period scheduled to last until 31 December 2020, providing circa five months for the Council to identify and implement appropriate and effective management of its supply chain risks and improve the established Brexit governance and risk management frameworks. It is essential that these activities are prioritised, especially as existing supply chain risks are likely to have been further exacerbated by the impacts of the Covid-19 pandemic. It is also important to note that the need to improve first line division and directorate contract management processes was highlighted in the Contract Management and Construction Scheme Industry Payment Deductions audit completed in August 2019, and that not all finding raised have been closed.

4.16.6 **Project management and delivery** - whilst the Council's Change Board continued to provide ongoing oversight of the Council's major projects portfolio throughout 2019/20, review of one major project included within the major projects portfolio, and a separate review of divisional and directorate management and oversight of projects delivered outwith the portfolio highlighted the need to establish first line programme management arrangements to ensure effective oversight and delivery of first line projects; that further improvements are required to ensure that senior responsible officers (SROs) and project managers consistently manage projects in line with the Council's established project management framework; and that adequate and suitably skilled project management resource is provided to support delivery of projects across the Council. These points were also highlighted in the 2018/19 annual opinion (refer paragraph 4.4.6).

4.16.7 **Operational service delivery controls** – significant weaknesses in key service delivery controls were identified in the Schools Admissions, Appeals, and Capacity Planning; Protection of Vulnerable Groups and Disclosures (Schools); Localities (Health and Social Care); and Social Media audits.

**Areas where positive assurance has been provided**

4.17 The following four green or 'effective' reporting outcomes were achieved within the Resources Directorate:

4.17.1 the City Region Deal Funding Process audit confirmed that Finance is effectively ensuring that the Council fulfils its responsibilities as the Accountable Body for the Edinburgh and South East Scotland City Region Deal;

4.17.2 the Employee Lifecycle and Payroll audit for the 2018/19 financial year confirmed that there were no significantly material or systemic errors in employee records and payroll transactions; and,

4.17.3 the Digital Services Incident and Problem Management audit confirmed that CGI (the Council's technology partner) is effectively managing and resolving incidents and problems experienced by users across the Council's technology networks.

4.18 A further four audits across the Place Directorate resulted in green 'effective' reporting outcomes:

4.18.1 the Building Standards Follow-Up audit confirmed that significant concerns raised in the March 2018 Building Standards Audit (5 High rated findings) have been effectively addressed.

4.18.2 the Strategic Housing Investment Plan audit also confirmed that the controls supporting development of the plan and ongoing delivery progress monitoring are effective.

4.18.3 two of the Place Directorate audits (The Transfer of the Management of Development Funding Grant, and the Port Facility Security Plan) are routine audits that are performed annually at the request of the Scottish Government and the Department for Transport respectively.

4.19 No new IA findings were raised during 2019/20 in relation to our ongoing agile audits of the Enterprise Resource Planning System and the Edinburgh Tram Extension projects, confirming that the control environments, governance, and risk management processes supporting these significant projects are operating effectively.

4.20 Whilst the 2019/20 annual audit of Implemented Management Actions Supporting Closed Internal Audit Findings resulted in an overall 'amber' (some improvement required) outcome and the reopening of three previously closed IA findings that had not been effectively implemented and sustained (one High; one Medium and one

Low) from a sample of ten; this reflects an improvement in comparison to the 2018/19 overall red (significant improvements required) rating audit outcome with two high rated findings (including one regraded from medium to high) and one low rated finding reopened from a total sample of 11.

**IA Assurance outcomes**

4.21 Of the 34 audits completed across the Council 11 (32.5%) were reported as 'effective' (green); 11 (32.5%) as 'generally adequate' (amber) and 12 (35%) were reported as 'significant enhancements required' (red).

4.22 A total of 83 findings (27 High; 38 Medium; and 18 Low) were raised in the 34 reviews completed across the Council during the 2019/20 financial year.

4.23 Appendix 3 includes details of all 2019/20 audits completed (including those carried forward from 2018/19) for the Council and the outcomes of the LPF reviews that have been provided to the Pensions Audit Sub-Committee for review and scrutiny.

**Status of Internal Audit Findings as at 31 March 2020**

4.24 There were 85 open IA findings across the Council as at 31 March 2020, including 1of the 26 historic Council findings that were reopened in June 2018.

4.25 Of the 83 open IA findings:

4.25.1 a total of 43 (51%) findings were open, but not overdue;

4.25.2 a total of 42 (49%) were reported as overdue as they had missed all of their originally agreed implementation dates (15 High; 23 Medium; and 4 Low);

4.25.3 evidence in relation to 7 (17%) of the 42 overdue findings was being reviewed by IA to confirm that it was sufficient to support their closure; and

4.25.4 35 (83%) residual overdue findings still required to be addressed.

**Comparison with Prior Year Outcomes**

4.26 The 2019/20 IA annual opinion has slightly improved in comparison to 2018/19, with a movement from the middle to the lower end of the red rated / significant improvement required category.

4.27 The rationale supporting this improvement considered the following IA assurance outcomes:

4.27.1 alignment between the total number of audits completed in the last three financial years (34 in 2019/20; 37 in 2018/19; and 34 in 2017/18) despite completion of only 72% of the 2019/20 annual plan.

4.27.2 the areas of concern highlighted in relation to ongoing management of the risks across the Council detailed at paragraph 4.16 above;

4.27.3 Significant progress with closure of the 26 historic IA findings that were reopened in June 2018, with 25 of these closed as at 31 March 2020;

4.27.4 no significant increase in the total number of IA findings raised, with 83 raised in 2019/20 in comparison to 82 and 126 in 2018/19 and 2017/18 respectively;

4.27.5 a positive improvement in the proportion of high rated findings raised, with 33% (27) raised in 2019/20 in comparison to 37% (30) and 37% (47) in 2018/19 and 2017/18 respectively;

4.27.6 a positive improvement in the percentage of overdue IA findings, with 49% overdue as at 31 March 2020 in comparison to 61% in as at 31 March 2019;

4.27.7 an improvement in the ageing profile of overdue findings, with 18% more than one year overdue (76% in 2018/19), and 14% now more than six months overdue (43% in 2018/19); and

4.27.8 It is important to note that the that the Council is not yet consistently addressing the risks associated with open IA findings by implementing management actions within agreed timeframes, as the improvement evident in both the percentage of overdue IA findings and their ageing profile is mainly attributable to closure of the remaining historic overdue findings (as detailed at paragraphs 4.24 and 4.25 above) which accounts for circa 31% of these movements.

**Internal Audit Independence**

4.28 PSIAS require that IA must be independent, and internal auditors' objective, in performing their work. To ensure conformance with these requirements, IA has established processes to ensure that both team and personal independence is consistently maintained and that any potential conflicts of interest are effectively managed.

4.29 IA does not consider that we have faced any significant threats to our independence during 2019/20, nor do we consider that we have faced any inappropriate scope or resource limitations (for example headcount restrictions) when completing our work.

4.30 Implementation of the new governance process that requires approval of changes to the IA annual plan by both the Corporate Leadership Team and Governance, Risk and Best Value Committee in January 2018 also effectively supports ongoing IA independence.

**Conformance with Public Sector Internal Audit Standards and IA Internal Quality Assurance**

4.31 IA achieved full conformance with PSIAS requirements during the 2019/20 annual plan year following implementation of an internal quality assurance programme.

4.32 This involved review of a sample of 10 of the 34 audits completed during 2019/20 (a 29% sample size) with coverage across all IA team members and managers to assess whether file quality was compliant with the Council's IA methodology and PSIAS requirements.

4.33 The review was performed by three team members (two Auditors with support and oversight by a Principal Audit Manager) who reviewed the audits completed by other team members, and then performed an independent review of audits completed by each other.

4.34 Files were assessed as either green (fully compliant); yellow (generally compliant); amber (partially compliant) and red (non-compliant) with the Council's IA methodology and PSIAS requirements.

4.35 The outcomes of the review confirmed that 40% of the files were fully compliant; 40% generally compliant; 20% compliant; and none non-compliant. This outcome reflects that IA only achieved its full complement of permanent resources in November 2019.

4.36 The themes identified from the reviews have been shared and discussed with the IA team in workshops and will be reflected (where required) in individual team member development plans and ongoing monthly performance discussions.

4.37 The next IA external quality assessment is due for completion in 2021/22 in line with the five year review requirement specified in the PSIAS.

## 5. Next Steps

5.1 The remaining 28% of the 2019/20 IA annual plan that has not been completed will be reviewed and considered in comparison to the Council's current risk profile and (where relevant) included in the 2020/21 IA annual plan to be presented to the Governance, Risk and Best Value Committee in September 2020 for review and approval.

5.2 IA will continue to monitor the open and overdues findings position, providing monthly updates to the Corporate Leadership Team, and quarterly updates to the Governance, Risk and Best Value Committee.

5.3 Due to the impact of Covid-19, not all reports supporting the 2019/20 annual opinion have been reviewed and scrutinised by the Committee prior to presentation of the annual opinion. The Committee has requested that all IA reports with an overall significant improvements required (red) outcome and those that include any high (red) rated findings are formally presented for review and scrutiny, together with any other reports that they specifically request. Details of the dates when IA reports were reviewed or are scheduled for future consideration by Committee are included at Appendix 3.

## 6. Financial impact

6.1 Whilst there is no direct financial impact associated with the content of this report, it is important to note the indirect financial impacts (time and resources) associated with implementation of agreed management actions to address IA findings raised.

## 7. Stakeholder/Community Impact

7.1 Whilst there has been a slight improvement in the annual opinion in comparison to 2018/19, this report highlights that the Council is currently exposed to a significant level of risk that puts achievement of its objectives at risk, and could potentially impact services delivered and support provided to citizens; stakeholders; community groups; and employees.

## 8. Background reading/external references

8.1 Internal Audit: Covid-19 Response

8.2 Public Sector Internal Audit Standards

8.3 Institute of Internal Auditors Three Lines Model

8.4 Internal Audit Opinion and Annual Report for the Year Ended 31 March 2019

8.5 Internal Audit Opinion and Annual Report for the Year Ended 31 March 2018

8.6 Internal Audit Report - Historic Internal Audit Findings

8.7 Process for Approving Changes to the Internal Audit Plan

8.8 Lothian Pension Fund Internal Audit Opinion and Annual Report for the Year Ended 31 March 2019

## 9. Appendices

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| 9.1 | Appendix 1 | Internal Audit Annual Opinion Definitions |
| 9.2 | Appendix 2 | Limitations and Responsibilities of Internal Audit and Management Responsibilities |
| 9.3 | Appendix 3 | Audits Completed Between 1 April 2019 and 31 March 2020 |
| 9.5 | Appendix 4 | Final Internal Audit Reports for Review and Scrutiny |

# Appendix 1 – Internal Audit Annual Opinion Definitions

The PSIAS require the provision of an annual Internal Audit opinion, but do not provide any methodology or guidance detailing how the opinion should be defined. We have adopted the approach set out below to form an opinion for Lothian Pension Fund.

We consider that there are 4 possible opinion types that could apply to the Council. These are detailed below:

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| **1. Effective** | The control environment and governance and risk management frameworks have been adequately designed and are operating effectively, providing assurance that risks are being effectively managed and the Council's objectives should be achieved. |
| **2. Some improvement required** | Whilst some control weaknesses were identified, in the design and / or effectiveness of the control environment and / or governance and risk management frameworks, they provide reasonable assurance that risks are being managed, and the Council's objectives should be achieved. |
| **3. Significant improvement required** | Significant and / or numerous control weaknesses were identified, in the design and / or effectiveness of the control environment and / or governance and risk management frameworks. Consequently, only limited assurance can be provided that risks are being managed and that the Council's objectives should be achieved. |
| **4. Inadequate** | The design and / or operating effectiveness of the control environment and / or governance and risk management frameworks is inadequate, with a number of significant and systemic control weaknesses identified, resulting in substantial risk of operational failure and the strong likelihood that the Council's objectives will not be achieved. |

# Appendix 2 - Limitations and responsibilities of internal audit and management responsibilities

**Limitations and responsibilities of internal audit**

The opinion is based solely on the internal audit work performed for the financial year 1 April 2019 to 31 March 2020. Work completed was based on the terms of reference agreed with management for each review. However, where other matters have come to our attention, that are considered relevant, they have been taken into account when finalising our reports and the annual opinion.

Professional judgement is exercised in determining the appropriate opinion, and it should be noted that in giving an opinion, assurance provided can never be absolute for the reasons noted below:

1. Internal Audit endeavours to plan its work so that it has a reasonable expectation of detecting significant control weaknesses and, if detected, performs additional work directed towards identification of potential fraud or other irregularities. However, internal audit procedures alone, even when performed with due professional care, do not guarantee that fraud will be detected. Consequently, Internal Audit reviews should not be relied upon to detect and disclose all fraud, defalcations or other irregularities that may exist.
2. There may be additional weaknesses in the Council's control environment and governance and risk management frameworks that were not identified as they were not included in the Council's 2019/20 annual Internal Audit plan; were excluded from the scope of individual reviews; or were not brought to Internal Audit's attention. Consequently, management and the Committee should be aware that the opinion may have differed if these areas had been included or brought to Internal Audit's attention.
3. Control environments, no matter how well designed and operated, are affected by inherent limitations. These include the possibility of poor judgment in decision-making; human error; control processes being deliberately circumvented by employees and others; management overriding controls; and the impact of unplanned events.

**Future periods**

The Internal Audit opinion is based on an assessment of the controls that operated across the Council during the year ended 31 March 2020. This historic evaluation of effectiveness may not be relevant to future periods due to the risk that:

- the design of controls may become inadequate because of changes in operating environment, law, regulation or other; or
- the degree of compliance with policies and procedures may deteriorate.

**Management responsibilities**

It is management's responsibility to develop and operate effective control environments and governance and risk management frameworks that are designed to prevent and detect current and future irregularities and fraud. Internal audit work should not be regarded as a substitute for these responsibilities.

# Appendix 3 - Audits completed between 1 April 2019 and 31 March 2020

| | | | No. of findings raised | | | | GRBV Review Date |
|---|---|---|---|---|---|---|---|
| | Review Title | Report Outcome | High | Medium | Low | Totals | |
| **Ref** | **Council Wide** | | | | | | |
| 1. | Brexit Impacts – supply chain management | **Some Improvement Required** | - | 2 | 1 | 3 | September 20 |
| 2. | Implementation of Assurance Actions and Annual Governance Statements | **Significant Improvement Required** | 1 | 2 | - | 3 | August 20 |
| 3. | Validation of Implemented Management Actions Supporting Closed Internal Audit Findings | **Some Improvement Required** | 1 | 1 | 1 | 3 | August 20 |
| 4. | Health and Safety – Life Safety | **Significant Improvement Required** | 3 | - | 2 | 5 | September 20 |
| 5. | Preparation of the Strategic Housing Investment Plan | **Effective** | - | - | - | - | Not requested |
| 6. | Unsupported Technology (Shadow IT) | **Significant Improvement Required** | 2 | - | - | 2 | September 20 |
| 7. | Risk Management | **Significant Improvement Required** | 2 | 3 | - | 5 | September 20 |
| 8. | Retention of Social Work Case Records (Looked After and Accommodated Children) | **Some Improvement Required** | - | 3 | - | 3 | July 2020 |
| | **Totals** | | **9** | **11** | **4** | **24** | |
| | **Resources** | | | | | | |
| 9. | CGI sub contract management | **Some Improvement Required** | - | 1 | 1 | 2 | July 20 |
| 10. | CGI partnership management and governance | **Some Improvement Required** | - | 1 | - | 1 | September 20 |
| 11. | Digital Services - Change Initiation | **Some Improvement Required** | - | 1 | 1 | 2 | September 20 |
| 12. | Digital Services - Incident and Problem Management | **Effective** | - | - | 1 | 1 | Not requested |
| 13. | Revenue budget setting and management | **Some Improvement Required** | - | 4 | - | 4 | July 20 |
| 14. | Model and Intelligent Automation Risk | **Some Improvement Required** | 1 | - | 1 | 2 | July 20 |
| 15. | Employee Lifecycle and Payroll for the 2018/19 Financial Year | **Effective** | - | 1 | - | 1 | September 20 |
| | **Totals** | | **1** | **8** | **4** | **13** | |

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| | Review Title | Report Outcome | No. of findings raised | | | | GRBV Review Date |
|---|---|---|---|---|---|---|---|
| | | | High | Medium | Low | Totals | |
| | **Communities and Families** | | | | | | |
| 16. | Schools Admissions, appeals and capacity planning | **Significant Improvement Required** | 2 | 3 | - | 5 | July 20 |
| 17. | Protection of Vulnerable Groups and Disclosures – Schools | **Significant Improvement Required** | 1 | 2 | - | 3 | September 20 |
| | **Totals** | | **3** | **5** | **-** | **8** | |
| | **Strategy and Communications** | | | | | | |
| 18. | Policy management framework | **Significant Improvement Required** | 2 | 2 | - | 4 | September 20 |
| 19. | Social Media Accounts | **Significant Improvement Required** | 2 | 1 | - | 3 | September 20 |
| 20. | City Region Deal Funding Process | **Effective** | | 1 | 1 | 2 | Not requested |
| | **Totals** | | **4** | **4** | **1** | **9** | |
| | **Health and Social Care** | | | | | | |
| 21. | Localities | **Significant Improvement Required** | 2 | - | - | 2 | July 20 |
| 22. | Health and Safety - Lone Working | **Significant Improvement Required** | 2 | 3 | - | 5 | August 20 |
| | **Totals** | | **4** | **3** | **-** | **7** | |
| | **Place** | | | | | | |
| 23. | Health and Safety - Tree Management | **Some Improvement Required** | 1 | - | 1 | 2 | August 20 |
| 24. | Port Facility Security Plan | **Effective** | - | 1 | 3 | 4 | Not requested |
| 25. | Building Standards Follow-up | **Effective** | - | - | - | - | Not requested |
| 26. | Transfer of the Management of Development Funding Grant | **Effective** | - | 1 | 2 | 3 | December 19 |
| 27. | Drivers – Findings only report | **Significant Improvement Required** | 1 | - | - | 1 | July 20 |
| | **Totals** | | **2** | **2** | **6** | **10** | |

| | Review Title | Report Outcome | No. of findings raised | | | | Committee Review Date |
|---|---|---|---|---|---|---|---|
| | | | High | Medium | Low | Totals | |
| | **Projects** | | | | | | |
| 28. | Governance of first line projects outwith the major projects portfolio | **Significant Enhancements** | 2 | - | - | 2 | September 20 |
| 29. | Major Project Governance – Meadowbank Redevelopment | **Some Improvement Required** | 1 | 2 | - | 3 | September 20 |
| 30. | Enterprise Resource Planning System – ongoing agile audit | **Effective** | - | - | - | - | Ongoing |
| 31. | Edinburgh Tram Extension – ongoing agile audit | **Effective** | - | - | - | - | Ongoing |
| | **Totals** | | **3** | **2** | **-** | **5** | |
| | **Lothian Pension Fund** | | | | | | |
| 32. | Charles River Project – Pre Implementation System Testing | **Effective** | - | 1 | - | 1 | March 20 |
| 33. | Pensions Entitlement Calculations | **Some Improvement Required** | - | - | 2 | 2 | March 20 |
| 34. | Settlement and Custodian Services | **Significant Improvement Required** | 1 | 2 | 1 | 4 | June 20 |
| | **Totals** | | **1** | **3** | **3** | **7** | |
| | **Total Findings Raised 2019/20 – 34 Audits** | | **27** | **38** | **18** | **83** | |
| | **2018/19 Total – 37 Audits** | | **30** | **32** | **20** | **82** | |
| | **2017/18 Total – 32 Audits** | | **47** | **55** | **24** | **126** | |

Appendix 4

# *The City of Edinburgh Council*

# Internal Audit

## Implementation of Assurance Actions and Linkage to Annual Governance Statements

Final Report

13th July 2020

CW1903

**Overall report rating:**

| | |
|---|---|
| **Significant improvement required** | Significant and / or numerous control weaknesses were identified, in the design and / or effectiveness of the control environment and / or governance and risk management frameworks. Consequently, only limited assurance can be provided that risks are being managed and that the Council's objectives should be achieved. |

# Contents



This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2019/20 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2019. The review is designed to help the City of Edinburgh Council assess and refine its internal control environment. It is not designed or intended to be suitable for any other purpose and should not be relied upon for any other purpose. The City of Edinburgh Council accepts no responsibility for any such reliance and disclaims all liability in relation thereto.

The internal audit work and reporting has been performed in line with the requirements of the Public Sector Internal Audit Standards (PSIAS) and as a result is not designed or intended to comply with any other auditing standards.

Although there are a number of specific recommendations included in this report to strengthen internal control, it is management's responsibility to design, implement and maintain an effective control framework, and for the prevention and detection of irregularities and fraud. This is an essential part of the efficient management of the City of Edinburgh Council. Communication of the issues and weaknesses arising from this audit does not absolve management of this responsibility. High and Critical risk findings will be raised with senior management and elected members as appropriate.

# 1. Background and Scope

## Background

Corporate governance provides the structure for setting organisational objectives; determining how the objectives will be achieved; and monitoring performance. An important aspect of corporate governance is also an effective organisational risk management framework.

Corporate assurance is a key element of corporate governance and is defined as the provision of accurate and current information for stakeholders by management about the efficiency and effectiveness of organisational policies, operations and controls, and the status of its compliance with statutory obligations.

**The three lines of defence assurance model**

The three lines of defence assurance model can be applied to support effective delivery of both corporate governance and assurance. The 'first line' (doers) are the Directorates and Divisions responsible for service delivery, with 'second line' (helpers) being the teams that oversee or specialise in management of specific risks (for example, Information Governance; Resilience; and Corporate Health and Safety). Second line teams may also complete reviews (for example Health and Safety audits) across the organisation to assess whether specific risks are being effectively managed. The 'third line' (checkers) include independent assurance providers such as Internal Audit and external assurance providers such as the Care Inspectorate or Education Scotland who provide assurance on the adequacy and effectiveness of organisational governance frameworks and the controls established to manage risk.

Where second and third-line assurance providers identify weaknesses in either governance or control frameworks that expose the organisation to risk, they will raise assurance actions or findings to be addressed by management within agreed timeframes.

To ensure that the Council is not exposed to unnecessary risks, it is important that Directorates and Divisions establish appropriate monitoring processes to support effective ongoing management, monitoring, and implementation of all assurance findings raised.

**Preparation of the Council's Annual Governance Statement**

The Council is required to prepare Annual Governance Statement (AGS) in accordance with the Local Authority Accounts (Scotland) Regulations 2014 (the Regulations) for inclusion in its audited annual accounts. Guidance is also included in the Scottish Public Finance Manual, issued by Scottish Ministers, on the proper handling and reporting of public funds. The AGS reports on the Council's compliance with its Code of Corporate Governance, which is aligned with the requirements of the Delivering Good Governance in Local Authorities 2016 published by the Chartered Institute of Public Finance and Accountancy (CIPFA) and the Society of Local Authority Chief Executives (SOLACE).

The regulations require the Council to conduct an annual review of its internal control systems with the outcomes presented either at a meeting of the Council or a sub-committee whose role covers audit and governance. The regulations also state that following consideration, the AGS on internal control must be approved for inclusion in the Council's Annual Accounts.

Chief Executives, in their role as Accountable Officer and the Head of Paid Service, sign the AGS and take personal responsibility for the information contained within it.

To ensure the completeness and accuracy of the AGS prior to signing, assurance must be obtained from Directorates and Divisions on the effectiveness of their internal control environments and ongoing

compliance with applicable legislation; regulations; statutory obligations and Council policies throughout the year.

This is achieved through the Annual Assurance Schedules (AAS) which are completed by each Directorate and Head of Division that are aligned with the content of the AGS. Divisional AAS are consolidated into the relevant Directorate AAS, which are subsequently combined to form the Council's overall AGS.

The AAS contains questions on the status of the internal control environment, and compliance with applicable Council policies and legislation and regulations. For each question, Service Areas and Directorates are required to confirm whether they are compliant, partially compliant or non-compliant.

To conclude accurately on the extent of compliance with each question included in the AAS, Directorates and Divisions should consider all assurance findings raised by second and third line assurance providers in the current financial year, and those not yet addressed from previous years, as these could highlight outstanding gaps and issues in internal control environments that should be disclosed in both Directorate and Divisional AAS and the Council's overarching AGS. As outlined previously, the lack of a robust process to provide a complete oversight of all assurance actions, particularly external assurance actions, limits the ability of Directorates and Divisions to accurately complete the AAS.

For the 2018/29 financial year a 'comply or explain' methodology was implemented to support completion of the divisional and directorate annual assurance statements that form the basis of the Council's annual governance statement.

This new methodology required that divisions and directorates only include written explanations where they considered that they were not fully achieving specific objectives together with details of improvement actions to be implemented to achieve future compliance, with no supporting narrative or evidence required to support compliant responses.

## Scope

The objective of the review was to assess whether Directorates and Divisions have established appropriate processes to collate, manage and address all second and third line assurance findings and actions and ensure that they are accurately reflected in Divisional and Directorate AAS; and to confirm that Divisional and Directorate AAS are accurately consolidated and incorporated into the Council's overarching Annual Governance Statement.

Our areas of audit focus as detailed in our terms of reference are included at Appendix 2.

### Directorates and Divisions selected for sample testing

We conducted a survey across all Divisions of the Council requesting details of their assurance providers; open assurance actions; and their involvement in preparation of Divisional and Directorate AAS.

Based on review of the responses received from the survey and analysis of open internal audit findings; health and safety assurance findings; and high risk findings raised during by the Information Governance Unit as part of the GDPR readiness review, the following Divisions and Directorates were selected for sample testing:

1) Capital Projects Team - Resources;
2) Schools and Lifelong Learning – Communities and Families;
3) Place Management – Place;
4) Place Development – Place;

5) Health and Social Care, and
6) Strategy and Communications

**Approach**

The following approach was applied to support completion of the review:

- Identify the key risks in relation to ensuring the completeness and accuracy of the Council's Annual Governance Statements and supporting Divisional and Directorate Annual Assurance Statements
- Identify the key controls established to mitigate these risks;
- Evaluate the design of the key controls in place to address the key risks;
- Assess the operating effectiveness of the key controls;
- Prepare a draft report detailing the findings raised and Internal Audit recommendations;
- Discuss all control gaps identified and agree management actions with key stakeholders at a workshop; and
- Prepare a final report detailing that includes agreed management actions and implementation dates.

Testing was performed across the period April 2018 and March 2019.

## Limitations of Scope

Testing of the implementation of individual assurance actions and verification of their status was excluded from the scope of this review.

## Reporting Date

Our audit work concluded on 10 February 2020 and our findings and opinion are based on the outcomes of our testing at that date.

# 2. Executive summary

## Total number of findings: 3

| Summary of findings raised | |
|---|---|
| **High** | 1. Assurance Management Framework |
| **Medium** | 2. Annual Assurance Methodology |
| **Medium** | 3. Annual Governance Statement Reporting Timetable |

## Opinion

Our review confirmed that there is currently no established Council wide control framework to ensure the complete and accurate collation; management; and resolution of directorate and divisional second and third line assurance findings, and inclusion of the risks and control gaps associated with these findings in Divisional and Directorate annual assurance statements. We also identified a number of moderate control weaknesses in both the design and effectiveness of the governance process supporting completion of annual assurance statements and their consolidation into the Council's overarching annual governance statement.

Consequently, only limited assurance can be provided that the risks associated with second and third line assurance findings are being effectively managed, and that the Council's annual governance statement includes any significant risks and control gaps associated with open assurance findings.

These outcomes are reflected in the 1 High and 2 Medium rated findings raised.

The High rated finding reflects the need to establish a Council wide framework to support effective recording; monitoring; oversight; and progress reporting on implementation of second and third line assurance findings; inclusion of their associated risks and controls gaps in divisional and directorate annual assurance statements; and inclusion in the Council's annual governance statement (as appropriate).

The first Medium rated finding raised highlights the need to ensure that there is a clear methodology supporting completion of divisional and directorate annual assurance statements that is aligned with the disclosures to be included in the Annual Governance Statement, and is consistently applied;

The second Medium rated finding demonstrates the importance of ensuring that the timetable for completion of annual assurance statements is followed by all divisions and directorates providing sufficient time for consolidation of their responses into the Council's annual governance statement, and enabling review by the Corporate Leadership Team and scrutiny by the Governance, Risk, and Best Value Committee review prior to its inclusion in the Council's financial statements.

Further information on these findings is included at Section 3.

**Health and Social Care Partnership**

Whilst the Health and Social Care Partnership (the Partnership) was included in the scope of the audit with the objective of reviewing implementation progress with the 17 recommendations raised in the joint Care Inspectorate and Healthcare Improvement Scotland services for older people progress review completed in December 2018, they did not have the capacity to support the audit work within the timeframes detailed in the terms of reference.

A narrative response was received from the Partnership on 2 March that outlines the processes that the Partnership applies to ensure ongoing management and oversight of second and third line assurance

findings. These responses have not been reviewed in detail by Internal Audit as our fieldwork had concluded on 10 February.

## Areas of good practice

- Good examples of monitoring and oversight of assurance actions were noted in the Schools and Lifelong Learning Division (S and LL), with the most recent Education Scotland (third line) inspection reports provided to the Sub-Committee for Children and Families in September 2019 for review by elected members and representatives from schools.

  Progress with implementation of agreed actions to address findings raised is monitored by S and LL Quality Improvement Officers. Where 'weak' findings are raised, Education Scotland can complete a 'continued engagement' inspection and report, in the following year. Where this is not performed, Quality Improvement Officers perform an internal follow up inspection within two years to report on implementation progress, with areas where insufficient progress has been made reported to Education Scotland.

  Outcomes of both the external and internal follow-up process are presented to the Subcommittee for Communities and Families.

  This process is aligned with the 'Scottish approach' to improvement where establishments and services are expected by Education Scotland to take responsibility for the quality of education they provide and take action to secure continuous improvement.

- Review of the annual assurance schedule content confirmed that it is aligned with the Chartered Institute of Public Finance and Accountancy (CIPFA) and Society of Local Authority Chief Executives (SOLACE) model framework Delivering Good Governance in Local Government guidance, and included comprehensive and detailed guidance on how each assurance statement within the schedule should be answered.
- A comprehensive timetable was prepared for completion of the 2018/19 Divisional and Directorate assurance schedules that included sufficient time for completion and review, and consolidation into the Council's overarching Annual Governance statement.

# 3. Detailed findings

| 1. Assurance Management Framework | High |
|---|---|

Whilst some divisions have established their own processes to ensure that assurance actions received from both second line and external assurance providers are completed, there is currently no established Council wide framework that supports recording; monitoring; oversight of implementation; and progress reporting to senior management; the Corporate Leadership Team (CLT) and relevant Council executive committees.

Directors and Heads of Divisions confirmed in interviews that they were confident that they would be advised of any issues with implementation of assurance actions though a combination of formal and informal communication methods.

Our sample testing confirmed that:

1. with the exception of Internal Audit and Corporate Health and Safety, oversight of progress with implementation of assurance findings (including those received from external assurance providers) was not routinely discussed at either directorate and divisional senior management and quarterly risk committee meetings;
2. assurance findings received from external assurance providers are typically reviewed by service management teams (for example the British Standards Institute assurance actions within the Capital Project Team), however, implementation progress is not consistently reported to Heads of Divisions as only some instances of reporting progress with significant findings to Heads of Divisions was evident, and is rarely reported to Directors.
3. there is no clearly established process to ensure that responsibility for completion of assurance actions are assigned to appropriately skilled and experienced team members;
4. inconsistent approaches are applied in relation to retention of evidence to confirm that assurance actions have been effectively implemented and sustained; and
5. no first line oversight is performed by managers to confirm that assurance actions have been effectively implemented. Instead reliance is placed on validation performed by second line and external assurance providers.

It should be noted that the last two points noted above in relation to retention of evidence and management oversight in advance of validation were also raised in the GDPR (Gap Analysis) Follow-up audit completed in August 2019.

**Risks**

The potential risks associated with our findings are:

- the risks and control gaps associated with open assurance findings are not reflected in either divisional and directorate annual assurance statements and the Council's annual governance statement.
- significant risks associated with assurance actions are not recorded in divisional; directorate or CLT risk registers.
- there is no or limited ongoing oversight of progress with implementation of open assurance actions by Heads of Divisions; Directors; CLT; and relevant Council executive committees.
- assurance actions are not effectively implemented and sustained, exposing the Council unnecessarily to risk.
- agreed implementation timeframes are not achieved exposing the Council to potential regulatory censure from regulators and external assurance providers.

- completed assurance actions are not 'closed' by assurance providers following validation

**1.1 Recommendation: Develop and implement an assurance management framework**

A framework to support the ongoing recording; monitoring; oversight of implementation of assurance actions and implementation progress reporting to senior management; the Corporate Leadership Team (CLT) and relevant Council executive committees should be designed and implemented across the Council to ensure that a consistent approach to managing assurance actions across the is applied, and provide assurance on the completeness and accuracy of annual assurance and annual governance statements.

This framework should include, but not be limited to:

1. guidance on how assurance actions should be recorded and allocated to appropriately skilled and experienced team members for implementation.
2. the requirement to include the risks associated with open assurance actions in divisional; directorate and Corporate Leadership Team risk registers (CLT) as appropriate.
3. ongoing management oversight responsibilities to confirm that implementation progress is aligned with agreed completion dates.
4. the need to agree evidence requirements to support closure with the assurance providers raising the findings and ensure that the necessary evidence is retained.
5. requirement for management to review implementation of significant actions prior to independent validation by assurance providers, particularly for external and regulatory related assurance actions.
6. ongoing implementation reporting requirements for heads of divisions; directors; CLT and relevant Council executive committees.
7. an escalation process to ensure that any significant assurance actions that are likely to miss their agreed completion dates are escalated and reported to heads of divisions; directors; CLT and relevant Council executive committees as appropriate.
8. the requirement to include details of risks and control gaps associated with open assurance findings in divisional and directorate assurance statements and the Council's annual governance statement.

**1.1a Agreed Management Action: Develop and implement an assurance management framework**

Discussions will be held with Directors on the outcomes of the Internal Audit report, and they will be requested to establish their own processes to ensure that the risks associated with all open assurance findings are completely and accurately reflected in their 2020/21 divisional and directorate annual assurance statements.

| | |
|---|---|
| **Owner:** Andrew Kerr, Chief Executive<br><br>**Contributors:** Laurence Rockey, Head of Strategy and Communications; Gavin King, Democracy, Governance and Resilience Senior Manager; Hayley Barnett, Corporate Governance Manager; Laura Callender, Governance Manager. | **Implementation Date:**<br><br>31 December 2020 |

**1.1b Agreed Management Action: Develop and implement an assurance management framework**

The Corporate Governance team will engage with Internal Audit (IA) to perform an exercise that reviews all open IA directorate assurance findings as at 31 March 2020, and assess whether the risks and control gaps associated with these findings have been incorporated in directorate annual assurance statements.

Where they have not been incorporated, feedback will be provided to Directors with a request that their annual assurance statements are updated as required.

| | |
|---|---|
| **Owner:** Andrew Kerr, Chief Executive<br><br>**Contributors:** Laurence Rockey, Head of Strategy and Communications; Gavin King, Democracy, Governance and Resilience Senior Manager; Hayley Barnett, Corporate Governance Manager; Laura Callender, Governance Manager. | **Implementation Date:**<br><br>31 May 2021 |

**1.1c Agreed Management Action: Develop and implement an assurance management framework**

An assurance management framework will be developed and implemented that covers the points raised by Internal Audit and includes:

- liaison with directorates to assess current and best practice;
- clearly defined roles and responsibilities for first line directorates and the second line Corporate Governance team;
- process flow;
- monitoring / reporting / closure requirements;
- an assessment of existing automated tools to determine whether they can support the process;
- issue guidance;

The framework will be implemented and rolled out across Council divisions and directorates to support completion of the 2021/22 annual governance statement for inclusion in the Council's 31 March 2022 annual financial statements.

| | |
|---|---|
| **Owner:** Andrew Kerr, Chief Executive<br><br>**Contributors:** Laurence Rockey, Head of Strategy and Communications; Gavin King, Democracy, Governance and Resilience Senior Manager; Hayley Barnett, Corporate Governance Manager; Laura Callender, Governance Manager. | **Implementation Date:**<br><br>31 December 2020 |

## 2. Annual Assurance Methodology — Medium

Review of the 'comply or explain' annual assurance methodology applied in 2018/19 confirmed that:

1. whilst division and directorate completion time was reduced, the methodology applied where rationale was required only for non-compliant assessments resulted in provision of insufficient information on effective controls across the Council required to support completion of the Council's Annual Governance Statement.
2. different approaches were applied by directorates when preparing directorate assurance schedules.

   For example, in Communities and Families, every instance of partial-compliance that had been highlighted in divisional assurance schedules was considered and consolidated to determine directorate level responses, whilst other directorates provided an overview of divisional responses with some instances of divisional partial-compliance not reported.

   Directors advised that this was attributable to insufficient guidance on how divisional assurance statement should be consolidated to form directorate assurance statements.
3. for the Resources directorate, 5 instances of partial compliance were identified in divisional assurance schedules (3 in Human Resources and 2 in Finance), however these were not reflected in the directorate assurance schedule.

   Of the 3 Human Resources instances of partial compliance, 2 were considered sufficiently significant by the Governance Democracy and Resilience Team for inclusion in the Council's overarching annual governance statement.

### Risk

The potential risks associated with our findings are:

- The Council's Annual Governance Statement does not completely and accurately reflect the consolidated disclosure included in divisional and directorate assurance statements, and does not provide an accurate self-assessment of the Council's overall control environment.

### 2.1 Recommendation: Annual assurance methodology and guidance

1. The format of the Assurance Schedule should be changed for the 2019/20 financial year to ensure that sufficient information is provided on the controls supporting 'compliant' responses to support inclusion (where appropriate) in the Council's Annual Governance Statement.
2. Guidance should also be prepared and issued to directors to clarify the process to be applied to consolidate divisional assurance statements into directorate statement, with focus on ensuring that the full population of partial or non-compliance disclosures and associated improvement actions are included.

### 2.1 Agreed Management Action: Annual assurance methodology and guidance

1. The format of the assurance schedule was reviewed at the start of the 2019/20 cycle and the previous compliant/partially compliant/not compliant format was reinstated, with the incorporation of corporate controls – completed February 202 and no further action required.
2. Review existing guidance to include advice on combining divisional returns into directorate returns, incorporating partial and non-compliant disclosures and improvement actions.

| | |
|---|---|
| **Owner:** Andrew Kerr, Chief Executive<br><br>**Contributors:** Laurence Rockey, Head of Strategy and Communications; Gavin King, Democracy, Governance and Resilience Senior Manager; Hayley Barnett, Corporate Governance Manager; Laura Callender, Governance Manager. | **Implementation Date:**<br><br>28 February 2021 |

| **3. Annual Governance Statement Reporting Timeframes** | **Medium** |
|---|---|

Review of annual governance statement reporting timeframes for 2018/19 highlighted that:

1. the reporting timetable allowed sufficient time (circa two months) for completion of directorate and divisional annual assurance statements, with guidance issued by the Governance Democracy and Resilience team 22 February requesting responses by 22nd April.
2. the reporting timetable was not consistently followed by directorates with four of the five directorates submitting their assurance schedules after the required deadline, with two responses received almost one month late.
3. delayed directorate responses resulted in delayed finalisation of the Council's annual governance statement which was not prepared in sufficient time for review by either the Corporate Leadership Team or the Council's Governance, Risk, and Best Value committee. A review was performed by the Chief Executive prior to its inclusion in the Council's annual financial statements.

   This concern was also noted by the external auditors in their 2018/19 annual report.

A timeline highlighting the delays in the process is included at Appendix 3 for information.

**Risk**

The potential risks associated with our findings are:

- non-compliance with CIPFA Guidance on Annual Governance Statement 'Delivering Good Governance in Local Government Framework, 2016 Edition' which states (at page 24) that the annual governance statement should be approved at a meeting of the Authority or Committee with a remit including Audit or Governance.
- Insufficient scrutiny of the annual governance statement by elected members prior to its publication.

**3.1 Recommendation: Annual governance statement reporting timeframes**

1. Future progress with completion of divisional assurance statements should be tracked at directorate operational meetings and progress with directorate assurance statements tracked and recorded at Corporate Leadership Team (CLT) meetings.
2. Any issues that could potentially result in delays with completion of annual assurance statements should be escalated by Heads of Divisions to Directors, and by Directors to CLT (as required) with appropriate actions implemented to ensure that reporting timeframes are achieved.
3. Any completion delays should also be escalated to the Governance Democracy and Resilience team, who should consider the impact of these delays on timeframes for presentation to the Corporate Leadership Team and Governance, Risk, and Best Value Committee.

**3.1 Agreed Management Action: Annual governance statement reporting timeframes**

During the 2019/2020 cycle the timeline was amended to support divisions and directorates in completing their returns while managing Coronavirus pressures. This ensured returns were completed and submitted on time and that significant reporting deadlines were met.

Unforeseen delays to submissions are a risk that the Democracy, Governance and Resilience Senior Manager is prepared to accept but will endeavour to mitigate wherever possible.

**Risk Accepted – no further action required**

# Appendix 1: Basis of our classifications

| Finding rating | Assessment rationale |
|---|---|
| **Critical** | A finding that could have a:<br>• ***Critical*** impact on the operational performance; or<br>• ***Critical*** monetary or financial statement impact; or<br>• ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or***<br>• ***Critical*** impact on the reputation of the organisation which could threaten its future viability. |
| **High** | A finding that could have a:<br>• ***Significant*** impact on operational performance; or<br>• ***Significant*** monetary or financial statement impact; or<br>• ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or***<br>• ***Significant*** impact on the reputation of the organisation. |
| **Medium** | A finding that could have a:<br>• ***Moderate*** impact on operational performance; or<br>• ***Moderate*** monetary or financial statement impact; or<br>• ***Moderate*** breach in laws and regulations resulting in fines and consequences; or<br>• ***Moderate*** impact on the reputation of the organisation. |
| **Low** | A finding that could have a:<br>• ***Minor*** impact on operational performance; or<br>• ***Minor*** monetary or financial statement impact; or<br>• ***Minor*** breach in laws and regulations with limited consequences; or<br>• ***Minor*** impact on the reputation of the organisation. |
| **Advisory** | A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice. |

Please see the Internal Audit Charter for full details of opinion ratings and classifications.

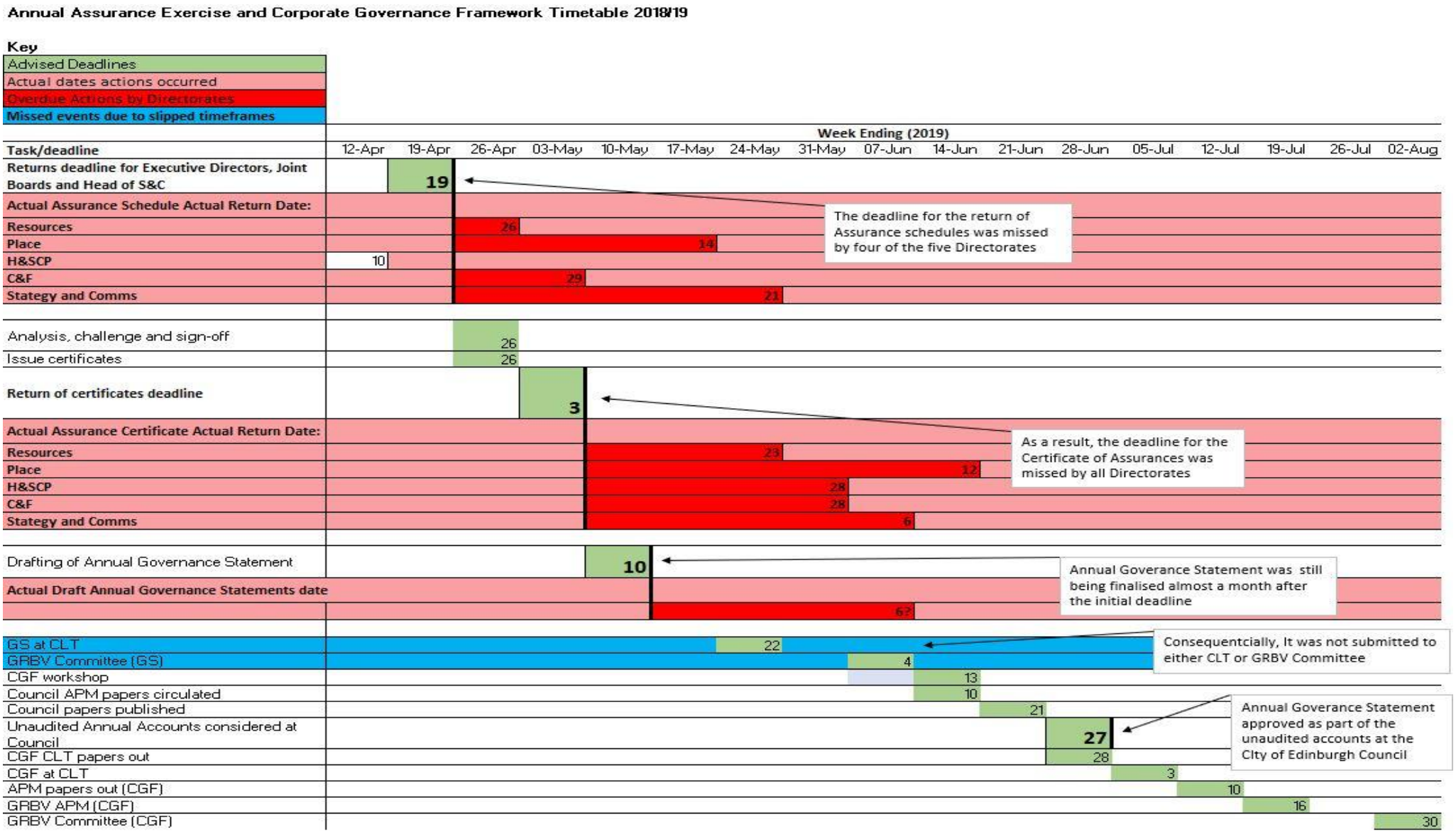
# Appendix 2: Areas of audit focus

The areas of audit focus and related control objectives included in the review are:

| **1. Ongoing monitoring of assurance actions** |
|---|
| • There is an established review and monitoring framework in place within Directorates / Divisions to identify and manage implementation of all assurance actions;<br>• Responsibility for the implementation of each assurance action is appropriately assigned and regularly followed up;<br>• There are processes in place within the Directorates to ensure that all risks associated with open assurance actions are appropriately reflected within Divisional / Directorate risk registers;<br>• When actions are reported as completed, Heads of Divisions have arrangements in place to ensure that actions have been effectively implemented and sustained with supporting evidence;<br>• Progress against the implementation of assurance actions is regularly reported to appropriate Directorate governance forums (for example senior management team meetings);<br>• Where assurance actions are not completed within the agreed time frame, there is engagement with assurance providers requesting the extension of implementation dates or agreeing alternative action plans;<br>• The Corporate Leadership Team (CLT) has appropriate oversight of all significant and systematic assurance findings raised and these are appropriately reflected in the CLT risk register. |
| **2. Preparation of annual assurance schedules** |
| • Detailed guidance and timeframes for the preparation of assurance schedules is provided to Directorates and Divisions by Strategy and Communications;<br>• Divisions and Directorates have established appropriate procedures to ensure that open assurance actions; their associated risks; and their impact on control environment are accurately reflected in assurance schedules;<br>• Directorates have appropriate procedures in place to ensure that their assurance schedules accurately reflect the consolidated content of Divisional AAS; and<br>• Appropriate review procedures are in place at both Directorate and Division level prior to the submission of assurance schedules to the Governance Democracy and Resilience Team. |
| **3. Preparation of the Annual Governance Statement (AGS)** |
| • Corporate Governance Framework and Assurance Schedules are appropriately designed and regularly reviewed and refreshed to reflect any new legislation and regulations; changes to Council policies; and confirm ongoing compliance with guidance from the Chartered Institute of Public Finance and Accountancy, and the Society of Local Authority Chief Executives;<br>• Assurance Schedules and supporting evidence and action plans received from each Directorate are subject to review and scrutiny by the Governance Democracy and Resilience Team and the Council's second and third line internal assurance providers to confirm their completeness and accuracy; |

- Where gaps are identified, feedback is provided to the relevant Divisions / Directorates with a request for them to reconsider their responses and / or provide additional evidence and action plans (where required);
- The draft Annual Governance Statement is reviewed and approved by the Council's Corporate Leadership Team (CLT) prior to presentation to relevant Executive Committees for review, scrutiny and approval prior to inclusion within the draft Annual Accounts; and
- As per the 'Delivering Good Governance Framework' developed by CIPFA, there are procedures in place to ensure that the AGS covers the period up until the Accountable Officer signs and is not restricted to the current financial accounting period.

# Appendix 3: Annual Assurance Timetable 2018/19



# *The City of Edinburgh Council*

## Internal Audit

## Validation of Implemented Management Actions Supporting Closed Internal Audit Findings

Final Report

20th July 2020

CW1909

| | |
|---|---|
| **Some improvement required** | Whilst some control weaknesses were identified, in the design and / or effectiveness of the control environment and / or governance and risk management frameworks, they provide reasonable assurance that risks are being managed, and the Council's objectives should be achieved. |

# Contents



This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2019/20 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2019. The review is designed to help the City of Edinburgh Council assess and refine its internal control environment. It is not designed or intended to be suitable for any other purpose and should not be relied upon for any other purpose. The City of Edinburgh Council accepts no responsibility for any such reliance and disclaims all liability in relation thereto.

The internal audit work and reporting has been performed in line with the requirements of the Public Sector Internal Audit Standards (PSIAS) and as a result is not designed or intended to comply with any other auditing standards.

Although there is a number of specific recommendations included in this report to strengthen internal control, it is management's responsibility to design, implement and maintain an effective control framework, and for the prevention and detection of irregularities and fraud. This is an essential part of the efficient management of the City of Edinburgh Council. Communication of the issues and weaknesses arising from this audit does not absolve management of this responsibility. High and Critical risk findings will be raised with senior management and elected members as appropriate.

# 1. Background and Scope

## Background

Internal Audit (IA) findings are raised where audit outcomes confirm that the controls established to mitigate the Council's most significant risks are either inadequately designed or are not operating effectively.

When finalising IA reports, management agree to implement actions that include control improvements to address the control weaknesses identified. Implementation of these agreed management actions will ensure that the associated risks are effectively managed, reducing the Council's overall exposure to risk.

It is essential that (once implemented), the control improvements are effectively sustained. If not, the Council remains exposed to an unnecessary level of risk.

Completion of a 'self-attestation' exercise in March 2018 confirmed that not all control improvements required to address IA findings raised in the period 1 April 2015 to 31 March 2017 had been effectively implemented and sustained. Consequently, a total of 32 historic IA findings were reopened and reported as overdue based on originally agreed implementation dates until the required control improvements were implemented and validated by IA.

IA then included a 'validation' audit in the 2018/19 and 2019/20 IA annual plans to validate whether control improvements implemented to address a sample of the balance of historic findings raised have been effectively sustained.

The 2018/19 validation audit considered a total of 11 historic findings where control improvements had been confirmed as implemented and sustained as part of the March 2018 self-attestation exercise. Of these, two high and one low (regraded from medium) findings were reopened as the outcomes of IA testing performed confirmed that this was not the case.

Between 1 January 2016 and 31 December 2018, a total of 89 IA findings (32 High and 57 Medium) were raised and subsequently closed following review by IA to confirm that the control improvements had been effectively implemented and sustained.

This population of findings was the basis for selection of the sample of IA included in the scope of the 2019/20 validation audit.

## Scope

The objective of this review was to validate whether a representative sample (11%) of the 89 High and Medium rated IA findings raised between 1 January 2016 and 31 December 2018 have been effectively implemented and sustained.

The sample of ten findings selected (5 High and 5 Medium) covered all Council directorates, including the Health and Social Care Partnership. Further details of the sample selected are included at Appendix 2.

Where the necessary control improvements have not been implemented and effectively sustained, the relevant findings and supporting management actions have been reopened; regraded (where

appropriate based on residual risk) and reported as overdue, based on the originally agreed implementation dates.

## Exclusions from Scope

The high rated Building Standards audit finding relating to Customer Information and Engagement actions was included within the original sample of ten findings for validation, however management advised that the originally agreed management actions were currently being reviewed and improved, and provided an action plan detailing the changes to be implemented. It was agreed that IA will review these changes as part of the planned Building Standards follow up audit scheduled for completion in the November 2020.

Consequently, the finding relating to Building Standards, Customer Information and Engagement was excluded from the overall sample reviewed, leaving a sample of 9 findings (four High and 5 Medium) to be validated.

### Reporting Date

Our audit work concluded on 4th March 2020, and our findings and opinion are based on the conclusion of our work as at that date.

# 2. Executive Summary

## TOTAL NUMBER OF FINDINGS: 3

| Summary of findings reopened | |
|---|---|
| **High** | 1. Communities and Families - Short Terms Homelessness Provision: Invoices are not checked for accuracy of prices (control design) |
| **Medium** | 2. Communities and Families Learning and Development - Schools Complaint Process – Complaints received by Helpline |
| **Low** | 3. Health and Social Care - Care Home Debt Management – Gross Funding – regraded from High |

### Opinion

In our opinion, some improvement is required (an amber rating) to ensure that management effectively implements and sustains the necessary control improvements to support closure of Internal Audit findings.

Our review confirmed that control improvements supporting six of the nine original findings (two high and four medium) have been effectively implemented and sustained, with three findings where further action is required to fully address the risks.

The three findings where further action is required were originally assessed as two high and one medium, however one high rated finding (Health and Social Care – Care Home Debt Management) has been downgraded from high to low, reflecting IA's assessment of the residual risk.

Consequently, these three findings and supporting management actions that have not been fully implemented and sustained will be reopened and reported as overdue based on originally agreed implementation dates.

This outcome reflects an improvement in comparison to the validation audit completed in April 2019 which confirmed that significant improvements were required (an overall red rating) to ensure that management effectively implements and sustains control improvements to support closure of IA findings with two high rated findings (including one regraded from medium to high) and one low rated finding reopened from a total sample of 11.

Details of our ratings classifications and an explanation of the conclusions applied to our validation outcomes are included at Appendices 2 and 3.

**Communities & Families Short Term Homelessness Provision: Invoice Quality Assurance Procedures (High rated finding)**

The reopened high rated finding relates to ongoing quality assurance checks to retrospectively confirm the accuracy of circa 100 weekly invoices for short term homelessness provision with an annual budget of circa £50m for this service.

The original finding included two agreed management actions, with one implemented and sustained (validation of contract rates prior to payment), and the other (ongoing quality assurance checks)

implemented but not sustained as no quality assurance reviews were performed for a period 5 months between March and July 2019.

Management acknowledged this gap, together with the need to ensure completeness of quality assurance records to provide evidence of ongoing checking and confirm that appropriate action had been taken where issues were identified.

**Communities & Families: Complaint Process – Complaints received by Helpline (Medium rated finding)**

The reopened medium rated finding relates to complaint handling arrangements for school where an unplanned staff absence resulted in the inability to access the complaints database and supporting complaint files with temporary records maintained for a period of 3 months from October 2019 to January 2020 until the issue was resolved

The original finding included one agreed management action which was implemented but could not be sustained as a result of the impacts of this key person dependency.

**Health & Social Care: Care Home Debt Management – Gross Funding (High rated finding, regraded to Low)**

The reopened finding has been regraded to low reflecting IA's assessment of the residual risk associated with the ongoing management, oversight and recovery of interim gross funding provided to care home residents.

The original finding included three agreed management actions, with two of these (recording the outcomes of gross funding reviews and refreshing and maintaining gross funding review procedures) effectively implemented and sustained and one (ongoing review of gross funding cases) partially implemented and sustained with reviews completed on a priority basis as the volume of gross funded care home clients has doubled in comparison to the position at the time of original November 2016 audit.

## Areas of good practice

The following areas of good practices were noted in relation to the six original findings where control improvements had been effectively implemented and sustained:

- Resources – Properties and Facilities Management - ongoing plan of scheduled Council building surveys is maintained. Surveys performed include identification and escalation of high risk items where remedial action is required. This is supported by clear guidelines and reporting requirements to oversee and manage the process.
- Resources – Customer and Digital Services - effective ongoing management of risks, issues and dependency (RAID) logs and reporting in relation to CGI change programmes.
- Place Management – effective ongoing management of mortuary demand and capacity including improved engagement and liaison with external stakeholders (for example, procurator fiscals; police; and undertakers). Guidance has also been prepared for both Council employees and external stakeholders to support effective ongoing mortuary capacity management.
- Health and Social Care and Resources - clear arrangements established in relation to ongoing completion of pre-employment verification checks by Human Resources for new Health and Social Care Partnership employees, with focus on ensuring that protection of vulnerable group (PVG) approvals are obtained and reviewed prior to commencing employment.

- Strategy and Communications – effective ongoing management and oversight of operational volumes of statutory activities (for example freedom of information requests) by Information Governance following implementation of General Data Protection Requirements (GDPR) legislation in May 2018.
- Strategy and Communications – effective ongoing management and ownership of the Register of Service Level Agreements by the Governance Team, including issue of reminders across directorates and divisions to review existing service level agreements (SLAs) with arm's length external organisations and maintenance of the SLA register.

# 3. Detailed findings

| 1. Communities & Families – Invoices are not checked for accuracy of prices (control design) | High |
|---|---|

**Original finding**

This high rated finding was originally raised in the Short Term Homelessness Provision review completed in June 2017, and established that:

- B&B providers submitted invoices (usually weekly) detailing the individual's name, the length of the stay, the price for the stay and any other costs such as flex rates.
- the rate per room and flex rates on the invoice were not checked before approving the invoice for payment.
- review of a sample of 25 invoices confirmed that 12 invoices for contracted B&Bs. could not be agreed to contract rates; and of 9 invoices for off-contract B&Bs, only two invoice rates could be agreed to rates recorded on the Homelessness Information System (HIS) database.
- no documentation was available to support 4 invoices.

**Validation outcomes**

The outcomes of our validation work confirmed that the first of the two agreed management actions have been implemented and sustained, whilst the second management action has been implemented but not sustained.

Consequently, this finding will be reopened as a High rated finding (reflecting the residual risk) with supporting management actions tracked against the originally agreed implementation dates.

Our testing established that:

- agreed contract rates are now automatically recorded by Procurement within the Oracle general ledger system and are checked against homelessness information system (HIS) records prior to payment processing.

**Conclusion:** Implemented and sustained

The monthly quality assurance checks performed by the team leader on invoices processed had ceased during the period March to July 2019 due to changes within the team. Additionally, the current quality checking template is not been populated with the full range of invoice checks performed and their outcomes prior to payment

**Conclusion:** Implemented but not sustained.

**Risks**

- Risk of inaccurate payments, including overpaying the providers; and
- Risk that fraudulent claims for payment are not detected.

**1.1 Recommendation: Quality Assurance Arrangements**

1. Management should decide whether there is a need to retrospectively perform quality assurance checks on invoices for the period March to July 2019, considering all relevant risks (including the potential risks of fraud and overpayment based on inaccurate invoices).
2. Where quality assurance checks for the period March to July 2019 are performed, these should be based on a representative sample of invoices processed. Where any errors are identified, the supplier should be contacted and appropriate action to taken to address the error (for example, offsetting the balance owed against future payments, or arranging payment refunds), and feedback / training provided to the team members who processed the invoices.
3. The full range of current quality assurance activities performed to confirm the accuracy of invoices prior to payment should be included in the quality checking template, together with the outcomes of the checks performed. These should include, but not be limited to:
    a. Date of invoice receipt and processing date
    b. Invoice number and Purchase Order Number
    c. Details of checks performed, and team member who completed the check.
    d. Oracle payment reference number
    e. Checking outcomes, including any remedial actions undertaken to address errors identified and date completed.

**1.1 Agreed Management Action: Quality Assurance Arrangements**

1. A risk based assessment has been made and the decision has been made to retrospectively quality assess invoices between March and July 2019. This decision will consider the volume and value of invoices processed and the potential risks of fraud and overpayment.
2. Where retrospective quality assurance checks are performed, appropriate action will be taken to address any significant errors identified with feedback / training provided to the team members who processed the invoices.
3. The quality checking template will be reviewed and updated, with the exception of item d above, to include:
    a. Date of invoice receipt and processing date
    b. Invoice number and Purchase Order Number
    c. Details of checks performed, and team member who completed the check
    d. Checking outcomes, including any remedial actions undertaken to address errors identified and date completed.

**Owner:** Alistair Gaw, Executive Director of Communities and Families

**Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Stephen Moir, Executive Director of Resources; Nicola Harvey, Head of Customer and Digital Services; John Arthur, Senior Manager, Business Support; Louise McRae, Business Support Manager; Nicky Brown**,** Homelessness and Housing Support Senior Manager; Brian Stewart, Temporary Accommodation Service Manager; Dawn Munro, Business Manager; Nichola Dadds, Senior Executive Assistant; Nickey Boyle ,Senior Executive Assistant: Alison Roarty, Commercial Team Lead.

**Original Implementation Date:** 31 October 2017

**Revised Implementation Date:** 31 December 2020

## 2. Communities and Families – Complaints received by Helpline — Medium

**Original Finding**

This medium rated finding was originally raised in the Complaints Process review completed in February 2017, and established that:

- Complaints submitted directly to the Communities and Families Helpline were sent to the appropriate head teacher for frontline resolution as a 'Stage 1' complaint, or were allocated to a Quality Improvement Officer or senior staff member for investigation as a 'Stage 2' complaint.
- Stage 1 complaints received via the Helpline were not logged in the complaints database until resolved and a web form submitted by the head teacher. Complaints were not tracked, and were not followed up if a web form was not submitted.
- Review of a sample of 20 recorded Helpline contacts between September and November 2016, of which 10 were classed as Stage 1 complaints and sent to the relevant head teacher to investigate confirmed that only 2 of the 10 were closed and logged on the Stage 1 database.
- In the remaining 8 cases, the head teacher may have resolved the complaint but not submitted a web form. However, there is a risk that the complaints were not followed up.
- In either case, these complaints would not have been reflected in the Council's complaints performance statistics for the quarter. We noted that 132 complaints and advice requests were received by the Helpline in September and October, compared to 129 Stage 1 Complaints and 27 Stage 2 complaints logged in 8 months between April and December 2016.

**Validation Outcomes**

The outcomes of our validation work confirmed that the agreed management action has been implemented but not sustained.

Consequently, this finding will be reopened as a medium rated finding (reflecting the residual risk) with supporting management actions tracked against the originally agreed implementation dates.

Our testing established that the complaints process did not operate effectively during the period October 2019 to January 2020 due to a specific key person dependency as Communities and Families had no access to the complaints database and supporting working papers during the long term absence of the complaint handling officer.

During that period, new complaints received were recorded on a separate spreadsheet by the Communities and Families Operations Manager until a new team member was appointed into the complaint handling role, however, a period of transition and training was required which also impacted the ongoing complaints management process.

**Conclusion:** Implemented but not sustained

**Risk**

- Complaints performance statistics were inaccurate for the three month when the complaints database could not be accessed.
- Progress with existing complaints recorded in the database and complaints files could not be monitored.

**2.1 Recommendation: Roles and Responsibilities**

1. Relevant team members should be provided with access to the complaints database and supporting working paper files, which should be located securely on a shared network drive. Contingency access arrangements should also be established to ensure that any potential future key person dependencies are addressed.
2. Complaints recorded on the temporary spreadsheet should be transferred across to the complaints database and performance statistics retrospectively updated. Management should also be advised of any significant changes in performance statistics resulting from this retrospective update.
3. Complaint handling procedures and guidance should be developed and maintained and shared with all relevant team members. These should include (but not be limited to) details of the process to be followed on receipt of complaints; how complaints should be allocated for investigation and resolution; investigation and remediation timeframes; and the requirement for stage 1 complaints received by schools to be notified to the central complaints team for recording on the complaints database.

**2.1 Agreed Management Action: Roles and Responsibilities**

1. Access to the complaints database will be arranged for all team members involved in the complaint handling process with supporting files saved in secured shared drives. Contingency access arrangements will also be developed and implemented.
2. The complaints cases that were recorded on the temporary spreadsheet will be transferred to the complaints database and the performance statistics retrospectively updated. Management will also be advised of any significant changes in performance statistic resulting from the retrospective update.
3. Complaint handling procedures and guidance will be developed and maintained and shared with all relevant team members as recommended.

**Owner:** Alistair Gaw, Executive Director of Communities and Families

**Contributors:** Andy Gray, Head of Schools and Lifelong Learning; Michelle McMillan, Operations Manager; Claire Thompson, Operations Manager; Nickey Boyle, Senior Executive Assistant

**Original Implementation Date:** 30 April 2017

**Revised Implementation Date:** 31 January 2021

## 3. Health & Social Care – Gross Funding | Low

**Original Finding**

This High rated finding was originally raised in the Care Home Debt Management review completed in November 2016, and established that:

- there are occasions when clients are placed in care homes within the private and voluntary sector where the client's financial contact does not have sufficient authority in place (i.e. power of attorney or guardianship) to access the client's funds and pay the care home fees. In this situation the Council may put in place a gross funding contract with the care home in order to pay the fees until such times as the Financial Contact can access the funds.
- once access to funds has been granted an invoice is raised to allow the care home fees to be repaid to the Council.
- At the time of the original audit there were circa 70 clients in receipt of gross funding. A sample of 20 clients was randomly selected for testing. In all cases reviewed, appropriate authorisation had been obtained to provide the funding and the rational for the funding was documented.
- the process for following up with the clients financial contacts to determine if the necessary authority is in place to transfer a client off the gross funding provision is less effective. During the audit the Care Home Services Gross and Miscellaneous spread sheet used to control gross funding provision, was reviewed and updated to include a new column to facilitate the recording of the current position for each client.
- of the 20 clients sampled, 8 had not been followed up to determine the current status, and further action was required for the remaining 12 including raising an invoice for repayment of funding from a client who had died in April 2016.

**Validation Outcomes**

The outcomes of our validation work confirmed that the two of the three agreed management actions have been implemented and sustained, with one action partially implemented and sustained.

As the volume of gross funded care home clients has doubled (140 current clients in comparison to 70 as at November 2016) and the follow-up process has been partially implemented and sustained with testing outcomes reflecting an improvement in comparison to the November 2016 review outcomes (refer below), this finding will be reopened and downgraded to a Low rated finding (reflecting IA's assessment of the residual risk) with supporting management actions tracked against the originally agreed implementation dates.

Our testing established that:

1. the gross funding spreadsheet is updated for cases that have been reviewed to reflect the date of review and details of any action taken in response to changes in a client's situation including deaths and instances where an invoice has been raised to recover fees where gross funding provisions have ended.

**Conclusion**: Implemented and sustained

2. review of a sample of 16 current gross funding cases covering both current and deceased clients highlighted the following 5 cases where either no or limited follow up had been performed.
   - Case Ref: 8063883, no action in file since April 2018

- Case Ref: 4023860, no action in file since 2016
- Case Ref: 8070425, ongoing case with a decision required regarding the potential write off of the outstanding balance
- Case Ref: 5046079, deferred payment due to house sale, with Legal services currently involved with case
- Case Ref: 8145963, ongoing case relating to house sale proceeds, no recent contact with solicitors

**Conclusion**: Partially implemented and sustained

3. gross funding processes and procedures have been adequately maintained.

**Conclusion**: implemented and sustained

## Risk

Failure to actively manage the gross funding portfolio could result in the Council paying gross funding for longer than is necessary. It also increases the risk of the Council being unable to recover gross funding paid

## 3.1 Recommendations: Gross Funding Case Management Reviews

1. Monthly reviews should be re-established to identify changes in client situations (including deaths) and appropriate actions implemented to recover care home fees, with the gross funding spreadsheet updated to reflect the date and details of actions taken, and future review dates scheduled.
2. Where it is clear that fees are unlikely to be recovered, a timely decision should be taken by management to write off the outstanding balance in line with applicable delegated authority limits.
3. Each of the cases detailed in the finding should be reviewed and updates obtained together with an indication of whether it is likely that funds will be recovered, and if so, when they are likely to be received. The update should be recorded in both the client's Swift records and the gross funding spreadsheets, with future follow-up dates scheduled to confirm progress.

## 3.1 Agreed Management Action: Gross Funding Case Management Reviews

1. Monthly reviews will be re-established for all clients currently receiving gross funding support and the gross funding spreadsheet updated to reflect the date and details of actions taken, with future review dates scheduled.
2. Where it is clear that fees are unlikely to be recovered, management will be requested to write off the outstanding balance in line with applicable delegated authority limits.
3. A review of each of the five cases highlighted in this review will be performed and appropriate remedial action implemented with both the Swift system and the gross funding spreadsheet updated and future review dates scheduled.

**Owner:** Judith Proctor, Chief Officer, Health and Social Care Partnership

**Contributors:** Stephen Moir, Executive Director of Resources; Nicola Harvey, Head of Customer and Digital Services; Neil Jamieson, Customer-Senior Manager; Sheila Haig, Customer Manager; Layla Smith, Operations Manager; Angela Ritchie, Senior Executive Assistant; Cathy Wilson, Operations

| |
|---|
| Manager; Alison Roarty, Commercial Team Lead; Elizabeth Davern, Team Manager Assessment and Finance. |
| **Original Implementation Date:** 30 November 2016 |
| **Revised Implementation Date:** 31 October 2020 |

# Appendix 1: Sample of IA findings selected for validation

The areas of audit focus and related control objectives included in the review are:

| Directorate | Audit report reference and title | Finding Ratings | Finding Title | Original Implementation Date |
|---|---|---|---|---|
| Resources | RES1615: Property Maintenance | High | Issue 2 – High Risk Items identified in Strategic Asset Management condition surveys | 28/2/2017 |
| | RES1713: CGI Contract Management – Programme Management | Medium | Issue 2 – Completeness and quality of Programme RAID log | 31/10/2018 |
| Place | PL1701: Planning Control- Building Standards | High | Issue 3 – Customer Information and Engagement | 30/3/2018 |
| | PL1603: Mortuary Services | Medium | Issue 4 – Capacity Management | 30/11/2016 |
| Communities and Families | SSC1701: Short Term Homelessness Provision | High | Issue 2 – Invoices are not checked for accuracy of prices (control design) | 30/6/2017 and 31/10/2017 |
| | CF1619: Complaint Process | Medium | Issue 2 - Complaints received by Helpline | 30/4/2017 |
| Health and Social Care | HSC1601 Care Home Debt Management | High | Issue 2 – Gross Funding | 30/11/2016 |
| | SW1601 Social Work: Pre-Employment Verification | Medium | Issue 5 – Procedures and Key Documentation | 31/3/2017 and 31/1207 |
| Strategy & Communications | CW1707: Review of the GDPR readiness programme | High | Issue 1 – Programme Progress and Information Governance Capacity | 28/9/2018 and 31/8/2018 |
| | RES1605: Service Level Agreement with outside entities | Medium | Issue 2 – Register of Service Level Agreements | 31/10/2016 |

# Appendix 2 : Basis of our classifications

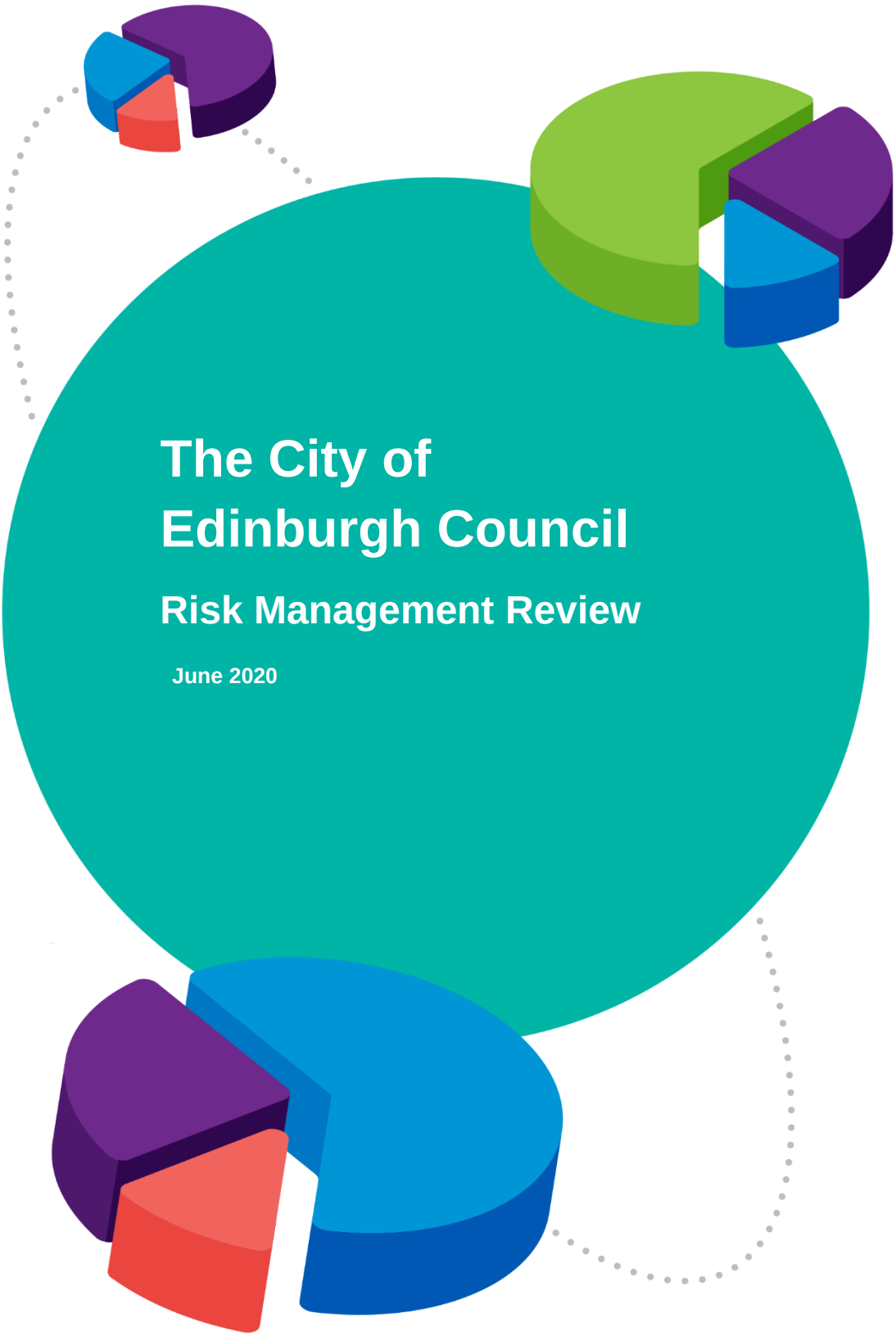
| Finding rating | Assessment rationale |
|---|---|
| **Critical** | A finding that could have a:<br>• ***Critical*** impact on the operational performance; or<br>• ***Critical*** monetary or financial statement impact; or<br>• ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or***<br>• ***Critical*** impact on the reputation of the organisation which could threaten its future viability. |
| **High** | A finding that could have a:<br>• ***Significant*** impact on operational performance; or<br>• ***Significant*** monetary or financial statement impact; or<br>• ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or***<br>• ***Significant*** impact on the reputation of the organisation. |
| **Medium** | A finding that could have a:<br>• ***Moderate*** impact on operational performance; or<br>• ***Moderate*** monetary or financial statement impact; or<br>• ***Moderate*** breach in laws and regulations resulting in fines and consequences; or<br>• ***Moderate*** impact on the reputation of the organisation. |
| **Low** | A finding that could have a:<br>• ***Minor*** impact on operational performance; or<br>• ***Minor*** monetary or financial statement impact; or<br>• ***Minor*** breach in laws and regulations with limited consequences; or<br>• ***Minor*** impact on the reputation of the organisation. |
| **Advisory** | A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice. |

Please see the Internal Audit Charter for full details of opinion ratings and classifications.

# Appendix 3: Conclusion definitions

| Conclusion | Definition |
|---|---|
| Implemented and sustained | Controls have been fully implemented, and our testing confirmed that they have been sustained |
| Partially implemented and sustained | Controls have been partially implemented, and our testing confirmed that the elements implemented have been sustained |
| Implemented but not sustained | Controls were initially implemented, but have not been sustained |
| Not implemented | Controls have not been implemented |

Scott-Moncrieff
business advisers and accountants
With Campbell Dallas
a Cogital company



# The City of Edinburgh Council

## Risk Management Review

June 2020

# The City of Edinburgh Council

## Risk Management Review



| Key Contacts | Audit team |
| --- | --- |
| *Nick Smith, Head of Legal and Risk/Monitoring Officer*<br>*Rebecca Tatar, Principal Risk Manager* | *Nick Bennett, Partner*<br>*Matthew Swann, Associate Director*<br>*Barbara Zahra, Audit Senior* |

# Executive Summary

## Conclusion

***There is scope for the Council to further develop its approach to risk management. We have concluded that at the CLT level that risk is generally well managed, with appropriate articulation of the corporate risks and appropriate discussion.***

***However, we have identified two high risk areas to further improve processes. There is a need to utilise information within training materials to clearly articulate how the risk framework should operate in practice, with appropriate training attended by relevant staff. We have also noted that risk registers have not been completed for all services, with capacity of the teams to devote sufficient time to this activity being a key limiting factor.***

***Based on the work performed we consider the conclusions in this report to be the equivalent of a report rated as "Significant Improvement Required' (red) rating" under the application of the Council's internal audit methodology***

### General management response

The Council is still on its risk management journey. Whilst there is an appropriate overarching risk management framework in place which has been developed by the Risk Management Team and approved by Policy and Strategy Committee, it is recognised that this is not yet being appropriately implemented by all services. It is also recognised that research and engagement by the Head of Legal Risk with a number of public sector bodies and professional risk management consultants has not identified any clear and consistent system or process for risk management and setting of risk appetite within an organisation as complex and diverse in terms of services as the Council. FY 19/20 also saw an agreed shift of responsibility and ownership of risk from Line 2 to Line 1 in accordance with the principles of the three lines of defence. This will embed more strongly over the next few years.

It is further recognised that the assurance mapping exercise which CLT and GRBV have agreed should be carried out (decision December 2019) will assist with improving the Council's risk and control framework and address some of the issues identified in this report.

## Background and scope

To examine the risk management policies and processes and the approach taken for risk identification, risk analysis and risk mitigation at strategic and operational level.

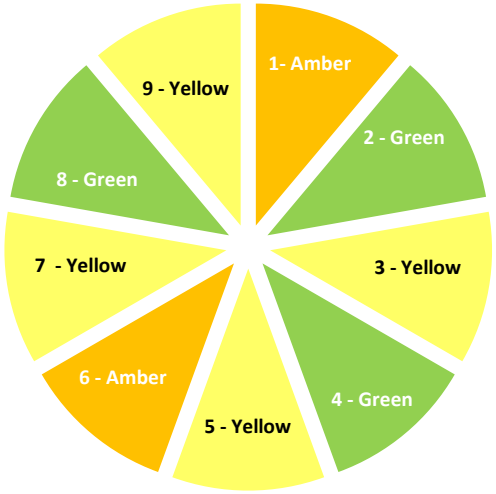
To undertake a detailed review of the risk management policies and processes and the approach taken for risk identification, risk analysis and risk mitigation of strategic and operational level.

The Council utilises a Three Lines of Defence model for the management of risk where the 'first line' is the team responsible for consistent application of the risk management framework; and the 'second line' is the team responsible for establishing and communicating an appropriate organisational risk management and governance framework and risk appetite statement framework for application by divisions and directorates. The

‘third line’ provides independent assurance (for example, Internal Audit) on the controls established to manage risks.

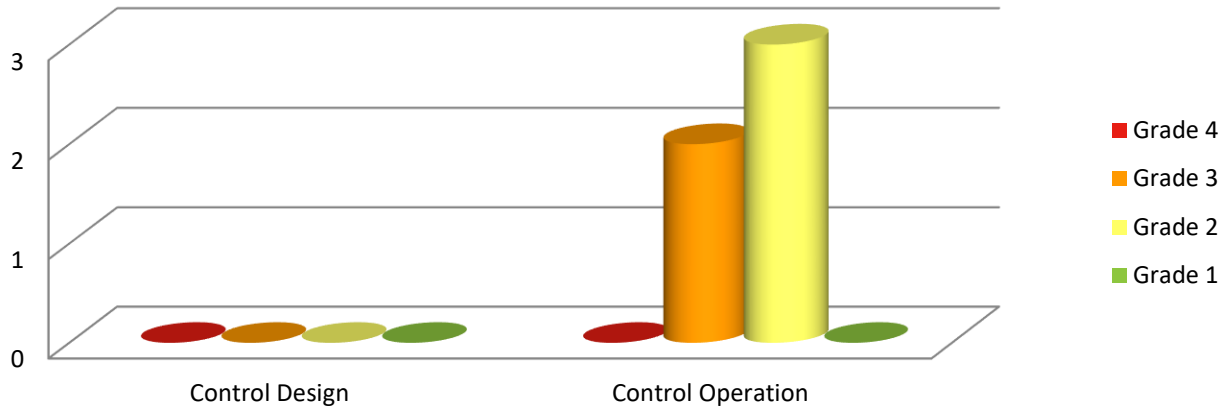
We have engaged with the Council’s Chief Internal Auditor to establish how the ratings of findings in this report should be interpreted in comparison to work undertaken under the Council’s audit approach. This is noted in Appendix 1. The overall rating noted in the conclusion is based on the application of the Council’s Internal Audit methodology to form an overall conclusion.

# Control assessment




- 1. The Council has a satisfactory risk management framework (risk policy and risk appetite statement) that this is aligned with CIPFA's guidance on risk management and good practice across the public and other sectors.
- 2. The second line risk management team has appropriate relevant experience and delivers appropriate training to first line management with responsibility for risk
- 3. First line management communicate the Council's approach to risk to relevant staff
- 4. Operational risk meetings and committees occur on a regular basis with actions identified and progressed appropriately.
- 5. The CLT risk committee sets an appropriate tone for the management of risk with actions identified to improve the control environment
- 6. Risk registers at the Heads of Service, Directorate and CLT are appropriately completed with relevant controls identified to manage the risk. This will include consideration of risks identified from other means such as internal audit.
- 7. An appropriate risk appetite/tolerance has been defined and this is communicated to relevant staff and applied where appropriate.
- 8. There is an appropriate approach to escalate risks across the Council and report to relevant groups
- 9. Appropriate horizon scanning is undertaken to identify emerging risks from out with the Council (e.g. Cyber, third party risks etc.)

## Improvement actions by type and priority




Five improvement actions (two amber and three yellow) have been identified from this review, all of which relate to the operation of controls themselves. This is the equivalent of two high (red) and three medium (amber) findings under the application of the Council's internal audit methodology. See Appendix A for definitions of colour coding.

# Key findings

### Good practice

We have gained assurance that the City of Edinburgh Council's procedures reflect good practice in a number of areas:

- The content of training is well developed and covers key areas in relation to risk management.
- Regular risk meetings have been established to help facilitate the appropriate escalation of risks.

### Areas for improvement

We have identified a number of areas for improvement which, if addressed, would strengthen the City of Edinburgh Council's control framework. The highest risk areas are:

- To develop and implement clear risk management operational processes for use by first line teams that align to training provided to first line staff and ensure that relevant staff attend the training.
- Ensure that risk registers have been completed across all directorates.

These are further discussed in the Management Action Plan below.

# Acknowledgements

We would like to thank all staff consulted during this review for their assistance and co-operation.

# Management Action Plan

## Control Objective 1: The Council has a satisfactory risk management framework (risk policy and risk appetite statement) and this is aligned with CIPFA's guidance on risk management and good practice across the public and other sectors.


### 1.1 Risk Management Framework and 1st Line of Defence training

We acknowledge that the Council has a risk management framework that is communicated to 1st line staff via training workshops given by the principal risk manager and through other training sessions. The main documentation of this process is included in training materials, this includes:

- Risk management policy
- Risk appetite in narrative form.

However, we have confirmed that not all relevant 1st line of defence staff have attended training in risk management processes to develop their understanding of the process and their role in managing risk effectively. We recognise that this was identified as an action in the proposed update to the Risk Management Model report prepared in November 2019. The content of this report was discussed and agreed with members of CLT and the approach was approved by the Executive Director of Resources,

Within the Risk Management Model report it is identified that the 2nd line of defence will have the role of *"supporting the leadership team / board with their identification and assessment of the upside and downside risks associate with both strategic and operational decisions."* This role is undertaken through quarterly risk CLT meetings which the Head of Legal and Risk and Chief Internal Auditor routinely attend. However, the Head of Legal and Risk and Chief Internal Auditor do not routinely attend other CLT meetings to undertake the key independent challenge function when key risks in relation to both operational and strategic decisions of the Council may be discussed. To enable the Head of Legal and Risk to contribute he is provided with CLT papers in advance to provide comment where necessary, and he is invited to attend and contribute to specific items of business, as appropriate. Based on our work at a range of other public bodies the lead risk officer would typically be included within those discussions, the council discharge this role via the Executive Director of Resources. It is recognised that this challenge function in normal CLT meetings is currently provided by the CLT collectively, however this is less independent than if either The Head of Legal and Risk or Chief Internal Auditor were present to undertake this role as neither would typically be a risk owner.

**Risk**

With not all relevant 1st line of defence staff having attended training, there is a risk that there is lack of clear understanding of the requirements of the risk management framework.

With no independent challenge provided to the CLT in relation to key operational and strategic decisions, there is a risk that the risks associated with these decisions are not fully identified and considered prior to decisions being made.

### Recommendation

A summary of the key elements of the framework included within relevant training materials should be formalised to provide a single central approach that is available to all 1st line of defence risk managers. This should include further development of the risk appetite statement as noted within recommendation 7.1. It should be identified which staff require to be trained and a record of attendance maintained, with non-attendance by staff raised to the relevant Head of Service as appropriate.

The approach for 2nd line to carry out its role in supporting the leadership team should be formally agreed to enable a clear understanding of the support to be provided to CLT, including reporting lines.

### Management Action:

Grade 3 (Operation)

It is acknowledged that the Council has an established risk management framework, and that further operational guidance will assist in ensuring that the framework operates effectively in practice.

A paper will be prepared and presented to the Corporate Leadership Team that details how the operational risk management framework will be refreshed and will operate in practice. This will include further details on the roles and responsibilities of the second and first line risk management teams, and first line service delivery managers for the identification; assessment; recording; and ongoing management of both strategic and operational risks, and proposed timeframes for implementation of these changes. (September 2020)

Following approval by the Corporate Leadership Team, the paper will be provided to the Council's Governance, Risk and Best Value Committee for review and scrutiny. (December 2020)

The operational aspects of the risk management framework will be shared across Council divisions and directorates and also incorporated into current training activities and materials (March 2021).

Directorates and divisions will be requested to identify all first line employees who should attend risk management training, with refreshed training delivered and training attendance recorded. Where there has been no attendance, this will be escalated to heads of divisions and directors (February 2021)

The Head of Legal and Risk or the Chief Internal Auditor will be invited to attend relevant Corporate Leadership Team and Change Board meetings, as appropriate, to support the recording and consideration of significant risks associated with both operational and strategic decisions. (October 2020)

**Action owner:** Chief Executive, Executive Directors and Head of Legal and Risk

**Due date:** 31 March 2021

# Control Objective 2: The second line risk management team has appropriate experience and delivers appropriate training to first line management with responsibility for risk

Green

## No reportable weaknesses identified

We have reviewed the content of training material and have noted that it covers key areas in relation to the risk management processes. The principal risk manager has appropriate relevant experience to undertake her role and utilises a range of appropriate networks to enable her knowledge to remain up to date.

Training is delivered by the principal risk manager and operations manager including sessions at relevant risk training meetings on topics including risk awareness and emerging risks, as well as how to score the risk in a heat map. As noted in recommendation 1.1, there is a need to ensure that training is undertaken by all relevant staff.

# Control Objective 3: First line management communicate the approach to risk to relevant staff

**Yellow**

## 3.1 Communication of Risks to staff

We have noted that regular risk meetings are diarised across departments in the form of risk management group meetings and quarterly Directorate Risk Committees. . This is deemed to be a suitable forum for discussion of risk. However, the process to cascade key risk matters identified to first line staff is not defined. Each head of department is free to decide how key information will be shared. Whilst we acknowledge that there is some benefit to maintaining a degree of flexibility, it would be beneficial to define key information that should be shared.

### Risk

Front line staff are not clear of the risks relevant to them and as a result do not respond appropriately to current risks.

### Recommendation

A clear protocol of what should be communicated to whom and by whom following risk management group meetings should be established. This should include:

- Who should be communicated with;
- What level of risk should be highlighted; and
- Any actions that are required to be taken by front line staff in relation to the risk.

**Management Action**:

Grade 2 (Operation)

An agenda item will be included in risk management group meetings to agree which new and emerging significant risks should be communicated across divisions and directorates and by which attendees, and which risks will be escalated for consideration at/to divisional and directorate risk committees.

A quarterly risk matters newsletter sharing the outcomes of ongoing horizon scanning will also be created and published by the corporate risk management team.

**Action owner:** Head of Legal and Risk **Due date:** 31 December 2020

# Control Objective 4: Operational risk meetings and committees occur on a regular basis with actions identified and progressed appropriately.

Green

## No reportable weaknesses identified

We reviewed a sample of the quarterly meetings risk management group meetings planned for January 2020 and confirmed that these occurred as planned for Communities and Families and Resources. The meeting of Place was incorporated in their SMT meeting. We noted that group risk management meetings for Communities and Families and Resources were held after the quarterly Risk Committee meetings which reduced the ability to escalate matters. However, this was confirmed as an isolated occasion with scheduling normally structured to facilitate the escalation of risk up to committees and across departments.

We noted that both Health and Safety and Internal Audit teams are present at the committee meetings to provide their input on matters related to risk.

# Control Objective 5: The CLT risk committee sets an appropriate tone for the management of risk with actions identified to improve the control environment

Yellow

## No further reportable weaknesses identified. Area for improvement noted at recommendation 7.1

The CLT committee and the GRBV committee both set an appropriate tone for risk management and the continual review of risks to the Council and the importance of risk management.

The Council has developed a risk appetite statement, although this is a description of the appetite rather than being translated into a mechanism that allows this to be freely applied in practice. This is a noted area for improvement within recommendation 7.1.

# Control Objective 6: Risk registers at the Heads of Service, Directorate and CLT are appropriately completed with relevant controls identified to manage the risk. This will include consideration of risks identified from other means such as internal audit.

Amber

## 6.1 Completion of Risk registers within Directorates

We identified during the course of the review that not all risk registers were completed by Heads of Service across a range of Directorates. We found that, based on our sample review, all registers were completed in the Resources Directorate, but there were instances of registers being unavailable or in draft within all other Directorates.

We noted that specific resource had been allocated within Resources to undertake and update the risk management processes whilst this was not the case in other Directorates of the Council.

### Risk

Insufficient recording of risks and accompanying controlling actions at an operational level may compromise the ability of service teams to effectively escalate risks within Directorates and to CLT.

### Recommendation

Management should review the approach to the allocation of resources to risk management. Specific responsibility should be allocated within first line teams, and completion of risk registers should be subject to regular monitoring by second line teams on a periodic basis.

### Management Action

Grade 3 (Operation)

The Council's Directors will ensure that directorate and the Corporate Leadership Team risk registers are updated on an ongoing basis to reflect all relevant and new and emerging risks escalated from divisions and directorates and more widely across the Council, and in line with refreshed operational risk management processes, with the most recent versions used as the basis for discussion at both directorate and CLT risk and assurance committees. (June 21)

Risk management will undertake ongoing assurance activities on a sample basis to confirm that divisional and directorate risk registers are being maintained, with an appropriate flow of risks from divisions into directorates. Any gaps identified will be raised at risk committees with follow up performed to ensure that they have been addressed by first line teams. (Oct 21)

**Action owner:** All Directors and Head of Legal and Risk **Due date:** Dec 2021

# Control Objective 7: An appropriate risk appetite/tolerance has been defined and this is communicated to relevant staff and applied where appropriate.

Yellow

## 7.1 Unclear articulation of risk appetite

The risk appetite statement in the Council is defined as:

- Service delivery: tolerate a low level of occasional isolated damage to its reputation in this regard
- Infrastructure: open to taking risks
- Compliance: averse to taking risks in this area
- Financial: cautious approach to financial risk and may be prepared to accept risk subject to a set balanced overall revenue budget every year and in accordance with the Council's reserves policy

This format is subjective and does not provide sufficient clarity for staff to apply this during their approach to actively managing risks. However, it is acknowledged that for an organisation of the complexity and size of a local authority, having detailed risk appetite at a granular level is not an easy matter to implement.

### Risk

Staff do not sufficiently understand whether risks have been appropriately managed resulting in either insufficient controls being implemented, or excessive controls being developed that are not commensurate with the appetite to risk in this area.

### Recommendation

The risk appetite statements should be further developed to enable risk managers to better understand whether appropriate mitigating actions have been implemented. This may include implementing an approach that has been proposed by the Head of Legal and Risk which provides a more direct link to the scores allocated to individual risks such as using a target risk as a proxy for risk appetite. In the absence of consistent best practice across the public sector, this novel approach recognises the practical impact of assessing risk appetite for every risk across a very complex and large organisation delivering multiple services.

**Management Action**

Grade 2 (Operation)

The new risk management operational processes will include guidance on how to determine (where relevant) and score an assessment of target risk that will be used as a proxy for risk appetite. (March 2021)

This guidance will be included in refreshed training materials and the second line sample based risk management assurance activities will also assess how effectively this is being applied on an ongoing basis by first line divisions and directorates with feedback on areas for improvement (where required) provided. (Dec 2021)

Directors and heads of Divisions will ensure that target risk is consistently identified, considered and assessed as part of ongoing first line risk management responsibilities. (June 2021)

**Action owner:** All Directors and Head of Legal and Risk **Due date:** June 2021

# Control Objective 8: There is an appropriate approach to escalate risks across the Council and report to relevant groups.

Green

## No reportable weaknesses identified

There is a formal structure to escalate risks upwards and across directorates via attendance of directors, heads of department, and the principal risk manager at relevant meetings where risk is considered. This process may benefit from being formally defined in the risk framework noted in recommendation 1.1

# Control Objective 9: Appropriate horizon scanning is undertaken to identify emerging risks from out with the Council (e.g. Cyber, third party risks etc.)

Yellow

## 9.1 Identification of Health and Social Care risks

Generally, we have noted that there are reasonable processes to identify emerging risks by the Principal Risk Manager from areas outwith the Council.

However, it is clear that the approach to escalating details of operational adult social care risks that remain the statutory responsibility of the Council between the Health and Social Care Partnership and the Council has not been formally developed. The current method of escalation is primarily to use the Chief Officers' role on CLT to be able to escalate emerging risks on as required at the Corporate Leadership Team Risk and Assurance Committee.

### Risk

Operational adult social care risks may not be understood from a Council perspective and insufficient action may be taken by the Council to address emerging risks.

### Recommendation

A formal protocol for escalating relevant operational adult social care risks with the Council should be established with the Health and Social Care Partnership. Consideration should be given as to whether there are other organisations where a similar approach should be implemented.

### Management Action

Grade 2 (Operation)

The Chief Officer of the HSCP will be requested to attend all CLT risk Committees or send an appropriate delegate to ensure that all significant HSCP risks are discussed and included in the CLT risk register (where relevant) – October 2020.

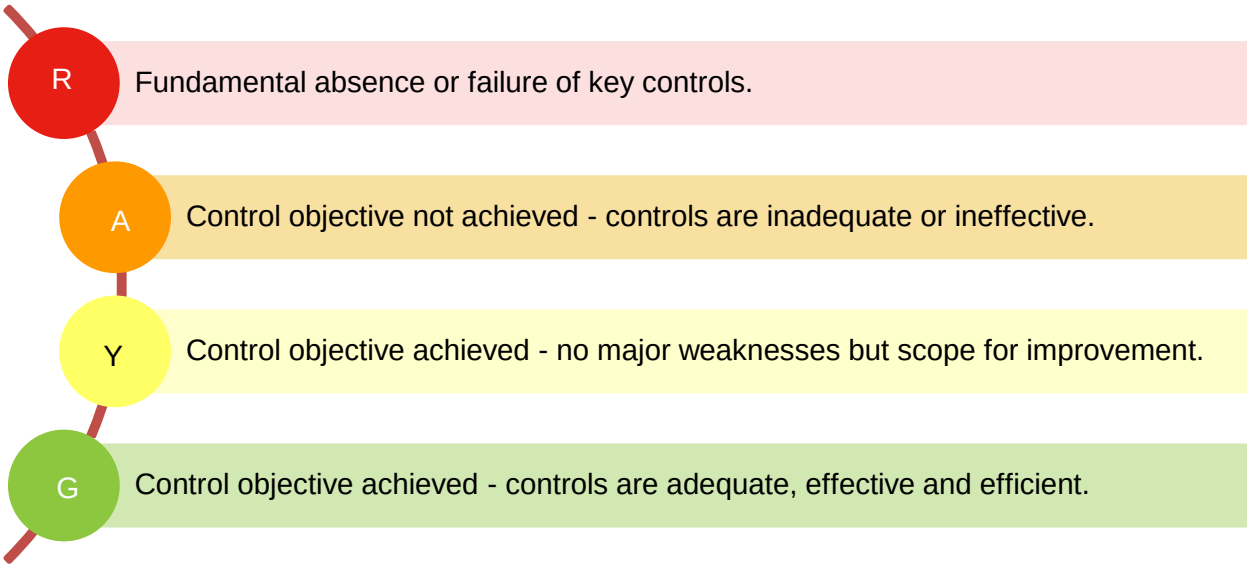
The Council's corporate risk team will also be invited to attend Health and Social Care Partnership Risk Committees to confirm that all relevant adult social care risks are being identified; assessed; recorded; managed and escalated (where appropriate) for discussion at the Corporate Leadership Team risk and assurance committee with relevant risks recorded in the Council's corporate risk register. (December 2020)

The Health and Social Care Partnership will be included in the scope of ongoing sample based assurance activities to be performed by corporate risk management (refer 6.1 above) to confirm that all relevant adult social care risks are being considered, assessed, and recorded in relevant risk registers. This process will also confirm that all relevant arm's length external organisation (ALEO) risks have been considered and included in directorate risk registers (where appropriate. (June 2021).

**Action owner:** All Directors and Head of Legal and Risk **Due date:** June 2021

# Appendix A – Definitions

## Control assessments




## Management action grades

| | |
|---|---|
| 4 | •Very high risk exposure - major concerns requiring immediate senior attention that create fundamental risks within the organisation. Equivalent to Critical rating |
| 3 | •High risk exposure - absence / failure of key controls that create significant risks within the organisation. Equivalent to High rating |
| 2 | •Moderate risk exposure - controls are not working effectively and efficiently and may create moderate risks within the organisation. Equivalent to Medium rating |
| 1 | •Limited risk exposure - controls are working effectively, but could be strengthened to prevent the creation of minor risks or address general house-keeping issues. Equivalent to low rating |

# *The City of Edinburgh Council*

## Internal Audit

## Model and Intelligent Automation Risk

Final Report

24th June 2020

RES1908

**Overall report rating:**

| | |
|---|---|
| **Some improvement required** | Whilst some control weaknesses were identified, in the design and / or effectiveness of the control environment and / or governance and risk management frameworks, they provide reasonable assurance that risks are being managed, and the Council's objectives should be achieved. |

# Contents



This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2019/20 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2019. The review is designed to help the City of Edinburgh Council assess and refine its internal control environment. It is not designed or intended to be suitable for any other purpose and should not be relied upon for any other purpose. The City of Edinburgh Council accepts no responsibility for any such reliance and disclaims all liability in relation thereto.

The internal audit work and reporting has been performed in line with the requirements of the Public Sector Internal Audit Standards (PSIAS) and as a result is not designed or intended to comply with any other auditing standards.

Although there is a number of specific recommendations included in this report to strengthen internal control, it is management's responsibility to design, implement and maintain an effective control framework, and for the prevention and detection of irregularities and fraud. This is an essential part of the efficient management of the City of Edinburgh Council. Communication of the issues and weaknesses arising from this audit does not absolve management of this responsibility. High and Critical risk findings will be raised with senior management and elected members as appropriate.

# 1. Background and Scope

## Background

This review was undertaken as part of the 2019/20 internal audit plan approved by the Governance, Risk & Best Value Committee in March 2019.

**Financial Models and Model Risk**

A model is defined as a tool (typically built in MS Excel) that makes quantitative estimates or predictions based on a set of underlying inputs and assumptions using a set of formulae and is generally used to determine either a specific outcome or range of outcomes based on a number of different potential scenarios (this is often described as 'what if' analysis). Models are useful as they help decision makers understand how variations in assumptions will impact outcomes.

Models are typically financial and can be used to (for example) predict future organisational sustainability; cash flows; funding requirements; and liquidity.

Model risk is defined as the potential risk of loss resulting from using inaccurate models to make significant operational or strategic decisions.

The Finance division within the Council has developed and uses a number of models to support ongoing financial analysis and decision making, for example use of models to forecast and monitor the Council's monies and debt portfolio by Treasury; financial analysis and options appraisals supporting significant Council capital and major projects; and to support ongoing budget monitoring.

Finance defines a model as a tool "that makes quantitative estimates or predictions based on a set of underlying inputs and assumptions using a set of formulae and is generally used to determine either a specific outcome or range of outcomes based on a number of different potential scenarios (this is often described as 'what if' analysis)

Finance issued a questionnaire to all finance teams, asking them to provide the details of any models used in their area. This was then used to create an inventory of all models used by Finance, in November 2019, to support completion of the audit.

Some financial models are developed in conjunction with external third parties. For example, the Council has worked in partnership with the Scottish Futures Trust to develop the Edinburgh Living and Street Lighting project financial models.

Finance management has advised that the FAST standard (a set of rules providing guidance on the structure and design of efficient spreadsheets) , whilst not mandated, is used in some areas of Finance to ensure that spreadsheet models are built in a consistent manner and are Flexible; Appropriate; Structured; and Transparent (FAST).

The FAST Standard notes that it 'is primarily concerned with good spreadsheet design. While its remit does not extend to the management and control environment in which spreadsheets are used (such as back-up, version control and testing)' and encourages modellers using the Standard to consider these important aspects of the business environment when building and deploying their models. Additionally, the FAST standard does not include any guidance in relation to initial and ongoing model integrity and security.

A number of tools are also available to validate the accuracy of models, for example, the Operis Analysis Kit (OAK) tool is used by the Capital and Major Projects team within Finance to validate the accuracy of the models that they have developed.

**Intelligent Automation**

Intelligent automation (IA) is a more advanced form of what is commonly known as robotic process automation (RPA) that can be applied to automate and improve the efficiency of any large scale activities or groups of repetitive tasks that draw on information from, or feed information to multiple systems (for example web based applications through to back end systems).

The Council commenced an IA initiative with Ernst and Young (EY) in 2017 that involved the Council's IA team working in partnership with EY to identify, develop and implement IA solutions following completion of an initial scoping exercise. This involved using the Blue Prism Robotic Process Automation (RPA) software package to create transactional pathways based on established business logic that direct virtual workers to perform processes that involve transactions, logic, and rules. The contract with EY has now concluded, and the Council's established IA team will continue to develop, apply, and manage IA solutions across existing Council processes.

It is important to note that IA solutions are applied only to processes that involve transactions, logic, and rules with no requirement to perform analysis or exercise judgement. At any point where either analysis or a decision is required, the IA process is paused and redirected to a Council employee for appropriate action.

Currently, five virtual workers are available for use and are supporting completion of circa 13K transactions monthly across the Council.

Management has advised that the key controls applied to the development and implementation of IA processes include:

- use of the Blue Prism application which is a standard, of-the-shelf software package that includes secure code that cannot be modified
- strict separation between established development, test, and production environments, with user acceptance testing completed, signed off by the process owner, with a further sign off requested prior to transfer into production. The Integration Advisory Board (IAB) is advised that change has been authorised and will be implemented prior to live deployment of new IA process
- inclusion of automatic exception identifications in each IA script to ensure that virtual worker processes are stopped where pre-defined exceptions are identified, and the exception recorded and not processed, enabling the virtual worker to move on to the next case.
- ongoing monitoring and oversight of IA virtual worker processes via an established system based control room to identify any issues that impact upon completion of the processes and enable their resolution. This provides a real time view of process completion; a process audit log and automatic error messages.

## Scope

The aim of the review was to assess the design adequacy and operating effectiveness of the key controls established to protect the integrity of assumptions; calculations; and formulae included in financial models designed to support management decision making; and the integrity and security of process automation designed and maintained to support ongoing use of intelligent automation.

## Approach

A questionnaire was sent to a sample of eight Finance model owners, asking them to complete a self-assessment detailing the operational controls built into their models and supporting model oversight arrangements for the following models:

- **capital monitoring** – monitors actual capital spend in comparison to budget across directorates and forms the basis of the capital monitoring report provided to the Finance and Resources committee.
- **local development plan** – used to calculate the projected funding gap (between local development plan infrastructure costs and expected planning development contributions) to deliver assets required to support economic growth. Model outcomes are used to inform the local development plan board, and the capital budget process.
- **Private sector leasing contract renewal** – modelling of potential costs when private sector leasing contracts are renewed.
- **non-staff monitoring** – forecasting tool used to inform monitoring and financial reporting of non-employee related costs including forecast of expenditure on temporary accommodation to support homelessness services.
- **resource allocation model –** records and reallocates revenue income and expenditure across services to support budget development and financial reporting.
- **purchasing tool for spot purchased services –** records and monitors spend on spot contracts across Health and Social Care.
- **Housing Revenue Account business plan** - informs the HRA budget setting process providing a 30 year view of future operations, investment and new initiatives
- **budget monitoring** - financial forecasting tool used to inform Resources Directorate (excluding Property and Facilities Management) monitoring and financial reporting

Testing was then performed for the period 1 April to 30 September 2019 across the eight models noted above to validate the survey responses received from the model owners.

The review also sought to provide assurance that the risks associated with unprotected formulae (in models) or code (in intelligent automation processes) that could potentially be changed, resulting in either inaccurate decision-making or process errors are effectively managed.

Our areas of audit focus as detailed in our terms of reference are included at Appendix 2.

### Limitations of Scope

The scope of our review was limited to:

- models developed and used by Finance. Models used within other directorates and divisions were specifically excluded from scope.
- assessment of the design of key controls established to ensure the integrity of models. Completeness and ac
- accuracy of data input to models were specifically excluded from the scope of our review

Models developed and used to support ongoing financial management of the Tram and Enterprise Resource Planning (ERP) projects, were also specifically excluded from the scope of this review, as these are subject to review within the scope of ongoing Trams to Newhaven and Enterprise Resource Planning project reviews.

### Reporting Date

Our audit work concluded on 31 March 2020, and our findings and opinion are based on the conclusion of our work as at that date.

# 2. Executive summary

## Total number of findings: 2

| Summary of findings raised | |
|---|---|
| High | 1. Development and management oversight of financial models |
| Low | 2. Management oversight of virtual processes |

## Opinion

**Financial models** – review of non-project related models across the Finance division confirmed that whilst some significant control weaknesses were identified in the design and operating effectiveness of the key controls, governance and risk management frameworks established to protect the integrity of model assumptions; calculations; and formulae, they provide reasonable assurance that risks are being managed, and the Council's objectives to design and use financial modes to support management decision making should be achieved.

It is also important to note that the controls and governance processes established by the Capital and Major Projects team within Finance to support development and ongoing use of project financial models are generally more effective in comparison to other models used across the Finance division. This conclusion is supported by Internal Audits ongoing work on the Trams to Newhaven and Enterprise Resource Planning financial models.

Our High rated finding reflects the need to improve the processes supporting the development, maintenance, and ongoing management oversight of models used by Finance to support decision making, reflecting the need to perform risk assessments of models prior to their development; implement appropriate controls to maintain the integrity of models, and the requirement to maintain an inventory of models that confirms that models have been subject to ongoing independent reviews to confirm their integrity.

**Finance management response**

Finance has established specialist financial modelling resources within the Capital and Major Projects team recognising the significance, complexity and risk associated with some financial models. Independent review and audit of models is also used for significant and complex models. Outwith the Capital and Major Projects team, mid-range complexity financial models are undertaken by professional staff with oversight by Finance management. Outputs from financial models are considered alongside a range of factors and considerations in relevant business cases and decision-making processes. Outputs from financial models are subject to review and refinement on an ongoing basis through business case development and budget / project monitoring arrangements.

**Intelligent automation** - whilst some minor control weaknesses were identified in the design of the key controls established to support ongoing use of intelligent automation, they provide assurance that risks are being managed, and the Council's objectives to improve process efficiency and accuracy through ongoing use of intelligent automation should be achieved.

Consequently, 1 High and 1 Low rated findings have been raised.

Our Low rated finding highlights the importance of documenting management's oversight of virtual processes, including details of solutions implemented to address any issues identified; ongoing review of consolidated error and audit logs to identify, address and prevent recurrence of any systemic themes; and

the need to confirm that automated alerts highlighting any issues with virtual processes cannot be manually disabled.

Further information is included at Section 3 below.

# 3. Detailed findings

| 1. Development, maintenance, and management oversight of financial models | High |
|---|---|

Review of the development, maintenance and ongoing management oversight of financial models used within Finance established that:

1. **Model risk assessments** – Inventory of the models prepared by the Finance did not include an assessment (for example, red, amber, green) of the risks associated with each model (for example, the potential impacts in the event that the model became corrupted and could not be restored). A 'Risk Assessment' field included in the inventory contained narrative risk commentary based on self-assessment performed by model owners.

   Senior management confirmed that there is currently no established model risk assessment process that considers risk across the full population of models.

2. **Model controls** – management has confirmed that there are currently no defined control requirements that should be consistently applied when developing and using models.

   Self-Assessment and subsequent Internal Audit Validation of the randomly selected sample of eight models identified that the majority of the models tested did not utilise the controls outlined in the Terms of Reference (please ref. Appendix 2 for details of the control objectives tested against)

   In addition, comparison of Internal Audit Validation outcomes with responses on the operational controls and oversight arrangements supporting the models provided by model owners, highlighted a number of areas where initial responses provided were not fully accurate or could not be validated due to lack of evidence.

   Details of the Self-Assessment, IA Validation and comparison between initial responses and subsequent testing outcomes are included in Appendix 3.

3. **Model inventory** - review of the Finance model inventory confirmed that it:

   - was a draft document that included a number of empty fields
   - included tools and spreadsheets that should not have been classified as a model as their outputs were not used to make quantitative estimates or predictions but instead were used for monitoring and reporting purposes.

   Details of the review of the Finance model inventory are also included in Appendix 3.

**Risks**

The potential risks associated with our findings are:

- Senior management currently has no holistic view of the full population of models used by Finance and associated model risks.
- Errors in models may not be detected, resulting in inaccurate estimates and predictions being used for decision making.

**1.1 Recommendation: Model risk assessments**

1. Management should define a method to assess the significance of each model (for example red, amber, green; or high, medium, low) based on an assessment of model purpose; complexity; and risk.
2. Risk assessment criteria should be discussed and approved at the Finance leadership team meeting and the risk assessment criteria documented and communicated to all model owners.
3. A risk assessment should be performed for all existing models used across Finance and applied consistently to all new models and reperformed where significant changes have been made to existing models.

**1.1 Agreed Management Action: Model risks assessments**

Management considers that risk assessment of models will be delivered more effectively as part of the response to 1.3.

| **Owner: N/A**<br><br>**Contributors: N/A** | **Implementation Date:**<br>N/A |
|---|---|

**1.2 Recommendation: Model operational controls**

1. Management should design and implement a proportionate risk based operational control framework to be applied to all Finance models that is aligned with model risk assessments. The control framework should include (but not be limited to):

- standard set of controls to be applied across all models (for example password and cell protection requirements) regardless of model risk assessment outcomes;
- the requirement to test significant models to confirm their accuracy and adequacy of operational controls prior to implementation;
- the requirement to ensure that all significant and complex models are supported by documentation that details how the model has been built and how it should be used, including details of any relevant model assumptions and operational controls;
- the requirement to test any changes made to models prior to use; and
- the requirement to update model documentation to reflect any changes made, using appropriate version controls.

2. Management should perform regular risk based ongoing reviews of models to confirm that model operational controls continue to be consistently and effectively applied.

**1.2 Agreed Management Action: Model operational controls**

Management will develop and implement a proportionate risk-based control framework and apply it to Finance models, as appropriate. This framework will be proportionate to the risks involved and will be developed in accordance with good modelling practice. It is worth highlighting that some of the controls above will not be appropriate to most models and could even reintroduce risk as they could hinder management and peer review. The control framework will be communicated to staff within Finance.

Following the development, approval and implementation of this framework, a risk-based review will be carried out on a half-yearly basis.

| **Owner:** Stephen Moir, Executive Director of Resources<br>**Contributors:** Hugh Dunn, Head of Finance; Alison Henry, Corporate Finance Senior Manager; Rebecca Andrew, Principal Accountant; John | **Implementation Date:**<br>1st June 2022 |
|---|---|

| | |
|---|---|
| Connarty, Business Partnering Senior Manager; Layla Smith, Operations Manager, Resources. | |

**1.3 Recommendation: Model Inventory**

The recently established finance model inventory should be updated to include the following additional information:

- the full population of Finance models that is based on the definition of models that has been adopted by Finance;
- the purpose of each model;
- the outcomes of the classification of the significance of each model, with supporting rationale;
- the last review date of each model;
- details of the current version of the model being used; and
- the model location on shared network drives.

**1.3 Agreed Management Action: Model Inventory**

This will be implemented as above with an additional column for risk assessment. Each team within Finance will be responsible for keeping their list up to date and it will be reviewed by management on a 6 monthly basis to ensure consistency.

| | |
|---|---|
| **Owner:** Stephen Moir, Executive Director of Resources<br>**Contributors:** Hugh Dunn, Head of Finance; Alison Henry, Corporate Finance Senior Manager; Rebecca Andrew, Principal Accountant; John Connarty, Business Partnering Senior Manager; Layla Smith, Operations Manager, Resources. | **Implementation Date:**<br>18th December 2021 |

**2. Management oversight of virtual processes** — **Low**

Review of management's ongoing monitoring and oversight of completion of IA virtual worker processes via the Blue Prism system control room confirmed that:

1. whilst oversight is performed using system generated error logs and audit reports, actions taken by management to address issues and errors identified are not currently documented.
2. There is currently no review of consolidated themes and trends that have impacted completion of virtual processes across a specified time period.
3. whilst automated alerts that highlight issues impacting completion of processes is a default system feature that is currently used, management was unable to confirm through reference to system software manuals and technical specifications whether this control could potentially be manually disabled.

**Risk**

The potential risks associated with our findings are:

- management cannot demonstrate that issues with virtual processes have been identified and resolved.
- systemic themes and errors impacting completion of virtual processes are not identified and resolved in a timely manner.
- continuous improvement opportunities are not identified and implemented.

- automated alerts could be be switched of, either inadvertently or in purpose, resulting in the inability to respond to process completion issues in a timely manner.

**2.1 Recommendation: Management oversight of virtual processes**

1. evidence of management oversight should be recorded and retained. This could involve simply annotating error logs and audit reports to confirm that they have been reviewed by management, together with details of actions taken to address any issues identified.
2. A consolidated report across a specified period of time (for example, weekly, monthly or quarterly) to identify and recurring systemic themes and trends and identify appropriate preventative solutions to ensure that these do not recur. Evidence of this review and details of actions taken should also be retained.

**2.1 Agreed Management Action: Management oversight of virtual processes**

Whilst oversight of the automated processes exists, Intelligent Automation management agrees with the audit's findings that more robust documented management oversight of the process control room is required. In order to address this the Intelligent Automation programme will take the following actions.

1. A Control Room Tracker will be created and updated daily by the process controllers. All process running that day will be logged, and outcomes detailed. This will be reviewed and signed off by management on a weekly basis. The specific revision history, currently contained in the deployment checklist documentation, for any processes that have experienced an issue will be updated **if** a logic change to the Blue Prism process has been required and a new release has been implemented.
2. An automated process Transaction Report will be run monthly and reviewed by management. This will be cross referenced with the Control Room tracker to identify any trends and/or emerging repeated issues. Where trends or issues are identified, these will be analysed and if necessary, added to the Enhancement Log for action. All changes to Blue Prism process logic will be added to the revision history for the specific process.

| | |
|---|---|
| **Owner:** Stephen Moir, Executive Director of Resources<br><br>**Contributors:** Nicola Harvey, Head of Customer and Digital Services; John Arthur, Senior Manager - Business Support; Gus Niven, Intelligent Automation Manager; Sarah Knowles, Senior Intelligent Automation Officer; Layla Smith, Operations Manager, Resources. | **Implementation Date:**<br>1st April 2021 |

**2.2 Recommendation: Automated alert functionality**

1. Management should confirm with the Blue Prism system supplier whether it is possible to manually disable the automatic system alerts control.
2. Where alerts can be disabled, management should obtain details of how to reinstate the control.
3. Where alerts can be disabled, guidance should be prepared and shared with the team confirming that care should be taken to ensure alerts are not disabled and confirming the reinstatement process.

**2.2 Agreed Management Action: Automated alert functionality**

The Blue Prism software displays automated alerts in the process Control Room on the running status of the individual processes. This is standard functionality. Additionally, all CEC automated processes have an automated email alert built into the Blue Prism template. However, Intelligent Automation management will agree to the following actions:

1. Contact Blue Prism to ascertain whether it is possible to manually disable the automatic alerts.
2. If it is possible to disable the automated alerts, then a full and detailed procedure of how to re-instate the automated alerts will be requested from Blue Prism including whether a lock can be implemented by Intelligent Automation management to prevent disablement.
3. Once the full and detailed procedure has been provided by Blue Prism then this will be added to the Intelligent Automation operations manual and a training session will be held with all development staff.
4. If it is possible to disable automatic alerts, Intelligent Automation will create and implement a process and communicate it to team members. The process will include:
   - a restriction stating that users should not disable the alerts;
   - a requirement for the Intelligent Automation team to periodically confirm that live process alerts have not been inadvertently disabled
   - a requirement for the Intelligent Automation team to ensure that any disabled alerts identified are promptly reinstated, and issue recorded.

| | |
|---|---|
| **Owner:** Stephen Moir, Executive Director of Resources<br><br>**Contributors:** Nicola Harvey, Head of Customer and Digital Services; John Arthur, Senior Manager - Business Support; Gus Niven, Intelligent Automation Manager; Sarah Knowles, Senior Intelligent Automation Officer; Layla Smith, Operations Manager, Resources. | **Implementation Date:**<br>1st April 2021 |

# Appendix 1: Basis of our classifications

| Finding rating | Assessment rationale |
|---|---|
| **Critical** | A finding that could have a:<br>• ***Critical*** impact on the operational performance; or<br>• ***Critical*** monetary or financial statement impact; or<br>• ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or***<br>• ***Critical*** impact on the reputation of the organisation which could threaten its future viability. |
| **High** | A finding that could have a:<br>• ***Significant*** impact on operational performance; or<br>• ***Significant*** monetary or financial statement impact; or<br>• ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or***<br>• ***Significant*** impact on the reputation of the organisation. |
| **Medium** | A finding that could have a:<br>• ***Moderate*** impact on operational performance; or<br>• ***Moderate*** monetary or financial statement impact; or<br>• ***Moderate*** breach in laws and regulations resulting in fines and consequences; or<br>• ***Moderate*** impact on the reputation of the organisation. |
| **Low** | A finding that could have a:<br>• ***Minor*** impact on operational performance; or<br>• ***Minor*** monetary or financial statement impact; or<br>• ***Minor*** breach in laws and regulations with limited consequences; or<br>• ***Minor*** impact on the reputation of the organisation. |
| **Advisory** | A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice. |

Please see the Internal Audit Charter for full details of opinion ratings and classifications.

# Appendix 2: Areas of audit focus

The areas of audit focus and related control objectives included in the review are:

| Audit Area | Control Objectives |
|---|---|
| Financial Models | 1. An inventory of all spreadsheet models used by Finance has been created and maintained<br>2. Models have been reviewed and allocated a risk rating based on their significance, complexity, and use.<br>3. Models are appropriately version controlled.<br>4. Independent review and testing of models is performed to confirm that they operate as designed prior to use.<br>5. Employees who will be developing or using the models are appropriately trained.<br>6. High risk models are subject to regular independent review to confirm their ongoing integrity.<br>7. The content of financial models is supported by the following key controls:<br>• cell protection to prevent changes to key formulae<br>• validation controls to confirm the ongoing accuracy of formulae<br>• clear row and column headings and titles<br>• use of data validation to ensure consistency of data<br>• documentation to support rebuild if required<br>• clear operating instructions for users<br>• password protection to ensure the model is accessed only by authorised employees<br>• storage on appropriately secured network drives<br>8. Model risk is recorded and assessed in the Finance risk register |
| Intelligent Automation | 1. An inventory of all existing processes where IA / virtual workers are used has been created and maintained.<br>2. Processes performed by virtual workers have been reviewed and allocated a risk rating based on their significance and complexity, and the potential for processing errors.<br>3. The IA development, testing and production environments are appropriately secured with access restricted to authorised team members.<br>4. Authorisation protocols have been established to support the transfer of IA processes between environments.<br>5. User acceptance testing (UAT) outcomes and IA processes are independently reviewed and approved by the IA team and business process owners prior to release into the production environment.<br>6. No testing is performed in the production environment. |

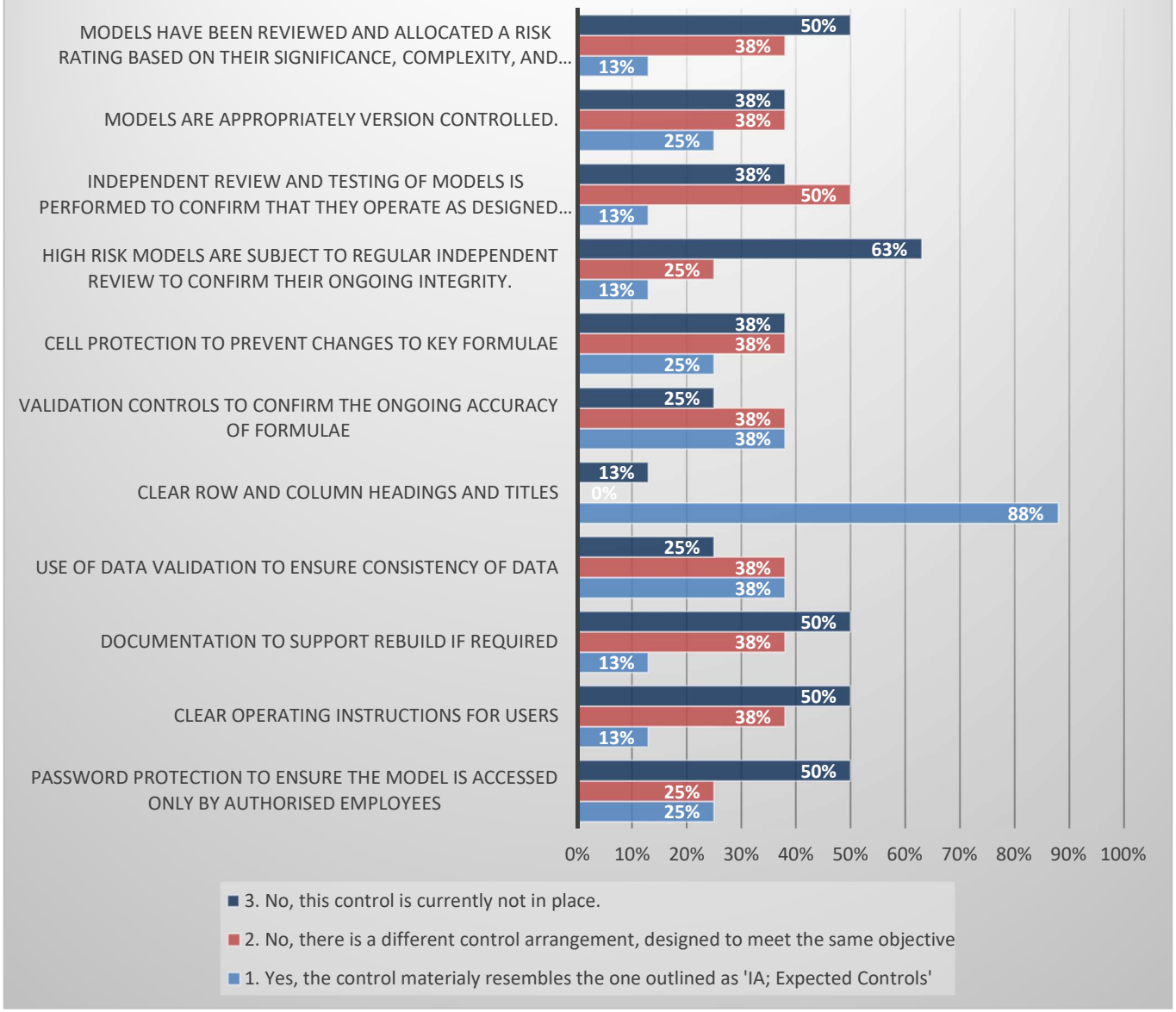
| | |
|---|---|
| | 7. IA scripts developed in Blue Prism are documented using process automation maps at an appropriate level of detail to enable transfer of ownership within the IA team, and support rebuild in the event that the IA process becomes corrupted.<br>8. The ability to modify existing IA scripts is restricted to authorised members of the IA team, and there is an effective process of ongoing monitoring and recording of the changes being made.<br>9. Council employees within the IA team have received a full handover from EY and are appropriately trained and skilled in the use of Blue Prism, and in ongoing monitoring of virtual workers via the control room.<br>10. Automated alerts have been established to identify issues impacting completion of the processes by virtual workers.<br>11. Performance of the Virtual Workers is consistently monitored to enable early identification of alerts highlighting issues and errors impacting completion of the processes. |

# Appendix 3: Summary of testing results

The outcomes of the survey performed in relation to eight models used across Finance (excluding the Capital and Major Project Team) in relation to the models that they use is detailed below in table 1.

Following this, Internal Audit performed testing on these eight models to validate the responses received from model owners and confirm the adequacy of the controls included to support their ongoing integrity. The outcomes of our testing are included in Table 2 below.

## Table 1: survey outcomes



# Table 2: Audit testing outcomes

The results of our audit testing are detailed below: :

- None of the eight models were subject to regular independent review to confirm their ongoing integrity with the outcomes of the review documented.
- For seven out of eight models, no documentation was available to confirm that the model has been reviewed and allocated a risk rating based on its significance,
- For seven out of eight models, no documentation was available to confirm that the independent review and testing was performed to confirm that it operates as designed prior to implementation.
- For six out of eight models, no documentation was available to support a rebuild in the event that the model was lost or damaged.
- Five out of eight models did not include cell protection, or a suitable alternative, to prevent changes to key formulae.
- For five out of eight models, clear operating instructions for users were not produced
- Four of the eight models were not supported by appropriate password protection, or a suitable alternative
- For three out of eight models, no version control arrangements were applied
- Three out of eight models do not include validation controls, or a suitable alternative, to confirm consistency of input and the ongoing accuracy of formulae.

# *The City of Edinburgh Council*

# Internal Audit

## PVG and Disclosures – Communities and Families

Final Report

29 July 2020

CF1904

**Overall report rating:**

| | |
|---|---|
| **Significant improvement required** | Significant and / or numerous control weaknesses were identified, in the design and / or effectiveness of the control environment and / or governance and risk management frameworks. Consequently, only limited assurance can be provided that risks are being managed and that the Council's objectives should be achieved. |

# Contents



This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2019/20 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2019. The review is designed to help the City of Edinburgh Council assess and refine its internal control environment. It is not designed or intended to be suitable for any other purpose and should not be relied upon for any other purpose. The City of Edinburgh Council accepts no responsibility for any such reliance and disclaims all liability in relation thereto.

The internal audit work and reporting has been performed in line with the requirements of the Public Sector Internal Audit Standards (PSIAS) and as a result is not designed or intended to comply with any other auditing standards.

Although there is a number of specific recommendations included in this report to strengthen internal control, it is management's responsibility to design, implement and maintain an effective control framework, and for the prevention and detection of irregularities and fraud. This is an essential part of the efficient management of the City of Edinburgh Council. Communication of the issues and weaknesses arising from this audit does not absolve management of this responsibility. High and Critical risk findings will be raised with senior management and elected members as appropriate.

# 1. Background and Scope

## Background

**Protection of Vulnerable Groups (PVG) Scheme**

The Protection of Vulnerable Groups (Scotland) Act 2007 (PVG Act) introduced a registration scheme (PVG Scheme) for individuals carrying out regulated work with children and protected adults. When someone applies to join the PVG Scheme, Disclosure Scotland carries out criminal record checks and shares the results with individuals and organisations.

**Regulated work**

Under the PVG Act, regulated work is defined by the activities performed as part of the role; the nature of establishments where the work is done; the position held; and the employees and people that the worker has a supervisory or management responsibility for.

Regulated work common within the Communities & Families Directorate, includes:

- caring for children and/or protected adults;
- teaching or supervising children and/or protected adults;
- providing personal services to children and/or protected adults; and
- working directly with children and/or protected adults.

Regulated work can also apply to other positions across the Council, even where the role does not involve any direct contact with children or protected adults, such as memberships of committees or sub-committees that are concerned with the provision of education, accommodation, social services, or health care services to children or protected adults.

It is a criminal offence for The City of Edinburgh Council (the Council) to offer regulated work to a barred person. The Police Act 1997 and the Criminal Records (Scotland) Regulations 2010 require the Scottish Local Authorities join the PVG Scheme and ensure that disclosure checks are performed on employees and volunteers, and records obtained prior to engaging them to do regulated work.

The Council has identified relevant posts that involve regulated activities and developed processes to ensure that prospective candidates are advised whether satisfactory PVG or Disclosure checks are required and required checks are completed prior to confirming appointment and their employment commencing.

In line with Disclosure Scotland's Code of Practice, the Council is also required to nominate a 'registered person' and 'lead signatory' responsible for ensuring any private information is handled properly and fairly. The lead signatory is the lead point of contact on all matters concerning registration between the Council and Disclosure Scotland. There are three lead signatories for the Council, one within Human Resources and two within the Communities and Families Directorate.

The Council is also required to maintain a list of authorised signatories who have been registered and assessed by Disclosure Scotland for the purpose of countersigning applications for checks.

**Disclosure checks**

The Council requires completion of Basic, Standard and Enhanced disclosure checks or PVG scheme membership to make sure that employees are suitable for certain types of work. Basic Disclosure checks are the lowest level of disclosure available and are used for posts where there is regular access to vulnerable service users, access to information about vulnerable service users, or where the role involves direct handling of cash. Disclosure Scotland does not monitor people with basic disclosure, so the certificate is only valid when it is created.

Standard and Enhanced Disclosures involve higher level checks. A Standard Disclosure is applied to roles such as solicitors or accountants, whilst Enhanced Disclosure would be applied to confirm whether applicants are suitable for adoption.

The Disclosure process involves Disclosure Scotland gathering criminal record and other relevant information about the applicant. Existing PVG Scheme members are continuously monitored by Disclosure Scotland to identify any new information that could affect the member's suitability for regulated work. Disclosure Scotland will decide if any of the information identified indicates that an individual is unsuitable to do regulated work and will then advise the employer.

**The Council's PVG and Disclosure framework**

PVG guidance for line managers has been developed by Human Resources and is available on the Orb (the Council's intranet). This includes a definition of regulated work and a 'Recruitment manager guide' that includes PVG checking requirements; interview questions for posts that require a PVG disclosure; and pre-employment screening and reference requirements.

Online e-learning training modules are also available via CECil, the Council's online learning portal and should be completed by recruiting managers prior to their involvement in the recruitment process.

The Recruitment managers guide advises that pre-screening for a post where a PVG is required takes around 6 weeks. A new employee must not be allowed to start work until the Scheme Record has been received from Disclosure Scotland and all other pre-employment checks have been completed.

**The Council's recruitment process**

Where a new post is created within the existing Council structure, the recruiting manager is required to assess whether it meets the definition of regulated work and confirm that a PVG or Disclosure is justified. Where a PVG or Disclosure Check is required, this is specified in the job advert or supporting documents. A PVG check should not be requested if the post is not included on the Council's list of PVG posts.

Recruiting managers are then required to ensure compliance with the Council's PVG framework by determining applicable posts, obtaining information on prospective employees, and assessing their suitability as part of the recruitment process.

Information on PVG and Disclosures is provided to applicants through the Candidate Portal, on the Council's website. Where an applicant is new to the Council but not a PVG member, they are required to complete a PVG Scheme application form. If they are already a Scheme member but need to add a Work Group to their current membership, they must complete an existing PVG member application form. Candidates are responsible for paying the relevant fee for new applications (apart from volunteers, whose fees are paid by the Council). The Council also pays for Scheme Record updates for existing PVG members. New PVG checks or a Scheme Record update may be required for an internal candidate applying for a post.

Recruiting managers are required to mail the completed PVG application, Criminal Convictions Self-Declaration form, and completed PVG cover sheet to HR's Onboarding team. Validated copies of original identification documents (a minimum of three forms of identity to confirm name, date of birth and address of the applicant – one of which should be photographic) are uploaded on the recruitment conversation within the askHR portal. Once checks are complete and appropriate certificates received, the Onboarding team log the outcome of checks within iTrent and notify the recruiting manager.

Where a PVG check is required, the new employee must not start in their role until all checks have been satisfactorily completed.

**PVG and Disclosure checks in schools**

In schools, Business Managers send the application form directly to Disclosure Scotland together with validated copies of original identification documents. The Business Manager receives the PVG certificate and is required to update the relevant sections within askHR. The Business Manager should also notify the Council's Onboarding team of the PVG outcome via the onboarding conversation on askHR.

Business Managers are also responsible for recruiting school volunteers in line with the Council's Guidance on safe recruitment of volunteers. Not all volunteers will undertake regulated work, therefore, the Business Manager is required to assess individual roles and circumstances in line with the Council's guidance. Volunteers for one-off school trips do not require a PVG; however, for all trips involving an overnight stay a PVG is required.

Due to the multi-functional nature of schools; for example, hosting after-school clubs and community activities, some employees, volunteers and facilitators may be subject to PVG checks if working inside schools outwith normal teaching hours. This includes Active Schools which coordinates sports activities in schools before and after school and at school lunchtimes.

In line with the Council's procurement process and contract terms and conditions, PVG checks are also required for any contractors/service providers carrying out regulated work. This includes those engaged directly by schools.

Council employees such as catering staff, cleaning staff and janitors may also require a PVG depending on whether they carry out regulated work within a school as part of their normal duties.

**PVG and Disclosure outcomes**

Where a PVG or Disclosure check reveals convictions or other matters in relation to new or existing employees or engaged individuals, the manager should complete a risk assessment to decide if they are suitable for the position with support from Human Resources.

Under the PVG Act, it is an offence for an individual to do, or to seek or to agree to do, any regulated work from which they are barred. It is also an offence for the Council to offer regulated work to an individual who is barred from that type of regulated work.

**Record keeping and secure processing of PVG and Disclosure information**

To ensure compliance with Data Protection legislation the Council has a Policy Statement on the Secure Processing of Disclosure Information, which recipients of Disclosure information must comply with. Disclosure information should only be used for the purpose for which it was requested and provided, and not shared with a third party unless the subject has given written consent.

Disclosure Scotland's Code of Practice states that PVG certificates should only be retained for as long as it is required for the purposes for which it was obtained. Disclosure information is not kept within a personnel file but within a lockable, non-portable storage unit. Access to storage units is strictly controlled and limited to named individuals who are required to see this information as part of their duties.

The Council should not keep Disclosures or Disclosure information for any longer than is required after a recruitment (or any other relevant) decision has been taken. The Council's policy statement advises this is no longer than 90 days. Following this all Disclosure information should be disposed of securely, with no image or photocopies of information retained.

The Council should, however, keep a record of the date of issue of the Disclosure, the name of the subject, the Disclosure type, the position for which the Disclosure was requested, the unique reference number of the Disclosure and details of the recruitment decision taken.

## Scope

The objective of this review was to assess the adequacy and effectiveness of the framework and processes established to ensure that all employees who perform regulated work with children within the Communities and Families Directorate of the Council comply with PVG and Disclosure requirements.

Our areas of audit focus as detailed in our terms of reference are included at Appendix 2.

Sample testing was performed at eight schools and considered data across the period 1 January 2019 to 31 December 2019.

### Limitations of Scope

- In line with the approved audit plan, this review only considered controls in place to manage PVG and Disclosure compliance across the Council's Communities and Families Directorate.
- This review did not consider pre-employment checks for Social Work posts within Health and Social Care, and Safer and Stronger Communities as this was previously reviewed in the Social Work Pre-Employment Verification audit undertaken in 2016.
- Similarly, this review did not consider vetting processes in place with The Looked After and Accommodated Children Service (LAAC) as this was previously reviewed in May 2018.

### Reporting Date

Our audit work concluded on 27 January 2020 and our findings and opinion are based on the conclusion of our work as at that date.

# 2. Executive Summary

## Total number of findings: 3

| Summary of findings raised | |
|---|---|
| High | PVG scheme membership for individuals in schools |
| Medium | Council PVG processes and guidance |
| Medium | Information Governance |

## Opinion

**Significant improvements required**

Our review identified a number of significant and moderate weaknesses in the design of the second line PVG framework and the operating effectiveness of first line operational controls established to ensure that all Council employees, volunteers, and contractors who perform regulated work with children within the Communities and Families Directorate comply with PVG and Disclosure requirements.

Consequently, only limited assurance can be provided that the risks associated with individuals engaged in regulated work with children are being managed and that the Council remains compliant with applicable legislative and statutory requirements.

Three Internal Audit findings have been raised (one High and two Medium) to ensure that the control weaknesses identified are addressed.

The High rated finding reflects the need to ensure that retrospective PVG checks are performed for all school cleaning staff employed prior to the introduction of the PVG scheme (circa 50-60); and the need to ensure that all schools Business Managers are aware of, and consistently apply, PVG requirements to volunteers and contractors engaged directly by the schools.

The first Medium rated finding identifies the need to ensure that lists of posts, where a PVG check is required, are regularly reviewed and maintained to ensure ongoing alignment with the Council's structure; the need to review and refresh guidance available on the Orb for school Business Managers; and the requirement for recruiting managers to ensure that new starts do not commence employment until satisfactory PVG membership has been confirmed, all required references have been received and details have been accurately reflected within the recruitment conversation on askHR.

The second Medium rated finding reflects that PVG information retained by both schools Business Managers and Human Resources is not being consistently destroyed within the 90 day period specified in the Council's policy statement on the Secure Processing of Disclosure Information published on the Orb; data protection legislation; and Disclosure Scotland's Code of Practice.

It is recommended that management ensures that the risks identified in this report are recorded in directorate and divisional risk registers until the findings raised have been addressed, and that management also considers whether the risks should also be highlighted in divisional and directorate assurance and annual governance statements.

**Impact of COVID-19 on PVG and Disclosure requirements**

It is recognised that Disclosure Scotland operations changed on 25 March 2020 in response to COVID-19. This includes replacing the paper application form process with an electronic only application process and prioritising checks for workers in COVID-19 response sectors which includes early years, primary and secondary education; childcare and social work. Associated impacts in addressing the recommendations in this report such as a delay or backlog in processing PVG applications is acknowledged.

# 3. Detailed findings

| 1. PVG membership for individuals in schools | High |
|---|---|

**Facilities Management employees**

PVG requirements for new employees were introduced in February 2011, and a three-year retrospective checking period for existing employees commenced in October 2012. The Council completed an initial assessment to identify existing Facilities Management employees performing regulated work within normal school hours and PVG membership is now a requirement for all new Facilities Management employees carrying out regulated work within schools.

The usage of schools has, however, increased over time to include breakfast clubs and after school clubs. The impact of this is that staff who had previously not required a PVG check (as their work pattern was classed unregulated) may now fall into a regulated work category resulting in membership of the PVG Scheme being required. It is also noted that a change to employee's work pattern/location could also trigger similar circumstances.

Completion of retrospective PVG checks following a change to roles as above was held pending an organisational review which commenced in 2016 and became operational for janitorial services in August 2018 and cleaning services in November 2019. Following completion of the review, management has confirmed that circa 14 janitorial and 260 cleaning operatives do not currently hold a PVG scheme membership for their Council role, however PVG membership may be in existence for a previous employer or voluntary role, and an exercise to identify these employees is currently underway

**Volunteers**

Parent/guardian volunteers

We established that Business Managers in Schools are unclear on PVG requirements for volunteers despite the availability of detailed guidance on the Orb. In particular, the following issues were noted:

- Three out of eight schools were not aware of the requirement to complete a volunteer application form, criminal convictions declaration and obtain two references for all school volunteers as per the Orb guidance.
- One school advised they were unsure of the definition of 'volunteering'. However, this is set out in the guidance on recruitment of volunteers and volunteering frequently asked questions provided on the Orb.
- Another school advised that they understood that PVG checks are not required if the volunteer is supervised. However, the Council's volunteer guidance advises that volunteers who care for children, or teach, instruct, train or supervise children, even if they are supervised by a class teacher, are still carrying out regulated work; and therefore, require a PVG check. The only exception is 'incidental contact' which is clearly defined in the guidance.
- One school advised it has never completed PVG checks on parent volunteers.

Active Schools volunteers

Review of a sample of four Council employees (e.g. teachers) volunteering to support Active Schools activities confirmed that (in all cases) a Council employee PVG membership was accepted as assurance, instead of requesting an update (the Short Scheme Record) that covers the voluntary position.

**Contractors**

We noted that Business Managers across schools do not apply a consistent approach to completion of risk assessments to determine whether PVG checks are required for contractors. Specifically:

- One Business Manager advised that they complete PVG checks on any contractor who is in the school for more than one day but not for a contractor in the school for one visit. However, the Council's guidance on the definition of 'regulated work' advises that the requirement for PVG checks is dependent on the nature of work completed; whether the contact is incidental; and whether there is an opportunity for unsupervised contact while performing their normal duties.
- In another school, a procurement waiver had been approved for a non-contracted supplier to carry out construction work. The construction work covered an extended period within the school and, due to the nature of the work, potential contact with children. Senior management within the school were unaware of the requirement to complete a risk assessment to evaluate the opportunity for these contractors to have unsupervised contact with children.
- For one supplier, it was noted that a procurement waiver had been approved and the Council's standard terms and conditions issued by Commercial and Procurement Services (CPS) to Communities and Families Management. However, no evidence is available to demonstrate these terms had been issued to, and then subsequently agreed and signed by the supplier.

CPS are aware of contract management issues within schools and have issued targeted communications to remind schools of the relevant requirements, including the Council's Contract Standing Orders; Waiver Guidance – including PVG and IR35; and the requirement to only issue the Council's Terms and Conditions.

**Risks**

The potential risks associated with our findings are:

- The Council may not be aware of an individual's criminal convictions and potentially harmful behaviour subsequent to commencement of their employment/engagement.
- The Council may be committing a criminal offence by allowing an unsuitable person to carry out regulated work within schools.
- Children could potentially be at risk from exposure to unsuitable individuals carrying out regulated work within schools.
- The Council may not receive important updates from Disclosure Scotland that may have resulted in a risk assessment and stopping inappropriate volunteer arrangements, including instances where Council employees resign but continue to volunteer with the Active Schools programme.
- The Council does not have assurance that contractors are completing PVG checks for their employees working in schools.

**1.1 Recommendations: PVG membership for existing Facilities Management employees**

a) Human Resources should provide Facilities Management with a list which details the PVG status of all existing Facilities Management employees.

b) Facilities Management should then review this list and identify all employees that carry out regulated work within schools as part of their duties but are not members of the PVG scheme. Applications for PVG scheme membership should be then be completed for these individuals as soon as possible.

c) A risk assessment should be completed, and the outcomes recorded to ensure that the interim risks associated with potentially unsuitable employees working unsupervised with children in schools are identified, recorded, and appropriate temporary measures implemented until PVG outcomes are received.

d) Appropriate longer terms actions should be implemented to address situations where PVG checks identify employees who may potentially be unsuitable to work in schools.

e) Communities and Families should seek regular assurance from Facilities Management that a current PVG is in place for all Facilities Management employees who carry out regulated work within schools.

**1.1a Agreed Management Actions: List of cleaning staff requiring PVG checks**

Human Resources will provide a list of all Facilities Management staff who are recorded as registered on the PVG Scheme to Facilities Management.

| | |
|---|---|
| **Owner**: Stephen Moir; Executive Director of Resources<br>**Contributors:** Katy Miller, Head of Human Resources; Steven Wright, Human Resources Lead Consultant; Craig Murchie, Talent and Organisational Development Consultant | **Implementation Date:**<br>1 April 2020<br>(Complete) |

**1.1b Agreed Management Actions: Completion of PVG applications for cleaning staff**

On the basis that Disclosure Scotland will only accept applications for individuals carrying out regulated work, it is proposed to split the review into two categories. Firstly, those employees who are, in the course of their duties, clearly carrying out regulated work and, secondly, those who will require a risk assessment to establish if their main duties are regulated.

We are currently in the process of identifying employees who may hold an existing PVG membership for a previous employer or voluntary role to enable an application for a scheme update and new certificate to be completed. Processes have also been established to complete PVG membership applications for the remainder of employees in the first category as soon as possible. We have consulted with Disclosure Scotland to ensure managers are aware of their revised processes and requirements.

The second category will take longer as there will need to be a risk assessment of duties to establish if the post falls within regulated work classification. A risk assessment template has been developed to assist completion of this.

The implementation date below reflects that the second category will take longer and is also dependent upon timescales dictated by Disclosure Scotland, whose operations are currently focused on COVID-19 response workers. This date may need to be altered due to the impact of Disclosure Scotland capacity and response times.

| | |
|---|---|
| **Owner**: Stephen Moir; Executive Director of Resources<br>**Contributors:** Peter Watton, Head of Property and Facilities Management; Mark Stenhouse, Senior Manager Facilities Management; Gohar Khan, Performance and Audit Officer; Katy Miller, Head of Human Resources; Steven Wright, Human Resources Lead Consultant; Craig Murchie, Talent and Organisational Development Consultant | **Implementation Date:**<br>31 March 2021 |

**1.1c Agreed Management Actions: Risk assessment for existing cleaning staff**

A workshop facilitated by the Council's Principal Risk Manager has been arranged to complete an interim risk assessment while Action 1.1b is completed.

| | |
|---|---|
| **Owner**: Stephen Moir; Executive Director of Resources<br>**Contributors:** Peter Watton, Head of Property and Facilities Management; Mark Stenhouse, Senior Manager Facilities Management; David Latimer, Facilities Operations Manager, Gohar Khan, Performance and Audit Officer; Rebecca Tatar, Principal Risk Manager | **Implementation Date:**<br>30 June 2020<br>(Complete) |
| **1.1d Agreed Management Actions: Longer term actions for existing cleaning staff** | |
| Where a risk assessment has been completed and it is determined by a Team Leader that an existing colleague is unsuitable for regulated work within a school, normal Human Resources policies and procedures will be followed on an individual case by case basis. | |
| **Owner**: Stephen Moir; Executive Director of Resources<br>**Contributors:** Peter Watton, Head of Property and Facilities Management; Mark Stenhouse, Senior Manager Facilities Management; Gohar Khan, Performance and Audit Officer; Katy Miller, Head of Human Resources; Steven Wright, Human Resources Lead Consultant; Craig Murchie, Talent and Organisational Development Consultant | **Implementation Date:**<br>31 March 2021 |
| **1.1e Agreed Management Actions: Ongoing assurance on PVG status of Facilities Management employees** | |
| Communities and Families will request written assurance from the Property and Facilities Management division, on a six-monthly basis to confirm that all Facilities Management employees who carry out regulated work within schools have a current PVG scheme membership. | |
| **Owner:** Alistair Gaw, Executive Director of Communities and Families<br>**Contributors:** Andy Gray; Head of Schools and Lifelong Learning; Michelle McMillan, Operations Manager; Claire Thompson, Operations Manager | **Implementation Date:**<br>31 May 2021 |
| **1.2 Recommendations: Assessing and monitoring PVG requirements for volunteers** | |
| a) Communities and Families should communicate to all schools, the requirement to comply with the Council's guidance on safe recruitment of volunteers at all times. Communication should include:<br>• links to the Council's 'Safe recruitment of volunteers guidelines', and 'School Volunteers PVG Scheme Membership questions and answers' and the volunteering 'frequently asked questions' available via the Orb.<br>• the requirement to complete a school volunteer application form; criminal declarations form and ensure receipt of two references (via the reference request template letter available via the Orb) for all school volunteers;<br>• requirement to obtain a satisfactory PVG scheme check for all school volunteers who will carry out regulated work (in line with the Council's guidance) prior to the individual volunteering within the school.<br>b) A process should be established to ensure recording and ongoing maintenance of monitoring PVG scheme details for all school volunteers who are performing regulated work with children. This should include requirement for Business Managers to complete the volunteer record keeping spreadsheet provided on the Orb and an annual review of all school volunteers to confirm volunteering arrangement is still in place and PVG scheme membership remains valid.<br>c) Volunteers who hold an existing PVG membership for a substantive post (such as teachers volunteering for Active Schools) should be required to complete a Short Scheme Record to cover any additional roles. | |
| **1.2a Agreed Management Actions: Communicating PVG requirements for volunteers** | |

Actions within this report will be addressed through a targeted 'Risk Matters' on PVG requirements which will be issued to all Head Teachers and Business Managers in schools. This will be supported by target training where required.

The Risk Matters communication will confirm the requirement to comply with the Council's volunteer recruitment process. This will include a reminder to ensure an application form; criminal declarations form and two references are obtained for all school volunteers and completion of PVG check where the volunteer will be carrying out regulated work.

Links will also be provided to the recruitment of school volunteers guidance available via the Orb.

| | |
|---|---|
| **Owner:** Alistair Gaw, Executive Director of Communities and Families<br>**Contributors:** Andy Gray; Head of Schools and Lifelong Learning; Michelle McMillan, Operations Director; Claire Thompson, Operations Director | **Implementation Date:**<br>28 February 2021 |

**1.2b Agreed Management Actions: Regular monitoring of volunteers**

The Risk Matters communication at 1.2a will include instruction to all Business Managers to complete and maintain the volunteer register provided via the Orb. In addition, Business Managers will be instructed to perform a review at the start of each academic year, to review the register and confirm PVG arrangements remain valid.

| | |
|---|---|
| **Owner:** Alistair Gaw, Executive Director of Communities and Families<br>**Contributors:** Andy Gray; Head of Schools and Lifelong Learning; Michelle McMillan, Operations Manager; Claire Thompson, Operations Manager | **Implementation Date:**<br>28 February 2021 |

**1.2c Agreed Management Actions: Monitoring volunteers who are employees**

A communication will be issued by Communities and Families to Active Schools to advise that a 'Short Scheme Record' is required for all volunteers who are City of Edinburgh employees.

In addition, Communities and Families seek written assurance from Active Schools, on a six-monthly basis to confirm that all volunteers who carry out regulated work within schools have a current PVG scheme membership.

| | |
|---|---|
| **Owner:** Alistair Gaw, Executive Director of Communities and Families<br>**Contributors:** Andy Gray; Head of Schools and Lifelong Learning; Michelle McMillan, Operations Manager; Claire Thompson, Operations Manager | **Implementation Date:**<br>31 December 2020 |

**1.3 Recommendations: Assessing and monitoring PVG requirements for contractors**

Communities and Families should issue communications to reinforce the need for consistent application of PVG requirements for all contractors and suppliers engaged to work in schools. This should include:

- requirement to consider the duties of each contractor on an individual basis regardless of time spent within the school in line with the Council's definition of regulated work;
- requirement to perform a risk assessment to establish if there will be opportunity for unsupervised and non-incidental contact while the contractor performs their normal duties;
- reminder that only the Council's terms and conditions can be issued to contractors and that where the school engages directly or through the waiver process it is their responsibility to ensure signed Council terms and conditions (available from Commercial and Procurement Services) are in place.

## 1.3 Agreed Management Actions: Communicating PVG requirements for contractors

Actions within this report will be addressed through a targeted 'Risk Matters' on PVG requirements which will be issued to all Head Teachers and Business Managers in schools. This will be supported by target training where required.

The Risk Matters communication will reinforce the need for consistent application of PVG requirements for all contractors and suppliers engaged to work in schools. This will include:

- requirement to consider the duties of each contractor on an individual basis regardless of time spent within the school in line with the Council's definition of regulated work;
- requirement to ensure that contractors are assessed in line with IR35 procedures and requirements set out on the Orb.
- requirement to perform a risk assessment to establish if there will be opportunity for unsupervised and non-incidental contact while the contractor performs their normal duties.
- reminder that only the Council's terms and conditions can be issued to contractors and that where the school engages directly or through the waiver process it is their responsibility to ensure signed Council terms and conditions (available from Commercial and Procurement Services) are in place.

In addition, assurance on these actions on a sample basis will be included as part of the Communities and Families Annual Self Assurance Framework for 2021.

| | |
|---|---|
| **Owner:** Alistair Gaw, Executive Director of Communities and Families<br>**Contributors:** Andy Gray; Head of Schools and Lifelong Learning; Michelle McMillan, Operations Manager; Claire Thompson, Operations Manager | **Implementation Date:**<br>28 February 2021 |

## 2. PVG processes and guidance — Medium

Whilst detailed and comprehensive PVG processes and guidance are published on the Orb, CECiL and Council's website for recruiting managers, business managers, employees and potential applicants, we noted that:

- Lists of all posts within Communities and Families, where a PVG check is required, had not been reviewed and updated by the Directorate and its Divisions since January 2013 to ensure that they remain aligned with changes in organisational structure.
- Three out of eight school Business Managers were unsure of the process for completing a risk assessment where any adverse issues during pre-employment checks were identified. The Recruitment manager guide on the Orb advises non-school managers to contact askHR but directs School Business Managers to the Orb, where no further information or risk assessment template is available.
- Two instances were identified where applicants commenced employment before a satisfactory PVG check had been recorded on AskHR. In both cases, the PVG certificate had been received from Disclosure Scotland, but the recruitment conversation had not been updated by the Business Manager in a timely manner to reflect this.
- Additionally, for one of the above applicants, who was an external candidate, only one reference was obtained. The Recruitment manager guide states that two references are required for external candidates.

### Risks

The potential risks associated with our findings are:

- PVG checks may not completed where required as lists of roles defining PVG requirements have not been reviewed and refreshed in line with organisational changes.
- Risk assessments may not be completed for potentially unsuitable candidates within schools.
- PVG applications are processed incorrectly resulting in onboarding delays.
- Potentially unsuitable applicants are permitted to carry out regulated work prior to completion of satisfactory pre-employment checks.

**2.1 Recommendations: Compliance with policies and procedures**

a) Lists of Council posts should be reviewed and refreshed across all Divisions within Communities and Families to ensure they include all current roles and an assessment of whether a PVG disclosure is required. A process should also be established across Communities and Families to ensure that lists are updated when any new roles are added to the structure.

b) The 'PVG scheme' page on the Orb should be updated to provide further information to Business Managers on the risk assessment process for PVG outcomes. This should include clear roles and responsibilities and where it is the responsibility of the individual school to undertake the assessment – provision of a risk assessment template and guidance for completion.

c) A communication should be issued to Business Managers to remind them that a candidate should not commence employment until all pre-employment checks are confirmed as satisfactory and communicated to Human Resources via askHR.

d) Regular reporting of compliance with pre-employment checks across the Council should be developed by Human Resources with persistent breaches reported to Heads of Divisions so remedial action can be taken.

**2.1a Agreed Management Action – Updating PVG requirements for all roles**

All divisions will be requested to review and update lists of PVG related posts. Managers will also be reminded that PVG requirements for any new roles should be assessed and recorded on the divisional list.

| | |
|---|---|
| **Owner:** Alistair Gaw, Executive Director of Communities and Families<br>**Contributors:** Andy Gray; Head of Schools and Lifelong Learning; Bernadette Oxley, Head of Children's Services; Jackie Irvine; Head of Safer Stronger Communities | **Implementation Date:**<br>31 March 2021 |

**2.1b Agreed Management Action – Risk assessment guidance for Business Managers**

The Orb will be updated with further information on the risk assessment process to be followed by Business Managers in Schools.

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|---|---|
| **Owner**: Stephen Moir; Executive Director of Resources<br>**Contributors:** Katy Miller, Head of Human Resources; Steven Wright, Human Resources Lead Consultant; Craig Murchie, Talent and Organisational Development Consultant | **Implementation Date:**<br>30 September 2020 |

**2.1c Agreed Management Action – Compliance with pre-employment checks - Communities and Families**

Actions within this report will be addressed through a targeted 'Risk Matters' on PVG requirements which will be issued to all Head Teachers and Business Managers in schools. This will be supported by target training where required.

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| The Risk Matters communication will remind Head Teachers and Business Managers in schools that a candidate should not commence employment until all pre-employment checks are confirmed as satisfactory and recorded within the onboarding conversation on askHR. The communication will also advise that Human Resources will report any individual breaches to Heads of Divisions. | |
| **Owner:** Alistair Gaw, Executive Director of Communities and Families<br>**Contributors:** Andy Gray; Head of Schools and Lifelong Learning; Michelle McMillan, Operations Manager; Claire Thompson, Operations Manager | **Implementation Date:**<br>28 February 2021 |
| **2.1d Agreed Management Action – Monitoring compliance with pre-employment checks - Human Resources** | |
| Individual breaches of pre-employment compliance will be reported to the appropriate Head of Division on an ongoing basis by Human Resources. | |
| **Owner**: Stephen Moir; Executive Director of Resources<br>**Contributors:** Katy Miller, Head of Human Resources; Steven Wright, Human Resources Lead Consultant; Craig Murchie, Talent and Organisational Development Consultant | **Implementation Date:**<br>30 September 2020 |

## 3. Information Governance — Medium

A review of policies and procedures detailing the Council's information governance protocols for the secure processing of PVG and Disclosure information established that:

- Business Managers for seven out of eight schools visited were not aware of or had read the Council's Policy Statement on the Secure Processing of Disclosure Information, which is published on the Orb.
- In one school visited, PVG related data had been retained for longer than the 90-day period stipulated within the Council's Records Retention Schedule. Management advised that the Business Manager was new in post and had been unaware of requirements. Internal Audit has since confirmed the data has been destroyed.
- PVG data held centrally by Human Resources is destroyed at the end of each calendar month, rather than on a 90-day schedule. As a result, data could be held for a period of up to 120 days before being destroyed. Management have advised, however, there are few instances where it has been held more than 90 days in practice.

### Risks

The potential risks associated with our findings are:

- Employees with PVG responsibilities are unaware of the Council's requirement to securely handle and share personal PVG and Disclosure data.
- Personal and sensitive data is retained longer than required, resulting in non-compliance with the Council's policy statement on the Secure Processing of Disclosure Information; data protection legislation; and Disclosure Scotland's Code of Practice.

### 3.1 Recommendations: Communication of data handling and disposal requirements

a) Communications should be issued by Communities and Families to:

- Request that all employees within schools who are involved in PVG checks confirm that they have read and understand the requirements set out in the Council's Policy Statement on the Secure Processing of Disclosure Information.

- Direct Business Managers to develop a retention schedule to monitor and confirm that all PVG related documents including certificates and photocopies of original documents are held for no longer than 90 days and then disposed of securely.

b) Human Resources should initiate a retention schedule to ensure that all PVG related documents are disposed of within 90 days.

**3.1a Agreed Management Action – Communication of PVG data requirements to schools**

Actions within this report will be addressed through a targeted 'Risk Matters' on PVG requirements which will be issued to all Head Teachers and Business Managers in schools. This will be supported by target training where required.

The Risk Matters communication will include a link to the Council's Policy Statement on the Secure Processing of Disclosure Information on the Orb and request that all Head Teachers and Business Managers review this.

Business Managers will also be requested to develop a retention schedule to ensure that PVG related documents should not be held for longer than 90 days and disposed of securely.

| | |
|---|---|
| **Owner:** Alistair Gaw, Executive Director of Communities and Families<br>**Contributors:** Andy Gray; Head of Schools and Lifelong Learning; Michelle McMillan, Operations Director; Claire Thompson, Operations Director | **Implementation Date:**<br>28 February 2021 |

**3.1b Agreed Management Action – Disposal of PVG data within 90 days**

In line with the current guidelines PVG related documents are *normally* disposed of within 90 days. However, Human Resources will review the process in light of the findings to ensure all PVG findings are disposed of within 90 days.

| | |
|---|---|
| **Owner**: Stephen Moir; Executive Director of Resources<br>**Contributors:** Katy Miller, Head of Human Resources; Steven Wright, Human Resources Lead Consultant; Craig Murchie, Talent and Organisational Development Consultant | **Implementation Date:**<br>31 January 2021 |

# Appendix 1: Basis of our classifications

| Finding rating | Assessment rationale |
|---|---|
| **Critical** | A finding that could have a:<br>• ***Critical*** impact on the operational performance; or<br>• ***Critical*** monetary or financial statement impact; or<br>• ***Critical*** breach in laws and regulations that could result in material fines or consequences***;*** *or*<br>• ***Critical*** impact on the reputation of the Council which could threaten its future viability. |
| **High** | A finding that could have a:<br>• ***Significant*** impact on operational performance; or<br>• ***Significant*** monetary or financial statement impact; or<br>• ***Significant*** breach in laws and regulations resulting in significant fines and consequences***;*** *or*<br>• ***Significant*** impact on the reputation of the Council. |
| **Medium** | A finding that could have a:<br>• ***Moderate*** impact on operational performance; or<br>• ***Moderate*** monetary or financial statement impact; or<br>• ***Moderate*** breach in laws and regulations resulting in fines and consequences; or<br>• ***Moderate*** impact on the reputation of the Council. |
| **Low** | A finding that could have a:<br>• ***Minor*** impact on operational performance; or<br>• ***Minor*** monetary or financial statement impact; or<br>• ***Minor*** breach in laws and regulations with limited consequences; or<br>• ***Minor*** impact on the reputation of the Council. |
| **Advisory** | A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice. |

# Appendix 2: Areas of audit focus

The areas of audit focus and related control objectives included in the review were:

| Audit Area | Control Objectives |
|---|---|
| 1. PVG Framework, guidance and information | 1.1 The Council has established a robust framework and supporting procedures for ensuring compliance with PVG requirements which are aligned to the Disclosure Scotland Code of Practice.<br>1.2 Roles and responsibilities for PVG checks and ongoing compliance have been clearly defined, communicated and are understood across all levels within Directorates and Divisions.<br>1.3 Detailed and up to date guidance is available to enable recruiting managers and business managers comply with requirements.<br>1.4 Learning materials have been developed to support compliance and all Communities and Families recruiting managers can evidence completion of relevant e-learning modules.<br>1.5 A 'registered person' (lead signatory) has been identified and a list of counter-signatories, who are registered with Disclosure Scotland, is maintained.<br>1.6 A list of PVG requirements for roles within each service has been developed and updated as required, and a process has been developed to assess the requirements for new roles. |
| 2. Onboarding processes | 2.1 Recruiting managers and business managers comply with all PVG and Disclosure requirements during the recruitment and onboarding processes including:<br>• Requesting PVG checks only for roles included within authorised lists.<br>• Ensuring that PVG requirements are included in job adverts and supporting documents.<br>• Inclusion of PVG related questions within interviews.<br>• Ensuring the correct application form is used and all mandatory sections completed, payment details recorded and is countersigned by approved signatory.<br>• Validating copies of required identification documents.<br>• Completion of criminal declaration.<br>• Updating PVG record templates.<br>• Completion of relevant PVG fields on askHR.<br>• Updating PVG outcomes onto iTrent.<br>2.2 Applicants do not begin employment without confirmation PVG requirements have been met; and any breaches are monitored and reported to senior officers.<br>2.3 Assessments of PVG requirements are reperformed in the event of material changes to an employee's role within the Council.<br>2.4 Processes are in place to undertake and manage PVG checks for volunteers in line with legislation and volunteer recruitment guidance |

| | | |
|---|---|---|
| | 2.5 | PVG checks are performed for all contractors providing services within schools in line with the Council's Procurement waiver procedure. |
| | 2.6 | PVG checks are performed and maintained for all facilities management and catering staff working within schools and nurseries. |
| 3. PVG and Disclosure outcomes | 3.1 | Where findings are identified through a PVG Scheme application, Scheme Record update or Disclosure check, the Recruiting Manager or Business Manager complete a risk assessment to assess suitability for the role. |
| | 3.2 | Upon receipt of PVG certificates Business Managers record the PVG outcomes the askHR onboarding conversations for the onboarding team to update iTrent. |
| | 3.3 | Depending on outcomes and subsequent risk assessments, action is taken where the individual is unable to undertake regulated activities including termination of employment where necessary. |
| 4. Information Governance | 4.1 | The Council has developed and communicated information governance controls for processing PVG and Disclosure information. |
| | 4.2 | PVG information is held within lockable, non-portable containers, and not personnel files. |
| | 4.3 | Access to information is controlled and for named individuals only, who require access in the course of their duties. |
| | 4.4 | Disclosure information is held for no longer than 90 days and disposed of securely. No photocopies or images of information is retained. |
| | 4.5 | Relevant sections in the Council's Records Retention Schedule includes requirement to securely destroy PVG information within 90 days of recruitment decision. |

# *The City of Edinburgh Council*

# Internal Audit

## Policy Management Framework

Final Report

29 July 2020

CE1902

**Overall report rating:**

| | |
|---|---|
| **Significant improvement required** | Significant and / or numerous control weaknesses were identified, in the design and / or effectiveness of the control environment and / or governance and risk management frameworks. Consequently, only limited assurance can be provided that risks are being managed and that the Council's objectives should be achieved. |

# Contents



This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2019/20 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2019. The review is designed to help the City of Edinburgh Council assess and refine its internal control environment. It is not designed or intended to be suitable for any other purpose and should not be relied upon for any other purpose. The City of Edinburgh Council accepts no responsibility for any such reliance and disclaims all liability in relation thereto.

The internal audit work and reporting has been performed in line with the requirements of the Public Sector Internal Audit Standards (PSIAS) and as a result is not designed or intended to comply with any other auditing standards.

Although there is a number of specific recommendations included in this report to strengthen internal control, it is management's responsibility to design, implement and maintain an effective control framework, and for the prevention and detection of irregularities and fraud. This is an essential part of the efficient management of the City of Edinburgh Council. Communication of the issues and weaknesses arising from this audit does not absolve management of this responsibility. High and Critical risk findings will be raised with senior management and elected members as appropriate.

# 1. Background and Scope

## Background

Policies are the high-level guiding principles of an organisation, and for the City of Edinburgh Council (the Council) provide the strategic link between the Council's vision and values, pledges and outcomes and its day to day operations. Policies are also a critical governance tool used to ensure that the Council complies with its applicable legislative and regulatory obligations and supporting guidance and standards.

The Council's public website includes a Policy Register which provides a searchable directory of approved Council policies aligned to the range of Council services provided. As at October 2019, there were 145 policies on the Policy Register. All policy documents should be available for the public to download. Management advise that the register has also been aligned with the Council's publication scheme which is a mandatory requirement under Freedom of Information legislation.

Directorates and Divisions create and own policies which must then be approved by the relevant Council Executive Committee. Strategy and Communications should then update the Policy Register following approval. Strategy and Communications are responsible for overview of all policies to ensure consistency and to reduce the risk of policy overlap or duplication, and also maintain the Council's policy register.

All policies should be supported by guidance that details the operational activities to be performed to ensure that the principles outlined in the policies are consistently and effectively achieved.

Consequently, it is essential that officers clearly understand and have access to the policies applicable to their role and understand their responsibilities in relation to the application of Council policies and supporting procedures.

**The Three Lines of Defence**

The Three Lines of Defence model can be applied to the ongoing management of Council policies where the 'first line' is the Divisions and Directorates who own the policies and are responsible for ensuring that their content is regularly reviewed and refreshed in line with the Council's policy management framework, whilst Strategy and Communications, as the 'second line' is responsible for developing and maintaining the Council's policy management framework and supporting guidance; ensuring it is communicated across the Council; and providing ongoing support and guidance to policy developers and managers.

The 'third line' provides independent assurance (for example, Internal Audit) on key controls established within the first and second lines to manage risks associated with the policy management framework and ongoing policy development and maintenance.

**The Council's Policy Framework**

In September 2013, the Council developed a Policy Framework to promote consistency and good governance in policy management across all Directorates. The framework is owned by Strategy and Communications and includes a policy hierarchy with levels of authorisation, standard policy definitions (policy; strategy; procedures and guidelines) and key elements that must be included within a policy. However, policy formulation, approval, renewal and revision are divisional / directorate responsibilities. The policy framework requires all policies to be reviewed annually.

A Policy Toolkit has been developed which includes guidance on how to create Council policies; maintenance of the Council's policy register; and policy review requirements. The toolkit also includes a policy template that has been developed to ensure that policies follow a standard format.

**Human Resources Policies**

The only exception to the framework requirement to review policies annually is Human Resources (HR). Management has advised that (following approval by the Council's Corporate Policy and Strategy Committee in December 2017), HR has implemented a separate policy template. Additionally, the Committee agreed that HR policies will be reviewed as and when a change to the existing policy is required, primarily as a result of: changes to legislation or statute; agreement of new national terms and conditions of service or Government Policy; organisational change; or resulting from changes agreed through Trade Union Consultation.

**Assurance on completion of Annual Policy Reviews**

Assurance in relation to the ongoing annual review of Council policies is obtained from Council Directorates and Divisions through their confirmation that they 'have arrangements in place for the annual review of policies owned by their service area, via the relevant Executive Committee, to ensure these comply with the Council's policy framework' as part of the divisional and directorate annual assurance statements that are consolidated annually to form the Council's annual assurance statements.

**Integrated Impact Assessments**

Since November 2017, all new and revised policies must consider whether an Integrated Impact Assessment (IIA) (previously Equalities and Rights Impact Assessment) is required to ensure that the Council meets its public sector duties in relation equalities and sustainability.

The IIA should be an integral part of policy development and should be applied during the development of new policies, annual reviews and when making amendments to existing policies, before any changes are agreed. Guidance including an IIA reporting template and checklist is available on the Orb.

**Essential Learning**

The Learning and Organisational Development team within Human Resources have been working with managers from across the Council to articulate essential learning requirements for new Council employees and role specific essential learning requirements for existing employees. All new employees are expected to read key council policies or complete key policy e-learning upon employment.

## Scope

The objective of this review was to assess the adequacy of design of the Council's Policy Management Framework and operating effectiveness of the key controls established to ensure that the Framework is consistently and effectively applied across all Council Directorates and Divisions, including the Health and Social Care Partnership. Sample testing was performed across the period 1 May 2017 to 1 November 2019.

Our areas of audit focus as detailed in our terms of reference are included at Appendix 2.

### Limitations of Scope

The following areas were specifically excluded from the scope of our review:

- Policy compliance – the review did not consider the extent of policy compliance by Directorates and Divisions across the Council; and
- The Edinburgh Health and Social Care Partnership – the audit only considered Council policies applicable to the EHSCP, and not those issued by NHS Lothian.

### Reporting Date

Our audit work concluded on 6 December, and our findings and opinion are based on the conclusion of our work as at that date.

# 2. Executive summary

## Total number of findings: 4

| Summary of findings raised | |
|---|---|
| **High** | 1. Completeness and accuracy of Council policies and online policy register |
| **High** | 2. Completion of Integrated Impact Assessments |
| **Medium** | 3. Policy framework guidance |
| **Medium** | 4. Policies essential learning |

## Opinion

**Significant Improvement Required**

Our review identified a number of significant control weaknesses in both the design and ongoing application of the Council's policy management framework across all Council Directorates and Divisions that require to be addressed. Consequently, only limited assurance can be provided that policies are being effectively developed, managed, and communicated across the Council and are aligned with applicable legislation, regulations, and statutory requirements.

Consequently, two High and two Medium rated findings have been raised.

We established that first (directorate and divisional) and second line (Strategy and Communications) responsibilities in relation to the policy management framework have not been defined, agreed and communicated. Notably, responsibility for confirming that policy management framework requirements are being consistently and effectively applied across the Council is presently unclear.

Whilst the Council's online policy register currently includes a total of 145 policies, a significant proportion of policies published on the register are out of date (circa 49%). We also identified a large number of documents held within Divisions that are described as policies that have not been approved by relevant Council Executive Committees.

Whilst the second line policy management framework is currently not operating effectively, it is expected that first line Directorates and Divisions will have established local arrangements for ongoing policy management to support both Heads of Division and Executive Director Annual Assurance submissions. Heads of Divisions have advised that local policy management arrangements have been established, however these approaches have not been documented and there is no evidence available to confirm that they are consistently applied.

Consequently, we have been unable to establish the full population of current Council policies and confirm that all policies are reviewed annually (with the exception of HR policies) in line with established policy framework requirements.

We have also been unable to confirm the accuracy of responses included in Executive Director's Annual Assurance Statements that are designed to provide assurance that Directorates and Divisions have established arrangements for the annual review of policies, via the relevant executive committee, as 142 of the 145 published policies had passed their scheduled review date; 71 policies had not been subject to an annual review; and 18 policies had not been reviewed in the last five years.

It is important to note that whilst our review has concluded that policy content is not being effectively managed, the extent of ongoing policy compliance across the Council was specifically excluded from the scope of our review.

We established that whilst Integrated Impact Assessments (IIA) were incorporated into the policy management framework in November 2017, and Strategy and Communications have proactively supported IIA learning across the Council (including reviewing guidance: creating a network of Equalities Advisors within Directorates: and providing training sessions to employees and elected members) the requirement to consider IIA requirements for both new and refreshed policies is not consistently applied.

Additionally, review of policy management framework guidance and templates on the Orb (including IIA guidance) identified a number of areas for improvement, including links to a Health and Social Care / Communities and Families Policy and Procedures Directory that contains a range of policies that are out of date and are not aligned with the content of the online policy register.

We also confirmed that there is currently a lack of clarity across Directorates and Divisions in relation to essential learning, including which policies should be classified as 'essential learning'; review and completion frequency; and the process for recording and monitoring completion. It is acknowledged that Human Resources are aware of this position and are actively working with Directorates and Divisions to ensure that these gaps are addressed.

Further information on these findings is included at Section 3.

# 3. Detailed findings

| 1. Completeness and accuracy of Council policies and the online policy register | High |
|---|---|

**Completeness and accuracy of Council policies**

Directorates and Divisions do not currently maintain policy review schedules that include the full population of the policies that they own; details of the Senior Responsible Officer (SRO); and the next scheduled review date.

Heads of Divisions have confirmed that they do apply processes to ensure that policies that they own are reviewed and refreshed as required and provided to the relevant executive committees for approval.

We also identified that there is a large number of local documents held within Divisions (for example within schools) described as policies, which do not meet the Council's definition of a policy and are potentially guidance or procedures.

In addition, the Orb includes a directory for Communities and Families and Health and Social Care policies and procedures. These include policies that are not listed in the Council's policy register published on the website (for example the Lone Working and Sponsorship Policies). Many of these policies are out of date and have not been developed using the approved Council template. It was also noted that some policies appeared to have been published in draft with incomplete sections, for example the Children's Social Care Case Transfer Policy.

Consequently, we have been unable to establish the full population of Council policies and confirm that all policies are reviewed at appropriate intervals to confirm their ongoing alignment with applicable legislation and regulations.

Additionally, we have been unable to confirm the accuracy of responses included in Executive Director's Annual Governance Statements in relation to established directorate / divisional arrangements for the annual review of policies that they own, via the relevant executive committee, to ensure these comply with the Council's policy framework.

**Completeness and accuracy of the online policy register**

Strategy and Communications have advised that the website refresh has prevented uploading policies to the online register over the past 12-18 months, however this should now be resolved.

Review of the Council's Policy Register published on the external website at 9 October 2019 confirmed that it included a total of 145 policies and established that:

- 142 policies on the register had passed their scheduled review date.
- for 71 policies there was no evidence within the register, that the policy had been subject to an annual review as required by the Council's policy framework.
- 44 policies had been reviewed by officers and outcomes reported to Executive Committee within the last year, however details of the review outcome or most recent version was not published on the Council's online Policy register.
- the following variations in review frequencies stated on the policy documents approved by Committee was noted:
    - Annual review – 53
    - Reviewed per legislative changes – 16

- Two to five year review – 5
- Review frequency not detailed – 71

- for 18 policies it had been more than 5 years since their last review.
- 100 policies on the register are not published using the approved Council policy template.
- 46 policies included a named Senior Responsible Officer (SRO), however 21 of these are no longer in the same post, with some no longer employed by the Council.
- many of the links to policy documents within the online policy register are broken, resulting in the reader receiving a 'cannot display page' error notice.
- there were a number of policy documents which stated 'draft' published on the register as approved, and
- there is a lack of understanding across Council Directorates and Divisions in relation to Strategy and Communications responsibilities for providing support and assistance with the online Policy register.

**Risks**

The potential risks associated with our findings are:

- inaccurate annual governance statement attestations in relation to ongoing policy management across the Council;
- existing policies do not reflect applicable legislative, regulatory and statutory requirements;
- potential for local actions that are not aligned with approved Council policies; and
- Inconsistencies the policy development process and communication and presentation of policies to both employees and the public.

**1.1 Recommendations: Directorate policy management**

Each Directorate should develop a policy management schedule that details the full population of Council policies that they own. This schedule should be used to ensure that all policies are managed and maintained / refreshed in line with applicable policy management framework requirements and to ensure that policies are updated in a timely manner to reflect changes in applicable legislation; regulations; and statutory requirements.

**1.1 Agreed Management Action: All Directorates**

The Corporate Leadership Team has discussed this recommendation and agreed that the established second line policy management framework within Strategy and Communications will be retained, with no requirement for directorates to retain individual policy registers.

Additionally, as part of their second line policy management framework responsibilities, Strategy and Communications will implement a process to issue quarterly reminders to each Directorate for policies due for upcoming review.

No further action is required by Directorates in relation to this recommendation.

**1.2 Recommendation: Policy register review**

A full review and refresh of the Policy Register should be performed to ensure that:

- All out of date and draft policies included in the register are identified and the Senior Responsible Officer requested to either provide a copy of the refreshed or complete a policy review within six months. The register should be updated to advise that the policy is currently under review and advise timescale for completion.

- Approved Council policies that are currently omitted from the register are added as soon as possible.
- Prior to inclusion, a check should be performed to confirm that the policies have been prepared using the Council's policy template; including a statement in the integrated impact assessment (IIA) section and have been approved by the relevant Executive Committee.
- Working links evidencing approval by relevant Committees should be included in the policy register for each policy.
- The Communities and Families and Health and Social Care policy and procedures directories on the Orb should be reviewed with links provided to the approved policy register. Additionally, all other documents should be reviewed and reclassified in line with the agreed policy, procedures and guidance definitions.

**1.2a Agreed Management Actions: Initial review of online policy register – Strategy and Communications**

Strategy and Communications will provide each Directorate an extract from the online policy register to enable a Directorate/Division level review to identify out of date policies; draft documents and any documents that have not been approved by Committees.

Directorates will then be required to complete actions at 1.2b.

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|---|---|
| **Owner**: Laurence Rockey, Head of Strategy & Communications<br>**Contributors:** Gavin King, Democracy, Governance and Resilience Senior Manager; Laura Callender, Governance Manager | **Implementation Date:**<br>31 July 2020<br>(Completed) |

**1.2b Agreed Management Actions: Initial review of online policy register – All Directorates**

Following receipt of the Directorate policy register extract provided by Strategy and Communications, each Directorate will perform an initial review of their section of the policy register to identify out of date and draft documents. A status update will be provided to Strategy and Communications for each document currently published online, to confirm whether the published version is:

- the most up to date approved version and no immediate action is required.
- is out of date but has been recently reviewed and reported to Committee in the annual policy assurance statement – a copy of the most recent version held by the Directorate or Division will then be sent to by Strategy and Communications for publication on the current online register.
- is out of date or in draft with no recently approved version available. Strategy and Communications will then remove the current online version from the online policy register and note that the document is being reviewed.

Strategy and Communications will update the current online policy register on the basis of returns and Directorates will commence their wider policy review set out at 1.2d.

| | |
|---|---|
| **Owner:** Stephen Moir, Executive Director of Resources<br>**Contributors:** Hugh Dunn, Head of Finance; Katy Miller, Head of Human Resources; Nicola Harvey, Head of Customer and Digital Services; Peter Watton, Head of Property and Facilities Management; Nick Smith, Head of Risk and Legal | **Implementation Date:**<br>31 December 2020 |
| **Owner:** Paul Lawrence, Executive Director, Place<br>**Contributors:** Gareth Barwell, Head of Place Management; Lynn Halfpenny, Director of Culture; Michael Thain, Head of Place Development | **Implementation Date:**<br>31 January 2021 |
| **Owner:** Alistair Gaw, Executive Director, Communities & Families | **Implementation Date:**<br>31 March 2021 |

| | |
|---|---|
| **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities and Chief Social Work Officer; Crawford McGhie, Senior Manager Estates and Operational Support; Andy Gray Head of Schools and Lifelong Learning; Bernadette Oxley, Head of Children's Services | |
| **Owner:** Judith Proctor, Chief Officer, Edinburgh Health & Social Care Partnership<br>**Contributors:** Tom Cowan, Head of Operations; Tony Duncan Head of Strategic Planning; Moira Pringle, Chief Finance Officer | **Implementation Date:**<br>31 October 2020 |
| **1.2c Agreed Management Actions: Ongoing review of policy register – Strategy and Communications** | |
| A working group led by Strategy and Communications with representation from Internal Audit and each Directorate will be established to identify and implement a process to support timely review and upload of approved policies, and Integrated Impact Assessments (IIA) for inclusion within the online register.<br>Following this, further actions to meet the recommendations will be communicated to all Directorates and Divisions. | |
| **Owner**: Laurence Rocky, Head of Strategy & Communications<br>**Contributors:** Gavin King, Democracy, Governance and Resilience Senior Manager; Laura Callender, Governance Manager | **Implementation Date:**<br>30 November 2020 |
| **1.2d Agreed Management Actions: Full Policy review – All Directorates** | |
| • Following Corporate Leadership Team approval of revised definitions of policies; procedures; guidance and templates (as per recommendations at 3.1), all Directorates will review their existing policies, procedures and guidance and reclassify as appropriate.<br>• A risk-based approach will be adopted across Directorates to determine how regularly individual policies will be reviewed, based on the expected frequency of changes in applicable legislation, regulations and statutory requirements. The agreed frequency for review will be recorded on the policy template and included in the published policy register. All policies will be then be reviewed regularly in line with the agreed frequency. (*Human Resources policies are exempt from this requirement as the review frequency has been agreed by Committee*).<br>• Policy documents on individual Orb pages for Divisions will be removed and links included to the Council's published policy register which will be the single source for all Council policies. *(With the exception of Human Resources and Health and Safety policies which are Council wide and are included with content specific webpages).* | |
| **Owner:** Stephen Moir, Executive Director of Resources<br>**Contributors:** Hugh Dunn, Head of Finance; Nicola Harvey, Head of Customer and Digital Services; Peter Watton, Head of Property and Facilities Management; Nick Smith, Head of Risk and Legal | **Implementation Date:**<br>31 October 2021 |
| **Owner:** Paul Lawrence, Executive Director, Place<br>**Contributors:** Gareth Barwell, Head of Place Management; Lynn Halfpenny, Director of Culture; Michael Thain, Head of Place Development | **Implementation Date:**<br>31 October 2021 |
| **Owner:** Alistair Gaw, Executive Director, Communities & Families<br>**Contributors:** Jackie Irvine, Head of Safer and Stronger Communities and Chief Social Work Officer; Crawford McGhie, Senior Manager Estates and Operational Support; Andy Gray Head of Schools and Lifelong Learning; | **Implementation Date:**<br>31 December 2021 |

| | |
|---|---|
| Bernadette Oxley, Head of Children's Services | |
| **Owner:** Judith Proctor, Chief Officer, Edinburgh Health & Social Care Partnership<br>**Contributors:** Tom Cowan, Head of Operations; Tony Duncan Head of Strategic Planning; Moira Pringle, Chief Finance Officer | **Implementation Date:**<br>31 October 2021 |
| **1.2e Agreed Management Actions: Review of Communities and Families/Health and Social Care directories within the Orb** | |
| The Communities and Families and Health and Social Care policy and procedures directories on the Orb will be reviewed and linked to policies within the approved policy register. All other policies will be reclassified in line with the definitions provided at recommendation 3.1a. | |
| **Owner:** Alistair Gaw, Executive Director, Communities & Families<br>**Contributors:** Jackie Irvine, Head of Safer and Stronger Communities and Chief Social Work Officer; Crawford McGhie, Senior Manager Estates and Operational Support; Andy Gray Head of Schools and Lifelong Learning; Bernadette Oxley, Head of Children's Services | **Implementation Date:**<br>30 June 2021 |
| **Owner:** Judith Proctor, Chief Officer, Edinburgh Health & Social Care Partnership<br>**Contributors:** Tom Cowan, Head of Operations; Tony Duncan Head of Strategic Planning; Moira Pringle, Chief Finance Officer | **Implementation Date:**<br>31 July 2021 |

| **2. Completion of Integrated Impact Assessments (IIAs)** | **High** |
|---|---|

Whilst the IIA guidance provided for policy developers on the Orb provides clear instruction on requirements using a simple flowchart and includes templates and checklists for completion, the following issues were also identified:

- links on the Health and Social Care 'policy development' page of the Orb still refer to Equalities and Rights Impact Assessments (ERIA);
- the links are broken and users are not redirected to the new IIA guidance;
- the current policy template has not been updated to reflect the introduction of IIAs and still refers to ERIAs; and
- the Council's website includes information on ERIAs; however it is noted there is limited reference to IIA. While IIAs have been completed for a number of Council wide plans such as the British Sign Language Plan, we were unable to find published IIAs for any recently approved Council policies.

Additionally, review of the current policy register published on the Council's website and recently approved policies established that:

- There is a lack of knowledge and understanding of IIA requirements and responsibilities across the Council, with all policy owners sampled advising they were not aware of IIA requirements, despite detailed guidance and templates being provided on the Orb and Equalities advisors being nominated by Head of Service.
- There is a lack of understanding of the requirement to complete an IIA for policies being revised in addition to new policies, with some policy developers believing that previously completed ERIAs were sufficient to cover the revised policy.
- The Council participates in an IIA Steering Group with other external agencies such as NHS

Lothian which reviews a sample of participants IIAs on a quarterly basis, however there is currently no established monitoring and oversight within the Council to confirm ongoing application of IIA requirements for new and refreshed policies within individual Directorate and Divisions.

**Risks**

The potential risks associated with our findings are:

- Inability to demonstrate compliance with current Integrated Impact Assessment legislation when developing or revising policies.
- Inability to demonstrate consideration of equality, human rights, sustainability and the environment in planning and policy decisions.
- Inaccurate and out of date Equalities and Rights Impact assessment information is made available in the public domain.

**2.1 Recommendations: Review and communication of IIA requirements**

a) The Orb should be updated to include links between the Policy Framework section and Integrated Impact Assessments (IIA) section to ensure all policy developers are aware of requirements;

b) The current policy template should be updated to replace the Equality and Rights Impact Assessment section with a statement outlining Integrated Impact Assessment requirements for each policy.

c) Integrated Impact Assessment requirements should be communicated via Newsbeat or a similar communication bulletin to enhance awareness of the need to comply with IIA requirements and remind all policy developers to complete an IIA when developing new or refreshing existing policies and to direct policy developers to nominated Directorate Equalities Advisors for ongoing support and guidance.

d) The Council's external webpage should be updated to include clearer references to IIAs and clearer links to the outcomes of completed IIA assessments.

**2.1a Agreed Management Actions – Updating Policy and IIA links on Orb**

The Orb will be updated to include links between the Policy Framework section and Integrated Impact Assessments (IIA) section to ensure all policy developers are aware of requirements.

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| **Owner:** Laurence Rockey, Head of Strategy & Communications<br>**Contributors:** Paula McLeay, Policy and Insight Senior Manager; Beth Hall, Strategy Manager | **Implementation Date:**<br>1 May 2020<br>(Complete) |

**2.1b Agreed Management Actions – Updating policy template to include IIA section**

The current policy template will be updated to replace the Equality and Rights Impact Assessment section with a statement outlining Integrated Impact Assessment requirements for each policy.

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| **Owner:** Laurence Rockey, Head of Strategy & Communications<br>**Contributors:** Paula McLeay, Policy and Insight Senior Manager; Gavin King, Democracy, Governance and Resilience Senior Manager; Beth Hall, Strategy Manager; Laura Callender, Governance Manager | **Implementation Date:**<br>1 May 2020<br>(Complete) |

**2.1c Agreed Management Actions – Communicating IIA requirements**

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| Integrated Impact Assessment requirements will be communicated via an appropriate channel across the Council enhance awareness of the need to comply with IIA requirements and remind all policy developers to complete an IIA when developing new or refreshing existing policies.<br>The communication will also include links to available guidance and contact details for Directorate Equality, Diversity and Rights Advisors who can provide additional support and guidance where required. | |
| **Owner:** Laurence Rockey, Head of Strategy & Communications<br>**Contributors:** Paula McLeay, Policy and Insight Senior Manager**;** Beth Hall, Strategy Manager | **Implementation Date:**<br>31 July 2020 |
| **2.1d Agreed Management Actions – Updating external website** | |
| The Council's external webpage will be updated to include clearer references to Integrated Impact Assessments (IIAs) and clearer links to the outcomes of completed IIAs. | |
| **Owner:** Laurence Rockey, Head of Strategy & Communications<br>**Contributors:** Paula McLeay, Policy and Insight Senior Manager; Beth Hall, Strategy Manager | **Implementation Date:**<br>1 May 2020<br>(Complete) |
| **2.2 Recommendations: Completion and publication of Integrated Impact Assessments (IIAs)** | |
| Heads of Divisions should implement processes to ensure Integrated Impact Assessments (IIA) requirements are considered and documented for all new and refreshed policies. Prior to submission of the policy for review and approval, checks should be performed to confirm that:<br>• IIA templates available on the Orb have been completed including the checklist, evidence table and summary report;<br>• approval has been provided by the head of division and documented where it is decided that an IIA is not required. Where an IIA has been completed, the head of division has approved the summary report with evidence of approval retained;<br>• the IIA has been completed prior to policy being drafted or revised with outcomes incorporated into the policy document where relevant; and<br>• plans have been developed to address IIA outcomes where action is required to confirm compliance. Action plans should have appropriate owners and implementation timescales with implementation progress monitored. | |
| **2.2 Agreed Management Actions: Completion and publication of Integrated Impact Assessments (IIAs) – All Directorates** | |
| Directorates will review all new and revised policies prior to submission for approval by Committee to confirm that all IIA requirements outlined in the recommendation above have been completed, with evidence of review and approval by the Head of Division retained.<br>Responsibility for monitoring progress with implementation of IIA action plans will be allocated to an appropriate senior responsible officer within each division to confirm that known gaps are being effectively addressed. | |
| **Owner:** Stephen Moir, Executive Director of Resources<br>**Contributors:** Hugh Dunn, Head of Finance; Katy Miller, Head of Human Resources; Nicola Harvey, Head of Customer and Digital Services; Peter Watton, Head of Property and Facilities Management; Nick Smith, Head of Risk and Legal | **Implementation Date:**<br>31 October 2021 |

| | |
|---|---|
| **Owner:** Paul Lawrence, Executive Director, Place<br>**Contributors:** Gareth Barwell, Head of Place Management; Lynn Halfpenny, Director of Culture; Michael Thain, Head of Place Development | **Implementation Date:**<br>31 October 2021 |
| **Owner:** Alistair Gaw, Executive Director, Communities & Families<br>**Contributors:** Jackie Irvine, Head of Safer and Stronger Communities and Chief Social Work Officer; Crawford McGhie, Senior Manager Estates and Operational Support; Andy Gray Head of Schools and Lifelong Learning; Bernadette Oxley, Head of Children's Services | **Implementation Date:**<br>31 December 2021 |
| **Owner:** Judith Proctor, Chief Officer, Edinburgh Health & Social Care Partnership<br>**Contributors:** Tom Cowan, Head of Operations; Tony Duncan Head of Strategic Planning; Moira Pringle, Chief Finance Officer | **Implementation Date:**<br>31 October 2021 |

| **3. Policy framework guidance** | **Medium** |
|---|---|

Review of the policy framework guidance included on the Orb highlighted that:

- First line and second line roles and responsibilities in relation to the policy management framework and confirmation of its ongoing application across the Council have not been clearly defined and communicated;
- The Orb guidance confirms that once a policy has been approved by the relevant executive committee, Strategy and Communications will update the policy register published on the Council's website. Directorates advised they are unclear on the process that should be applied to ensure that the register is updated.
- The Council's policy toolkit page does not include links to the policy definitions and templates or the policy register. Prior to the recent Orb refresh these documents were available for users to access and download;
- Clicking on the main 'developing our policies' Orb page directs the reader to a Health and Social Care policy page that contains a different set of policy definitions, templates and information, and could potentially result in confusion.

**Risks**

The potential risks associated with our findings are:

- Policies are not reviewed and updated in a timely manner and inline with legislative and statutory requirements.
- Policies available to the public via the online register are not current and may provide out of date information or not be aligned to relevant legislation.
- Policies are published in an inconsistent format with key information omitted.
- Council employees prepare policy documents which are not inline with the approved policy toolkit.

**3.1 Recommendations: Policy framework guidance**

a) Clear definitions should be established for policies; procedures; and guidance, approved by the Corporate Leadership Team and Corporate Policy and Strategy Committee, and communicated across all Council Directorates and Divisions;

b) First and second line roles and responsibilities in relation to the policy management framework and confirmation of its ongoing application across the Council should be clearly defined and communicated and included in the guidance published on the Orb;

c) Guidance and supporting templates on the Orb should be reviewed and refreshed to include links to agreed policy definitions and templates and the policy register checks performed to confirm that these can be accessed.

**3.1a Agreed Management Action: Policy framework – definitions for policies, procedures, and guidance**

Clear definitions will be established for policies; procedures; and guidance and will reflect that policies outline the Council's response to legislation; regulations and statutory requirements, specifying what the Council will do to ensure compliance, whilst procedures and guidance detail how policy objectives will be achieved.

The definitions will be agreed by the Corporate Leadership Team and The Policy and Sustainability Committee and will be communicated across all Council Directorates and Divisions.

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| **Owner:** Laurence Rockey, Head of Strategy & Communications<br>**Contributors:** Gavin King, Democracy, Governance and Resilience Senior Manager; Beth Hall, Strategy Manager; Kevin Wilbraham, Information Governance Manager; Laura Callender, Governance Manager | **Implementation Date:**<br>1 March 2021 |

**3.1b Agreed Management Action: Policy framework - first and second line roles and responsibilities**

Following the outcomes of the Working Group (see recommendation 1.2c), First line (directorate) and second line (Strategy and Communications) roles and responsibilities in relation to the policy management framework and confirmation of its ongoing application will be communicated across Directorates and Divisions and included in the guidance published on the Orb.

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| **Owner:** Laurence Rockey, Head of Strategy & Communications<br>**Contributors:** Gavin King, Democracy, Governance and Resilience Senior Manager; Laura Callender, Governance Manager | **Implementation Date:**<br>1 March 2021 |

**3.1c Agreed Management Action: Policy framework – review of guidance, templates and Orb pages**

Guidance and supporting templates on the Orb will be reviewed and refreshed to include links to agreed policy definitions and templates and the policy register and checks performed to confirm that these can be accessed.

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|---|---|
| **Owner:** Laurence Rockey, Head of Strategy & Communications<br>**Contributors:** Gavin King, Democracy, Governance and Resilience Senior Manager; Laura Callender, Governance Manager | **Implementation Date:**<br>1 March 2021 |

**4. Policies essential learning** — **Medium**

All new employees are expected to read key council policies or complete key policy e-learning when they join the Council.

Whilst essential learning guidance is available on the Orb, our review highlighted that some Divisions were unclear about essential learning requirements including relevant content for employees;

frequency; recording completion and the time that should be allocated to employees to complete the learning.

Human Resources acknowledge the need to provide clarity on essential learning regarding Council policies and any associated learning activities. A review is planned during 2020, the outcomes of which will be reported to the Council Leadership Team.

Essential learning templates for employee roles are available on the Orb, however our review noted Legal and Risk within the Resources Directorate are not available. Human Resources has advised draft templates have been developed by Learning and Development and are awaiting Head of Service approval.

**Risks**

The potential risks associated with our findings are:

- employees do not understand their responsibilities for ensuring ongoing compliance with applicable Council policy requirements, and do not understand the specific policy requirements that are relevant to their roles, resulting in potential non-compliance with policies and unnecessary exposure to risk.

**4.1 Recommendation: Policies and essential learning**

a) Following completion of the planned review and subsequent decision by the Corporate Leadership Team, communications should be issued to provide clarity on which policies are deemed essential reading. This should include any associated learning activities, and only if appropriate and agreed by CLT, how completion of essential reading is monitored by managers.

b) Essential learning templates for Legal and Risk, should be reviewed and approved by the Legal and Risk Senior Management Team and then communicated and published on the Orb.

**4.1a Agreed Management Action: Communicating essential policies and any associated learning activities**

Following a report to CLT, agreed actions around key council policy learning requirements will be communicated.

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| **Owner:** Stephen Moir, Executive Director of Resources<br>**Contributors:** Katy Miller, Head of Human Resources; Margaret-Ann Love, Lead HR Consultant; Caroline Bayne, L&D Team Leader | **Implementation Date:**<br>30 December 2020 |

**4.1b Agreed Management Action: Learning templates - Legal and Risk**

Essential learning templates for Legal and Risk will be approved and communicated to relevant staff by 30 September 2020.

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| **Owner:** Stephen Moir, Executive Director of Resources<br>**Contributors:** Nick Smith, Head of Legal and Risk | **Implementation Date:**<br>30 September 2020 (Complete) |

# Appendix 1: Basis of our classifications

| Finding rating | Assessment rationale |
|---|---|
| **Critical** | A finding that could have a:<br>• ***Critical*** impact on the operational performance; or<br>• ***Critical*** monetary or financial statement impact; or<br>• ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or***<br>• ***Critical*** impact on the reputation of the Council which could threaten its future viability. |
| **High** | A finding that could have a:<br>• ***Significant*** impact on operational performance; or<br>• ***Significant*** monetary or financial statement impact; or<br>• ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or***<br>• ***Significant*** impact on the reputation of the Council. |
| **Medium** | A finding that could have a:<br>• ***Moderate*** impact on operational performance; or<br>• ***Moderate*** monetary or financial statement impact; or<br>• ***Moderate*** breach in laws and regulations resulting in fines and consequences; or<br>• ***Moderate*** impact on the reputation of the Council. |
| **Low** | A finding that could have a:<br>• ***Minor*** impact on operational performance; or<br>• ***Minor*** monetary or financial statement impact; or<br>• ***Minor*** breach in laws and regulations with limited consequences; or<br>• ***Minor*** impact on the reputation of the Council. |
| **Advisory** | A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice. |

# Appendix 2: Areas of audit focus

The areas of audit focus and related control objectives included in the review are:

| Audit Area | Control Objectives |
|---|---|
| Policy Framework | • Roles and responsibilities for policy management have been clearly defined, communicated and are understood across all levels including Governance, Directorates and Divisions;<br>• A schedule of Council statutory duties and powers, and applicable legislation and regulations has been developed and is regularly maintained, to ensure that policies reflect all relevant requirements;<br>• All Council policies currently in use (with the exception of HR policies) have been developed using the approved template, and include all mandatory sections complete, with a nominated policy owner responsible for implementation, communication and ongoing policy review and maintenance;<br>• All Council policies currently in use have been approved by relevant Committees and published in the Policy Register via the Council's website;<br>• Once approved, new and updated policies are communicated to relevant employees and other stakeholders (including members of the public);<br>• All Council policies (with the exception of HR policies) are reviewed annually or when there has been a policy or legislative change, with the most recent version made publicly available in a timely manner via the Council's website; and<br>• Archiving processes are in place to ensure superseded policies are no longer available to the public and Council employees. |
| Supporting Procedures | • Supporting procedures and/or guidance have been developed for all new and updated Council policies, where appropriate;<br>• Procedures include detailed steps for staff to follow and include clear roles and responsibilities;<br>• Procedures are updated to reflect policy revisions, legislative changes, system changes, and organisation/team restructures;<br>• Procedures and guidance are reviewed and approved by the relevant Senior Management Team (SMT); and other bodies such as Trade Unions; where appropriate; and<br>• New and updated procedures are communicated to relevant employees and are easily accessible via the Orb, with previous versions archived. |
| Integrated Impact Assessments (IIA) | • Processes have been established to consider and assess the impact of proposed new and revised policies on equalities, human rights, sustainability and the environment;<br>• Guidance and supporting information have been developed and communicated to ensure policy developers are aware of and understand requirements; |

| | |
|---|---|
| | • Decisions on whether an IIA is considered to be required or not are clearly documented and approved;<br>• IIAs are informed by relevant data and evidence, with both positive and negative impacts considered and incorporated;<br>• Results of assessments are recorded, with action plans developed and approved as required and published on the Council website; and<br>• Monitoring and oversight arrangements are in place to ensure that IIAs are completed to a suitable and consistent standard with results reported to appropriate governance forums. |
| Training | • Council policies considered as Essential Learning are included within role specific learning;<br>• Training / awareness raising requirements to support and facilitate understanding of Council policies are considered in consultation with Learning and Development prior to implementation;<br>• Completion of training is recorded and monitored through regular one to one catch ups with employees and annual looking back/forward conversations; and<br>• Training materials (face to face; online) are subject to regular review and updated in line with any policy changes. |
| Monitoring and oversight | • Review processes are in place to ensure all Council policies are developed in line with the agreed policy framework and supporting templates to ensure consistency, and prevent duplication and overlap;<br>• Monitoring processes are in place within each Directorate to confirm that policies are reviewed annually (with the exception of HR policies) and to support the policy statement within the annual assurance statements; and<br>• Escalation arrangements are in place to report and enforce improvement actions where policies are inconsistent with the framework. |

# *The City of Edinburgh Council*

## Internal Audit

### Edinburgh Health & Social Care Partnership

### Lone Working

Final Report

13 July 2020

HSC1902

**Overall report rating:**

| | |
|---|---|
| **Significant improvement required** | Significant and / or numerous control weaknesses were identified, in the design and / or effectiveness of the control environment and / or governance and risk management frameworks. Consequently, only limited assurance can be provided that risks are being managed and that the Council's objectives should be achieved. |

# Contents



This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2019/20 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2019. The review is designed to help the City of Edinburgh Council assess and refine its internal control environment. It is not designed or intended to be suitable for any other purpose and should not be relied upon for any other purpose. The City of Edinburgh Council accepts no responsibility for any such reliance and disclaims all liability in relation thereto.

The internal audit work and reporting has been performed in line with the requirements of the Public Sector Internal Audit Standards (PSIAS) and as a result is not designed or intended to comply with any other auditing standards.

Although there is a number of specific recommendations included in this report to strengthen internal control, it is management's responsibility to design, implement and maintain an effective control framework, and for the prevention and detection of irregularities and fraud. This is an essential part of the efficient management of the City of Edinburgh Council. Communication of the issues and weaknesses arising from this audit does not absolve management of this responsibility. High and Critical risk findings will be raised with senior management and elected members as appropriate.

# 1. Background and Scope

## Background

The City of Edinburgh Council (the Council) and NHS Lothian (NHSL) respectively have legal duties under the Health and Safety at Work etc Act 1974; and Management of Health and Safety at Work Regulations 1999 to ensure the safety and welfare of anyone working within the Edinburgh Health and Social Care Partnership (the Partnership) as far as reasonably practicable. The law requires employers to consider carefully, and then deal with, any health and safety risks for people working alone.

The Health and Safety Executive (HSE) defines lone workers as those who work by themselves without close or direct supervision and has published health and safety guidance on the risks of lone working aimed at anyone who employs or engages lone workers. This guidance was revised in March 2020 to take account of COVID-19 and an increased number of lone workers working at home and a rise in individuals completing duties alone due to social distancing measures.

The Partnership provides services across communities that are delivered by Council and NHSL employees who carry out duties on behalf of the Partnership through either their relevant parent organisation or integrated Partnership teams. Employees may be required to work alone within service user's homes; communities; or in isolated office or public premises for all or part of their working hours. As a result, lone workers can be vulnerable and exposed to hazards including an increased risk of physical or verbal abuse and harassment from patients, service user, their relatives or members of the public.

Regulation 3 of the Management of Health and Safety at Work Regulations 1999 requires employers to complete health and safety risk assessments for employees and others who could be affected through the activities that they carry out. Workers also have responsibilities to take reasonable care of themselves and other people affected by their work activities and to co-operate with their employers in meeting their legal obligations.

## Lone working frameworks

### City of Edinburgh Council

Lone Working Guidance developed by the Council's Corporate Health and Safety team is available via the Orb (the Council's intranet). This provides general guidance on lone working safety measures and includes a checklist and risk assessment for completion by lone workers and their managers. The guidance is designed to ensure ongoing compliance with Health and Safety at Work regulations.

The guidance requires divisions to develop lone working procedures that include adequate information, instruction, training, communication and supervision arrangements linked to work activities, and suggests that line managers should complete risk assessments (as required by the legislation) to decide what arrangements are necessary to ensure that a lone worker is not exposed to significantly greater risks than other employees before a task or service provision begins.

Risk assessments should be used to identify whether the work can be carried out safely by a lone worker, and areas where lone working magnifies the risks presented by the hazards. It should also identify appropriate control measures and any further action required to ensure the employees' health and safety.

In line with the Council's guidance, the following roles and responsibilities apply across the Partnership:

- Managers should ensure that local lone working procedures have been established.
- Line managers should ensure that appropriate risk assessments are carried out in their areas, that include an assessment of risks faced by lone workers and the steps to be applied avoid or control risks where necessary.
- Employees are required to apply divisional lone working procedures and apply the controls identified in the lone working risk assessments.

A joint Health and Social Care / Communities and Families Lone Working policy and supporting procedures for social work and social care staff are available for staff and managers to access via the Orb.

**Training and supervision requirements**

Essential learning templates for Council health and social care job roles are published via the Orb. The templates have been developed by the Council's Learning and Development team in conjunction with service area managers and subject matter experts and detail the type of training required, how often it should be undertaken and how the training is delivered. The templates should be reviewed annually to identify any required training that is not captured within the templates. Line managers should record completion of mandatory training within MyPeople (the Council's HR system).

The Council's Social Care and Social Work Supervision policy and supporting procedure sets out requirements for the frequency and recording of one to one supervision meetings for different staff groups, this includes a requirement to consider risk assessments and training relevant to lone working.

**NHS Lothian**

Within NHSL, lone working is part of the Violence and Aggression policy. Managers are required to complete the Risk Assessment and Risk Reduction System (known as the Purple Pack). The aim of this is to identify any staff training or other requirements relating to violence and aggression and lone working.

### Lone working devices and technology

Technology such as mobile phones, alarms and monitoring services can be used to support lone workers. Most lone workers in the Council do not have access to lone working devices, however, a lone working technology solution for homecare workers is currently being explored. Other control measures are in place for some lone workers, for example use of call-in/call-out systems; electronic diaries; mobile phones and personal alarms.

Some NHSL lone workers use lone working devices (allocated based on risk assessment outcomes) that are monitored by an external service provider. The worker registers the device with the provider and advises which addresses will be visited as the devices do not use GPS. The worker contacts the provider at the start and end of each visit, and (if there is an issue) presses the alert button. The provider will listen in to the worker for signs of distress and will alert the police where required.

### Information sharing

Risks to lone workers when visiting service users may be reduced if they are made aware of any previous violent behaviour. Where there has been a 'near miss' or an incident involving a team member, it is essential that the information is shared with other team members, colleagues and third-party service providers who may be visiting the same individual. All incidents of aggression should be recorded and highlighted in the service user's file and where possible across shared systems.

A data sharing agreement has been established between the Council and NHSL to support information sharing across the Partnership and guidance on cross system access for NHSL and Council staff is provided via the Orb.

Where significant risks in relation to specific service users have been recorded, Council guidance advises that consideration should be given to arranging visits in a neutral venue (e.g. locality office). Service user assessments should be reviewed regularly to consider whether visits should be suspended, or alternative arrangements established to ensure staff safety, for example joint visits with more than one team member or Police accompanied visits.

### Incident monitoring and assurance reporting

Employee harm related incidents and near misses are reported through the Council's Safety, Health and Environment System (SHE) and the Datix system for NHSL. Quarterly incident reporting from both the Council and NHSL is provided to the Partnership Executive Management Team, the Partnership Quarterly Incident Management and Health and Safety Groups, and Council Health and Safety Group.

In April 2019, the Partnership adopted an integrated health and safety assurance framework to ensure that key health and safety risks are identified and escalated. Twelve key risk topics have been identified with quarterly reporting on how risks are being controlled across services. Standard templates are used to prepare quarterly reporting. Information is collated by tier, by team/service manager (level 4); then hub/cluster/ mental health & substance misuse manager (level 3); and then consolidated by locality manager in the level 2 report to the Partnership Executive Management Team; Quarterly Health and Safety Group; Council Health and Safety Group and NHS Lothian Health and Safety Committee.

### Previous lone working assurance reviews

Lack of clear lone working procedures and controls across the Partnership was identified as part of a risk profiling exercise undertaken by the Council's Corporate Health and Safety team in 2018 which highlighted that integrated Partnership teams were applying the separate Council and NHSL lone working standards. In April 2019, the Partnership agreed to implement a one organisation approach to managing health and safety, by adopting a single framework and associated reporting. Work has progressed to develop this with completion of joint NHSL/Council workshops at a team leader level to discuss requirements. In the interim, both Council and NHSL guidance and risk assessments continue to be used, although management has advised that some integrated Partnership teams have adopted use of the NHSL Purple Pack.

### Scope

The objective of this review was to assess the adequacy of design and operating effectiveness of the key controls established to ensure the safety of lone workers delivering adult social care services within the Edinburgh Health and Social Care Partnership. This included ensuring all aspects of the Health and Safety Executive's guidance on lone working has been considered and applied (where relevant) to all lone working roles.

The review also provides assurance in relation to the following risks:

Council Corporate Leadership Team (CLT) risk register as at December 2019

- As a result of potential gaps in training or understanding, and deliberate or accidental actions, there is a risk of non-compliance with legislative requirements, the Council's health and safety policies or operational procedures. This could lead to an incident resulting in regulatory breaches, harm to staff, service users or members of the public, subsequent liability claims, fines and associated reputational damage.

Health and Social Care Partnership risk register as at January 2020

- There is a risk that the Partnership is unable to comply with statutory health and safety regulations due to the lack of awareness and responsibility amongst Partnership staff leading to an increase in the potential harm to both staff and service users.
- There is a risk that staff and service user information is not shared effectively across teams due to separate NHS and CEC IT systems for recording staff and service user information leading to an increased risk that the correct information is not available to ensure safe care and staff governance.

## Limitations of Scope

NHS Lothian processes and controls established to support lone workers delivering healthcare services on behalf of the Partnership were specifically excluded from the scope of this review.

Our areas of audit focus as detailed in our terms of reference are included at Appendix 2.

## Approach

Review of lone working arrangements was performed on a sample basis across teams operating within the North West and South East localities. This included:

- three cluster occupational therapy (OT) teams
- one cluster social work team, one cluster home care team,
- one mental health team and
- one hub home care and re-ablement service.

## Reporting Date

Our audit fieldwork stopped on 17 March 2020 to enable the Partnership to focus on their Covid-19 resilience activities, and it is estimated that circa 70% of fieldwork testing was complete. Our findings and opinion are based on the conclusion of our work as at that date.

# 2. Executive summary

## Total number of findings: 5

| Summary of findings raised | |
|---|---|
| **High** | 1. Lone working framework |
| **High** | 2. Lone working controls, devices and equipment |
| **Medium** | 3. Incident monitoring and assurance reporting |
| **Medium** | 4. Essential learning, training. and supervision arrangements |
| **Medium** | 5. Health and Safety Risk Management and Covid-19 impacts |

## Opinion

**Significant improvement required**

Our review identified a number of significant and moderate control weaknesses in both the design and effectiveness of the Edinburgh Health and Social Care Partnership's (the Partnership) lone working control environment and governance and risk management frameworks. Consequently, only limited assurance can be provided that the risks associated with lone working are being effectively managed, and that the Partnership's objectives of ensuring the health and safety of lone workers in line with applicable legislation and regulations is achieved.

These outcomes are reflected in the 2 High and 3 Medium rated findings raised.

The High rated finding reflects the need for the Partnership to ensure that both the Council's and NHS Lothian's (NHSL) respective legal responsibilities in relation to ongoing compliance with statutory employer health and safety requirements are clearly defined and included in the Edinburgh Integration Joint Board's (EIJB) Scheme of Integration.

This finding also highlights the need for review of the current Health and Social Care lone working policy and procedures to ensure they are aligned with current Health and Safety Executive (HSE) guidance; the Council and NHSL policies; and effectively support Council and NHSL teams that work together to deliver Partnership services where lone working is involved. This includes ensuring that lone working risk assessments are consistently completed and reviewed and establishing new ways of sharing information across all partner organisations and third-party agencies to improve awareness, identification, and recording of high-risk service users and incidents to inform the lone working risk assessment process.

The second High rated finding demonstrates the need to ensure that consistent procedures are established and applied across localities and Partnership teams to enable confirmation of lone worker locations and maintain ongoing contact; emergency contact details are accurately maintained and can be used in the event of an incident; and that adequate lone working devices and equipment are provided to all lone workers, especially in case of high risk assessment outcomes.

The requirement to improve the current Partnership health and safety incident reporting process (including reporting lone working incidents and near misses); governance; and the first and second line health and safety assurance framework is detailed in the first Medium rated finding, whilst the second Medium finding highlights inconsistencies in identification of health and safety essential learning requirements; the processes applied to record and monitor completion of essential learning and training;

and the regularity of ongoing social worker supervision meetings. These findings in relation to essential learning and training and supervision meetings also demonstrate lack of alignment with Scottish Social Services Council (SSSC) code of practice requirements.

The final medium rated finding raised reflects that the Partnership risk management framework is currently being reviewed, and recommends that the health and safety lone working risks identified in this report (together with any findings raised by other assurance providers that have not yet been addressed) are recorded in team, locality, and Partnership risk registers, with significant and systemic risks escalated to Partnership management for inclusion in the Partnership risk register and the annual assurance statement.

**Consideration of lone working in relation to COVID-19**

Whilst the Partnership's response to Covid-19 was not specifically included in the scope of this review, it is important to highlight that the Partnership's response to the pandemic and new legislation and national guidance potentially introduces some new lone working risks, for example, due to implementation of working from home, social distancing measures, and workforce capacity and availability. These risks are reflected in revised HSE guidance available via the HSE website.

It is recommended that the Partnership completes a review of lone worker risk assessments in relation to any new working practices adopted to ensure that all lone working risks have been identified, and that appropriate mitigating controls are established in line with the guidance from Corporate Health and Safety included in the managers' news bulletin dated 2 June 2020.

It is also recognised that in response to COVID-19, essential learning for new or repurposed employees has been condensed. It is important that the Partnership ensures that personal safety and lone working training remains a part of this condensed learning.

## Management Response

Partnership management recognise the need to fully address the issues identified in this internal audit review. Due to COVID-19 impacts on resources and capacity, associated changes to working practices and linkages with Transformation Programme workstreams, the Partnership proposes to establish a working group to review each of the findings in detail and to ensure that holistic solutions are developed to address these issues across the Partnership.

The Partnership working group will be established by the Head of Operations and a detailed action plan which covers all the recommendations within the report produced by **31 December 2020**.

The detailed plan will be reviewed by internal audit to confirm that it addresses all findings raised in this report, and individual management actions raised to support subsequent follow-up by internal audit to ensure that the control gaps identified have been effectively addressed. The implementation date of **28 February 2021** reflects time to work collaboratively with internal audit to agree this.

# 3. Detailed findings

| 1. Lone working framework | High |
|---|---|

**1. Employer's legal responsibilities**

Review of the Edinburgh Integration Joint Board (EIJB) Integration Scheme (revised September 2019) confirmed that whilst it sets out legal and governance arrangements for each party (the City of Edinburgh Council and NHS Lothian) in relation to integration, it does not include a specific section on the employment status of employees delivering services through the Edinburgh Health and Social Care Partnership (the Partnership).

Review of integration schemes for four other IJBs confirmed inclusion of a specific section which clearly identifies that the employment status of staff does not change as a result of integration, and that they remain employed by their respective organisations.

The Partnership website does state that Partnership staff are employed by either the Council or NHS Lothian.

**2. Lone working policies and procedures**

General concerns were raised by employees during the audit in relation to lack of integrated policies and technology systems supporting delivery of Partnership services by integrated Council and NHS Lothian teams.

An example was provided where a Council employee manages a service delivered by an integrated team from an NHS building that is subject to compliance with five different Council and NHS Lothian policies. The manager advised that the Council employees had not been provided with training by NHS Lothian to support ongoing compliance with their policies.

Review of the joint Health and Social Care / Communities and Families Lone Working Policy and lone working procedures available via the Orb, and processes applied across localities and divisions also established that:

1. They have not been reviewed since February 2013.
2. They do not fully reflect the revised Health Safety Executive (HSE) lone working guidance.
3. They do not fully reflect the integrated Health and Social Care working arrangements introduced in 2016, and the Council's 2018 guidance.
4. They had not been reviewed or updated in response to a finding raised by Council's Corporate Health and Safety team in January 2018 that recommended considering whether the joint policy and procedures continued to meet the needs of each Directorate.
5. Several of the policy hyperlinks to relevant internal and external reference documents are no longer accessible.
6. No documented local lone working procedures had been established to support delivery of three of five services reviewed. In one service, the responsible senior officer had only been in post for five weeks, following a two-year vacancy. Consequently, compliance issues with lone working guidance and levels of supervision were acknowledged and accepted.
7. Guidance on review of lone working risk assessments is contradictory, as the Council's health and safety policy requires risk assessments to be reviewed at least annually whilst the joint Health and Social care policy requires quarterly review.

8. The Council's Lone Working guidance in relation to review of risk assessments is not specific as it states that the risk assessment must be reviewed periodically or when there has been a significant change.

**3. Completion of risk assessments**

Line managers are required to complete risk assessments to assess risks to lone workers and take steps to avoid or control these risks where necessary. A checklist and generic risk assessment template are included in the Council guidance to support the assessment process.

The following issues were noted during sample testing across services:

1. Only two of five services were fully compliant with risk assessment requirements (cluster home care, and hub home care and reablement services).
2. One service area completed its first team risk assessment during the audit.
3. No team risk assessments were in place for the remaining two service areas. There are now plans to remedy this.
4. Limited evidence was available to demonstrate that generic risk assessments are completed in consultation with or communicated to lone workers.
5. Individual lone working risk assessments are not routinely completed unless specifically required, for example, due to pregnancy or stress-related circumstances or as part of a return to work process.
6. Limited evidence was available to demonstrate that dynamic risk assessments are completed and recorded prior to service users visits by lone workers such as social workers and occupational therapists. Management advised that whilst these are not recorded, due diligence checks are performed prior to first visits to ensure that risks are assessed, and this includes engagement with referring agencies, colleagues, and relevant information held on systems.

   Reliance on generic rather than dynamic risk assessments was also highlighted by the Council's Corporate Health and Safety team during the course of our audit.

**4. Red flags and information sharing to enable identification of lone working risks**

Discussions with locality team leaders and H&S advisers highlighted that:

1. Known lone working issues and red flag alerts are not consistently recorded in the SWIFT case management system or shared with relevant services and teams.
2. There are issues accessing relevant information from cross service systems for example, housing notes entered on SWIFT, and case notes on the NHS Trak system, resulting in a reliance on these being communicated by the leading service/agency.
3. There is a requirement for more effective joint working to ensure access to and sharing of information on risks and incidents recorded across the wider Partnership and third-party agencies including other Council services such as housing services; NHS services; and Community Police.
4. A short-term Red Flag working group was established in October 2019 with the objective of addressing these concerns and was chaired by the Council's Corporate Health and Safety team, however this group has not met again.
5. A proposal to establish a corporate Red Flag Working group chaired by the Chief Social Work Officer to explore a Council wide approach was recommended at the Council Health and Safety Group in November 2019 but has not progressed further due to associated complexities.

## Risks

The potential risks associated with our findings are:

- Legal responsibilities and duties of the City of Edinburgh Council (the Council) and NHS Lothian for ensuring the health and safety of lone workers delivering integrated Partnership services are not documented and agreed.
- Policies and procedures are not aligned with currently applicable legislative, regulatory, and statutory requirements and best practice.
- Operational procedures developed by services are not aligned with the Council's policy.
- New and emerging lone working risks are not identified, assessed and addressed, exposing lone workers to unnecessary levels of risk.
- Breach in health and safety legislation and the Scottish Social Services Council code of practice.

## 1.1 Recommendation: Legal responsibilities for employees

The next scheduled review of the Edinburgh Integration Joint Board's Integration Scheme should include a section on the employment status of employees delivering integrated services across the Partnership, which clearly sets out how each party will meet its legal responsibilities, particularly in relation to health and safety.

## 1.1 Agreed Management Actions: Legal responsibilities for employees

These recommendations will be addressed within scope of the detailed action plan referred to in the Executive Summary wider management response at Section 2.

## 1.2 Recommendations: Review of Lone Working Policies and Procedures

a) The Partnership should engage with Communities and Families and NHS Lothian to consider the appropriateness and relevance of the current joint lone working policy and agree whether a standalone policy should be developed for all teams (including integrated teams) supporting delivery of adult social care services is required.

b) The Partnership should then engage Corporate Health and Safety and Communities and Families and NHS Lothian (if required) to design and implement a new lone working policy and supporting procedures for use across all teams delivering adult social care services across the Partnership.

   The approach to developing and implementing the new policy should include, but not be limited to:

   - Alignment with applicable Council and NHS Lothian health and safety/lone working policies; legislation; revised Health and Safety Executive (HSE) guidance and best practice.
   - Completion of an Integrated Impact Assessment prior to development in accordance with the joint Council and NHS Lothian guidance available on the Orb.
   - Consultation with a representative group of lone workers from teams across the Partnership to identify low and high-risk lone worker activities undertaken and to ensure the policy and procedures consider all needs and circumstances.
   - Review schedule to ensure the policy and associated procedures and any linked guidance documents are reviewed initially after one year, and at least every three years thereafter, or immediately following any changes in applicable legislation and regulations. All documents should include version control and clearly state the date of the last review, and the next scheduled review date.

- Assigning ownership of the policy to a senior responsible officer, responsible for ensuring that the policy is regularly reviewed and updated in line with applicable legislative, regulatory, and statutory requirements and communicated across all relevant Partnership teams.
- Review and approval of the policy by appropriate governance forum(s) and executive committees, with supporting procedures should be approved by senior management.
- Identification of associated training and learning requirements for the integrated policy for both Council and NHS Lothian employees working across integrated teams and in Council and NHS Lothian buildings.
- Communication and publication of the policy on platforms appropriate for integrated Partnership teams. For example, the Partnership's website, the Council's online policy register and NHS Lothian website as well as internal communication to employees via the Orb; the NHS intranet and Partnership employee newsletter.

**1.2 Agreed Management Actions: Review of Lone Working Policies and Procedures**

These recommendations will be addressed within scope of the detailed action plan referred to in the Executive Summary wider management response at Section 2.

**1.3 Recommendations: Locality lone working procedures and risk assessments**

a) Following review of the Partnership's lone working policy, standard lone working procedures should be developed for use across the Partnership. Where procedures need to be adapted to meet the needs of specific services and teams; employee roles; and service user profiles, these should be reviewed and approved by senior management to ensure consistent with the Partnership's policy. This should include a full review of the effectiveness of established locality processes and controls, and how and whether these are aligned with the new policy requirements (refer recommendations 2.1 to 2.2).

b) Detailed risk assessment guidance and processes should also be developed to ensure consistency in approach across services. This should include guidance on:

- ***generic*** risk assessments that consider typical lone working hazards and possible controls which might reasonably reduce the risks for a particular role or team;
- ***specific*** *risk* assessments which should be completed for individual circumstances; one-off or unusual lone working activities; and
- ***dynamic*** risk assessments which reflect individual circumstances; service users or environmental hazards to be reviewed and updated on an ongoing basis.
- risk assessment completion frequency should be reviewed to ensure mitigating controls remain effective and appropriate.

The guidance should also state the requirement for line managers to ensure that risk assessments are completed in consultation with and communicated to lone workers to ensure awareness of hazards and possible mitigating controls.

c) Local procedures and guidance should include clear roles and responsibilities for monitoring compliance with, and the ongoing effectiveness of controls in place and include appropriate contingency arrangements for ensuring continued oversight where line manager posts are vacant or where there is extended absence.

**1.3 Agreed Management Actions: Locality lone working procedures and risk assessments**

These recommendations will be addressed within scope of the detailed action plan referred to in the Executive Summary wider management response at Section 2.

**1.4 Recommendations: Information sharing protocols and processes**

Review of lone working policies and procedures should also include a review of information sharing arrangements across the Partnership, in consultation with the Council's Information Governance Unit (IGU). This should include:

a) Review of roles that require direct access to other Council and NHS systems (for example SWIFT/AIS and Trak) to enable sharing of service user risk information relevant to lone working risk assessments. and implementation of these access arrangements.

b) Development and communication of information sharing protocols with local police and other services across the Council such as Housing Services and Criminal Justice Social Work. These protocols should provide a clear explanation of what types of information can be shared; how and with whom and the processes to be applied.

c) Consideration of whether the Council wide Red Flag Working Group should be re-established at an operational level to ensure that known issues across the Council are discussed and communicated on a Council wide basis.

**1.4 Agreed Management Actions: Information sharing protocols and processes**

These recommendations will be addressed within scope of the detailed action plan referred to in the Executive Summary wider management response at Section 2.

**1.5 Recommendations: Red flag technology solution**

The Partnership should liaise with Council management to explore whether a red flag technology solution can be developed as part of the Council's refreshed digital strategy. This should consider the feasibility of implementing a consolidated single customer view or 'golden record' that shows details of all citizens using Council services; the services that they currently use (for example; Council tax; health and social care and criminal justice); identifies any citizens assessed as high risk to Council employees from a lone working perspective; and provides details of any incidents previously experienced by Council employees when dealing with these citizens or their families.

**1.5 Agreed Management Actions: Red flag technology solution**

This recommendation will be addressed within scope of the detailed action plan referred to in the Executive Summary wider management response at Section 2.

**2. Lone working controls, devices and equipment** — **High**

**1. Maintaining contact with lone workers**

The following issues were identified with service area arrangements for monitoring movements and maintaining contact with lone workers whilst working in the community and on home visits to service users:

<u>Out of hours working:</u>

- No call-in process has been established to confirm that home care workers finishing after 10pm have safely returned home following their last visit of the day. Home care management advised

that this is a locality wide issue, which was escalated to North East cluster and hub management in January 2020.

- In one locality visited, cluster and hub procedures require a safety check to be completed by a duty senior at the end of the day to ensure all staff have returned or checked in. Discussion with line managers highlighted that interpretation of the safety check process differs from this procedure, with seniors advising that active checks or follow up action was not required where officers returned home following their final visit; only if they had noted an intent to return to the office.
- Call in processes for Mental Health Officer (MHO) duty calls outwith locality arrangements are administered by a business support team until 16:45 Monday to Friday, and thereafter transferred to a contact centre out of hours team. Employees advised however, that no handover processes are in place to ensure check-in with MHO's where the visit commences before 16:45 but does not end until after 16:45.

Use of online calendars:

- Where local processes require officers to log details of appointments/visits in online calendars, it was identified that calendar permissions for some officers prevent managers/duty seniors from being able to view full details within calendar entries to determine the location of lone workers if required.
- In contrast, it was noted that the calendar permissions used by some officers provided access to personal sensitive client data included in calendar entries (including client name; address and social work service user ID number) to all Council employees with access to outlook calendars.

**2. Emergency contact procedures**

The Council's current Lone Working guidance advises that emergency contact procedures should be established, and training given to employees. Review of the procedures for a sample of services noted the following inconsistencies:

- Documented procedures that clearly set out the process to be followed where a lone worker cannot be contacted have not been developed across all services in the localities reviewed.
- One local procedure did not include sufficient detail for example, its states that if there are no replies to safety check calls the duty manager will escalate to the police. This misses other key checks such as trying other contact numbers, family members and home address. There is also no review schedule in place for this document.
- Whilst emergency arrangements were referred to in local procedures for two areas, a detailed process to be followed in the event of failed contact was still to be developed.
- Emergency contact and next of kin details for employees are recorded on MyPeople, however, line managers cannot view this information directly and in the event of an emergency would be required to contact Human Resources via askHR.
- Service areas have developed local processes to record emergency contact details for employees. It was noted that processes are inconsistent across services for example: one area used a password protected database; one area used a manual list while another area held individual employee record cards. A further area, where the senior officer was only in post five weeks, had no process in place. The officer advised a process would be established as soon as possible.
- It was also noted no review processes have been established to prompt regular review and update of records held, with employees in two areas confirming that their records required update.

- Photographic identification and staff descriptions are not held by services for sharing with the police in an emergency situation and would need to be requested from the security pass database maintained by Properties and Facilities Management.

**3. Lone working devices and equipment**

The Council's Lone Working guidance advises that local procedures should consider use of devices that help monitor lone workers to ensure they remain safe. Review of current arrangements highlighted the following:

Mobile phones

- Basic mobile phones (which do not have smart phone/internet functionality) have been provided to lone workers working in localities. During fieldwork there was consistent feedback that the lack of functionality (no satellite navigation or GPS tracking functions) and low battery life mean that basic mobile phones are not fit for purpose for lone workers.
- Provision of effective smart phones is a known long-standing issue. One service area visited was piloting smart phones on behalf of all locality occupational therapists. The business case to support the pilot highlighted inconsistencies between adult and child occupational therapy services, and a general lack of co-ordinated approach for different job roles within localities and Council-wide.

Personal alarms

- Provision of personal alarms is not consistent across the Partnership. Some employees advised they were unaware of whether personal alarms are provided but advised they would welcome this safeguard. One service advised that employees are expected to advise if they require an alarm and another service advised they record acceptance of personal alarms within employee files.
- Review of an incident report for a lone working related incident, where a lone worker had been followed and felt unsafe, noted that no alarm had been carried by the employee. It was however noted, that the manager advised the employee to obtain a personal alarm from the office and reminded them to carry this at all times while out of the office after the event.

First Aid

- The Council's lone working guidance states that consideration should be given to mobile workers carrying first aid kits. It was noted, that while first aid procedures are referred to in locality lone working guidance, lone workers are not routinely provided access to a mobile first aid kit.

**Risks**

The potential risks associated with our findings are:

- The Partnership is unable to confirm safety and location of employees and respond to an emergency incident if required.
- Limited access to next of kin details if required in an emergency situation.
- Failure to provide employees access to equipment that would significantly enhance personal safety.

**2.1 Recommendations: Establishing consistent call-in / contact monitoring procedures**

a) Standard call-in processes including end of day safety checks should be implemented across all lone working roles to ensure that all lone workers have returned home safely from a final appointment or visit if not expected to return to the office. Call in processes should be supported

by documented and detailed escalation protocols where contact is unsuccessful. This should include formal handover processes for between services and out of hours teams.

b) Clear protocols should be established (in consultation with the Council's Information Governance Unit) for use of online calendars to monitor lone working visits and appointments. This should include limiting access to view full details only to officers who need to know this to ensure service user confidentiality.

c) Standard emergency procedures for lone working should be documented for all service areas across the Partnership. This should include contingency plans with detailed actions to be taken should a pre-arranged contact not be made; an alarm device activated, or confirmation not received of safe return to home or office base.

All team members should be consulted in developing processes, and processes should be rolled out with training.

d) A standard process should be implemented across the Partnership for recording details of lone workers, in consultation with the Council's Information Governance Unit. This should include contact details for the employee; next of kin details; a description of the employee; car details (make/model/colour) if applicable and a photograph (this could be through the Council/NHS employee identification badge process).

The NHS Scotland violence and aggression in the workplace toolkit (published 2017) includes a lone worker data sheet template which could be adapted for this purpose. This information should be held in confidence for sharing with the police in an emergency situation.

A regular review process should be implemented to ensure contact and personal details remain up to date.

**2.1 Agreed Management Action: Establishing consistent call-in / contact monitoring procedures**

These recommendations will be addressed within scope of the detailed action plan referred to in the Executive Summary wider management response at Section 2.

**2.2 Recommendation: Review of lone working devices and equipment**

The Partnership should undertake a review of the lone working devices and technology in use across all services and teams. This should include:

- Review of devices and technology currently available to all lone workers and requirements for each lone worker job role in line with risk assessment outcomes.
- Reviewing the effectiveness of basic mobile phones for mitigating lone working risks and assessing the feasibility of alternative options. The cost implications with providing all lone workers with Smartphones are acknowledged, together with recognition that many lone workers may have their own Smartphone device, therefore feasibility of use of a lone worker Smartphone application with features such as activity logging; GPS location tracking and panic alarm functionality in case of emergency should be considered. Where provision of a Smartphone or application is not feasible, limitations of basic mobile phones should be captured through risk assessments and compensating controls identified.
- The review of devices and technology should also consider provision of personal alarms and access to mobile first aid kits for lone workers across the Partnership. Supply of these should again be captured via risk assessments.

- Guidance should be provided for use of all devices provided and where required supported by training to ensure effective, consistent and appropriate use of the technology provided, in line with relevant Council policies and procedures.

**2.2 Agreed Management Actions: Review of lone worker devices and equipment**

These recommendations will be addressed within scope of the detailed action plan referred to in the Executive Summary wider management response at Section 2.

| **3. Incident monitoring and assurance reporting** | **Medium** |
|---|---|

Our review confirmed that the first line Health and Social Care Partnership (Partnership) assurance model did not operate effectively in relation to identification and resolution of lone working health and safety concerns.

Additionally. whilst the second line Corporate Health and Safety team identified a number of lone working concerns in their January 2018 audit, these were not effectively addressed by the Partnership.

The situation was further exacerbated by turnover in the Corporate Health and Safety team that impacted their ability confirm whether the recommendations made had been implemented by the Partnership in line with their established second line assurance model.

Specifically:

**1. Partnership – First line incident recording and reporting**

Review of health and safety incident recording and reporting processes in relation to lone working established that:

1. Lone working root causes - whilst the Council's Safety, Health, and Environment (SHE) incident management and reporting system ensures that all health and safety incidents and near misses can be recorded, it does not support recording of lone working as a root cause associated with incidents. Information on the root cause can be captured in the incident notes section of the system, however, this does not flow through into the management information produced from the system.
2. Third party lone working incidents – there is a lack of awareness of lone working incidents experienced by third parties supporting delivery of Partnership services as these are not recorded in either the Council's SHE or NHSL Datix systems.
3. During audit fieldwork lone workers advised limited arrangements are in place to ensure lessons learned from lone working related incidents and near misses for third-party providers are captured and communicated across the Partnership.

**2. First line reporting to Partnership health and safety governance forums**

Consistent feedback was provided that the templates used for quarterly reporting of key risk topics are aligned to NHS Lothian policies, procedures and terminology and are therefore difficult for Council teams to complete fully and accurately.

Review of a sample of level 2 (locality) and level 4 (team / service) reports submitted for Quarter one (Q1) and Quarter three (Q3) 2019/20, also highlighted the following issues:

- All seven questions set out in the Q1 violence and aggression/lone working directly relate to NHS Lothian policies and procedures which are outlined in the 'NHS purple pack'.
- Inconsistent reporting across localities for level 2 (locality) data. For example, one locality collated data for all areas in a single column, while another locality recorded data for clusters, hub and mental health services separately.
- Reporting errors were noted. For example, one service area completed reports for Q1 and Q3 using the quarter 2 thematic template, resulting in incomplete and inaccurate reporting on six key risk themes over a six-month period which suggests a lack of management review.
- Limited assurance that issues reported in previous quarters were subsequently followed up and resolved. For example, issues with reporting completion of Council training and e-learning modules.
- A lone working incident recorded in SHE in November 2019 had not been included in the 'adverse events and reporting of injuries; diseases; and dangerous occurrences regulations (RIDDOR) review section of the Q3 level 4 report.
- Recognising that reporting could be more robust, the Partnership's Executive Management Team requested that reporting on Q1 key risk topics (which included violence and aggression/lone working) was resubmitted in Q3. However, this information was not included in four of the six Q3 reports reviewed.
- One service area that was included in the framework in early 2020 was not provided with training to support their understanding and facilitate accurate completion of health and safety reports.

**3. Second line assurance – Corporate Health and Safety**

The Council's Health and Safety team completed an audit of lone working across the Council in January 2018. Our review identified the following issues in relation to confirming that Health and Safety audit recommendations made had been implemented by Partnership management teams:

- Responsibility for confirming implementation of recommendations with divisional and directorate management teams was not re-assigned to another Health and Safety team member when the Health and Safety Adviser leading this work left the Council.
- Individual reports and action plans issued to health and social care teams as part of the review could not be located by other Health and Safety team members.
- Issues of concern outlined in the health and safety audit summary report from January 2018 continue to be reportable issues, particularly in relation to policy review, risk assessment, control adequacy, training and review of emergency procedures.

**Risks**

The potential risks associated with our findings are:

- Inability to identify significant and systemic health and safety incidents experienced by Council and third-party workers that occurred when employees were working alone.
- Incomplete and inaccurate health and safety reporting is provided to established Partnership Health and Safety governance forums.
- Limited assurance that Partnership management has implemented recommendations made by the second line Corporate Health and Safety team.

### 3.1 Recommendations: Incident recording and reporting

a) Partnership management should engage the Corporate Health and Safety team to determine whether it is possible to configure the Safety Health and Environment (SHE) reporting system to record lone working as a root cause associated with health and safety incidents and near misses recorded in the system.

   Where SHE configuration is not possible, management should consider implementing an alternative recording and reporting process to record health and safety incidents that occurred as a result of lone working.

b) A process should be established to ensure that Partnership management is made aware of health and safety incidents and near misses experienced by third-party employees supporting delivery of Partnership services, especially where these relate directly to adult social care service users and a 'red flag' should be raised for awareness.

c) Significant and systemic health and safety incidents that are directly linked to lone working should be reported to the relevant Partnership governance forum within the established Partnership Health and Safety Assurance framework.

### 3.1 Agreed Management Action: Incident recording and reporting

These recommendations will be addressed within scope of the detailed action plan referred to in the Executive Summary wider management response at Section 2.

### 3.2 Recommendations: Incident monitoring and lessons learned

A process should be implemented to ensure that post-incident reviews are completed, and lessons learned are shared following lone working incidents involving Partnership or third-party employees. The process should include, but not be limited to:

- Line management support and debriefing to ensure any injuries are recorded and post-incident support needs are identified and addressed.
- An interim assessment to establish whether any other lone workers could potentially be exposed to similar risks supported by appropriate communication where necessary.
- Full investigation of the incident, with a review of associated risk assessments to assess the adequacy of existing controls and identify further controls to prevent recurrence.
- Communication of lessons learned across the Partnership, Council, NHS Lothian and third-party providers involved in provision of adult social care services for the Partnership.

### 3.2 Agreed Management Action: Post-incident reviews and lessons learned

These recommendations will be addressed within scope of the detailed action plan referred to in the Executive Summary wider management response at Section 2.

### 3.3 Recommendations: Reporting to Partnership health and safety governance forums

The process supporting consolidation of health and safety data across teams / services; hub / clusters / mental health & substance misuse; and then localities for upward reporting to Partnership health and safety governance forums established as part of the health and safety assurance framework should be reviewed and refreshed. The revised process should include, but not be limited to:

- Alignment of the reporting process with the key health and safety requirements specified in the Council's health and safety policies and procedures.
- Reinforcing the requirement to ensure that supporting rationale is provided where information is incomplete, or where compliance related issues have been identified.
- The requirement for management to review quarterly reports to confirm their completeness and accuracy at each reporting level, and prior to submission of consolidated reports to relevant Partnership health and safety governance forums.
- Clear expectations for reporting on progress with incomplete actions or issues to ensure they are adequately addressed.
- A process for ensuring any changes to thematic health and safety topics are effectively communicated to all relevant managers sufficiently in advance of the report preparation process.
- Providing detailed process documentation and guidance and communication detailing how the reports should be prepared, supported by examples and training (where required).

**3.3 Agreed Management Action: Reporting to Partnership health and safety governance forums**

These recommendations will be addressed within scope of the detailed action plan referred to in the Executive Summary wider management response at Section 2.

**3.4 Recommendations: Corporate Health and safety audit recommendations**

a) The Council's Corporate Health and Safety team should ensure that a handover is performed when team members leave. This handover process should include transfer of responsibility for ensuring that first line divisional and directorate management confirmation of implementation of recommendations has been obtained.

b) The Partnership should implement an oversight process to monitor progress with implementation of outstanding Corporate health and safety audit recommendations, with implementation progress included in quarterly reporting provided to relevant Partnership health and safety governance forum within the established Partnership health and safety assurance framework, and overdue actions reported to the Partnership's Executive Management team for escalation where necessary.

**3.4a) Agreed Management Action: Corporate Health and safety audit recommendations – handover process**

The Council's Corporate Health and Safety team will ensure that a handover is performed when team members leave, where possible. This will include transfer of responsibility for ensuring that first line divisional and directorate management confirmation of implementation of recommendations has been obtained.

| | |
|---|---|
| **Owner:** Stephen Moir, Executive Director of Resources<br>**Contributors:** Nick Smith, Head of Legal and Risk; Robert Allan, Corporate Health and Safety Manager | **Implementation Date:**<br>31 December 2021 |

**3.4b) Agreed Management Action: Corporate Health and safety audit recommendations – Partnership oversight processes**

These recommendations will be addressed within scope of the detailed action plan referred to in the Executive Summary wider management response at Section 2.

| 4. Essential learning, training, and supervision arrangements | Medium |
|---|---|

Review of essential learning templates published on the Orb for the Health and Social Care Partnership (the Partnership) and a sample of employee training records established that:

**1. Completion of lone working and health and safety training**

- The requirement to complete mandatory / essential personal safety lone working training is inconsistent, despite most locality roles involving an element of lone working. For example, lone working training is included in the essential learning templates for senior social workers, social workers, social care workers, social care assistants and community therapy assistants but not for senior occupational therapists, occupational therapists, community care assistants, mental health officers, home care managers, home care coordinators or home care organisers.
- Personal safety lone working training is also not assessed as mandatory / essential for similar non-locality-based health and social care roles such as emergency home care coordinators and organisers.
- Managers advised that 'Personal Safety Lone Working' training is undertaken by all employees on induction regardless of whether it is classified as mandatory or not. Review of thirteen training records identified that only ten employees had completed the training.
- Essential learning templates only require personal safety lone working training to be completed on employment, with no requirement to complete refresher training. Sample testing noted that some employees completed training in 2009/10, prior to the Health and Social Care Partnership being established and introduction of the Council's lone working guidance.
- Only five of thirteen locality employees had completed any type of risk assessment training. Locality essential learning templates specify that all locality health and social care roles should complete the Corporate Health Safety (CHS) Risk assessment training every three years.
- There was no evidence to confirm completion of 'Accident Investigation and SHE Corporate Health Safety' training, which is required to be completed every three years by all locality roles as specified in essential learning templates.
- Only three of thirteen locality officers had attended either half or full day 'Dealing with Conflict' courses in line with the Council's lone working guidance. Additionally, this training requirement is not included in locality essential learning templates

**2. Monitoring and recording completion of essential learning**

Managers of office-based staff advised that completion of essential policies learning is recorded and monitored through MyPeople. However, a system walkthrough of MyPeople identified a number of issues including difficulty in navigating the system to locate the user defined field (UDF), and inability to record, monitor and report on completion recurring policy learning and associated training.

In addition, an individual system to record and monitor completion of training against expected completion dates is in place for home care teams. Review of a cluster monitoring sheet for 54 home care staff noted that:

1. The training record was last updated in July 2019, and no dates were recorded for completion of lone working training for six of the fifty-four employees. The line manager noted that updating the monitoring sheet is performed by business support.
2. Training records were not aligned to the home care essential learning template, for example, completion of risk assessment training was recorded as one-off training for social care workers and as not required for social care assistants, however the essential learning template requires all locality job roles to complete risk assessment training every three years.
3. Only twenty-nine of the fifty-four social care workers / assistants were recorded as having completed risk assessment training.
4. It was also noted that the monitoring sheet highlighted overdue dates for other types of core tutor led and e-learning mandatory refreshers, for example manual handling, management and administration of medicines and public protection.

**3. Social worker supervision meetings**

Evidence was provided to demonstrate that there is opportunity for employees to feedback any concerns in relation to work, training and wellbeing issues via team meetings and one to one supervision meetings.

Review of this process in two of four service areas reviewed established that:

- Formal six-monthly supervision meetings with some home care workers in one team had not been held. The manager advised that some gaps were due to staff absence, however acknowledged that improvements are required.
- For one team no supervision meetings had taken place for two years due to a vacancy. The new senior social worker appointed in January 2020 has since held supervision meetings and advised that future meetings will be scheduled every four weeks in line with policy.

**Risks**

The potential risks associated with our findings are:

- Training needs for all job roles have not been adequately identified and addressed.
- Breach in health and safety legislation, that places a duty on the Council to ensure that employees can work safely in accordance with their training and instructions given to them.
- Breach of the Scottish Social Services Council (SSSC) code of practice requirement to provide good quality induction, learning and development opportunities and ensure employees undertake relevant learning.
- Lone working concerns are not raised and discussed at supervision meetings.
- Breach of SSSC code of practice requirement to effectively manage and supervise social service workers to support continuous improvement and improvement through reflective practice.
- Potential censure from the SSSC and the Care Inspectorate.

**4.1 Recommendations: Review and alignment of Essential Learning Templates**

Following review of lone working policies and procedures (refer recommendation 1.1) essential learning templates for all Partnership job roles should be reviewed and aligned with support from the Council's Learning and Development team.

This should include the requirement for all Partnership roles with an element of lone working to complete relevant personal safety lone working; risk assessment; and dealing with conflict training as part of their induction process and on an ongoing basis at a specified frequency (for example every three years).

Once agreed with service managers, the essential learning templates should be approved by the relevant Head of Division and published on the Orb. Details of the refresh should be communicated via the Health and Social Care blog and Manager's News to ensure awareness of requirements.

**4.1 Agreed Management Actions: Review of essential learning requirements**

These recommendations will be addressed within scope of the detailed action plan referred to in the Executive Summary wider management response at Section 2.

**4.2 Recommendations: Monitoring completion of essential learning**

a) Support and guidance should be requested from Learning and Development on the process line managers should follow to record completion of employee essential learning in MyPeople. This should include guidance on accessing and navigating the system and clear expectations on what information is required to be recorded for each individual. Guidance should also be provided on how information in MyPeople can be reported to allow regular monitoring of completion of refresher training.

b) Standard processes should be developed across localities to ensure that there is effective recording and monitoring of completion of essential learning and other training by all employees where this cannot be recorded on MyPeople.

c) Key performance indicators should be established for completion of essential learning and training with reporting provided to the Partnership's Health and Safety assurance framework. This should include commentary on issues and barriers preventing training. Instances of specific non completion across localities or by employees should also be reported to enable management to implement appropriate remedial action.

**4.2 Agreed Management Actions: Monitoring completion of essential learning**

These recommendations will be addressed within scope of the detailed action plan referred to in the Executive Summary wider management response at Section 2.

**4.3 Recommendations: Regular supervision meetings**

a) Line managers and supervising officers should be reminded of the responsibility to ensure that regular supervision meetings take place within required timescales and in line with Scottish Social Services Council (SSSC) code of practice requirements.

b) Responsibility for undertaking supervision meetings should be re-assigned where line manager posts are vacant to ensure that all employees have the opportunity to regularly discuss any concerns.

c) Completion of regular supervision meetings should be monitored via a key performance indicator as part of the Partnerships Health and Safety assurance framework. This should include commentary on issues and barriers preventing completion of regular supervision meetings which should be escalated and addressed by senior management. Persistent non-completion of regular supervision meetings should also be reported to enable remedial action to be taken by senior management.

## 4.3 Agreed Management Actions: Regular supervision meetings

These recommendations will be addressed within scope of the detailed action plan referred to in the Executive Summary wider management response at Section 2.

## 5. Health and Safety Risk Management and Covid-19 impacts — Medium

There are currently no risk registers for localities or their associated teams. Management has advised that the current Partnership risk management framework is being reviewed and will include development and ongoing use of locality risk registers.

Additionally, review of the Partnership's 2019/20 annual governance statement confirmed that none of the points noted in the findings raised in this report had been identified for inclusion and disclosure in the health and safety section of the statement.

Finally, it is important to ensure that lone working risk assessments are reassessed to reflect the current and potential future impacts of Covid-19 on the Partnership's lone working arrangements.

### Risks

The potential risks associated with our findings are:

- Significant and systemic adult social care health and safety risks (including lone working) are not identified, assessed and addressed.
- Significant and systemic health and safety risks are not escalated for inclusion in either the Council's or NHS Lothian (where appropriate) corporate risk registers.
- Significant and systemic health and safety risks are not disclosed in the Partnership's annual governance statement.
- Findings raised by other assurance providers (for example, the Corporate Health and Safety team) are not recorded, addressed and disclosed in the annual governance statement.

### 5.1 Recommendations: Health and safety risk management

a) Partnership management should design and implement a refreshed risk management framework to ensure that:

- All relevant risks (including health and safety and lone working) are consistently identified; assessed; and recorded across localities.
- Risks associated with findings raised by other assurance providers (for example, Corporate Health and Safety) are included in risk registers, together with actions to be implemented to address them.
- Actions are agreed and allocated to relevant team members to ensure that appropriate measures are implemented to mitigate or address the risks identified, within agreed implementation timeframes.
- Risk registers are reviewed at locality governance forums to ensure that all significant and systemic risks are identified and escalated to management for inclusion in the Partnership risk register.
- All risks included in the Partnership risk register and risks associated with all open assurance findings (regardless of source) are reflected in the Partnership's annual governance statement.

b) Line managers should be reminded to review all current risk assessments to make sure they take account of the changing working environment and associated impacts of COVID-19.

**5.1a) Agreed Management Actions: Health and safety risk management**

Completion of this action is part of a wider action to refine the Risk Management Framework for the Partnership, which will include Localities. Management will provide an update and further detailed actions once the overall Risk Management Framework has been approved. Consideration will be given to the points set out in the recommendation.

| | |
|---|---|
| **Owner:** Judith Proctor, Chief Officer<br><br>**Contributors:** Tom Cowan, Head of Operations, Edinburgh Health and Social Care Partnership; Deborah Mackle, South West Edinburgh Locality Manager; Nikki Conway, South East Edinburgh Locality Manager; Angela Lindsay, North East Edinburgh Locality Manager; Mike Massaro-Mallinson, North West Edinburgh Locality Manager | **Implementation Date:**<br><br>30 June 2022 |

**5.1b) Agreed Management Actions: COVID-19 lone worker risk assessments**

A reminder will be issued to all Partnership localities and services to request that all current risk assessments are reviewed to ensure they take account of the changing working environment. Further changes to risk assessment templates and procedures will be addressed as part of the wider detailed action plan.

| | |
|---|---|
| **Owner:** Judith Proctor, Chief Officer<br><br>**Contributors:** Tom Cowan, Head of Operations, Edinburgh Health and Social Care Partnership; Deborah Mackle, South West Edinburgh Locality Manager; Nikki Conway, South East Edinburgh Locality Manager; Angela Lindsay, North East Edinburgh Locality Manager; Mike Massaro-Mallinson, North West Edinburgh Locality Manager | **Implementation Date:**<br><br>30 September 2020 |

# Appendix 1: Basis of our classifications

| Finding rating | Assessment rationale |
|---|---|
| **Critical** | A finding that could have a:<br>• ***Critical*** impact on the operational performance; or<br>• ***Critical*** monetary or financial statement impact; or<br>• ***Critical*** breach in laws and regulations that could result in material fines or consequences***;*** *or*<br>• ***Critical*** impact on the reputation of the Partnership which could threaten its future viability. |
| **High** | A finding that could have a:<br>• ***Significant*** impact on operational performance; or<br>• ***Significant*** monetary or financial statement impact; or<br>• ***Significant*** breach in laws and regulations resulting in significant fines and consequences***;*** *or*<br>• ***Significant*** impact on the reputation of the Partnership. |
| **Medium** | A finding that could have a:<br>• ***Moderate*** impact on operational performance; or<br>• ***Moderate*** monetary or financial statement impact; or<br>• ***Moderate*** breach in laws and regulations resulting in fines and consequences; or<br>• ***Moderate*** impact on the reputation of the Partnership. |
| **Low** | A finding that could have a:<br>• ***Minor*** impact on operational performance; or<br>• ***Minor*** monetary or financial statement impact; or<br>• ***Minor*** breach in laws and regulations with limited consequences; or<br>• ***Minor*** impact on the reputation of the Partnership. |
| **Advisory** | A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice. |

# Appendix 2: Areas of audit focus

The areas of audit focus and related control objectives included in the review are:

| Audit Area | Control Objectives |
|---|---|
| 1. Legal responsibilities | 1.1 Lone working responsibilities in relation to ongoing compliance with applicable legislation and the Edinburgh Integration Joint Board; NHSL and other relevant third-party legal responsibilities in relation to lone working incidents that impact integrated partnership working teams have been clearly defined, agreed, and communicated. |
| 2. Provision of advice and information | 2.1 Policies and supporting procedures aligned to best practice and legislative requirements have been developed to manage lone working across the Partnership.<br>2.2 Comprehensive and up to date information and guidance on lone working is available to managers and workers. This includes clearly defined roles and responsibilities and guidance on completion of lone working checklists and risk assessments.<br>2.3 Localised lone working procedures aligned to the Partnership's policy are in place for all relevant Partnership services<br>2.4 Risk assessment templates have been developed which cover both generic and role specific lone working.<br>2.5 Comprehensive learning materials are provided, supported by provision of training on areas including managing violence and aggression, conflict resolution; personal safety and incident reporting. |
| 3. Lone Worker Risk Assessments | 3.1 The Partnership has recorded the population of lone workers in operation across all services.<br>3.2 Identification of potential for lone working forms part of the onboarding process for new employees, with appropriate training included as part of induction processes.<br>3.3 Individual and generic risk assessments are completed in consultation with workers with the outcomes recorded and communicated to all relevant team members.<br>3.4 Appropriate control measures are identified, implemented (prior to lone working activities commencing), and recorded, for example: provision of personal safety devices, call in processes, system flagging and preventative measures such as alternative locations.<br>3.5 Processes are in place to escalate and address outstanding actions from individual assessments.<br>3.6 Individual risk assessments are reperformed at regular intervals or where there is a change to employee or service user circumstances. |

| | |
|---|---|
| 4. Review of Lone Working Procedures and Incidents | 4.1 Procedures, guidance, and templates are reviewed regularly and immediately following lessons learned from any significant incidents or changes to working practices. Reviews are completed in consultation with lone working representatives.<br>4.2 Risk assessments are reperformed regularly to provide assurance on continued effectiveness of existing control measures, for example, testing personal alarms and ensuring contact details are up to date.<br>4.3 All actions required as result of reviews are recorded with appropriate owners and timeframes allocated.<br>4.4 Processes are in place to identify, review and take action to address common themes arising from both risk assessments and recorded incidents.<br>4.5 Common hazards and risks identified for groups of Council and NHS Lothian employees are subject to the same risk reduction measures based on shared best practice; (e.g. joint visits to high-risk individuals, and provision of safety devices).<br>4.6 All incidents, near misses, accidents and ill-health/absence related to lone working are reported, investigated and followed up.<br>4.7 Regular supervision arrangements are in place for all lone workers with any training/learning requirements recorded and addressed.<br>4.8 Emergency procedures have been established, are easily accessible and have been communicated and are easily accessible to all employees. |
| 5. Information sharing | 5.1 The data sharing agreement established between the Council and NHSL includes provision for sharing information in relation to lone working and the risks presented by specific clients.<br>5.2 Similar data sharing agreements have been established with other organisations involved in supporting delivery of partnership services that could potentially involve lone working risk.<br>5.3 The Partnership clearly states how it will use and share any personal data held.<br>5.4 Access to and visibility of personal data is controlled through system access permissions which are reviewed regularly to ensure they are appropriate.<br>5.5 An information sharing protocol is in place which details how the Partnership or Third Parties will notify each other of any known service hazards or risks identified either at outset of contract or as they emerge.<br>5.6 The protocol ensures that any changes to these service hazards or risks are notified to service providers on a timely basis.<br>5.7 Systems are in place to notify employees and third parties of known hazards such as system flagging, with clear procedures in place to support operation and understanding. |

# *The City of Edinburgh Council*

# Internal Audit

## Tree Management

Final Report

2 July 2020

PL1902

**Overall report rating:**

| | |
|---|---|
| **Some improvement required** | Whilst some control weaknesses were identified, in the design and / or effectiveness of the control environment and / or governance and risk management frameworks, they provide reasonable assurance that risks are being managed, and the Council's objectives should be achieved. |

# Contents



This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2019/20 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2019. The review is designed to help the City of Edinburgh Council assess and refine its internal control environment. It is not designed or intended to be suitable for any other purpose and should not be relied upon for any other purpose. The City of Edinburgh Council accepts no responsibility for any such reliance and disclaims all liability in relation thereto.

The internal audit work and reporting has been performed in line with the requirements of the Public Sector Internal Audit Standards (PSIAS) and as a result is not designed or intended to comply with any other auditing standards.

Although there are a number of specific recommendations included in this report to strengthen internal control, it is management's responsibility to design, implement and maintain an effective control framework, and for the prevention and detection of irregularities and fraud. This is an essential part of the efficient management of the City of Edinburgh Council. Communication of the issues and weaknesses arising from this audit does not absolve management of this responsibility. High and Critical risk findings will be raised with senior management and elected members as appropriate.

# 1. Background and Scope

## Background

The City of Edinburgh Council (the Council) is responsible for maintaining in a safe condition an estimated 140,000 mature trees, from a total estimated population of 731,000 trees of varying age and species across Edinburgh. The Council also undertakes works on private trees when these pose an imminent public danger.

The Council's duty of care in relation to tree management is set out in the following legislation:

- The Occupiers Liability (Scotland) Act 1960
- The Health and Safety at Work Act etc 1974, section 3 (1);
- Land Reform (Scotland) Act 2003;
- Roads (Scotland) Act 1984;
- Town and Country Planning (Scotland) Act 1997;
- Wildlife and Countryside Act 1981; and
- Nature Conservation (Scotland) Act 2004.

According to the Health and Safety Executive (HSE) statistics, tree work has a major injury incidence rate, higher than that of the construction industry. In accordance with legislation and HSE operational guidance on 'Management of the risk from falling trees or branches' (revised March 2013), the Council should:

- Survey its trees;
- Have this performed by a competent person via a Visual Tree Assessment (VTA);
- Take reasonable action to ensure that they are safe; and
- Create individual tree reports, recording potentially serious structural faults posing as potentially serious risk to public safety, and show where a tree is to be retained.

By law, chainsaw operators must have received adequate training relevant to the type of work they undertake. They are also required to wear appropriate chainsaw protective clothing whenever they use a chainsaw. The *Provision and Use of Work Equipment Regulations 1998 (PUWER 98)* sets the minimum competency for people using chainsaws. Further industry and HSE guidance are also relevant including aerial tree work; working with machinery; working at height and tree climbing. All workers involved in tree management are required to hold appropriate qualifications and relevant experience.

**Council's approach to Tree Management**

The Council's Trees and Woodland Action Plan 'Trees in the City 2014-2019 brings together the Council's 43 current tree policies and outlines how the Council intends to manage trees and woodlands in its ownership. It sets out the Council's tree-related policies and provides guidance to the public on tree related matters and on their rights and responsibilities.

The Council's Forestry Service inspects and maintains mature trees in public parks; natural heritage sites/nature reserves; other public green spaces; cemeteries; streets; highways; schools; sheltered housing; and some woodlands. The service consists of four Tree and Woodland Officers who survey and inspect trees and issue work orders, and a team of eleven arborists who carry out tree management works. In 2019/20, a total of 5464 inspections and 821 work orders were completed which included works on 3925 individual trees.

The service also inspects trees on land managed by other council services such as Property and Facilities Management (including schools) and Housing Services with tree on highways / roads; cycle networks / walkways; and former City Development land locations added to the work programme over the last few years.

The service also deals with enquiries and reported tree management issues from the public; undertakes planned project work including tree planting; and performs Dutch Elm disease inspections; as well as dealing with insurance reporting, emergency activity, and post-storm clear-up activities.

Tree Inspections

In line with the 'Trees in the City' action plan, all trees that are the responsibility of the Council should be inspected for safety by qualified people, on a cycle between one and five years according to size, condition, and previous survey recommendations for each tree. However, following a fatal accident in 2016, and on the advice of the HSE, the city has been zoned into different inspection durations, determined by tree age, condition, and location, as follows:

- annual inspection - large mature trees with recorded defects;
- three-yearly inspection - trees in schools and public parks, on streets or in residential locations; and
- five-yearly inspection - small, newly planted, and young trees.

Following inspection, the Council's Forestry Service will raise a work order to complete any works required in line with the following categories:

- urgent - within 48 hours
- high - within 28 days
- medium - within 3 months
- low - within 12 months

An asset register of trees is held within the *Ezytreev* database which is used to record and update the health, classification and maintenance records of Council owned trees that are inspected.

Management review of tree management risks

In May 2019, the Executive Director of Place presented a report to the Council's Corporate Leadership Team (CLT) advising that limited progress had been made in implementing the Council's tree policies, with estimates suggesting that less than half of the Council's most hazardous trees had been condition surveyed, and of those that had been surveyed, many had not been re-inspected within agreed time frames.

The report advised that over 82,000 Council owned trees required an initial condition survey, and further resource would be required to ensure that the Council meets its legal obligations and duty of care. The paper also advised that additional resources were required for completion of subsequent re-inspections and dealing with the backlog of tree management works. Following agreement from CLT, the service undertook a cost comparison to consider the cost of engaging external arborists versus recruitment of additional Council officers on a permanent basis. As a result, at the time of our audit, the recruitment of four additional officers was in progress.

**Incident Management**

The Council's Emergency Plan as at May 2019 includes a requirement for the Forestry Service to respond on an on-call basis to remove fallen trees from public roads, footpaths and to clear watercourses to aid flood prevention. The Council operates an emergency call-out system in the event of dangerous trees, and a duty officer is on call 24 hours a day, 365 days a year.

The Council engages private contractors to attend in emergency situations, ensuring that there is a stand-by team of arborists where this cannot be covered by internal resources. Incidents are received via the Council's Customer Hub and directly to the Forestry Service to action. The Council aims to attend emergency tree incidents within one-hour of reporting to assess the situation and start the process of making the site safe. The target response time for non-emergency works is 10-days. Management has advised that tree management is not currently included within the Council's Severe Weather plan; however, a Storm Event action plan was developed and approved in November 2019.

**Million Tree City**

On 28 January 2020, the Council's Culture and Communities Committee agreed the next steps to support the ambition for Edinburgh to be a 'Million Tree City' including establishment of an Edinburgh Million Tree forum with representation from the Council and key partners, including the Woodland and the Scottish Wildlife Trusts. These next steps included development of a costed action plan to identify the associated costs; potential grant funding available; and resources required from the Council.

The Committee also requested that an annual report on progress with achieving the ambition, detailing the number of trees planted and removed was provided.

## Scope

The objective of this review was to assess the adequacy of design and operating effectiveness of the key controls established to ensure that the Council manages the condition of its trees, ensuring that their quality is maintained and does not present any significant risks to the general public. This involved confirming that a trees' asset register is maintained; tree condition is regularly assessed; and preventative measures are implemented to address any concerns identified by Council employees or reported by citizens.

No specific risk is currently recorded on the Place Directorate or service level risk register. Nor is tree related safety recorded on the risk registers of other Council services with trees on their landholdings. However, this review aimed to provide assurance in relation to the following Corporate Leadership Team (CLT) risks as at December 2019:

- **Response to a major incident -** a sudden high impact event causes harm to people and damages infrastructure, systems or buildings. This could be as a result of weather, electronic or physical attack or accident. Impacts could include buildings, staff and/or systems being non-operational for a time, resulting in a reduced ability to deliver services. Also, part of this risk is that a failure to deliver an appropriate level of service in response to a sudden operational requirement may lead to harm to people and reputational damage to the Council.
- **Health and Safety (H&S)** - as a result of potential gaps in training or understanding, and deliberate or accidental actions, there is a risk of non-compliance with legislative requirements, the Council's health and safety policies or operational procedures. This could lead to an incident resulting in regulatory breaches, harm to staff, service users or members of the public, subsequent liability claims, fines and associated reputational damage.

Our areas of audit focus as detailed in our terms of reference are included at Appendix 2.

## Reporting Date

Our audit work concluded on 3 March 2020 and our findings and opinion are based on the conclusion of our work as at that date.

# 2. Executive summary

## Total number of findings: 2

| Summary of findings raised | |
|---|---|
| **High** | 1. Strategic direction and operational delivery |
| **Low** | 2. Tree management risks |

## Opinion

**Some improvement required**

Whilst some significant and minor control weaknesses were identified in the control environment and governance and risk management frameworks established to support delivery of tree management services across the City by the Council, they provide reasonable assurance that risks are being managed, and that the Council's objectives to maintain trees across the City in line with relevant legislation and regulations and to deliver the 'Million Tree City' strategy should be achieved.

Consequently, one High and one Low rated finding have been raised.

The High rated finding raised highlights the need to review and refresh the existing tree management strategy to ensure it is effectively aligned with the 'Million Tree City' ambition agreed by the Culture and Communities Committee in January 2020, and to confirm that the Council has sufficient capacity and financial resources to address the current backlog of tree maintenance activities - in addition to current and expected future demand for tree management services, including ongoing completion of tree inspections and responding to urgent incidents. This finding also reinforces the need to establish service level agreements with other Council divisions where tree management services are provided, for example, maintenance of trees in school grounds.

The Low rated finding notes that the capacity risks associated with delivery of tree management services across the City have not been recorded by either divisional or directorate risk registers, together with actions that are planned or in progress, and associated timeframes to ensure that they are appropriately mitigated or addressed.

Further information on the findings raised is included at Section 3.

**Covid-19 impacts on tree management activities**

Whilst the Council's Forestry service response to Covid-19 was not specifically included in the scope of this review, it is important to highlight that the pandemic and new legislation and national guidance in relation to social distancing is likely to introduce additional and potentially urgent demand for tree management services, as it is important to ensure that walkways across the City are sufficiently clear to support effective social distancing, and are not impeded by overhanging trees.

Consequently, it will be essential to ensure that the Council's Forestry service has sufficient capacity and financial resources to either complete any urgent work required, or secure external contractors to support its delivery.

### Areas of good practice

The following areas of good practice were identified:

- employees and contracted suppliers undertaking tree management works are suitably qualified and competent and hold relevant certifications and training including those required for operating machinery.

- robust health and safety processes have been established to ensure that risk assessments are completed for all works undertaken at height; using chainsaws and machinery (including appropriate measures to reduce risks to employees from hand-arm vibration exposure); and that appropriate Personal Protective Equipment (PPE) is also issued to employees.

# 3. Detailed findings

| 1. Strategic direction and operational delivery | High |
|---|---|

**1. Tree Management Strategy and action plan**

Review of the Trees in the City action plan established that:

- It has not been reviewed since it was developed in 2014 to ensure that the objectives and actions included in the plan remain relevant and aligned with current strategies (such as Million Tree City);
- It has not been reviewed to confirm ongoing alignment with revised risk zones across the City;
- Delivery timeframes have not been specified and no criteria has been established to measure delivery progress;
- Delivery progress is not monitored and reported to senior management and relevant Council executive committees; and
- No assessment has been performed to confirm the adequacy of resources required to support timely delivery of plan actions.

**2. Operational delivery and resource planning**

Review of resource planning and operational delivery of the Council's Forestry service confirmed that:

- **Capacity and workforce planning** - a workplan detailing service priorities (for example, completing surveys in line with risk assessments, whilst completing tree planting, and responding to tree related incidents) and resource requirements required to support delivery of the Trees in the City action plan has not been prepared.
- **Workforce capacity** - there was limited capacity within the Trees and Woodland team with four officers responsible for carrying out inspections and issuing job orders, resulting in a reactive approach with a focus on urgent and high priority work, and limited capacity to complete routine and preventative inspection activities.

  Management has acknowledged the need to increase resources and capacity across the team, with recruitment for four additional team members currently being progressed.
- **Pilot process** - the revised tree survey process piloted for six months from July 2019 with the objective of increasing team capacity and efficiency through implementation of refreshed survey methods and recording processes was due to be reviewed after three months, with subsequent amendments trialled for another three months prior to review and approval by the Service Manager. An initial review of the pilot had not yet been completed as at end of February 2020.
- **Performance reporting** - no performance reporting has been established to monitor completion of workorders in line with the published timescales on the Council's website.
- **Service level agreements (SLAs)** - with the exception of Housing Property Services, no SLAs and recharge agreements have been established for work performed by forestry services across other Council divisions. Additionally, the Housing Property Services SLA requires to be reviewed and refreshed.

**Risks**

The potential risks associated with findings are:

- Service strategy and supporting operational plans are not aligned with the Council objectives and / or regulatory requirements.

- Lack of resource planning results in failure to allocate adequate resource to meet the Council's legislative duty of care.
- Pilot processes are not evaluated to provide assurance that legislative and statutory duties are fully met.
- Limited visibility of service performance and associated risks with under performance.
- Limited understanding of the extent of tree management requirements demand from other divisions; the associated costs; and resources required to supporting ongoing tree management across the City.

**1.1 Recommendation: Strategic planning**

1. The 'Trees in the City' strategy document should be reviewed and refreshed to ensure that it remains aligned with Council priorities and emerging initiatives such as 'Million Tree City', amended risk zones and revised surveying methods and a revised plan produced that incorporates outstanding 'Trees in the City' actions that have not yet been completed, and also any new actions required to support delivery of the Million Tree City strategy.
2. The review should include an assessment of progress in achieving the actions set out in the 2014-19 Trees in the City action plan, with any outstanding actions re-evaluated for inclusion in the new strategy.
3. The revised action plan should include SMART (specific; measurable, achievable; realistic and timely) objectives and actions that have been allocated to appropriate owners, with key performance measures established for each action to support ongoing delivery progress monitoring and reporting.
4. The revised strategy should be approved by senior management and relevant Council executive committee and published on the Council's website.
5. The strategy should be reviewed annually to ensure it remains aligned with Council objectives and statutory/legislative requirements and approved by relevant Council governance forums and executive committees. Following annual review of the strategy, the action plan should be reviewed to ensure it remains aligned to achievement of the strategy.

**1.1 Agreed Management Action: Review of Trees in the City**

Parks and Greenspace management accept the internal audit recommendation made. A full review of "Trees in the City" will be undertaken as advised. Initial timescale for this work will be completion by 31 August 2021. The implementation date of 30 October 2021 should provide sufficient time for internal audit to review.

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|---|---|
| **Owner:** Paul Lawrence, Executive Director of Place<br>**Contributors:** Gareth Barwell, Head of Place Management; David Jamieson, Parks, Greenspace & Cemeteries Manager | **Implementation Date:** 31 October 2021 |

**1.2 Recommendation: Capacity and workforce planning**

1. The Forestry Service should develop a Tree Management capacity and workforce plan that is aligned with the actions detailed in their strategic plan; incorporates all activities to be performed in line with legislative requirements; and incorporates all tree management services performed across the City, including those for other Council divisions.
2. The workforce plan should detail proposed timings and locations for ongoing cyclical tree management work such as tree condition surveys; tree maintenance; tree planting and tree inspections. The work programme also should clearly set out priorities. For example, ensuring the service prioritises and addresses the current backlog of outstanding tree condition surveys, and survey frequencies for specific risk zones.

3. The workforce plan should include sufficient capacity for increased seasonal workloads, and service level agreements with other Council areas, and assess the service's capacity to respond to emergency works; public incidents; and ongoing reactive maintenance requirements.
4. The workforce plan should be supported by a costed resource plan that assesses resource requirements (including administration / business support requirements); availability of appropriately skilled, experienced and competent resources within the service, and the potential requirement for and costs associated with ongoing use of external contractors to supplement ongoing service delivery.
5. The workforce plan should be reviewed by management every six-months to confirm that it remains aligned with priorities and legislative requirements, with details of significant delays reported to senior management and relevant Council executive committee as required.

**1.2 Agreed Management Action: Capacity and workforce planning**

Parks and Greenspace management accept the internal audit recommendation made. This piece of work will be completed in tandem with the review of the Trees in the City document. Initial timescale for this work will be completion by 31 August 2021. The implementation date of 30 October 2021 should provide sufficient time for internal audit to review.

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|---|---|
| **Owner:** Paul Lawrence, Executive Director of Place<br>**Contributors:** Gareth Barwell, Head of Place Management; David Jamieson, Parks, Greenspace & Cemeteries Manager | **Implementation Date:** 31 October 2021 |

**1.3 Recommendation: Review and evaluation of pilot survey programme**

1. The Forestry Service should complete an evaluation of the pilot survey programme as planned to determine whether the changes piloted should be permanently implemented. This should include (but not be restricted to):
   - Review of the piloted changes to confirm that they remain aligned with applicable regulations and statutory requirements. Where permanent changes to the process are proposed the service should consult with the Corporate Health and Safety Team and any other relevant bodies to ensure the Council will continue to meet statutory requirements.
   - An assessment of the potential risks and impacts associated with these changes.
   - An assessment of the quantitative and qualitative benefits realised from the pilot processes applied.
   - Preparation of a proposal paper detailing the permanent changes (and their expected future benefits) to be implemented.
   - The proposed changes should be reviewed; scrutinised and approved by senior management prior to permanent implementation.
2. In addition, existing tree management policies; procedures and guidance should be updated to reflect any changes, with revisions to existing policies considering Integrated Impact Assessment (IIA) requirements (guidance on IIA requirements is available on the Orb, and from the Policy and Insight team within Strategy and Communications).

   Revised policies should be approved by relevant governance forums and Council executive committees as required.

**1.3a) Agreed Management Action: Review and evaluation of pilot survey programme**

Parks and Greenspace management accept the internal audit recommendation made. This piece of work will be completed in tandem with the review of the Trees in the City document. Initial timescale for this work will be completion by 31 August 2021. The implementation date of 30 October 2021 should provide sufficient time for internal audit to review.

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|---|---|
| **Owner:** Paul Lawrence, Executive Director of Place<br>**Contributors:** Gareth Barwell, Head of Place Management; David Jamieson, Parks, Greenspace & Cemeteries Manager | **Implementation Date:** 31 October 2021 |

**1.3b) Agreed Management Action: Review and update of policies, procedures and guidance to reflect outcomes of pilot survey programme**

Parks and Greenspace management accept the internal audit recommendation made. This piece of work will be completed in tandem with the review of the Trees in the City document. Initial timescale for this work will be completion by 31 August 2021. The implementation date of 30 October 2021 should provide sufficient time for internal audit to review.

| | |
|---|---|
| **Owner:** Paul Lawrence, Executive Director of Place<br>**Contributors:** Gareth Barwell, Head of Place Management; David Jamieson, Parks, Greenspace & Cemeteries Manager | **Implementation Date:** 31 October 2021 |

**1.4 Recommendation: Strategic and operational performance management, monitoring, and reporting**

The Forestry Service should design and implement a strategic and operational performance management framework to enable ongoing monitoring and reporting of strategic and operational service performance. This should include (but not be limited to):

- Review of existing service delivery performance measures and indicators (KPIs) and service standards (such as completion of works orders and incident response times) to ensure that they remain aligned with statutory and legislative requirements and revised processes following completion of the pilot.
- KPIs should be SMART (specific; measurable, achievable; and timely) and should include a range of quantitative (e.g. number of works/inspections completed against target); qualitative (e.g. % satisfaction with works completed – citizens and other Council services) and financial indicators (e.g. forecast budget versus actual budget).
- KPIs should be reviewed and approved by management prior to their implementation.
- A performance dashboard should be designed and implemented that illustrates performance against both strategic (refer recommendation 1.1) and operational KPIs with supporting rationale provided in instances where KPIs have not been achieved.
- The performance dashboard should be provided to relevant governance forums for review by senior management, and also to relevant Council executive committees (at an appropriate frequency) for review and scrutiny.

**1.4 Agreed Management Action: Strategic and operational performance management, monitoring, and reporting**

Parks and Greenspace management accept the internal audit recommendation made. This piece of work will be completed in tandem with the review of the Trees in the City document. Initial timescale for this work will be completion by 31 August 2021. The implementation date of 30 October 2021 should provide sufficient time for internal audit to review.

| | |
|---|---|
| **Owner:** Paul Lawrence, Executive Director of Place<br>**Contributors:** Gareth Barwell, Head of Place Management; David Jamieson, Parks, Greenspace & Cemeteries Manager | **Implementation Date:** 31 October 2021 |

## 1.5 Recommendation: Review and development of service level agreements

The Forestry Service should:

1. Complete a review of tree management services requested by and delivered across other Council divisions and consider (with reference to the capacity and workforce plan – refer recommendation 1.2) whether the Council can continue to support these services based on the capacity of current resources, and the external support that may be required.
2. Existing Service Level Agreements (SLAs) should then be reviewed and refreshed to ensure they reflect the full range and costs of tree management services provided. This should include a review of financial and recharging arrangements to ensure that costs incurred by Forestry services are recovered.
3. SLAs should be developed, agreed, and implemented for tree management services provided to other Council divisions where they currently do not exist.
4. Regular meetings should be established with divisions to discuss Forestry services performance in line with agreed SLAs and operational key performance indicators. Performance dashboards should also be provided to support discussions at these meetings (refer recommendation 1.4).
5. SLAs should be reviewed annually to ensure that they continue to reflect the forestry services delivered across Council divisions and incorporate any necessary changes.

## 1.5 Agreed Management Action: Review and development of service level agreements

Parks and Greenspace management accept the internal audit recommendation made. Initial timescale for this work will be completion by 31 August 2021. The implementation date of 30 October 2021 should provide sufficient time for internal audit to review.

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|---|---|
| **Owner:** Paul Lawrence, Executive Director of Place<br>**Contributors:** Gareth Barwell, Head of Place Management; David Jamieson, Parks, Greenspace & Cemeteries Manager | **Implementation Date:** 31 October 2021 |

## 2. Tree Management risks — Low

A risk register is in place for the Parks and Greenspace service which includes tree management related risks. However, there are no specific tree management risks currently recorded in either the Place Management divisional or Place directorate risk registers reflecting the risks associated with the backlog of tree maintenance activities to be performed across the City, and the need to ensure that the Forestry service team has either sufficient internal capacity to complete this work, or adequate budget to outsource its completion to external third party contractors.

In addition, tree management related risks are not recorded within the divisional risk registers for the areas of the Council in receipt of tree management services such as Schools and Lifelong Learning (Communities and Families) and Housing services (Place Development).

## Risks

The potential risks associated with our findings are:

- Senior management is not aware of the capacity and resourcing challenges associated with the ongoing delivery of tree management services across the City, and appropriate measures are not implemented to address these risks.

## 2.1 Recommendation: Tree management risks

**Place Management risk registers**

- Forestry services should record and assess the risks associated with ongoing delivery of tree management services in the Place Management divisional risk register.
- Appropriate mitigating actions should be agreed to address these risks and allocated to appropriate Forestry services team members for completion within agreed completion timeframes.
- The Place Management team should consider whether the tree management risks should be escalated for inclusion in the Place Directorate risk register.
- Progress with implementation of agreed mitigating actions should be monitored until these have been completed.

**2.1 Agreed Management Action: Tree management risks – Place Management**

Parks and Greenspace management accept the internal audit recommendation made. Immediate action to include all identified risks relating to service delivery should be included in Place Management risk register.

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|---|---|
| **Owner:** Paul Lawrence, Executive Director of Place<br>**Contributors:** Gareth Barwell, Head of Place Management; Alison Coburn, Operations Manager; David Jamieson, Parks, Greenspace & Cemeteries Manager | **Implementation Date:** 31 December 2020 |

**2.2 Recommendation: Tree management risks – landholding Council divisions**

**Risk registers for other landholding Council divisions**

- Schools and Lifelong Learning and Housing Services should record and assess the risks associated with ongoing delivery of tree management services within their estates in the Communities and Families and Place Development divisional risk registers.
- Appropriate mitigating actions should be agreed to address these risks with the Forestry Service and recorded within the risk register.
- Where appropriate, management should consider whether the tree management risks should be escalated for inclusion in the Directorate risk register.
- Progress with implementation of agreed mitigating actions should be monitored until these have been completed.

**2.2.1 Agreed Management Action: Tree management risks – Place Development**

Tree management risks will be considered at the Place Development risk committee and included within the Directorate and divisional risk registers where deemed appropriate.

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| **Owner:** Paul Lawrence, Executive Director of Place<br>**Contributors:** Michael Thain, Head of Place Development; Alison Coburn, Operations Manager | **Implementation Date:** 31 March 2021 |

**2.2.2 Agreed Management Action: Tree management risks – Communities and Families**

Tree management risks will be considered at the Communities and Families risk committee and included within the Directorate and divisional risk registers where deemed appropriate.

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| **Owner:** Alistair Gaw, Executive Director of Communities and Families<br>**Contributors:** Andy Gray, Head of Schools and Lifelong Learning; Michelle McMillan, Operations Manager | **Implementation Date:** 31 March 2021 |

# Appendix 1: Basis of our classifications

| Finding rating | Assessment rationale |
|---|---|
| **Critical** | A finding that could have a:<br>• ***Critical*** impact on the operational performance; or<br>• ***Critical*** monetary or financial statement impact; or<br>• ***Critical*** breach in laws and regulations that could result in material fines or consequences***;*** *or*<br>• ***Critical*** impact on the reputation of the Council which could threaten its future viability. |
| **High** | A finding that could have a:<br>• ***Significant*** impact on operational performance; or<br>• ***Significant*** monetary or financial statement impact; or<br>• ***Significant*** breach in laws and regulations resulting in significant fines and consequences***;*** *or*<br>• ***Significant*** impact on the reputation of the Council. |
| **Medium** | A finding that could have a:<br>• ***Moderate*** impact on operational performance; or<br>• ***Moderate*** monetary or financial statement impact; or<br>• ***Moderate*** breach in laws and regulations resulting in fines and consequences; or<br>• ***Moderate*** impact on the reputation of the Council. |
| **Low** | A finding that could have a:<br>• ***Minor*** impact on operational performance; or<br>• ***Minor*** monetary or financial statement impact; or<br>• ***Minor*** breach in laws and regulations with limited consequences; or<br>• ***Minor*** impact on the reputation of the Council. |
| **Advisory** | A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice. |

# Appendix 2: Areas of audit focus

The areas of audit focus and related control objectives included in the review are:

| Audit Area | Control Objectives |
|---|---|
| Tree Management Policies | • A risk-based approach for tree management has been developed and clearly documented setting out priority for works, frequency and timing for inspection surveys in line with Health and Safety guidance;<br>• A work programme for each risk zone and trees in other Council locations, and maintenance of newly planted trees has been developed detailing all activity to be undertaken, timelines and expected resource requirements;<br>• Delivery of the work programme is monitored and reviewed regularly to take account of emerging incidents and issues; with rationale for any changes approved and recorded;<br>• A detailed resource plan has been developed to ensure work programmes are cost effective, adequately resourced, and to avoid unnecessary delays, including allocation of adequate management and administration resources;<br>• A comprehensive Tree Asset Register is in place to ensure accurate and complete data on individual trees including location, ownership, health, condition, inspection and maintenance arrangements is recorded;<br>• The Tree Asset Register also records where trees have been removed, and any new trees planted in line with Council's planting programme; and<br>• Up to date information and guidance on the Council's tree management approach and programme of works is available to the public via the Council's website. |
| Monitoring and reporting progress | • Service Level Agreements established between the Trees and Woodlands team and other Council services include key performance measures, which are regularly monitored, reported and acted upon;<br>• The Council regularly monitors and reports at both a senior officer and Committee level on a full range of tree management related performance including meeting its duty of care; progress with inspection programmes;<br>• Processes are in place to ensure data held within the Tree Asset Register and database is complete and accurate, including appropriate review and sign-off, and annual data audits;<br>• An action plan which sets out how the Council intends to manage the risks associated with back-logs to the programme, with detailed actions, owners and timescales has been developed with progress monitored and reported regularly; and<br>• Plans are in place to review and update the Council's five-year action plan 'Trees in the City' prior to end of 2019, to ensure it reflects the Council's longer-term strategy and revised inspection zones. |
| Incident Management and public enquiries | • The Council's approach to tree-related emergencies is outlined within an Incident Management Plan, with roles and responsibilities clearly defined;<br>• Processes are in place to ensure all public enquiries and reported issues are recorded and dealt within agreed timeframes and outcomes are monitored and reported;<br>• A process is in place to evaluate risk of reported incidents to ensure a timely response to potentially high-risk enquiries and issues reported;<br>• Key performance measures for response times are in place, monitored and reported regularly and action taken for underperformance; and<br>• A lessons learned approach is in place to regularly review emergency incidents and publicly reported issues, in order to take a proactive approach including amendments to the work programme as required. |

| | |
|---|---|
| Training and experience | • Skills and experience required for all roles within the Trees and Woodlands team have been clearly defined and included in team role specifications;<br>• All team members are suitably qualified and competent, holding relevant and valid certifications;<br>• Training records are in place to ensure refresher training and continuing professional development (CPD) requirements for relevant professional bodies are maintained; and<br>• Processes are in place to ensure contractors/external companies have appropriate working procedures, insurance, record keeping, qualifications and experience in all aspects of tree work. |
| Health and Safety - machinery and equipment | • Procedures are in place to ensure risk assessments are carried out and industry/HSE guidance followed when working with chainsaws; machinery and at height, including measures to reduce risks from hand-arm vibration exposure;<br>• All workers who use a chainsaw have received appropriate training and obtained a relevant certificate of competence or national competence award, and are competent under PUWER 98;<br>• Procedures are in place to ensure chainsaws and other equipment is regularly maintained in accordance with manufacturer's recommendations and serviced by a competent person; and<br>• The Council ensures all officers wear Personal Protective Equipment (PPE) which meets relevant PPE standards to protect the user against health or safety risks at work. |

# *The City of Edinburgh Council*

# Internal Audit

## First Line Project Governance

Final Report

6th August 2020

MP1902

**Overall report rating:**

| | |
|---|---|
| **Significant improvement required** | Significant and / or numerous control weaknesses were identified, in the design and / or effectiveness of the control environment and / or governance and risk management frameworks. Consequently, only limited assurance can be provided that risks are being managed and that the Council's objectives should be achieved. |

# Contents



This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2019/20 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2019. The review is designed to help the City of Edinburgh Council assess and refine its internal control environment. It is not designed or intended to be suitable for any other purpose and should not be relied upon for any other purpose. The City of Edinburgh Council accepts no responsibility for any such reliance and disclaims all liability in relation thereto.

The internal audit work and reporting has been performed in line with the requirements of the Public Sector Internal Audit Standards (PSIAS) and as a result is not designed or intended to comply with any other auditing standards.

Although there is a number of specific recommendations included in this report to strengthen internal control, it is management's responsibility to design, implement and maintain an effective control framework, and for the prevention and detection of irregularities and fraud. This is an essential part of the efficient management of the City of Edinburgh Council. Communication of the issues and weaknesses arising from this audit does not absolve management of this responsibility. High and Critical risk findings will be raised with senior management and elected members as appropriate.

# 1. Background and Scope

## Background

Delivery of effective transformation and change is essential to ensure that the City of Edinburgh Council (the Council) can deliver on its pledges and strategic objectives whilst maintaining and improving the services it delivers at lower cost and with less resources.

For each project/programme of change across the Council, it is expected that sound project management and governance practices are in place. In 2018, the Strategic Change and Delivery (SC&D) team developed a standard project management toolkit, which is available via the Orb (the Council's intranet) to support Senior Responsible Officers (SROs) and Project Managers to successfully deliver projects across the Council. As a second line team SC&D also provides guidance and support to project teams at all stages of the project lifecycle.

It is the responsibility of first line senior management within each Directorate to identify all planned and emerging projects and to ensure that all projects within the Directorate apply effective project management and governance practices. This includes completing a prioritisation matrix to assess whether a project should be included within the Council's Change Board Portfolio (a portfolio of the largest projects across the Council); effective use of standard project management tools; and ensuring there is effective oversight and scrutiny of all projects that are wholly managed by Directorates and not included in the Council's Change Board Portfolio.

An Internal Audit review of the Council's Portfolio Governance Framework (completed June 2019) established that while significant progress had been made in relation to the scrutiny and oversight of the Council's Change Board Portfolio, further assurance is required around first line Divisional and Directorate governance and oversight of project management.

The first in a planned series of project management training workshops facilitated by Strategic Change and Delivery (with support from an external project management consultant) was delivered in February 2020 and focused on project management principles at the project initiation stage. The one-hour workshop was open to all Council employees interested in project management, and circa 100 employees registered to attend, although the workshop was limited 50 places due to room capacity.

## Scope

The objective of this review was to assess the design adequacy of the key controls established to ensure there is effective first line project governance and oversight across all Council Directorates.

The audit also assessed the operating effectiveness of project management arrangements and tools currently in place to support one project/programme within the Place Directorate that is not included within the Council's Change Board Portfolio.

The review also provides assurance in relation to the following Corporate Leadership Team (CLT) risk:

- **Major Programme and Project Delivery and Assurance** – the Council is unable to ensure the effective management and successful delivery, on time and budget, of major programmes and projects. This risk also outlines the need for the Council to prioritise and deploy project delivery resource effectively, according to business needs, ensuring that benefits are realised.

Our areas of audit focus as detailed in our terms of reference are included at Appendix 2.

Testing was performed across the period January 2019 to December 2019.

### Limitations of Scope

The following areas were specifically excluded from the scope of this review:

- Second line Strategic Change and Delivery team and Change Board oversight of the Council's major projects portfolio; and
- the Health and Social Care project management office as this is subject to a separate review included in the Edinburgh Integration Joint Board 2019/20 audit plan.

**Reporting Date**

Our audit work concluded on 21 February 2020, and our findings and opinion are based on the conclusion of our work as at that date.

# 2. Executive summary

## Total number of findings: 2

| Summary of findings raised | |
|---|---|
| **High** | 1. Directorate portfolio governance |
| **High** | 2. Project management skills, experience, and training |

## Opinion

**Significant improvement required**

Our review identified significant weaknesses in the design and effectiveness of key controls established to ensure that there is effective first line governance and oversight of projects that are not included in the Council's Change Board Portfolio by directorates.

Consequently, only limited assurance can be provided that directorate and divisional projects are being consistently and effectively managed; are likely to be successfully delivered; and that suitably skilled and experienced project delivery resources have been effectively deployed according to business needs to support realisation of expected benefits.

A key aspect of our findings is that it has not been possible to establish the total population and significance of projects currently being delivered across directorates as no registers of these projects are maintained.

We also identified three projects of significant value and risk that had not been assessed to determine whether they should be included in the Council's Change Board Portfolio and subject to governance through the established Change Board framework. Progress with these projects had been reported directly to executive committees.

Consequently, two High rated Internal Audit findings have been raised.

The first finding reflects the need for directorates to establish processes that will enable them to clearly define activities and changes that should be classified as projects; identify planned projects across their services and assess level of governance required; and ensure that proportionate governance processes are established to support effective delivery of these projects by appropriately skilled and experienced project managers, whilst managing any potential service delivery impacts.

The second finding highlights the need for directorates to ensure that all project managers have relevant skills and experience and knowledge of the Council's project management methodology to support

effective delivery of projects, and the need to invest in appropriate ongoing essential project management learning and training and maintain records of training completion.

### Management Response

Project governance, management, and methodology is currently being reviewed holistically across the Council as part of the design of the Council's Adaptation and Renewal Programme.

This process will involve ensuring that there is sufficient capacity and capability to support any projects that will continue to be delivered by first line directorates and divisions, and will also involve development and implementation of a first line programme management framework that will ensure effective ongoing identification, governance, resourcing, and oversight of first line projects.

The first line programme management framework will address all of the recommendations raised by Internal Audit in this report.

**Owner:** Andrew Kerr, Chief Executive

**Contributors:** Laurence Rockey, Head of Strategy and Communications; Gillie Severin, Strategic Change and Delivery Senior Manager; Simone Hislop, Change Manager, Delivery Unit; Emma Baker, Change Manager, Delivery Unit; Donna Rodger, Executive Assistant.

**Implementation Date**: 31st May 2021

### Areas of good practice

The scope of this audit included review of the design and operating effectiveness of project management arrangements established to support a Place Directorate project that is not within the Council's Change Board Portfolio.

Our approach was to independently select a project from a list provided by management; however, management was unable to confirm that the list was complete.

The project selected for review from the list provided was the Saughton Park Redevelopment. This project was recently delivered with a significant amount of Heritage Lottery Funding which included the appointment of a Project Manager. The terms of the grant required the Council to ensure a standard of project management and governance, including the regular submission of status reports.

Our review of a sample of key project documentation confirmed that the project had been effectively managed in line with the external funding requirements and also with the Council's project management methodology. Key areas of good practice included:

- A clearly established project governance structure that included roles and responsibilities, remits and memberships of project groups and reporting lines.
- Ongoing status progress reports that included progress with project delivery; status against plan; change control details; top five risks; key issues; financial status and commentary; milestone reporting; financial and non-financial benefits tracking; key dependencies; and an exception report.
- Effective ongoing use of risk registers, cash flow projections, project plans, stakeholder engagement, evaluation reports and third-party contract management.

# 3. Detailed findings

| 1. Directorate portfolio governance | High |
|---|---|

Review of first line project governance arrangements within directorates and divisions identified:

1. **Project definition** - there is currently no standard definition of which activities and change initiatives should be classified as projects in comparison to simple process improvement or business as usual change activity, that is consistently applied across Directorates and Divisions
2. **Identification of activities and change initiatives** - there is no clear process enabling identification of proposed activities and change initiatives to determine which should be classified as projects and assessed (using the established project prioritisation assessment matrix) to confirm whether the projects should be included in the Change Board Portfolio.

   Three projects of significant value and risk had not been assessed to determine whether they should be included in the Change Board Portfolio. Progress with these projects had been reported directly to executive Committees and not through the Council's established Change Board framework.
3. **Directorate project governance** - directorates do not currently have a holistic view (for example a register) of projects being delivered across their divisions, and there are no established processes to ensure that directorate and divisional projects are effectively governed with appropriate ongoing oversight of delivery progress (including budget and risk management), and benefits realisation.

   Review of papers and agendas for a sample of 40 directorate and divisional senior management team meetings confirmed that oversight of projects was inconsistent. Whilst, evidence of discussion of live and planned projects was noted at 17 meetings, this was limited to major projects already governed by the Council's Change Board and four were presentation of the upcoming Change Board pack by the Strategic Change and Delivery team. Additionally, first line directorate/divisional projects are not included as a standing agenda item on Senior Management Team Meetings.
4. **Project and risk management methodology awareness -** there is a lack of awareness of the Council's established project management methodology and the project management toolkit (which includes a standard Risks, Actions, Issues and Dependencies (RAID) log template and Change Board framework) developed by the Strategic Change and Delivery team despite its publication on the Orb; circulation to current project managers; and delivery of ad hoc training across the Council.
5. **Project management skills and experience –** as there is no complete list of projects across the directorates and divisions, we were unable to validate the extent to which service delivery staff are also assigned project management work, and whether the impact on service delivery has been considered.

   The 2018/19 Portfolio Governance Framework review found that 40% of the Change Board Portfolio projects as at March 2019 were being delivered by project managers who also had a service delivery responsibility.
6. **Alignment with the Council's risk management framework –** review of eight directorate and supporting divisional risk register where first line projects are being delivered confirmed that:

   - one Directorate risk register (Communities & Families) and two divisional risk registers (Finance and Place Development) have recorded risks relating to failure to deliver strategic programmes/projects of change.

- one Directorate (Communities & Families) and two divisional risk registers (Property & Facilities Management and Schools and Lifelong Learning) have recorded specific risks relating to large projects within their remit or a Council project on which the division has a key dependency.
- two divisional risk registers had incomplete information (Place Development and Schools and Lifelong Learning). Both registers were in draft format and while risks had been identified, risk owners, risk scoring, mitigating controls, further actions and action owners had not been identified.

## Risks

The potential risks associated with our findings are:

- Lack of visibility of the planned changes and associated costs, risks, benefits delivery, and time spent on change and project activities (including any potential impact on ongoing service delivery) outwith the change board portfolio across first line directorates and divisions.
- Failure to identify high value/risk projects that should be included the Council's change board portfolio and subject to ongoing governance and oversight by the Change Board.
- Investment in project activities that are not aligned with the Council's strategic objectives and financial priorities.
- Inability to identify linkages between projects and manage limited resources and employees effectively.
- Increases in project scope and delivery timeframes due to lack of effective ongoing governance and oversight.

## 1.1 Recommendation: Project definition, identification, and methodology

a) A definition should be created for use by directorates and divisions to support identification of projects across their services that is aligned with the project prioritisation matrix used to identify major projects for inclusion in the Council's portfolio of change. The definition should be agreed by the Council's Change Board.

b) A process should be established by all directorates to ensure that details of planned changes within divisions across the services that they deliver are recorded centrally and assessed to determine whether the changes should be classified as projects; and confirm that a prioritisation matrix to determine whether the project should be included in the Council's Change Board portfolio has been completed. The assessments should be completed by an appropriately senior person with project management experience.

c) A projects register should be created for each Directorate to detail all projects governed through both directorate governance arrangements and through the Council's Change Board Portfolio. The projects register should include the following details:

- Senior Responsible Officer and Project Manager;
- prioritisation matrix assessment score;
- anticipated project cost;
- anticipated project benefits;
- overall governance forum responsible for review and sign-off;
- project phase – in line with project management guidance on Orb (Initiation; Planning; Pipeline, Delivery; Close)
- current project RAG (red; amber; green) status (in line with the RAG status guidelines provided on the Orb);

- project gateways dates;
- next key milestone and decision points; and
- duration of the project and estimated completion date.

An appropriate person within each directorate and division should be assigned responsibility for the ongoing maintenance and review of the projects register.

d) The Council's standard project management methodology as detailed in the project management toolkit should be consistently and effectively applied by directorates and divisions to all first line projects. This should include adoption of standard status/highlight reporting across projects.

## 1.2 Recommendation: Directorate project portfolio governance

A standard portfolio governance approach should be developed and implemented across all directorates to enable effective ongoing oversight and scrutiny of first line projects. This should include but not be limited to:

a) a tiered governance approach that is proportionate to project values and/or risks, with high profile projects subject to governance at Directorate level; mid-tier projects by Heads of Divisions; and low tier projects by Service Managers level;

b) establishment of governance forums aligned to each tier (for example, Programme Boards or standing agenda slots at Senior Management Team meetings). The remit of the governance forums should include:

- review of and approval of project business cases to confirm that they are aligned with both Directorate and Council strategic objectives; there is sufficient budget to support the project, and that whole of life costs associated with the change have been assessed and agreed with Finance; risks associated with proposed changes are aligned with risk appetite; and that benefits have been quantified (where possible) or recorded and will be monitored throughout the life of the project;
- review of the completed prioritisation matrix to determine whether the project should be included in the Council's change board portfolio, and confirmation that matrix outcomes have been shared with the Strategic Change and Delivery team.
- review of project resources to ensure that either external project managers or appropriately skilled and experienced employees with sufficient capacity to support project delivery whilst maintaining ongoing service delivery are allocated to projects.
- ongoing review of project delivery progress; budget management; project risks, issues, and dependencies; and benefits realisation.
- ongoing oversight of third-party project dependencies and deliverables (including the Council's technology partner CGI).
- appropriate escalation of any relevant project risks and issues for inclusion in Directorate or Council risk registers where required.
- quarterly review of the Directorate projects register to identify any potential issues across the full portfolio of projects being delivered across divisions.

c) The approach should be formally documented, communicated across all divisions and published on the Orb.

## 1.3 Recommendations: Project risk identification and management

a) The Council's Directorates and Divisions should engage the second line Corporate Risk Management and Strategic Change and Delivery teams to provide project specific risk management guidance (and training where required). This should include guidance for

systematically and proactively identifying, assessing, quantifying and managing project risks (including third party risks), issues, and dependencies.

The risk management guidance should be incorporated into the existing project management framework included in the project management section of the Orb.

b) Consolidated project risk reporting should be provided by Divisions on a quarterly basis to Directorate Risk Committees with further aggregated reporting of high/increasing project risks across Directorates reported to the Council Leadership Team.

## 2. Project management skils, experience, and training — High

Review of project management skills, experience, and training across directorates and divisions confirmed that:

1. **skills assessment** - there is currently no established skills assessment process to assess and confirm the adequacy of project management skills and capabilities of employees who have been asked to either manage or support delivery of first line projects.
2. **essential learning and training** - there is no minimum essential learning requirement and standard training programme to support the training needs of employees asked to manage or support delivery of first line projects.
3. **skills matrix** – there is no established skills matrix that records employee project management skills and experience and training attendance.
4. **training completed** - review of training completed and recorded across directorates and divisions established that the following training is either planned or had been provided for employees, some of who may not currently be involved in delivering or supporting projects:
   - the Place Directorate has prepared a business case for provision of external PRINCE2 training to 36 Place employees with the Place.
   - two Operations Managers in Schools and Lifelong Learning had attended external PRINCE2 training; and
   - four Safer and Stronger Communities employees attended an internal Project Management Overview course.
5. **Obsolete project management guidance** - whilst the Strategic Change and Delivery project toolkit and guidance has been published on the Orb, an Orb search using the terms 'project management' and 'project' confirmed that employees are directed to historic project management resources including an out dated toolkit published by the Housing and Regeneration Improvement Programme Office and orphaned content originally published by the Corporate Programmes Office.

### Risk

The potential risks associated with our findings are:

- Ineffective management of projects delivered by first line directorates and divisions leading to delay, overspend and/or reputational damage.

### 2.1 Recommendations: Project management training

a) A skills assessment should be performed to determine the skills required to support project management and delivery across the Council. This should be based on a combination of past experience (successful delivery of projects) and completed training and used as the basis of

assessing whether external project managers and employees have the required skills and experience prior to their appointment as project managers.

b) In addition to the proposed training session to be delivered by Strategic Change and Delivery, an online project management training module should be developed and implemented. Both should be aligned with the standard project management methodology developed by Strategic Change and Delivery as detailed in the project management toolkit.

c) Essential learning requirements for project managers should be established and completed by all project managers appointed to support delivery of projects. This could include (for example) attendance at ongoing Strategic Change and Delivery project management training workshops and completion of the online training module. Alternatively, an appropriate range of external project management training courses should be identified

**2.2 Recommendation: Project management skills matrix – all directorates**

A centralised skills matrix should be established and maintained by Council's programme management office that records project management skills and experience across Council directorates and divisions, enabling identification and allocation of appropriately skilled and experienced employees to projects.

**2.3a Recommendation: Obsolete project management guidance – Housing and Regeneration Improvement Programme Office**

The Orb should be reviewed, and links to obsolete project management guidance published by the Housing and Regeneration Improvement Programme Office removed, ensuring that only the most recent project management section published by Strategic Change and Delivery is available.

**2.3b Recommendation: Obsolete project management guidance – Corporate Programmes Office orphaned content**

The Orb should be reviewed, and links to obsolete project management guidance previously published by the Corporate Programmes Office removed, ensuring that only the most recent project management section published by Strategic Change and Delivery is available.

# Appendix 1: Basis of our classifications

| Finding rating | Assessment rationale |
|---|---|
| **Critical** | A finding that could have a:<br>• ***Critical*** impact on the operational performance; or<br>• ***Critical*** monetary or financial statement impact; or<br>• ***Critical*** breach in laws and regulations that could result in material fines or consequences***;*** *or*<br>• ***Critical*** impact on the reputation of the Council which could threaten its future viability. |
| **High** | A finding that could have a:<br>• ***Significant*** impact on operational performance; or<br>• ***Significant*** monetary or financial statement impact; or<br>• ***Significant*** breach in laws and regulations resulting in significant fines and consequences***;*** *or*<br>• ***Significant*** impact on the reputation of the Council. |
| **Medium** | A finding that could have a:<br>• ***Moderate*** impact on operational performance; or<br>• ***Moderate*** monetary or financial statement impact; or<br>• ***Moderate*** breach in laws and regulations resulting in fines and consequences; or<br>• ***Moderate*** impact on the reputation of the Council. |
| **Low** | A finding that could have a:<br>• ***Minor*** impact on operational performance; or<br>• ***Minor*** monetary or financial statement impact; or<br>• ***Minor*** breach in laws and regulations with limited consequences; or<br>• ***Minor*** impact on the reputation of the Council. |
| **Advisory** | A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice. |

# Appendix 2: Areas of audit focus

The areas of audit focus and related control objectives included in the review are:

| Audit Area | Control Objectives |
|---|---|
| Project and programme governance design | Each Directorate has established first line governance and oversight arrangements to ensure visibility of all current and emerging projects, including:<br>• A proportionate governance approach based on project value and/or risk – with high profile projects monitored at Directorate Level, mid-tier projects by Heads of Divisions and low tier projects at Service Manager level.<br>• Establishment of appropriate governance forums (through Senior Management Teams or Programme Boards) to oversee projects and programmes within each Directorate and Division.<br>• Assessment of emerging projects for inclusion in the Council's major projects portfolio using the project prioritisation matrix to determine whether they should be included in the major projects portfolio.<br>• Requirement for business cases to be prepared for all projects (with proportionate level of detail) and then approved by the appropriate governance forum and relevant Council executive committee (where required).<br>• Regular consolidated summary reporting of total costs; progress delivery and management of risks, issues, and dependencies to Heads of Divisions for service level projects and to Executive Directors for Divisional projects to ensure visibility of project delivery across the Directorate.<br>• Adequate visibility of resourcing to ensure that appropriately skilled and experienced employees with project management experience and sufficient capacity to support delivery of projects/programmes whilst maintaining ongoing service delivery are allocated to projects.<br>• Processes to ensure effective oversight of third party project deliverables (including the Council's technology partner CGI) involved This should include (as a minimum):<br>  ○ Formal clarification of third-party roles, responsibilities, and project deliverables.<br>  ○ Visibility of risks, issues and dependencies logs.<br>  ○ Regular progress reporting at an agreed level of detail.<br>  ○ Regular meetings to discuss performance and progress; and<br>  ○ Established processes to escalate performance issues.<br>• All significant project risks are recorded in divisional and directorate risk registers. |
| Project management – Place project | • The project has been assessed for inclusion in the Council's major projects portfolio using the project prioritisation matrix.<br>• An appropriately detailed business case has been prepared and approved by the appropriate level governance forum.<br>• A documented project plan has been developed which details the timeframes, ownership and progress of all key project deliverables.<br>• Project costs (including ongoing lifecycle and whole of life costs) and benefits (based on baseline measurements) have been quantified and are monitored by the appropriate level governance forum. |

| | |
|---|---|
| | • An up-to-date risks, actions, issues and dependencies (RAIDs) log is in place and all existing and new and emerging risks, issues and dependencies are appropriately owned and effectively managed.<br>• The RAIDs log is monitored by the appropriate level governance forum and, where appropriate, risks escalated to the Directorate/Divisional risk register.<br>• Actions from the project governance forum are documented, appropriately delegated, and tracked through to completion.<br>• A post implementation review is scheduled to complete a 'lessons learned' exercise and confirm that all anticipated benefits have been realised.<br>• The Senior Responsible Officer and project manager for the project are appropriately skilled with proven project delivery experience and have sufficient capacity to balance project delivery with maintaining services. |

# *The City of Edinburgh Council*

# Internal Audit

## Major Project Governance – Meadowbank Redevelopment

Final Report

17 July 2020

MP1901

**Overall report rating:**

| | |
|---|---|
| **Some improvement required** | Whilst some control weaknesses were identified, in the design and / or effectiveness of the control environment and / or governance and risk management frameworks, they provide reasonable assurance that risks are being managed, and the Council's objectives should be achieved. |

# Contents



This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2019/20 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2019. The review is designed to help the City of Edinburgh Council assess and refine its internal control environment. It is not designed or intended to be suitable for any other purpose and should not be relied upon for any other purpose. The City of Edinburgh Council accepts no responsibility for any such reliance and disclaims all liability in relation thereto.

The internal audit work and reporting has been performed in line with the requirements of the Public Sector Internal Audit Standards (PSIAS) and as a result is not designed or intended to comply with any other auditing standards.

Although there is a number of specific recommendations included in this report to strengthen internal control, it is management's responsibility to design, implement and maintain an effective control framework, and for the prevention and detection of irregularities and fraud. This is an essential part of the efficient management of the City of Edinburgh Council. Communication of the issues and weaknesses arising from this audit does not absolve management of this responsibility. High and Critical risk findings will be raised with senior management and elected members as appropriate.

# 1. Background and Scope

## Background

Delivery of effective transformation and change is essential to ensure that the City of Edinburgh Council (the Council) can deliver on its pledges and strategic objectives whilst maintaining and improving the services it delivers at a lower cost and with less resources.

For each project/programme of change across the Council, it is expected that sound project management and governance practices are applied, and in early 2018, the Strategic Change and Delivery (SC&D) team within Strategy and Communications developed a standard project management toolkit, available on the Orb (the Council's intranet) to support Project Managers and Senior Responsible Officers (SROs) with successful delivery of projects in the Council.

The toolkit covers the end to end project lifecycle and includes guidance on how to define and monitor the delivery of project benefits. It also includes a project prioritisation matrix that calculates a classification score for each project to determine whether it should be included within the Council's major projects portfolio, where project progress is subject to review and oversight by the Council's Change Board (essentially the Corporate Leadership Team).

It is the responsibility of senior management within each Directorate to identify all planned emerging projects and ensure that a prioritisation matrix assessment is completed and provided to the SC&D team for review. Should a particular project be included within the portfolio, it is the responsibility of the project's SRO to provide data to the SC&D team on a monthly basis in the format of a dashboard provided within the project management toolkit.

As a second line team, SC&D's role is to maintain a holistic project management and reporting governance framework; oversight of the Council's project portfolio; and provision of ongoing portfolio reporting to senior management and Change Board. The SC&D team is also responsible for providing guidance and support to project teams at all stages of the project lifecycle.

As at December 2019, there were 53 major projects, with a total value of £233m included within the portfolio and therefore subject to enhanced scrutiny by the Change Board. Breakdown across each Directorate and Council wide is as below:

- Place Directorate 22
- Communities and Families 15
- Resources 10
- Strategy and Communications 4
- Council Wide 2

**Meadowbank Redevelopment**

The Meadowbank redevelopment project aims to deliver a new sports centre, mixed tenure housing and commercial development as well as open space and local amenities. The programme is being delivered as two projects: the sports centre which is due to complete by summer 2020; and the wider housing and local amenities development which is at an early stage in the design and development process with an estimated completion in 2024/2025 subject to statutory consents and approvals. . The total value of the programme is in the region of £98m.

Delivery of the sports centre project is supported via an external project management consultant, whilst the wider site project is being supported by internal project management resource for this stage of the project within the Council's Place Development service.

The original Meadowbank site included three plots of land (A, B and C), and it was agreed at a meeting of the full Council in March 2016 that plots A and B would be transferred to the Council's Housing Revenue Account (HRA) at an agreed value (based on estimated sales price per square foot) to support development of affordable housing, with the capital receipt from HRA allocated to funding the new sports centre development. It was also agreed that Plot C would be sold for commercial development.

A Meadowbank Redevelopment Programme Board was established in August 2018 and is chaired by the programme's Senior Responsible Officer (SRO). In addition, the Sports Centre project has a separate governance forum, the Investment Steering Group (ISG).

The Meadowbank Redevelopment Programme is included within the Council's Change Board Portfolio and is required to submit a monthly dashboard which reports current status of the project and enables Portfolio-level consolidated reporting.

**Contract management arrangements for projects**

Contract management risks (including use of third party contractors to support project delivery) are owned by first line directorates and divisions who are responsible for ensuring that these risks are mitigated by consistently applying the Council's established contract management framework.

Under the Council's current Contract Standing Orders (3.2.17) the Executive Director for the Directorate with the largest spend or anticipated spend shall put in place arrangements for efficient contract and supplier management including the identification of a Contract Manager or Project Manager and management of benefits and performance. The original framework now being used to support the Meadowbank project was established in November 2015, when an earlier version of the Contract Standing Orders was in place.

In addition to the established framework, there is now a requirement for a Contract Handover and Management Report, that sets out procedures for ongoing supplier performance monitoring and escalation throughout the project lifecycle as per the Council's Contract Management Manual.

Project management of individual suppliers, called-off under the framework involves regular supplier performance reviews designed to ensure that the Council actively manages third party supplier performance; risks; changes; and disputes that could impact successful and timely delivery of the project in question.

## Scope

The objective of this review was to assess the adequacy of design and operating effectiveness of the key controls established to ensure effective project governance to support delivery of the Meadowbank Redevelopment programme.

The audit also assessed whether the project management framework applied across the Meadowbank Programme is aligned with the SC&D team's project management toolkit.

Whilst aspects of the project started prior to implementation of the new framework in 2018, our review assessed whether the project governance framework applied is adequately designed, consistently applied; and broadly aligned with the framework requirement to support ongoing reporting to the Change Board.

The review also provides assurance in relation to the following Corporate Leadership Team (CLT) risk as at December 2019.

- **Major Programme and Project Delivery and Assurance** – the Council is unable to ensure the effective management and successful delivery, on time and budget, of major programmes and

projects. This risk also outlines the need for the Council to prioritise and deploy project delivery resource effectively, according to business needs, ensuring that benefits are realised.

Our areas of audit focus as detailed in our terms of reference are included at Appendix 2.

Testing was performed on a sample basis from the inception of the project to 31 January 2020.

### Reporting Date

Our audit work concluded on 20 February 2020, and our findings and opinion are based on the conclusion of our work as at that date.

# 2. Executive summary

## Total number of findings: 2

| Summary of findings raised | |
|---|---|
| **High** | 1. Programme governance and project management |
| **Medium** | 2. Professional Services - contract management arrangements |

## Opinion

**Some improvement required**

Whilst some significant and moderate control weaknesses were identified in the design and effectiveness of the control environment established to support the Council's governance of the Meadowbank Redevelopment Programme, they provide reasonable assurance that project risks are being managed and that the Council's objectives to deliver a new sports centre, new housing and local amenities should be achieved.

Consequently, one high rated and one medium rated finding have been raised. Further information is included in Section 3.

The High rated finding reflects the need to improve programme governance and ensure that the project is managed in line with the Council's established project management framework. This finding also highlights the need to retrospectively document the methodology applied to determine the valuation supporting the most recent internal land transfer (plot C - £6.3M) between the Council's Housing Revenue and capital accounts, and re present the methodology to the Programme Board.

It is acknowledged that the valuation process was not complex; the Council's standard process was used to determine the value of internal transfers between Council budgets; and that the methodology applied was likely discussed at the Board, however, it is important that there is a clear audit trail detailing the methodology applied, and confirming review of the methodology by the Programme Board given the significant value involved.

The medium rated finding has identified the need to develop an overarching supplier management framework for professional services engaged through the Council's Construction Professional Services Framework Agreement, which will ensure that the Council's Contract Management Framework is consistently applied across all projects (including Meadowbank) and Council divisions that call-off from the framework, with a focus on instances where the supplier provides services to more than one project or division.

### Areas of good practice

We noted strong and effective stakeholder engagement throughout these initial stages of the Meadowbank Redevelopment Programme, with identification of key stakeholders and a detailed communication and engagement plan developed. An independently chaired 'Meadowbank Sounding Board' has also been established and will remain in place throughout the Programme.

The Sounding Board was established in 2019, and its purpose is to be a consultation forum and single source of information for the local community, and a mechanism to communicate community views to Council Officers. Board membership includes Ward Councillors; the Convenor and Vice-Convenor of the Housing, Homelessness and Fair Work Committee; and local representatives including Community Councillors, local residents and local campaign groups. The Board is chaired by a person independent of the Council.

## Management Response

Acknowledgment of project maturity

The wider site development part of the programme was at a very early stage during the audit period. The project team was engaging with the community and developing designs to inform an application for Planning Permission in Principle during this time and the programme governance arrangements and reports to the Programme Board reflect this; for example, we were not able to document benefits to be delivered through the project because this was subject to community consultation.

The financial viability and formal business case for the wider site development has not yet been developed. This will be prepared over the course of the next 18 months and to do this a development partner will be sought through formal OJEU Procurement. This partner will assess the demand for the private homes and the commercial units on the site during a pre-development period along will detailed work on the designs and cost assumptions for the affordable homes. The Business Case and Development Agreement and Construction Contracts will be approved and awarded before Construction will commence.

It is therefore clear that this project, although it has been live for over two years, is still at a very early stage of the project.

Programme Board Remit and Reporting

A documented remit, schedule of meetings, standard agenda, rolling actions log, and improvements to the action log have been put in place for the Programme Board since the initial fieldwork findings were discussed in February 2020.

In addition, the Change Board sign off has been altered since February 2020 to provide an audit trail that this document is signed off by the Senior Responsible Officer (SRO).

# 3. Detailed Findings

| 1. Programme governance and project management | High |
|---|---|

**1. Programme governance**

a. Programme Board remit and reporting

Whilst a high-level governance structure has been documented for the Meadowbank Redevelopment Programme that sets out reporting lines between project teams, the Programme Board, Change Board and Council Committees, there is currently no documented remit that details membership; roles and responsibilities; decision making powers and meeting frequency for the Programme Board.

Programme Board meetings are not currently scheduled to take place at regular intervals (e.g. every 6 weeks). Eight meetings were held in the period between August 2018 and January 2020, with gaps of up to 14 weeks noted between some meetings. Management advised that the frequency of meetings tends to be led by key decisions.

A standard agenda and reporting format which details the key information to be reported regularly to the Programme Board has not been established. Additionally, whilst brief action notes are recorded for the Programme Board, review of the action notes for the eight meetings held established that key decisions were not always clearly set out, with a number of decisions noted to be subject to further discussion or action. Additionally, completion actions are not logged and monitored through an ongoing action log.

b. Land valuation methodology and governance

The Meadowbank Plot C land valuation was used to determine the value of a transfer from the Council's General Fund Account to the Housing Revenue Account (HRA) and was considered alongside a number of other factors to request contingency funding to offset an expected funding shortfall for the sports centre development

Review of the process applied to value plot C on the Meadowbank site and subsequent review and approval of the valuation by the project Board established that:

- whilst rate per unit information based on market value was provided by Property and Facilities Management Investments team and used by the project team to calculate an estimated value of £6.3M based on a range of alternative scenarios, there was no clearly defined and documented methodology supporting the calculation.
- whilst valuation and appraisal information included in the Meadowbank Programme Board pack dated 8 October 2019 and the options appraisal pack dated 16 October 2019 provided a range of values depending on the percentage of affordable housing provided on the site, they did not clearly demonstrate what assumptions were applied to arrive at the final recommended valuation of £6.3M.
- recognising that the valuation was of a significant value, but low risk (as it supported an internal transfer) there was no evidence of independent review of the valuation calculation by appropriately qualified internal Council estates officers, and limited evidence of programme board review, challenge, and approval of scenarios applied by the project team and the recommended valuation in programme board meeting minutes.

  Management has advised that the standard process was followed to achieve the £6.3M valuation supporting the transfer from the Council's General Fund to the Housing Revenue Account (HRA) to enable the site to be treated holistically as with similar mixed tenure housing developments. They

advised it also allowed the payment of the receipt to the General Fund as part of the funding package for the Sports Centre, removing the need to wait for this to be paid as a land receipt from the private sector.

**2. Project management**

a. Project tools and methodology

The Council's project management toolkit includes tools and reporting templates for reporting, tracking benefits and recording risks. It is noted that, with the exception of use of the Change Board status report template, these have not been consistently used for the wider site housing element of the Meadowbank Redevelopment Programme (the Programme) that is project managed internally by the Council.

In contrast, similar type project tools are used for the sports centre element of the Programme that is managed by an external project manager.

b. Risk management

Three risk registers are in place for the Programme: a sports centre project risk register; a wider site risk register; and a wider site design team risk register. However, there is currently no overarching Programme risk register covering both sports centre and the wider site that captures consolidated key risks, assumptions, issues and dependencies (RAIDS)

Additionally, review of the 16 risks recorded on the wider site risk log as at January 2020 identified that:

- these had not been updated since January 2019;
- it is not clear whether key controls recorded against each risk represents a one-off action which fully mitigates the risk or an ongoing mitigating activity;
- further mitigating actions recorded against each risk are high-level and are noted to be ongoing with no set timescale;
- impacts of risks, assumptions, and issues relating to financial and non-financial benefits realisation are not captured; and
- no risks related to third party suppliers (e.g. business continuity or performance) are recorded.

c. Change Board reporting

Review of a sample of Change Board dashboard reports for the Programme identified that non-financial benefit reporting is high-level and focuses on outcomes rather than a specific and measurable financial benefit reflecting the early stage of the project.

Additionally there is currently no benefits tracker (as required per the Council's project methodology) that details baseline information to support ongoing benefits measurement and expected timeframes for benefit realisation, and supports ongoing monitoring of benefits realisation throughout the project.

Limited evidence was available to confirm that the monthly dashboard report was reviewed and signed-off by the Senior Responsible Officer (SRO) prior to submission to the Strategic Change and Delivery team in line with reporting responsibilities set out in the Change Board guidance on the Orb.

## Risks

The potential risks associated with our findings are:

- a lack of clarity regarding decision-making responsibilities.
- insufficient and ineffective central oversight of progress and direction.
- detail of the assumptions and calculations used to determine the Plot C land valuation were not

reported in sufficient detail to the Board prior to presenting relevant capital transfers and contingency funding requirements to Finance and Resources Committee.

- limited assurance that actions required to support decision making are satisfactorily completed.
- risks are not fully captured; considered and mitigated effectively.
- reporting of non-financial and qualitative benefits for the Programme is incomplete.
- inadequate oversight of the programme by SRO and Programme Board.

## 1.1 Recommendation: Programme Board Terms of Reference

A Terms of Reference for the Programme Board should be developed and approved. The Terms of Reference should be aligned to the requirements set out in the Change Board governance framework and include, but not be limited to, the following information:

- Purpose of the Programme Board;
- Decision-making remit;
- Delegated responsibilities for relevant sub-groups
- Roles and responsibilities of key officers including Senior Responsible Officer (SRO), Project Manager and Project Management Office (PMO);
- Frequency of meetings;
- Reporting expectations including standing agenda items, depth of information required and clear responsibilities and timescales for both project manager and senior responsible officer review and submission of Change Board reports; and
- Alignment with the Council's established major projects governance structure including the Change Board and relevant executive committees.

## 1.1 Agreed Management Action – Programme Board Terms of Reference

A Terms of Reference will be developed and approved by the Programme Board and will include:

- Purpose of the Programme Board;
- Decision-making remit;
- Delegated responsibilities for relevant sub-groups
- Roles and responsibilities of key officers including Senior Responsible Officer (SRO), Project Manager and Project Management Office (PMO);
- Frequency of meetings;
- Reporting expectations including standing agenda items, depth of information required and clear responsibilities and timescales for both project manager and senior responsible officer review and submission of Change Board reports; and
- Alignment with the Council's established major projects governance structure including the Change Board and relevant executive committees.

| | |
|---|---|
| **Owner:** Paul Lawrence, Executive Director of Place<br>**Contributors:** Michael Thain, Head of Place Development; Tricia Hill, Development & Regeneration Manager; Jen Blacklaw, Senior Construction Project Manager; Nick Cairns, Construction Project Manager | **Implementation Date:**<br>31 December 2020 |

## 1.2 Recommendation: Standard format for Programme Board reporting

A standing agenda and standard reporting format should be developed to ensure that the Meadowbank Redevelopment Programme Board is consistently provided with sufficiently detailed information to fulfil relevant governance and scrutiny roles and responsibilities. Reporting should capture relevant

information for both the sports centre project, and the wider site project, and should include, but not be limited to, the following information:

- Project Manager summary of current position; key issues and decisions required;
- Work completed in the reporting period;
- Current programme status - aligned to Council methodology;
- Key programme risks – including movement in risk profile, new risks and closed risks;
- Change Register to record amendments to work programme and / or scope;
- Financial summary detailing spend to date in line with approved budget;
- Key milestones for the next reporting period; and
- Benefits realisation and tracking.

In addition, the methodology and rationale supporting the valuation of Plot C at circa £6.3M by the project team should be re-presented to the programme Board.

**1.2 Agreed Management Action – Programme Board – standard reporting format**

A standing agenda and reporting format will be adopted for all future Programme Board reporting. As a minimum this will include:

- Project Manager summary of current position; key issues and decisions required;
- Work completed in the reporting period;
- Current programme status - aligned to Council methodology;
- Key programme risks – including movement in risk profile, new risks and closed risks;
- Change Register to record amendments to work programme and / or scope;
- Financial summary detailing spend to date in line with approved budget;
- Key milestones for the next reporting period; and
- Benefits realisation and tracking.

It is management's view that the standard valuation process was followed in relation to Plot C, although not explicitly reported to the Board. However, the methodology and rationale will be re-presented to the Board and noted within the minutes.

| | |
|---|---|
| **Owner:** Paul Lawrence, Executive Director of Place<br>**Contributors:** Michael Thain, Head of Place Development; Tricia Hill, Development & Regeneration Manager; Jen Blacklaw, Senior Construction Project Manager; Nick Cairns, Construction Project Manager | **Implementation Date:**<br>31 December 2020 |

**1.3 Recommendation: Recording actions arising from Programme Board meetings**

1. The current process for recording outcomes from Programme Board meetings should be reviewed to ensure that key discussions; all decisions taken; and any further actions required (particularly where a decision has been subject to satisfactory completion of an action) are adequately recorded.
2. A rolling action log should be developed to ensure that all actions resulting from the Programme Board are captured and tracked through to satisfactory completion. The action log should include an agreed timeframe for completion of actions; note when actions were actually completed and when

reported/approved. The rolling log should be monitored with any revised dates clearly noted and advised to the Programme Board.

3. Additionally, decisions made where further information or follow-up work is required should be revisited at subsequent Programme Board meetings to ensure that the agreed actions have been satisfactorily completed and the decision remains appropriate.

## 1.3 Agreed Management Action – Rolling actions log

The process for recording outcome of all Programme Board meetings will be reviewed to ensure that all actions are adequately recorded including a responsible officer and target date.

A rolling actions log will be developed and put in place to ensure all actions are tracked through to completion. This will include:

- agreed timeframe for completion of actions;
- a note of when actions were actually completed and when reported/approved.

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| **Owner:** Paul Lawrence, Executive Director of Place<br>**Contributors:** Michael Thain, Head of Place Development; Tricia Hill, Development & Regeneration Manager; Jen Blacklaw, Senior Construction Project Manager; Nick Cairns, Construction Project Manager | **Implementation Date:**<br>31 December 2020 |

## 1.4 Recommendation: Project management tools

The Council's project management toolkit and supporting guidance should be utilised (where possible) to enhance the consistency and quality of reporting, improve risk management, and facilitate senior responsible officer oversight of the Programme. This should include:

1. Development and ongoing use of a Risks Assumptions Issues and Dependencies (RAID) log that captures relevant information in line with the RAID log template and guidance available via the Orb. The RAID log should include key risks for both the sports centre and wider side and should be a standing agenda item for review at Programme Board meetings.
2. Development and ongoing use of benefits tracker that monitors achievement of actual in comparison to expected financial and qualitative benefits. Benefits should also be assigned owners responsible for realisation. Progress with benefit delivery should also be monitored throughout the life of the Programme and reported to the Programme Board.

Where required, training and support should be sought from the Council's Strategic Change and Delivery team to support implementation of these agreed management actions.

## 1.4 Agreed Management Action: Use of Council project management toolkit

The Project Team will work with the Strategic Change and Delivery team to adopt relevant elements of the project management toolkit. As a minimum this will include a RAID log and benefits tracker at the appropriate stage of the project.

An example of a benefits tracker for a project at a similar stage of delivery will be requested from the Change and Delivery team to inform the approach of the use of this tool.

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| **Owner:** Paul Lawrence, Executive Director of Place<br>**Contributors:** Michael Thain, Head of Place Development; Tricia Hill, Development & Regeneration Manager; Jen Blacklaw, Senior Construction Project Manager; Nick Cairns, Construction Project Manager | **Implementation Date:**<br>31 March 2021 |

## 1.5 Recommendation: Change Board reporting

In line with the Change Board reporting responsibilities set out in the Change Board governance framework, Change Board monthly dashboard reports should be:

- Reviewed by a secondary team member to validate the reporting with source information (i.e. Programme Board reports and cost and benefit data);
- reviewed and approved by the SRO, prior to submission to the Strategic Change and Delivery team.

**1.5 Agreed Management Action: Review and validation of monthly dashboard reports**

Change Board monthly dashboard reports will be:

- Reviewed by a secondary team member (the Development & Regeneration Manager) to validate the reporting with source information (i.e. Programme Board reports and cost and benefit data);
- Reviewed and approved by the SRO, prior to submission to the Strategic Change and Delivery team.

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| **Owner:** Paul Lawrence, Executive Director of Place<br>**Contributors:** Michael Thain, Head of Place Development; Tricia Hill, Development & Regeneration Manager; Jen Blacklaw, Senior Construction Project Manager; Nick Cairns, Construction Project Manager | **Implementation Date:**<br>31 December 2020 |

**2. Professional Services - contract management arrangements** — **Medium**

Third-party professional services such as architects; quality surveyors and external project management resource, have been appointed for the Meadowbank Redevelopment Programme through the Council's Construction Professional Services Framework Agreement.

Discussion with the Council's Commercial and Procurement Service (CPS) confirmed that at the time the current framework was awarded (November 2015), it was not handed over to a single nominated contract owner in line with the version of the Council's Contract Standing Orders that were in place at the time.

CPS management has advised that contract handover packs were developed and distributed to users of the framework, and that there should be ongoing management of individual suppliers called-off under the framework by project managers across the Council in line with the Council's established Contract Management Framework requirements.

**Risks**

The potential risks associated with our findings in relation to management of the overall professional services framework are:

- Failure to monitor third party service delivery in relation to the Programme;
- Lack of clarity on roles, responsibilities and contractual obligations which may impact successful and timely delivery of Programme objectives;
- Limited opportunity to resolve disputes; and
- Lack of assurance on the adequacy of performance for suppliers engaged in multiple projects across the Council.

**2.1 Recommendation: Contract management – Professional Services Framework**

The Council's Commercial and Procurement Services should develop and implement processes to support effective ongoing first line (divisional and directorate) management of all third-party

suppliers appointed via the Construction Professional Services Framework for the duration of their contracts.

## 2.1 Agreed Management Action – In life contract management – professional services

The Council is in the process of replacing the existing framework agreement with a new Professional Services Framework Agreement which is scheduled to come online in October 2020. The Procurement Requirement Form for this new framework was submitted by the Place Directorate (Place Development). The Procurement Plan for this new framework was approved by the Resources Directorate (Property and Facilities Management).

As noted in the Background and Scope, contract management risks (including use of third party contractors to support project delivery) are owned by first line Directorates and Divisions who are responsible for ensuring that these risks are mitigated by consistently applying the Council's established contract management framework.

Commercial and Procurement Services (CPS) will submit a proposal to the Place, Resources and Communities & Families Directorates for the identification and agreement of an appropriate first line Directorate, and associated Contract Owner and Contract Manager(s), that will assume overall responsibility for ongoing management of the new framework once it has been put in place, in line with the Council's Contract Standing Orders. CPS will provide that Directorate, and others involved in the management of the new framework, with guidance in terms of officer roles and responsibilities.

This guidance will involve developing and implementing proportionate processes to support effective ongoing first line (Divisional and Directorate) contract management of all third-party suppliers appointed via the new Professional Services Framework for the duration of their contracts. The success of this will be dependent upon the active support and engagement by those Divisions and Directorates across the Council that make use of the new framework.

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| **Owner:** Stephen Moir, Executive Director of Resources<br>**Contributors:** Hugh Dunn, Head of Finance, Iain Strachan, Chief Procurement Officer, Mollie Kerr, Contract and Grants Senior Manager, Brodie Smithers, Senior Category Manager | **Implementation Date:**<br>31 December 2020 |

# Appendix 1: Basis of our classifications

| Finding rating | Assessment rationale |
|---|---|
| **Critical** | A finding that could have a:<br>• ***Critical*** impact on the operational performance; or<br>• ***Critical*** monetary or financial statement impact; or<br>• ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or***<br>• ***Critical*** impact on the reputation of the Council which could threaten its future viability. |
| **High** | A finding that could have a:<br>• ***Significant*** impact on operational performance; or<br>• ***Significant*** monetary or financial statement impact; or<br>• ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or***<br>• ***Significant*** impact on the reputation of the Council. |
| **Medium** | A finding that could have a:<br>• ***Moderate*** impact on operational performance; or<br>• ***Moderate*** monetary or financial statement impact; or<br>• ***Moderate*** breach in laws and regulations resulting in fines and consequences; or<br>• ***Moderate*** impact on the reputation of the Council. |
| **Low** | A finding that could have a:<br>• ***Minor*** impact on operational performance; or<br>• ***Minor*** monetary or financial statement impact; or<br>• ***Minor*** breach in laws and regulations with limited consequences; or<br>• ***Minor*** impact on the reputation of the Council. |
| **Advisory** | A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice. |

# Appendix 2: Areas of audit focus

The areas of audit focus and related control objectives included in the review are:

| Audit Area | Control Objectives |
|---|---|
| Project governance | • The project has been assessed for inclusion in the Council's major projects portfolio using the project prioritisation matrix.<br>• A project governance forum has been established with a clearly defined remit which details key members, their roles and responsibilities.<br>• A full project business case has been prepared for the project; approved by the project board; the Change Board; and relevant Council Executive Committees.<br>• The business case is updated to reflect any significant project changes and is re-distributed to all relevant governance forums for approval.<br>• Key deliverables have been identified and allocated to appropriate individuals who have a clear understanding of their delivery requirements and timeframes.<br>• A clear project plan which details timeframes; ownership; dependencies and progress of all key project deliverables has been developed and is regularly updated throughout the project.<br>• Project costs and benefits have been quantified; validated and are reflected in the project business case.<br>• Processes have been established to ensure that project costs and benefits are monitored throughout the life of the project through to post implementation.<br>• An up-to-date risks, issues and dependencies log is in place with evidence that all existing and new and emerging risks, issues, and dependencies are appropriately owned and effectively managed.<br>• Complete and up to date progress reports are provided to the programme board and the Strategic Change and Delivery team within required timeframes for inclusion in reporting provided to the Change Board.<br>• Actions from governance meetings are documented; appropriately delegated; and tracked through to completion.<br>• Post implementation reviews are scheduled / have been held to reflect on 'lessons learned' and confirm that all anticipated benefits have been realised. |
| Project skills and experience | • The programme is overseen by a Senior Responsible Officer and delivered by Project managers who are appropriately skilled with proven project delivery experience.<br>• The programme is adequately resourced with appropriately skilled and experienced employees who have sufficient capacity to support delivery of projects alongside service delivery (where applicable).<br>• The programme follows the Council's project management methodology and uses the project management tool kit to ensure effective management and delivery.<br>• Where required, project management training has been delivered to ensure consistent application of project management methodology and project tools across all the programme. |
| Oversight of third parties | • Governance processes have been established to ensure effective oversight of third parties involved in delivery of projects. This includes (as a minimum): |

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| | ○ Formal clarification of third-party roles, responsibilities, and project deliverables.<br>○ Visibility of risks, issues and dependencies logs.<br>○ Regular progress reporting at an agreed level of detail.<br>○ Regular meetings to discuss performance and progress; and Established processes to escalate performance issues.<br>• Secure processes have been established for sharing private or commercially sensitive information with third parties. |
| Stakeholder engagement | • Internal and external parties who will either support the project or will be impacted by the changes to be delivered have been identified; and<br>• Appropriate stakeholder engagement and communication plans have been established, with key stakeholder engagement milestones reflected in the project plan. |