Governance, Risk and Best Value Committee

10.00am, Tuesday 13 August 2019

Internal Audit Annual Opinion for the year ended 31 March 2019

Item number

Executive/routine

Wards

Council Commitments

1. Recommendations

1.1 It is recommended that the Committee notes the Internal Audit opinion for the year ended 31 March 2019.

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Report

Internal Audit Annual Opinion for the year ended 31 March 2019

2. Executive Summary

2.1 This report details Internal Audit's annual opinion for the City of Edinburgh Council (the Council) for the year ended 31 March 2019. Our opinion is based on the outcomes of the audits carried out as part of the Council's 2018/19 Internal Audit annual plan, and the status of open Internal Audit findings as at 31 March 2019.

2.2 No 'Critical' Internal Audit findings have been raised during the course of 2018/19 and the total number of findings and High rated findings raised has decreased when compared to prior years. However, a number of significant weaknesses in the Council's control environment have been identified, and an increasing trend in the percentage and ageing of overdue IA findings as at 31 March 2019 is evident when compared to prior years.

2.3 Internal Audit's independent and professional opinion is that the Council's established control environment; governance and risk management arrangements have not adapted or evolved sufficiently to support effective management of the changing risk environment and the Council's most significant risks, putting achievement of the Council's objectives at risk.

2.4 Consequently, Internal Audit is reporting a 'red' rated opinion, with our assessment towards the middle of this category, reflecting that significant enhancements are required to the Council's established control environment; governance; and risk management arrangements to ensure that the Council's most significant risks are effectively mitigated and managed. This outcome remains unchanged in when compared to the Internal Audit opinion presented for the 2017/18 financial year.

2.5 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 within the Council.

2.6 This report has been prepared fully in line with Public Sector Internal Audit Standards (PSIAS) requirements.

3. Background

3.1 The objective of Internal Audit 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 Public Sector Internal Audit Standards (PSIAS) requirements.

3.2 The PSIAS provide a coherent and consistent internal audit framework for public sector organisations. Adoption of the PSIAS is mandatory for internal audit 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, Internal Audit 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 Internal Audit findings (dating back to 1 April 2016) had either not been implemented or had been implemented but not sustained at that time.

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.

4. Main report

Internal Audit Opinion

4.1 Internal Audit considers that significant enhancements are required to the control environment, governance and risk management arrangements to ensure that the Council's most significant risks are effectively mitigated and managed and is raising a 'red' rated opinion (see Appendix 1 category 3), with our assessment towards the middle of this category. This opinion is aligned with the outcome reported for the 2017/18 financial year and is subject to the inherent limitations of internal audit (covering both the control environment and the assurance provided over controls) as set out in Appendix 2.

4.2 No 'Critical' Internal Audit findings have been raised and the total number of findings (including High rated findings) raised has decreased when compared to prior years which highlights some positive improvement. However, a number of new and significant weaknesses in the Council's control environment have been identified, together with an increasing trend in the percentage and ageing of overdue IA findings as at 31 March 2019 in comparison to prior years.

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

Areas where improvement is required

4.4 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.

4.4.1 The majority of Internal Audit findings raised have highlighted that key first line management controls (most notably quality assurance reviews) have either not been established or, where established, are not consistently reviewed to confirm their ongoing effectiveness to support management of key service delivery risks. This is highlighted in the outcomes of several reviews, including GDPR (gap analysis) Follow-up; Homelessness; Contract Management; HMO Licencing; Developer Contributions; IR35 and Right to Work; and Schools First Line Assurance Framework reviews.

4.4.2 Significant concerns were also highlighted in relation to effective management of technology risks, as the Council's technology partner CGI has not yet implemented ongoing vulnerability scanning as a service. Consequently, potential network vulnerabilities may not be fully identified and addressed in a timely manner. This has impacted the Council's ability to obtain both Cyber Essentials Plus accreditation as recommended by the

Scottish Government, and a Public Services Network code of connection certificate from the UK Government.

4.4.3 The technology Certifications and Software Licencing review has also confirmed that CGI has not yet established adequately designed processes to support effective ongoing management of the Council's full population of software licences, which could potentially impact user access and also has associated cost implications for the Council.

4.4.4 Additionally, the Financial Systems Access Controls review identified a significant finding. The outcomes of this review will be reported separately to the GRBV as a 'B' agenda item.

4.4.5 The Validation review also confirmed that completed management actions are not yet being consistently sustained, with 3 of our sample of 11 previously closed findings (27%) having to be reopened. One finding was reopened as a High; one regraded from a Medium to a High; and one finding downgraded from Medium to Low.

4.4.6 Reviews of major projects and organisational change confirmed that the Council's Change Board is now providing effective oversight of the Council's major projects portfolio, and that projects are generally well managed. However, further improvements are required to ensure that senior responsible officers (SROs) and supporting project managers consistently manage projects in line with the Council's established project management framework (notably the fleet Project and implementation of the Roads Services Improvement Plan); whole of life (capital and revenue) costing is applied when calculating project costs; the impact of changes on support provided by Council Directorates to the Health and Social Care Partnership is consistently considered when preparing business cases; and that adequate project management resource is provided to support delivery of major projects.

4.4.7 Whilst the Property and Facilities Management Division has consistently achieved their financial savings targets, the Asset Management Strategy review confirmed that a new realistic and achievable Council Asset Management strategy is required to ensure that ongoing financial savings targets and service delivery improvements are achieved across the Council's operational property portfolio, to support effective and ongoing property portfolio management, optimisation, and maintenance. We also highlighted that complete and accurate data and management information on the occupancy status; market and lease values; and condition of the Council's property assets is required to support achievement of the Council's property management objectives.

Areas where positive assurance has been provided

4.5 Although some improvements are required, the Payments and Charges review used a combination of data analytics and sample testing to confirm that the majority of adult residential care home; licencing; and parking permit fees that generate circa £55M income annually for the Council are accurately calculated and applied. Whilst some errors in the calculation and application of charges were identified, none of these were significantly material.

4.6 A total of 5 reviews within the Place Directorate were reported as 'adequate', most notably Waste and Cleansing Performance Management Framework review which confirmed that the performance management framework established following delivery of the Waste and Cleansing improvement plan has been adequately designed and is operating effectively. Two of these reviews (The Transfer of the Management of Development Funding Grant, and the Port Facility Security Plan) are performed annually at the request of the Scottish Government and the Department for Transport respectively.

Basis of Opinion

4.7 Our opinion is based on the outcome of 34 audits completed across the Council in the year to 31 March 2019, and the status of open internal audit findings as at 31 March 2019.

4.8 As the Council is the administering authority for the Lothian Pension Fund (LPF), our opinion also includes the outcome of the three audit reviews performed for LPF and the status of their open audit findings as at 31 March 2019.

4.9 A separate Internal Audit opinion for the LPF was prepared and presented at the Pensions Audit Committee on 25 June 2019. This was an 'amber' rated opinion, with our assessment towards the middle of this category. Whilst all three reviews completed for LPF were rated as 'adequate' with 2 findings (1 Medium and 1 Low) raised, the amber assessment was primarily attributable to the status of overdue LPF IA findings (3 High; 1 Medium; and 2 Low) which were between 9 and 13 months overdue as at 31 March 2019.

4.10 No audits have been referred by the Edinburgh Integration Joint Board (EIJB) Audit and Risk Committee for inclusion in the 2018/19 IA annual opinion as the 4 reviews completed in the 2018/19 plan year had no direct impact on the services delivered by the Council as part of the Health and Social Care Partnership.

4.11 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 Internal Audit team.

Audit outcomes

4.12 Of the 34 audits completed across the Council 5 (23%) were reported as 'adequate' (green), 13 (38%) as 'generally adequate' (amber) and 14 (41%) were reported as 'significant enhancements required' (red). A further two programme audits

(Enterprise Resource Planning and Tram Extension) are ongoing agile programme audits and will conclude at the end of the programmes being delivered. However, no significant findings have been raised to date in either of these reviews.

4.13 A total of 80 findings (30 High; 31 Medium; and 19 Low) were raised in the 34 reviews completed across the Council.

4.14 Appendix 3 includes details of all 2018/19 audits completed (including those carried forward from 2017/18) for the Council and the outcomes of the LPF reviews

4.15 Appendix 4 details the remaining four 2018/19 audits to be completed for the Council, and their current status.

Status of Internal Audit Findings as at 31 March 2019

4.16 There were 83 open IA findings across the Council as at 31 March 2019, including 16 of the 26 historic Council findings that were reopened in June 2018.

4.17 Of the 83 open IA findings:

4.17.1 a total of 51 (61%) were reported as overdue as they had missed all of their originally agreed implementation dates (13 High; 33 Medium; and 5 Low);

4.17.2 evidence in relation to 20 (39%) of the 51 overdue findings was being reviewed by IA to confirm that it was sufficient to support their closure;

4.17.3 31 (61%) residual overdue findings still required to be addressed; and

4.17.4 a total of 32 (39%) were open, but not overdue;

Comparison to Prior Year

4.18 The 2018/19 IA annual opinion has not changed in comparison to 2017/18 where a red rated opinion was also reported, with our assessment also towards the middle of the category.

4.19 The rationale supporting the unchanged annual opinion in comparison to the 2017/18 financial year has taken into account the following:

4.19.1 the areas of concern highlighted in relation to ongoing management of the Council's most significant risks as highlighted at 4.4.1 to 4.4.7 above;

4.19.2 a positive decreasing trend in the total number of Internal Audit findings raised, with 82 raised in 2018/19 in comparison to 126 and 113 in 2017/18 and 2016/17 respectively;

4.19.3 a positive decreasing trend in the number of high rated findings raised with 30 raised in 2018/19 in comparison to 47 and 26 in in 2017/18 and 2016/17 respectively;

4.19.4 the increasing trend in the percentage of overdue IA findings with 61% that were overdue as at 31 March 2019 in comparison to 42% in 2017/18 and

40% in 2016/17. The historic overdue findings reopened in June 2018 account for 10% of this increase.

4.19.5 the ageing profile of overdue findings has also deteriorated with 43% more than six months overdue (34% in 2017/18); and 76% more than one year overdue (44% in 2017/18). The increase in the number of findings more than one year overdue is attributable to the remaining historic overdue findings which account for 31% of the increase. This highlights that the Council is not yet addressing the risks associated with Internal Audit findings raised within agreed timeframes.

4.19.6 as at 31 March 2019 good progress was evident with implementation of the 26 historic Internal Audit findings that were reopened in June 2018, as 10 (38%) had been closed; 5 (19%) were with IA for review to confirm whether they could be closed; with management updates required for the remaining 11 (61%).

Internal Audit Independence

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

4.21 We do not consider that we have faced any significant threats to our independence during 2018/19, nor do we consider that we have faced any inappropriate scope or resource limitations (for example headcount restrictions) when completing our work.

4.22 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 2019 also effectively supports ongoing Internal Audit independence.

Conformance with Public Sector Internal Audit Standards

4.23 Internal Audit has not fully conformed with PSIAS requirements during 2018/19 for the following reasons:

4.23.1 Ongoing recruitment challenges arising from staff turnover and an increase in the size of the in-house internal audit team team has impacted upon the implementation of the internal quality assurance process to ensure consistency of audit quality.

4.23.2 We consider that these resourcing challenges have been managed to ensure sufficient and appropriate audit coverage.

Action taken to address instances of non PSIAS conformance

4.24 Complementary resources were drawn down from the existing co-source arrangement with PwC and temporary resources secured from the external market to address resourcing gaps and ensure completion of the annual audit plan.

4.25 A new quality assurance process has been designed and will be applied to a sample of reviews completed in the 2019/20 plan year.

5. Next Steps

5.1 IA will focus on delivery of the remaining 2018/19 reviews to be completed whilst progressing with delivery of the 2019/20 IA plan.

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.

6. Financial impact

6.1 No direct financial impact.

7. Stakeholder/Community Impact

7.1 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, and community groups.

8. Background reading/external references

8.1 Public Sector Internal Audit Standards

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

8.3 Internal Audit Opinion and Annual Report for the Year Ended 31 March 2017

8.4 Internal Audit Report - Historic Internal Audit Findings

8.5 Internal Audit Overdue Findings and Late Management Responses as at 25 March 2019

8.6 Process for Approving Changes to the Internal Audit Plan

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

9. Appendices

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 2018 and 31 March 2019

9.4 Appendix 4 2018/19 Reviews Nearing Completion

9.5 Appendix 5 Final Internal Audit reports Completed in the Last Quarter of 2018/19

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:

1 Adequate *An adequate and appropriate control environment and governance and risk management framework I is in place enabling the risks to achieving organisation objectives to be managed*	**2 Generally adequate but with enhancements required** *Areas of weakness and non-compliance in the control environment and governance and risk management framework that that may put the achievement of organisational objectives at risk*
3 Significant enhancements required *Significant areas of weakness and non-compliance in the control environment and governance and risk management framework that puts the achievement of organisational objectives at risk*	**4. Inadequate** *The framework of control and governance and risk management framework is inadequate with a substantial risk of system failure resulting in the likely failure to achieve organisational objectives.*

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.

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 2018 to 31 March 2019. 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.

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 2018/19 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.

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 assessment of controls relating to the Council is for the year ended 31 March 2019. 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.

Responsibilities of Service Management and Internal Audit

It is Service Management's responsibility to develop and effective control environments and governance and risk management frameworks that are designed to prevent and detect irregularities and fraud. Internal audit work should not be regarded as a substitute for Management's responsibilities for the design and operation of these controls.

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.

Appendix 3 – Audits completed between 1 April 2018 and 31 March 2019

			No. of findings raised			
	Review Title	**Report Outcome**	**High**	**Medium**	**Low**	**Totals**
Ref	**Council Wide**					
1.	Contract Management and Construction Industry Scheme Payment Deductions	**Significant Enhancements**	2	-	-	2
2.	Validation	**Significant Enhancements**	2	-	1	3
3.	Financial System Access Controls	**Significant Enhancements**	1	-	-	1
4.	Emergency Prioritisation and Complaints – Customer Contact Centre	**Generally Adequate**	-	2	1	3
5.	GDPR (Gap Analysis) Follow-up	**Generally Adequate**	1	1	1	3
6.	IR35 and Right to Work	**Generally Adequate**	1	1	1	3
7.	Payments and Charges	**Generally Adequate**	-	5	-	5
8.	Organisational Change	**Generally Adequate**	-	1	-	1
	Totals		**7**	**10**	**4**	**21**
	Resources					
9.	Public Sector Cyber Action Plan for Cyber Resilience Review	**Significant Enhancements**	1	2	-	3
10.	Public Services Network Accreditation	**Significant Enhancements**	2	1	-	3
11.	Certifications and Software Licencing	**Significant Enhancements**	2	-	-	2
12.	Implementation of Asset Strategy and CAFM system	**Significant Enhancements**	3	-	-	3
13.	Implementation of Facilities Management Service Level Agreement	**Generally Adequate**	1	-	-	1
	Totals		**9**	**3**	**-**	**12**
	Communities and Families					
14.	Schools First Line Assurance Framework	**Significant Enhancements**	1	-	-	1
15.	Homelessness Services	**Significant Enhancements**	2	1	-	3

	Appendix 3 – Completed Audits Supporting the 2018/19 IA Annual Opinion		No. of findings raised			
	Review Title	**Report Outcome**	**High**	**Medium**	**Low**	**Totals**
16.	Quality, Governance and Regulation	**Generally Adequate**	1	1	1	3
	Totals		**4**	**2**	**1**	**7**
	Strategy and Communications					
17.	Portfolio Governance Framework	**Generally Adequate**	1	-	1	2
	Totals		**1**	**-**	**1**	**2**
	Health and Social Care					
18.	Emergency Prioritisation and Complaints – Telecare	**Generally Adequate**	-	1	1	2
	Totals		**-**	**1**	**1**	**2**
	Place					
19.	Localities Operating Model	**Significant Enhancements**	1	-	1	2
20.	Developer Contributions	**Significant Enhancements**	3	-	-	3
21.	HMO Licencing	**Significant Enhancements**	2	2	-	4
22.	The Council's Roads Service Improvement Plan	**Significant Enhancements**	2	1	1	4
23.	*Structures and Flood Prevention	**Generally Adequate**	-	1	2	3
24.	Street Lights and Road Traffic Signals	**Generally Adequate**	-	2	3	5
25.	Port Facility Security Plan	**Adequate**	-	1	1	2
26.	Waste and Cleansing Performance Management Framework	**Adequate**	-	-	1	1
27.	Transfer of the Management of Development Funding Grant	**Adequate**	-	-	3	3
28.	Carbon Reduction Commitment Scheme	**Adequate**	-	-	-	-

	Appendix 3 – Completed Audits Supporting the 2018/19 IA Annual Opinion		No. of findings raised			
	Review Title	**Report Outcome**	**High**	**Medium**	**Low**	**Totals**
29.	Edinburgh Mela Ltd. – Due diligence review in advance of the City of Edinburgh Council Grant Award	**Adequate**	-	2	-	2
	Totals		**8**	**9**	**12**	**29**
	Projects					
30.	*Fleet Project Management	**Significant Enhancements**	1	-	-	1
31.	*Schools and Customer Transformation	**Generally Adequate**	-	2	-	2
32.	Garden Waste	**Generally Adequate**	-	2	-	2
33.	Tram Extension	**Ongoing Agile Audit**	-	1	-	1
34.	Enterprise Resource Planning	**Ongoing Agile Audit**	-	1	-	1
	Totals		**1**	**6**	**-**	**7**
	Lothian Pension Fund					
35.	Unlisted Investment Valuations and Application of Fund Administration Fees and Charges	**Adequate**	**-**	**-**	**-**	**-**
36.	Unitisation (Employer Asset Tracking)	**Adequate**	**-**	**1**	**1**	**2**
37.	Stock Lending	**Adequate**	**-**	**-**	**-**	**-**
	Totals		**-**	**1**	**1**	**2**
	Total Findings Raised 2018/19 – 37 Audits		**30**	**32**	**20**	**82**
	2017/18 Total – 32 Audits		**47**	**55**	**24**	**126**
	2016/17 Total – 38 Audits		**26**	**65**	**22**	**113**

*** Audits carried forward from 2017/18**

Appendix 4 – 2018/19 Reviews nearing completion

The following table shows the Internal Audit reviews from the 2018/19 Internal Audit plan that are nearing completion at the time of preparing this report.

Ref	Directorate	Title	Status
1.	Communities and Families and Health and Social Care	Looked After and Accommodated Children – St Katherines	IA is working with Strategy and Communications; Communities and Families and the Edinburgh Integration Joint Board to finalise a combined report for presentation to the Governance, Risk and Best Value Committee.
2.	Councilwide	Health and Safety – Life and Limb Risks	Will be carried forward into 2019/20.
3.	Place	Building Standards Follow-up	Management is finalising evidence to be provided to IA support closure of previously raised IA findings.
4.	Resources	Payroll	Payroll data has been provided to support completion of testing and the review is scheduled for completion by the end of July 2019.

Appendix 5

The City of Edinburgh Council

Internal Audit

Contract Management and Construction Industry Scheme Payment Deductions

Final Report

8 August 2019

RES1809

Overall report rating:

Significant enhancements required	Significant areas of weakness and non-compliance in the control environment and governance and risk management framework that puts the achievement of organisational objectives at risk

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Content

This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2018/19 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2018. 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

There are approximately 1,300 contracts identified on the Council's Contract Register. This number includes frameworks, with a number of potential suppliers associated with each individual framework. The approximate number of actual suppliers on the register is circa 1,800, some of whom will have a number of separate contracts.

Contract management and the three lines of defence

The Three Lines of Defence model can be applied to contract management across the Council. The 'first line' comprises Directorates and Divisions that own and manage service delivery contract management risks following completion of procurement; the 'second line' includes specialist centralised teams who establish and oversee compliance with relevant contract management policies and frameworks and challenge the effectiveness of contract management risk management by service areas; with the third line (for example, Internal Audit) providing independent assurance on the operation of key contract management controls across the Council.

Contract Management Framework

Whilst service delivery can be undertaken by contractors and sub-contractors on behalf of the Council, responsibility for any significant legislative; regulatory; or security breaches (for example third party failure to comply with GDPR regulations in relation to data provided by the Council) remains with the Council.

An effective Contract Management Framework that is consistently applied by all Council contract owners and managers should ensure that this risk is effectively managed; that procured services achieve Best Value for the duration of the contract; and also support effective service delivery.

Contracts and Grants Management Team

The second line Contracts and Grants Management team (C&GM) was established in August 2017 in response to an Internal Audit review of Contractor Management (completed March 2017) which highlighted that the Council had no established supplier management framework to ensure effective ongoing management of third party contracts (once procured) by Directorates and Divisions. The C&GM team comprises approximately 5 FTE.

C&GM has provided ongoing support to all Council service areas with management of their third party supplier risks, and contract (and sub contract) performance management by developing and implementing a contract management framework, comprising a contract management manual and toolkit to support Divisions and ensure that consistent contract management processes are applied across the Council in line with the contract management principles and Executive Director responsibilities for contract management specified within the Council's Contract Standing Orders.

Contract Management Framework requirements

The Contract Management Framework requires contracts to be classified as either Tier 1; 2 or 3 based on the value, risk, and complexity of contract, with Tier 1 contracts presenting the highest level of cost and risk to the Council. A contract classification tool has been designed by the C&GM team to support the classification process.

Following implementation of the framework, C&GM started the tiering assessment process to support their identification of the Council's highest value and highest risk contracts, with the expectation that

Divisions would then complete the tiering assessment process for the remainder of the contracts that they manage.

To manage risk effectively and ensure business continuity, the financial standing of suppliers delivering high risk services should be monitored through completion of ongoing contract health checks as detailed in Appendix 3 of the contract management manual.. Responsibility for completion and advising Finance of changes in contract or supplier risk rests with service area contract managers.

Management has advised that, in accordance with the Council's contract management manual, Finance conducts financial appraisals on those suppliers identified by service areas as high risk and will produce reports highlighting issues and concerns. Financial appraisals are performed by Finance on suppliers and contractors identified as supplying Tier 1 contracts on the contract register, out with the contract management manual.

Additionally, Finance monitors all suppliers where the Council spends more than £500,000 per annum, using news alert systems and annual reviews. Finance will alert both the C&GM team and service areas if there are issues identified.

Guidance and example indicators are provided in the Contract Handover and Mobilisation report, for contract managers to use when assessing if a supplier may be experiencing financial difficulties. Service areas must advise, and work with, Finance, C&GM and potentially Legal Services if a supplier's financial standing appears to be weakening to a material degree.

C&GM also provides guidance; training; and performs ongoing contractual compliance reviews to confirm that the Council's most significant contracts are being managed in line with the framework.

The Public Contracts Scotland Tendering technology solution (PCS-T)

A new technology solution (the Public Contracts Scotland Tendering technology solution, known as PCS-T) provided free and hosted by the Scottish Government, and widely used across the Scottish public sector, is currently being piloted by C&GM to determine how effectively the system will support ongoing maintenance of the Council's contracts register and supporting information, with all relevant contractual documentation available in a single location.

This will include direct access for services to the relevant contracts that the manage, enabling them to update their contract information. Management has advised that work is underway to upload all relevant contractual documentation to the system, with a view to full system implementation by mid 2020. C&GM are performing the pilot now and uploading relevant contractual documentation, to support the success of the wider roll out across the Council by this target date.

Previous Internal Audit reviews

Two recent reviews have also been completed that raised findings in relation to contract management in the Communities and Families Directorate and Health and Social Care Partnership. These were

1. Communities and Families - Management of Care Providers – issued January 2017; and
2. Health and Social Care Partnership - Purchasing Budget Management – issued July 2018

The findings raised in these reviews have been considered as part of our current review to ensure that there has been no duplication of Internal Audit recommendations and agreed management actions.

It is also acknowledged that the Health and Social Care contracts manager was appointed in January 2019 to a post that had been vacant for more than twelve months, and that the Health and Social Care contracts team are in the process of establishing operational procedures by 31 October 2019 to support closure of an IA finding raised in the review noted above.

Construction Industry Scheme

Management of third party contractors and subcontractors may also involve complying with the requirements of the UK Government's Construction Industry Scheme (CIS), administered by Her Majesty's Revenue and Customs (HMRC).

The scheme requires contractors to deduct money from subcontractor's payments and pass it directly to HMRC using an online system. These deductions are treated as advance payments towards the subcontractor's tax and National Insurance. The 2018 CIS standard deduction rate was 20%.

Whilst contractors must register for the scheme, subcontractors are not required to register, however, higher rate deductions (30%) are taken from payments if they are not registered. Subcontractors can also apply to HMRC for gross payment status, enabling them to be paid with no deductions.

The Council is required to register with the CIS as a contractor, as it spends an average of more than £1 million per year on construction in any 3-year period, on permanent or temporary buildings or structures and civil engineering works (for example roads and bridges).

As a contractor, the Council must ensure that it has:

- a current CIS registration prior to recruiting any subcontractors;
- checked whether the subcontractor should be employed the instead of offering a contract, as a penalty may be applied by HMRC if the subcontractor should have been employed as per IR35 regulations;
- checked with HMRC to establish whether subcontractors are CIS registered;
- applied payment deductions at the appropriate rate and transferred them to HMRC;
- filed monthly returns and maintained full CIS records – penalties can be applied if returns are not filed and records maintained; and
- advise HMRC of any significant organisational changes.

Scope

The review primarily focused on assessing the design adequacy and operating effectiveness of the second line C&GM Contract Management Framework, and whether it is consistently applied by contract managers across the Council following completion of the procurement process.

The review also assessed the effectiveness of the controls in place to ensure that any necessary construction scheme industry payments are made completely and accurately to HMRC, with monthly returns filed and records maintained.

Sample testing was performed on six Tier 1 and 2 contracts selected randomly from the Council's contracts register across Health and Social Care; Communities and Families; and Place Directorates.

Our sample testing was performed during the period 1 October 2017 to 31 October 2018.

Limitations of Scope

The procurement process and financial appraisals performed by Finance were specifically excluded from scope as the review focused on the effectiveness of supplier management following completion of procurement.

Further details on the scope of our review are included at Appendix 2 – Areas of Audit Focus.

Reporting Date

Our audit work concluded on 28 February 2019 and our findings and opinion are based on the outcomes of our testing at that date.

2. Executive summary

Total number of findings: Two

Summary of findings raised	
High	1. Contract Management by Directorates and Divisions
High	2. Contracts and Grant Management Team

Further detail on the basis of the classifications applied to our findings is included at Appendix 1.

Opinion

Contract and Supplier Management - Significant enhancements required

Our review established that significant enhancements are required across both the first (Directorates and Divisions) and second (Contracts and Grants Management Team) lines of defence as contract and supplier management risk is currently not consistently and effectively managed across the Council.

As highlighted in the background section of the report, the Three Lines of Defence model can be applied to contract management across the Council. Whilst it is a first line Directorate/Divisional responsibility to ensure that the Council's contract management framework is consistently applied, and that the associated risks are identified and managed effectively, it is also essential to establish an effective contracts management framework (second line Contracts and Grants Management responsibility) to assist Directorates and both support and challenge the effectiveness of their contract management arrangements.

Additionally, the second line Contracts and Grants Management team will only be able to provide support with ongoing management of the most significant contract risks if Divisions ensure that they accurately enter and maintain contract details (including the relevant named contract managers) in the Council's contract register.

Ongoing Directorate/Divisional contract management

The Contracts and Grants Management team (C&GM) was established in August 2017, and has made significant progress with the development and launch of the contract management manual and toolkit across the Council. However, our review of a sample of six Tier 1 and Tier 2 contracts that could potentially expose the Council to significant risk confirmed that they are not being consistently managed by first line management in line with the requirements of the manual and applicable Council Contract Standing Orders across the Health and Social Care Partnership (the Partnership); Communities and Families; and Place Directorates.

Additionally, no first line quality assurance checks are performed across the Partnership; Communities and Families; or Place to provide ongoing first line assurance that their most significant high risk contracts are being effectively managed on an ongoing basis.

Of the three Directorates and six contracts included in our sample, contract and supplier management risks were managed most effectively by the Place Directorate.

Contracts and Grants Management Team assurance

The C&GM team, recognising the lack of ongoing assurance provision in relation to contract and supplier management risk across the Council, has proposed they implement second line assurance contract compliance reviews, to confirm the extent of ongoing compliance with the contracts manual and Contract Standing Orders across the Council's most significant contracts.

However, further work is required to ensure that the C&GM team resourcing and deliverables are reviewed and refreshed to confirm that the team has the capacity to support delivery of the planned contract compliance reviews, as well as other ongoing work.

Management has advised that project plans will be developed to support Council wide implementation of the Scottish Government's Public Contracts Scotland Tendering technology solution as this is currently being piloted by the team to support a more automated approach to ongoing contract management across Directorates and Divisions.

Consequently, two high rated findings have been raised, one in respect of contract management by Directorates and Divisions, and one in respect of the C&GM team.

Areas of good practice

Our review identified the following areas of good practice:

- Development and implementation of a comprehensive contracts and grants management training module on the Council's Interactive Learning platform (CECIL) by the C&GM team;
- C&GM has delivered various workshops to contract managers;
- A Contract Managers' Forum has been established with representation from all service areas where C&GM deliver focused sessions to contract managers on subjects such as key performance indicators and Brexit;
- Contract training has also been delivered to Partnership managers regarding the correct use of agency employees.

Construction Industry Scheme - Adequate

Our review confirmed that an adequate and appropriate control environment has been established across the Council to ensure ongoing compliance with the UK Government's Construction Industry Scheme (CIS), administered by Her Majesty's Revenue and Customs (HMRC).

Management Response from Contracts and Grants Management Team in respect of the Second Finding

Upon its establishment in August 2017, the C&GM team focused on putting in place a Council-wide contact management framework, which was then implemented across the Council. By way of context, the team has approximately 5 FTE, and the Council has approximately 1,300 contracts on its contract register. This work was substantially completed in June 2018, with the framework being published on the Orb. Since then, the team has been working with all Directorates to further embed the framework, including the CECiL training module and other training/forums referred to above, as well as dedicating significant resources to supporting service areas address specific contract/supplier management matters. As the framework is further embedded it is expected that the role of C&GM will naturally evolve to be more focussed on monitoring of compliance and performance, particularly if the PCS-T contract management module is rolled out and adopted.

The C&GM team has supported services in the delivery of significant contract management efficiencies in 2019/20 and anticipate this will continue in future financial years, and support improved financial and non-financial outputs.

Particular successes have been achieved in demand management relating to employment agency spend for the Partnership, the delivery of a model single supplier, invoice, and manager contract arrangement for one particular service which can be rolled out to cross Directorate contracts and also the recovery of contractual rebates. C&GM have delivered learning events focussed on contract management, Key Performance Indicators, whole life costing, demand management and PCS-T to ensure good practice is embedded in Commercial and Procurement Services and other teams.

The work of C&GM was independently assessed by Scotland Excel, on behalf of Scottish Government, as part of the March 2019 Procurement and Commercial Improvement Programme (PCIP) assessment of the Council. In this focused assessment, the Council's scores on Contract and Supplier Management increased from 3 to 3.5 (out of 4) and Contractual Obligations and Additional Benefits increased from 3 to 3.5 (again out of 4), the Scottish local authority average score being 2.06 and 1.68 respectively. The Council's overall score increased to 87%, placing the Council in the top performance band well above the national average of 70%.

Health and Social Care Partnership management response

The two contracts selected by Internal Audit for review (Castlegreen / North Merchiston Four Seasons Health Care, and Jubilee House are not reflective of the majority of contracts managed for the Partnership, as one was established in 2007 and the other was an emergency response to a need to increase care home capacity.

The Partnership recognises the need for improved compliance with the Council's Contract Management Framework and has recently reviewed its application across existing Partnership contracts and prepared a report for the Procurement Board that includes recommendations on how this can be improved, for example, by using an enhanced risk assessment matrix (the social work framework) for Partnership contracts to reflect the nuances and vulnerabilities of the client base supported by the providers, and reviewing and monitoring localities spend that isn't aligned to block contracts or frameworks as highlighted in the EIJB Purchasing Budget audit.

Ideally, these recommendations will be incorporated into the Council's established contract management framework to ensure consistency of approach.

The social work framework referenced in the Procurement Board report will be used to assess all current Partnership contracts, and contract management responsibilities within the team realigned based on the outcomes of this review. Our priority is to ensure that we have appropriate levels of assurance and consistent monitoring arrangements established across all contracts. The outcomes of this work will be shared with Internal Audit

A new providers' process is scheduled for launch in August 2019. Weekly meetings with providers are scheduled and we should have met with every provider under block contract arrangements (circa 141 contracts) by the end of November.

We are aiming to be in a position where all contracts have been reclassified with a monitoring plan in place by the end of the year and have requested support from the Contracts and Grants Management to implement the PCS-T technology system to support our ongoing contracts management processes.

3. Detailed findings

1. Contract Management by Directorates and Service Areas	High

Our review established that the Contracts and Grants Management contract management manual and toolkit (designed to ensure ongoing compliance with the Council's Contract Standing Orders in relation to procurement, and effective and consistent management of supplier risk) is applied with varying levels of consistency across the Communities and Families; Health and Social Care; and Place Directorates. The following variations in approach were noted:

1. **Completeness and accuracy of contracts register**

Review of the Council's contracts register confirmed that the contract register was not complete and accurate as it did not reflect the full population of service area / Directorate contracts. Additionally, where contract details were recorded, contract manager details across the Council were consistently incomplete and / or inaccurate. Specifically:

- the recently appointed Health and Social Care Partnership (the Partnership) contracts manager, who commenced in January 2019, is identified in the contract register as managing 145 live contracts;
- a total of 95 Partnership contracts were allocated to a named contract manager who is no longer employed by the Council. Management has advised that this has been addressed following completion of the audit; and
- for C&F, the majority of named contract managers were not the commissioning officers, but operational managers and team leaders.

2. Supplier management governance approach

- Currently, no quality assurance checks are performed across the Partnership; Communities and Families; or Place to provide ongoing first line assurance that their most significant high risk (Tier 1 and Tier 2) contracts are managed in line with the requirements of the contract management manual and applicable Council Contract Standing Orders;
- The Partnership has established a Procurement Board, chaired by the Chief Finance Officer of the Integration Joint Board, that provides oversight of contract management and is attended by the C&GM team. Operational management of contracts is the responsibility of the established contracts team in the Partnership, comprising five team members, led by a contracts manager who was appointed in January 2019;
- Communities and Families (C&F) have two Commissioning Officers who are responsible for cost, compliance, and Best Value, with a Team Leader from the relevant Division allocated responsibility for the ongoing quality assurance and transparency of the care provision.

  Six monthly supplier review meeting arrangements were implemented in early 2019, to address the outcomes of the "Management of Care Providers" Internal Audit review completed in January 2017, however the roles and responsibilities of the Commissioning Officers and Team Leaders in relation to ongoing supplier management have not been clearly defined and documented; and
- Place supplier management arrangements vary by necessity due to the diverse nature of services and supporting contracts across the Directorate. The two contracts included in our sample were managed by Place Development - Housing and Regulatory Services (H&RS) where contract management responsibilities are a long established and embedded part of the Operations Managers' responsibilities.

3. Contract Tiering Assessments

Initial contract tiering assessments for the six contracts included in our sample had been performed by the C&GM team as part of their initial process to identify the Councils highest value and highest risk contracts, however, there was limited involvement from contract managers in the relevant Divisions.

Management has advised that tiering assessments are now being performed retrospectively for the Health and Social Care Partnership.

4. Ongoing supplier performance management

Whilst our sample testing focused solely on the Communities and Families and Place Directorates and the Health and Social Care Partnership, we have confirmed that the findings noted below could potentially apply across the rest of the Council.

Whilst key supplier performance indicators had been developed for each of the six contracts included in our sample, supplier performance was not being managed and reviewed on an ongoing basis in line with the requirements of the contract management manual and toolkit. Specifically:

- Partnership supplier performance meetings were sporadic with no clearly defined schedule; no standard agendas had been developed to cover the areas specified in the contract management manual; and meeting outcomes and agreed actions are not minuted and shared with the supplier.

  Management has advised that a programme of supplier performance meetings is currently being considered by the recently appointed Contracts Manager.
- C&F has implemented a series of six monthly supplier performance meetings with effect from April 2019 in response to the findings raised in the Internal Audit review of Management of Care Providers completed in Jan 2017.

  Our review of the templates designed to support these meetings highlighted that they do not include all of the suggested areas detailed in the contract review meeting guidance prepared by C&GM.

5. Benefits Monitoring Processes

No benefits monitoring processes have been established in either the Partnership or C&F.

6. Ongoing Contract Health Checks

Ongoing contract health checks had not been performed by the relevant contract managers across all three Directorates for our sample of six contracts in line with the requirements of the contract management manual at Appendix 3.

Additionally, financial health checks were only performed by first line Divisional contract managers as part of the initial procurement process, irrespective of the contract duration and value.

During the course of our review, the holding company for the supplier for one of the Partnership contracts included in our sample (valued at circa £22 million), went into financial administration, requiring an immediate consideration and implementation of contingency options.

Health and Social Care Partnership management has advised that they had been aware of the potential sale of this supplier and had been attending meetings with the Convention of Scottish Local Authorities (COSLA) in relation to the proposed sale.

7. Contract risk management

We established that the risks associated with individual contracts are not consistently assessed; documented; discussed at ongoing supplier performance meetings (where established); and escalated for inclusion in directorate and divisional risk registers where required.

8. Expiring contracts and use of waivers

In the Partnership, a number of contracts have historically been extended through waivers with no clear and evidenced consideration of alternative options.

One of the contracts included in our sample (Castlegreen Care Home, which is worth over £2 million per annum), was initially procured in December 2007 for a 7-year period plus the option of a 3-year extension.

This extension has been applied twice – initially in 2014 and again in 2017 through to 31st March 2020. By the end of the current period, this contract will have been in place for nearly 12½ years with no review of contract terms and conditions.

Partnership management has advised that Castlegreen waiver extension was approved by the Council's Finance and Resources Committee in January 2018, and the Jubilee House Contract (the other contract included in the sample) waiver approved by Finance and Resources in June 2018.

Risks

1. Failure to adhere to requirements of the Council's Contract Standing Orders and the contract management manual;
2. Contract management risk is not effectively managed across the Council; and
3. Contracts are not managed in line with applicable legislation.

1.1 Recommendation - Completeness and accuracy of the contract register

- Where high risk contracts are identified by the Contracts and Grants Management team with incomplete contract manager details as part of their ongoing operational activities, C&GM will provide feedback to Directorates / Divisions and request them to update the contracts register.
- Contract manager details for all remaining contracts should be obtained at the time of renewal, or when new waivers are submitted, and their details added to the Council's current contracts register.

1.1 Agreed management actions - Completeness and accuracy of contracts register

Contracts and Grants Management

Where contracts are identified with incomplete contract register details, these will be provided to Directorates / Divisions with a request for them to update the contracts register.

Owner: Stephen Moir, Executive Director of Resources

Contributors: Iain Strachan, Chief Procurement Officer; Gavin Brown, Senior Contracts and Grants Manager; Hugh Dunn; Head of Finance; Layla Smith Resources Operations Manager; Annette Smith, Executive Assistant

Health and Social Care Partnership

A review will be performed to confirm that the Council's contracts register is completely and accurately populated for all relevant Partnership contracts with contract tiering assessments and accurate contract manager details.

Appropriate processes will also be implemented to ensure that contract register details are updated following procurement; at the time of renewal; or when new waivers are submitted and approved.

Owner: Judith Proctor, Chief Officer, Health and Social Care Partnership **Contributors:** Moira Pringle, Chief Finance Officer, Edinburgh Health and Social Care Partnership; Alana Nabulsi, Contracts Manager; Cathy Wilson, Operations Manager	**Implementation Date:** 31 March 2020

Communities and Families

A review will be undertaken to populate the contracts register with accurate details of named officers.

We will follow a similar process to HSC and Place in relation to updating of the register at the point of procurement, renewal, or submission of new waivers.

Owner: Alistair Gaw, Director, Communities and Families **Contributors:** Michelle McMillan, Operations Manager; David Hoy, Commissioning Officer, Sean Bell, Senior Manager	**Implementation Date:** 31 March 2020

Place

A recent review of the contracts register was carried out. However, an annual review of the contracts register will be undertaken to ensure that the Council's contracts register is completely and accurately populated for all Place contracts, with contract tiering assessments and accurate contract manager details included.

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Lynne Halfpenny, Director of Culture; Gareth Barwell, Head of Place Management; Michael Thain, Head of Place Development; Alison Coburn, Operations Manager.	**Implementation Date:** 31 March 2020

1.2 Recommendation – supplier management quality assurance

- An ongoing risk based quality assurance process will be implemented across Directorates and Divisions with the objective of ensuring that the most significant contracts (Tier 1 and Tier 2) are being effectively managed in line with applicable Council Contract Standing Orders and the contract management manual and toolkit;
- Where gaps are identified, appropriate actions and timeframes will be agreed for their resolution;
- Outcomes of the quality assurance reviews will also be shared with the Contracts and Grants Management team, with guidance requested (where required) on appropriate actions to address the gaps identified;
- Outcomes of the quality assurance reviews will be reported to Directorate / senior management team meetings, and confirmation provided when the gaps identified have been resolved; and
- Gaps identified will also be reflected, where appropriate, in both Directorate and Divisional risk registers and annual governance statements and (where required) in the Council's annual governance statement.

1.2 Agreed Management Actions - supplier management quality assurance

Health and Social Care Partnership

Quality assurance monitoring is performed over the two Partnership contracts included in the Internal Audit sample, through the Multi Agency Quality Assurance meetings held every two months – one for care at home/care and support, and another one for care homes and adult residential. The terms of reference of this enhanced monitoring arrangement include care inspectorate grades and care service feedback complaints.

There are also areas of excellent practice with some weekly supplier meetings and ongoing monitoring, and some suppliers have payment terms that are linked to quarterly performance (for example the Sustainable Community Support Programme).

These recommendations are accepted and will be implemented following implementation of the refreshed Contracts management framework (that includes an enhanced contract risk assessment matrix for the Partnership) and refresh of the Partnership contracts register.	
Owner: Judith Proctor, Chief Officer, Health and Social Care Partnership **Contributors:** Moira Pringle, Chief Finance Officer, Edinburgh Health and Social Care Partnership; Alana Nabulsi, Contracts Manager; Cathy Wilson, Operations Manager	**Implementation Date:** 29 June 2021
Communities and Families Recommendations are accepted and will be implemented. A quality assurance process will be put in place taking into account the contract management toolkit and the council contract standing orders. We will continue to have regular supplier meetings as are already in place. This has been strengthened in recent months in relation to the commissioning of out of council residential placements and suppliers are being held to account in relation to the achievement of agreed outcomes for children and young people**.**	
Owner: [Alistair Gaw, Director, CF **Contributors:** [Michelle McMillan, Operations Manager; David Hoy, Commissioning Officer; Sean Bell, Senior Manager	**Implementation Date:** 29 June 2021
Place This will be incorporated into the Place regular monitoring reports on procurement to provide assurance that risk assessments are happening, especially for tier 1 and 2 contracts and that appropriate action is taken. This will be undertaken in conjunction with the Contracts and Grants Management and Commercial Partner team in procurement to ensure consistency of approach and shared learning.	
Owner: Paul Lawrence, Executive Director of Place **Contributors:** Lynne Halfpenny, Director of Culture; Gareth Barwell, Head of Place Management; Michael Thain, Head of Place Development; Alison Coburn, Operations Manager.	**Implementation Date:** 31 March 2021
1.3 Recommendation – contract manager support and guidance	
• Based on the outcomes of the risk based quality assurance process (refer 1.2 above), management will determine whether further guidance and support is required for contract managers within their Directorates / Divisions and will engage with the Contracts and Grants Management team to ensure that relevant support and guidance is provided (for example, training on completion of ongoing contract health checks); and • Management will ensure that all new and existing contract managers have completed the contract management training module included in CECiL and that this is refreshed at an appropriate frequency (at least annually).	
1.3 Agreed Management Actions - contract manager support and guidance	
Health and Social Care Partnership These recommendations have been accepted and will be implemented as recommended.	

Owner: Judith Proctor, Chief Officer, Health and Social Care Partnership **Contributors:** Moira Pringle, Chief Finance Officer, Edinburgh Health and Social Care Partnership; Alana Nabulsi, Contracts Manager; Cathy Wilson, Operations Manager	**Implementation Date:** 17 December 2021
Communities and Families Recommendations accepted and will be implemented.	
Owner: [Alistair Gaw, Director, CF **Contributors:** [Michelle McMillan, Operations Manager; David Hoy, Commissioning Officer; Sean Bell, Senior Manager	**Implementation Date:** 17 December 2021
Place This recommendation is accepted, and this will be added as appropriate to the Place mandatory training matrix at the next review.	
Owner: Paul Lawrence, Executive Director of Place **Contributors:** Lynne Halfpenny, Director of Culture; Gareth Barwell, Head of Place Management; Michael Thain, Head of Place Development; Alison Coburn, Operations Manager.	**Implementation Date:** 31 August 2020
1.4 Recommendation – review of contract waivers	
• The Contracts and Grants Management team will provide Divisions / Directorates with monthly management information detailing the volume of contracts currently in place through a Contracts Standing Orders waiver, and follow up performed to ensure that any significant recurring waivers identified have been addressed by Directorates / Divisions; • Directorates / Divisions will perform a review of these contracts with the focus on contracts that have been subject to more than two consecutive waivers; • Where contracts have been consistently waived with no review of applicable contract terms and conditions, Commercial and Procurement Services will be engaged, and a review will be performed prior to approval of subsequent waivers; and • Where contracts have been consistently waived, Commercial and Procurement Services will be engaged to determine whether the contract should be formally procured in line with applicable Council standing orders.	
1.4 Agreed Management Action - review of Contract Standing Order waivers	
Contracts and Grants Management Team Recommendation agreed. Monthly management information on waivers will be provided to Directorates / Divisions for their review and follow up performed to ensure that significant recurring waivers have been addressed.	
Owner: Stephen Moir, Executive Director of Resources **Contributors:** Iain Strachan, Chief Procurement Officer; Gavin Brown, Senior Contracts and Grants Manager; Hugh Dunn; Head of Finance; Layla Smith Resources Operations Manager; Annette Smith, Executive Assistant	**Implementation Date:** [Date here]
Health and Social Care Partnership These recommendations have been accepted. The outcomes of the waiver review will be presented to and discussed at the Procurement Board, and appropriate action taken to address waivers that have been consistently waived. March 2020.	

Owner: Judith Proctor, Chief Officer, Health and Social Care Partnership **Contributors:** Moira Pringle, Chief Finance Officer, Edinburgh Health and Social Care Partnership; Alana Nabulsi, Contracts Manager; Cathy Wilson, Operations Manager	**Implementation Date:** 27 March 2020
Communities and Families Recommendations accepted. We have reduced the need for waivers through the development of framework arrangements and contracts that are in place. However, we will review the waivers currently in place and report this to Communities and Families Directorate Senior Management Team meeting with the Corporate and Procurement Services commercial partner.	
Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Michelle McMillan, Operations Manager; David Hoy, Commissioning Officer; Sean Bell, Senior Manager	**Implementation Date:** 27 March 2020
Place Service area management teams currently receive this information (at least on a quarterly basis) and this will continue, with escalation of any issues to the Place SMT as appropriate.	
Owner: Paul Lawrence, Executive Director of Place **Contributors:** Lynne Halfpenny, Director of Culture; Gareth Barwell, Head of Place Management; Michael Thain, Head of Place Development; Alison Coburn, Operations Manager.	**Implementation Date:** 31 March 2020

2. Contracts and Grants Management strategic direction	**High**

1. Identification and review of significant high risk Council contracts

Contracts and Grants Management has advised that identification of the Council's most significant high risk contracts will focus on the top 50 contracts (by value) in each Directorate, with the objective of determining to whether further cost savings can be generated from these contracts.

This approach does not specifically consider supplier management risks, such as:

- volume and duration of contracts;
- volume of waivers applied to contracts;
- capability and capacity of contract managers;
- ongoing financial viability of suppliers; and
- consideration of the risks associated with each contract, such as reputational risk, or possible service failure.

2. Contract Management Compliance Reviews

Whilst recognising the work undertaken by the C&GM team since its establishment, including the implementation of the Council's contract management framework, and other operational work, it is noted that no formal compliance reviews have yet been performed to assess whether contract managers across the Council are consistently and effectively applying the contract management manual and toolkit manual and toolkit to support effective management of supplier risk.

The Chief Procurement Officer has identified the need for C&GM to perform a risk-based systematic programme of contractual compliance reviews to identify areas where contract management improvement is required.

3. Project Governance supporting implementation of the Public Contracts Scotland Tendering (PCS-T) system

We confirmed that (as yet) no project plans and training for contract managers have been developed to support implementation of this new system across the Council, as the system is currently being piloted to support a more automated approach to ongoing contract management across Directorates and Divisions. Additionally, whilst the system has the ability to support the procurement process, management is not currently considering implementing this functionality.

4. Contract management training module – monitoring of completion rates

Whilst C&GM have developed and launched a C&GM training module on the Council's Interactive Learning (CECIL) platform, completion of the training is currently not an essential requirement for Contract Managers and completion rates are not formally monitored.

Risks

- Contract management risk is not effectively managed across the Council; and
- Contracts are not managed in line with applicable legislation.

2.1 Recommendation – Identification of High Risk Contracts and Contracts and Grants Management Capacity

- Management should extend the scope of the process to identify the Council's most significant contracts to include those that expose the Council to significant risks. These contracts should be used as the basis of compliance reviews (refer recommendation 2.2 below); and
- The C&GM team should consider how it will plan its ongoing work, including delivery of contract management compliance reviews.

2.1 Agreed Management Action - Identification of High Risk Contracts and Contracts and Grants Management Capacity

Currently, there are approximately 120 Tier 1 contracts on the Council's contract register, and 291 Tier 2 contracts. The C&GM Team will assist services in identifying those contracts they have which should be categorised as either Tier 1 or Tier 2, and this will be dealt with under the Council's contract management framework, including at contract mobilisation post contract award. This work will be dependent upon active service area engagement.

Commercial and Procurement Services will shortly be commencing a review of the Council's current Commercial and Procurement Strategy (2016-2020), which will be submitted to the Finance and Resources Committee for adoption in March 2020. This will include detail on how the operational work of the team will support the strategy, including the work of the C&GM Team. A suitable section will be included in the Strategy around contract management support/training, including an estimated number of compliance reviews that are to be undertaken and the Directorates to which they relate, and if practicable specific contracts. Compliance with the strategy is reported annually to Finance and Resources Committee, in August, so this will enable annual monitoring against this.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Iain Strachan, Chief Procurement Officer; Gavin Brown, Senior Contracts and Grants Manager; Hugh Dunn; Head of Finance; Layla Smith Resources Operations Manager; Annette Smith, Executive Assistant	**Implementation Date:** 30 September 2020

2.2 Recommendation - Contract Management Compliance Reviews

A rolling programme of compliance reviews should be designed and implemented that focus on the highest risk contracts. The scope of the reviews should include (but not be restricted to):

- confirming that first line contract managers are effectively and consistently managing contracts in line with the contract management manual and toolkit;
- documenting review outcomes that support the design of appropriate action plans for service areas to address any significant instances of non-compliance;
- escalating any systemic weaknesses identified to appropriate governance forums (for example Directorate risk committees and / or the Corporate Leadership Team); and
- ensuring that suitable follow-up is performed to confirm that all agreed actions have been effectively implemented and sustained.

2.2 Agreed Management Action - Contract Management Compliance Reviews

The C&GM team will design and implement a rolling programme of compliance reviews, focused on the Tier 1 and 2 contracts, this programme to take account of the limited resources in the team, and other ongoing work. The scope of these reviews will, as appropriate, include the recommendations above. Again, this work will be dependent upon active service area engagement and responsiveness, including for service areas to implement identified actions. It is to be noted, however, that the staffing resources in the C&GM team may not be sufficient to include all aspects referred to above, including follow-up and monitoring of implementation.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Iain Strachan, Chief Procurement Officer; Gavin Brown, Senior Contracts and Grants Manager; Hugh Dunn; Head of Finance; Layla Smith Resources Operations Manager; Annette Smith, Executive Assistant	**Implementation Date:** 31 December 2020

2.3 Project Governance supporting implementation of the Public Contracts Scotland Tendering technology system

- Management should determine the basis of the 'go / no go' system implementation decision following completion of the Public Contracts Scotland Tendering technology system pilot.
- If the decision is made to implement the system, a project management and governance framework should be designed and applied to support system implementation. The project management and governance framework should be aligned and applied in line with the Council's established project management guidance and toolkit;
- The system should be fully tested prior to implementation, with details of the testing performed to support the 'go / no go' live implementation decision; and
- Management should also consider whether the system would effectively support the Procurement process and improve its efficiency.

2.3 Agreed Management Action - Project Governance supporting implementation of the Public Contracts Scotland Tendering system

This system is already well-established in other public sector partners, and supported by the Scottish Government, and has been identified by Scotland Excel as an appropriate e-solutions system to support contract and supplier management. Training sessions have already been held, including a day session focussed entirely on contract management functionality. All members of the team have had access to the system for a suitable period of time, to allow for learning on a test system and have

built up a thorough knowledge of the system's capability to upload contract documentation. The mass upload of contract documentation is a key factor in the successful roll out of the system, and the team continues to get support from contemporary teams in Scottish Government and other public sector partners who have carried this out. Training sessions have been held with a number of contract managers across 4 directorates, focussing on 6 Tier 1 contracts, some with cross-directorate delivery. 40 suppliers have also been involved in the trial to date. The team are continuing to monitor the trial, with regular updates from contract managers and will use all lessons learned to prepare the project plan for full roll out of the system.

The C&GM team will design and apply a suitable project management and governance framework to support PCS-T implementation. This will include additional suitable system testing, and training for service area contract managers who would be using the system to store and access contract documentation. As stated above, the team is already also working with public sector partners, to identify best practice to assist the successful roll out the contract management module. Commercial and Procurement Services are already considering the possible adoption of PCS-T as the Council's eProcurement system, bringing an end to end approach to procurement and management of contracts. This work is continuing, and the PCS-T Working Group which has been established within Commercial and Procurement Services will take forward both aspects.

If it is decided to adopt PCS-T for the Council's actual procurement processes, and not just contract management, then it is noted that the actual implementation of that would take longer, as there would be a greater direct impact upon other Council services.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Iain Strachan, Chief Procurement Officer; Gavin Brown, Senior Contracts and Grants Manager; Hugh Dunn; Head of Finance; Layla Smith Resources Operations Manager; Annette Smith, Executive Assistant	**Implementation Date:** 31 December 2020 (for PCS-T contract management)

2.4 Recommendation - Contract management training module – monitoring of completion rates

- Management should obtain management information from the Council's Interactive Learning platform (CECIL) system and review to confirm that all contract managers who are managing Tier 1 and 2 high risk contracts have completed the training module; and
- Instances where training has not been completed should be communicated to both contract managers and their line managers, with a request for completion.

2.4 Agreed management action - Contract management training module – monitoring of completion rates

The Contracts and Grant Management Team will monitor the completion of the contract management training module and advise contract managers/their Heads of Service should this not have been completed for Tier 1 and 2 contracts. This is dependent upon Divisions ensuring the names of contract managers on the contract register is accurate and assisting with the categorisation of contracts.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Iain Strachan, Chief Procurement Officer; Gavin Brown, Senior Contracts and Grants Manager; Hugh Dunn; Head of Finance; Layla Smith Resources Operations Manager; Annette Smith, Executive Assistant	**Implementation Date:** 31 December 2020

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or*** • ***Critical*** impact on the reputation of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or*** • ***Significant*** impact on the reputation of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation of the organisation.
Low	A finding that could have a: • ***Minor*** impact on operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***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.

Appendix 2 - Areas of audit focus

The audit areas and related control objectives that we tested in detail were:

Audit Area	Control Objectives
Contract management framework	1. Confirm that there is an established process supporting ongoing maintenance of the contracts register, with new contracts added following completion of procurement and expired contracts removed; 2. Select a representative sample of new and existing contracts across varying value ranges from the contract register and confirm that: • appropriate contract owners and managers have been established and are aware of their ongoing contract management responsibilities; • a tiering assessment has been performed by the Contract Manager to determine the extent and nature of ongoing contract management activities; which has been reviewed and approved by C&GM; • baseline performance measures and SMART (specific; measurable; achievable; relevant; and time bound) key performance indicators (KPIs) have been defined and agreed with the supplier to ensure that anticipated contractual benefits are delivered; which are then provided within agreed timeframes; reviewed by the contract manager (and owner if required) and discussed at ongoing supplier performance meetings; • regular supplier performance meetings have been established at an appropriate frequency that reflects the scale and complexity of the contract; following a standard agenda (that includes potential continuous improvement opportunities); with actions documented; allocated to appropriate owners for delivery within agreed timeframes; with completion progress monitored; • a benefits monitoring process has been established and is consistently applied to ensure that anticipated financial (e.g. savings) and non-financial (e.g. improved service delivery) are being achieved, and that the contract is delivering value for money; • processes have been established and consistently applied to address any performance issues; new and emerging contractual risks; contractual and operational performance changes; disputes; and the formation and use of exit strategies; and • ongoing contract health checks have been performed / are scheduled at an appropriate frequency to consider whether commercial terms remain appropriate; new and emerging risks; and the supplier's ongoing financial viability.
Training	1. Training is provided by C&GM for all new contract owners and managers, with refresher training also provided at appropriate frequencies; 2. Training is comprehensive and covers all aspects of the contract management process throughout the contract lifecycle; and

	3. Using the sample of contracts selected above, establish whether and when contract owners and managers attended the C&GM contract management training.
Contractual compliance reviews	1. The volume of contractual compliance reviews performed by C&GM; 2. The methodology applied to select the contracts to be reviewed is adequate and effective, resulting in an appropriately representative risk based sample; 3. Review scopes adequately determine whether the contract management process is consistently and effectively applied by contract owners and managers; 4. Review outcomes are documented and action plans developed to address any significant instances of non-compliance; and 5. Systemic weaknesses are escalated to appropriate governance forums (for example Directorate risk committees and / or the Corporate Leadership Team); and 6. Follow-up is performed to confirm that all agreed actions have been effectively implemented and sustained.
Construction Industry Scheme framework	1. The Council has a current CIS registration 2. Select a representative sample of sub-contractor payments and confirm that; • a check has been performed to confirm that it is appropriate to award the contract (as opposed to an employment contract); • a check has been performed to establish whether subcontractors are CIS registered; • appropriate payment deductions have been applied and transferred to HMRC; • payment records for the sample have been retained and included in the monthly returns provided to HMRC. 3. Monthly returns have been filed for the last year and full CIS records (details of checks performed and deductions made) have been maintained; and 4. A process has been established to identify any potential breaches (missed payments) and communicate these to HMRC.

The City of Edinburgh Council

Internal Audit

Emergency Prioritisation & Complaints
Customer Contact Centre

Final Report

23 July 2019

CW1806

Generally adequate but with enhancements required	Areas of weakness and non-compliance in the control environment and governance and risk management framework that may put the achievement of organisational objectives at risk

Contents

This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2018/19 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2018. 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 Customer Contact Centre (Contact Centre) provides a 24-hour service and is the initial contact point for citizens to raise emergency requests. The Contact Centre comprises 200 Customer Advisers; 160 are based in Waverley Court with the remainder in locality offices.

Contact Centre teams focus on first touch resolution for all calls received, working closely with service areas where further escalation and support is required to ensure that all referrals have been appropriately progressed; and that accurate service commitments and expectations are provided to citizens. Call handlers are trained to work for specific service areas and manage 36 direct telephone lines. These include the following direct emergency lines:

- Social Care Direct – the adult and child lines that are the single point of contact for referrals to social care services and raising public protection concerns during working hours; and
- Out of hours emergency adult and child social care - provides a social work and home care response outwith working hours.

A central emergency services number (published on the Council website) is available at all times and is used by the out of hours team to handle all emergency requests not covered by direct emergency lines noted above (for example, requests from homeless citizens in relation to temporary accommodation).

The Contact Centre operates an automated call menu system (IVR 'interactive voice response') that provides self-service links and call routing. Emergency requests can be received at any time and via any of the 36 lines managed.

Service specific training has been delivered and call scripts are used to assist call handlers with identifying and handling emergency requests. Call scripts include links to contact numbers for teams in the relevant service. Call handlers will apply an agreed escalation process where there is no immediate response to an emergency situation by the service.

For some essential services, such as Social Care Direct, professional advisers work alongside call handlers to provide support when referrals require escalation or immediate professional input.

The performance update report provided to the Corporate Policy and Strategy Committee in May 2019 covering performance between January to March 2019 details a performance target of 60% of calls answered within 60 seconds for all telephone lines, including emergency services.

This target was achieved for all emergency social care lines. A total of 32 of the 36 lines managed by the Contact Centre achieved the 60% target.

Customer contact complaints are monitored and recorded, with 53 complaints received over the period January to March 2019, which equates to less than 1% of total calls handled in this period. The main complaint themes related to service failure. Complaints raised with the Contact Centre that relate to service area handling of an emergency request are logged and passed to the service area to resolve.

Scope

The objective of this review was to assess the design adequacy and operating effectiveness of processes and key controls that ensure emergency requests received from citizens are prioritised and

addressed. The process supporting complaints received in relation to emergency requests was also reviewed.

This review focussed on emergency social care services (Social Care Direct; emergency home care and social work); and out of hours emergency homeless services. Sample testing was performed for the period 1 April to 30 November 2018.

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

Limitations of Scope

Large scale or serious emergencies / major incidents and disruptions, led by the Council's Resilience service on behalf of the Chief Executive or Public Safety were outwith the scope of this review. The Resilience service is a Category 1 Responder and therefore part of the UK and Scottish Government established, statutory resilience planning and response structures. Public Safety does not have a leading or coordinating role in any of the Council's resilience arrangements or response.

Reporting Date

Our audit work concluded on 24 June 2019, 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	
Medium	1. Contact Centre procedures and operational processes
Medium	2. Third party service provision – Health and Social Care Partnership
Low	3. Partnership engagement protocols

Opinion

Our review has confirmed that the Customer Contact Centre's ability to ensure that emergency support requests received from citizens are effectively prioritised and addressed is generally adequate with enhancements required. Moderate areas of weaknesses were identified with established governance arrangements and the operational control framework supporting provision of Contact Centre services to both third parties and internal Council service areas (Clients).

These weaknesses reflect the need to ensure first line Contact Centre call monitoring quality assurance checks are consistently applied across all teams who manage emergency call lines. It is important to ensure that this is addressed, and that comprehensive performance measures (aligned with Client engagement protocols) are established.

This includes ensuring adequate 'on call' resources are always available to support and provide advice on complex queries received by the out of hours teams, notably the homelessness service.

The second medium finding reflects the requirement for the Edinburgh Health & Social Care Partnership to review the tripartite service level agreement established in 2013 for providing Emergency Social Care Services to the City of Edinburgh, East Lothian and Midlothian Council. This is essential to ensure arrangements remain aligned with applicable regulatory and statutory requirements; operational processes; and demand, and that funding arrangements; fees; and internal recharges are completely and accurately calculated and applied.

Similarly, the Contact Centre should establish Client engagement protocols for all Contact Centre services provided and ensure these are regularly monitored and reviewed.

Consequently, two medium and one low rated finding has been raised. Our detailed findings and recommendations are provided at section 3 of this report.

Areas of good practice

We also noted the following areas of good practice:

- Processes have been established to ensure emergency requests are appropriately prioritised;
- An effective performance monitoring and quality assurance framework is in place for the contact centre Social Care Direct teams; and
- A comprehensive new employee induction programme has been established and is supported by an essential training matrix for all Contact Centre employees.

3. Detailed findings

1. Contact centre procedures and operational processes	Medium

Our review of existing contact centre policies, procedures and operational processes established that:

1.1 Operational processes

- **Review of call flow documentation –** call flows that provide guidance for call handlers on how to manage calls are in place and are subject to review, however, no formal review schedule is in place with call flows for some service areas reviewed more frequently than others.

  Instances were noted where information contained within calls flows were out of date. For example:

  - Care & Response – undated process notes, and processes noted as last updated in 2015;
  - Homelessness out of hours service – duty desk telephone numbers, housing options team address & winter contingency plans; and
  - Adult Social Care - no date of last review is noted on the document.

- **Homelessness service on call support** from the daytime homelessness service is not always available immediately to the OOH service team. Homelessness Service management advised on call support is provided on a voluntary basis. Contact Centre management however, advised support and advice is always available from a senior officer within the Contact Centre.

- **Operational process inconsistencies –** the following inconsistencies with established processes was noted relation to call handling for OOH homelessness calls:

  - In 3 out of 5 calls sampled, callers were not provided with adequate details of which locality office they should to present to. Office address; opening hours; and details of the duty system should have been provided.
  - The name and date of birth of the caller for 3 of 5 calls sampled was not recorded in Capture (contact centre call logging system). It is noted, the details were logged within the Homelessness Information System, however due to systems compatibility, contact centre staff are required to log details twice.
  - In one instance, the initial call handler requested too much information prior to transferring the call to a trained homelessness call handler. On review, the team leader agreed too much information had been gathered initially, however there was sound rationale behind this.

These issues were raised with a Homelessness OOH service team leader during the audit. It was acknowledged these were training issues that would be resolved.

1.2 Quality assurance and supervision – Out of Hours (OOH)

- **Call monitoring quality checks** for OOH calls are not performed as frequently as daytime quality checks.
- **Team leader and call handler meetings** – one to one meetings between team leaders and call handlers are not scheduled regularly to review performance and competence and address any gaps.

Management has advised that this is often due to the sporadic shift patterns of OOH workers, and service demand issues.

1.3 Performance Reporting

Review of service performance data reported to the Corporate Policy and Strategy Committee noted that an Adult Social Care Direct emergency line is reported to Committee as an Emergency Child line.

Risks

Absence of effective controls may result in:

- Inadequate or inappropriate response to emergency situations.
- Inadequate support provision from services to Contact Centre Out of Hours staff.
- Inconsistent service performance due to limited support and supervision.
- Individual call handler performance, development and training issues not being identified and addressed.
- Incorrect data on service performance being reported to relevant Council executive committees.

1.1 Recommendations - Review of operational processes

1. A review schedule should be developed for all call flows, templates and any linked guidance documents to ensure they are reviewed at least every three years, or sooner if there are changes in the service area. All documents should include version control and clearly state date of last review, and the next scheduled review.
2. Requirements for on-call support for the homelessness out of hours service should be clarified, documented and communicated.

Agreed Management Actions

1. This recommendation will be implemented with a review of the documents for call flows and templates for the out of hours services. These will all have version control and review date.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Nicola Harvey; Head of Customer and Digital Services Neil Jamieson, Customer Senior Manager; Lisa Hastie, Customer Contact Manager; Elspeth Thompson, Customer Contact Manager; John Clark, Customer Contact Team Leader; and Rory Buckie	**Implementation Date:** 31.10.2019

2. Review and document the process for homelessness out of hours support to contact centre.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Nicola Harvey; Head of Customer and Digital Services Neil Jamieson, Customer Senior Manager; Lisa Hastie, Customer Contact Manager; Elspeth Thompson, Customer Contact Manager; Brian Stewart, Homelessness and Housing Support Service Manager; John Clark, Customer Contact Team Leader; and Rory Buckie, Customer Contact Team Leader.	**Implementation Date:** 31.10.2019

1.2 Recommendations - Quality assurance

1. First line (service delivery) quality assurance processes for out of hours services should be designed; documented; communicated; and implemented. The process should, where possible be aligned to that of day services and include (but not be limited to)
    - quality assurance roles and responsibilities.
    - frequency and scope of quality assurance checks.

- sampling methodologies to be applied (for example coverage across all team members on an ongoing basis; increased focus on new team members; and sample sizes linked to call and response volumes).
- consolidation of quality assurance outcomes (including actions to address any significant issue and themes) and how these are reported to management and relevant Executive Committees.

2. Quality assurance processes should be linked to team member supervision, training and performance objectives, with regular one to ones scheduled to ensure action is taken to address any performance issues or gaps identified.
3. Where systemic themes or trends are identified from quality assurance reviews, management should consider whether existing operational processes should be revisited.

Agreed Management Actions

1. Agree, process will be defined to recognise the uniqueness of the service models used for day service and out of hours service. It should be noted, the out of hours night shift is highly experience with the average length of service for the team who operate nightshift is 10 years, 19 years for longest serving member of staff.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Nicola Harvey; Head of Customer and Digital Services Neil Jamieson, Customer Senior Manager; Lisa Hastie, Customer Contact Manager; Elspeth Thompson, Customer Contact Manager; Jennifer Wilson, Deputy Contact Centre Manager; Steven Munce, Service Quality and Planning Manager; John Clark, Customer Contact Team Leader; and Rory Buckie, Customer Contact Team Leader.	**Implementation Date:** 31.10.2019

2. Supervision and guidance for out of hours staff will be reviewed, looking at shift patterns to ensure support in place. The process will be documented and follow up implemented to ensure completed.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Nicola Harvey; Head of Customer and Digital Services Neil Jamieson, Customer Senior Manager; Lisa Hastie, Customer Contact Manager; Elspeth Thompson, Customer Contact Manager; Jennifer Wilson, Deputy Contact Centre Manager; Steven Munce, Service Quality and Planning Manager; John Clark, Customer Contact Team Leader; and Rory Buckie, Customer Contact Team Leader.	**Implementation Date:** 31.10.2019

3. Agree, process will be put in place to identify and review themes or trends, following establishing clear quality assurance processes, supervision and guidance for out of hours teams as above.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Nicola Harvey; Head of Customer and Digital Services Neil Jamieson, Customer Senior Manager; Lisa Hastie, Customer Contact Manager; Elspeth Thompson, Customer Contact Manager; Jennifer Wilson, Deputy Contact Centre Manager; Steven Munce, Service Quality and Planning Manager; John Clark, Customer Contact Team Leader; and Rory Buckie, Customer Contact Team Leader.	**Implementation Date:** 31.10.2019

1.3 Recommendations - Performance reporting

1. Reporting to Corporate Policy and Strategy Committee should be updated to reflect relevant activity reported for Adult Social Care Direct lines.

Agreed Management Action

1. When line data was transferred in the Solidus to Mitel changeover, the call data was merged. Call volumes are same as the two lines merged, it is just description of line that requires to be changed. Will be updated to show as Social Care Direct Emergency in Corporate Policy and Strategy reporting.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Nicola Harvey; Head of Customer and Digital Services Neil Jamieson, Customer Senior Manager; Lisa Hastie, Customer Contact Manager; Jennifer Wilson, Deputy Contact Centre Manager.	**Implementation Date:** 30.09.2019

2. Third party service provision – Health and Social Care Partnership

Medium

The Contact Centre provides out of hours Emergency Social Care Services (ESCS) on behalf of the Edinburgh Health and Social Care Partnership to the City of Edinburgh Council, East Lothian and Midlothian Council.

Review of a tripartite Service Level Agreement (SLA) in place found:

- The document was developed in 2013, and the file name still refers to 'draft'. It is unclear whether the document has been finalised as management were unable to locate a final signed copy of the agreement which had been signed by all three parties. It is also not clear whether it is collectively owned by all three authorities.
- The full ESCS SLA should be subject to review every two years, however it has not been reviewed since drafted in 2013. As a result, the document has not been updated to reflect the arrangements of the Edinburgh Health and Social Care Partnership established in May 2015. Management has advised that a review is currently underway.
- The ESCS is funded on a combined population and usage basis across the three authorities. Whilst the SLA includes a section on budget and financial arrangements, we have been unable to confirm whether these arrangements are being consistently applied, and whether the Council's costs are being over or under recovered.
- Additionally, the assumptions used to calculate funding requirements are based on a 50/50 weighting for volume of usage and mid-year population projections. Based on the SLA, 2012 population projections are currently being used.
- The ESCS budget allocated to cover premises and supplies and services costs is a specified percentage of total employee costs and should be reviewed annually. We were unable to confirm if an annual review takes place.
- Monitoring and oversight arrangements as set out within the SLA including bi-annual meetings with all three authorities to discuss performance; escalate issues; assess and evaluate risks and review application of policies and procedures are not being operated in practice.
- Internal recharging arrangements are unclear and have not been subject to regular review to ensure they remain reflective of current service levels and demand.

Risks

Absence of effective controls may result in:

- Service Level Agreements that do not reflect current working arrangements and operations.
- Parties are not being aware of and therefore do not fulfil, respective responsibilities and obligations.
- Areas of individual and shared responsibility not being clearly defined, with no legal basis for delineation.
- Financial implications of providing services not reflecting current volumes and demand, and the

costs of the services provided may not be fully recovered.

2. Recommendations: SLAs – third party service provision

1. The Edinburgh Health and Social Care Partnership should, in agreement with the other authorities; review and update the Service Level Agreement for out of hours Emergency Social Care Services (ESCS) provided to the City of Edinburgh, East Lothian and Midlothian Councils. This should include (but not be limited to) the following:
   - Immediate review of the funding arrangements and apportionment for overhead costs for the ESCS to ensure they are representative of service usage and budgets, and an annual thereafter as per the terms of the Service Level Agreement.
   - Full review of the SLA in conjunction with the other authorities at least every two years to ensure it remains aligned with service delivery operational processes and relevant regulatory and professional standards.
   - Implementation of the governance arrangements as set out within the terms of the SLA, supported by regular review meetings with all three authorities to monitor service provision against key performance indicators, and any emerging risks or issues.
2. A Partnership Protocol should also be developed in conjunction with Customer contact to agree internal recharging arrangements where applicable and the key performance indicators the Out of Hours teams will be contributing to.

Agreed Management Actions

1. A review of the Service Level Agreement (SLA) for the Emergency Social Care Services (ESCS) is underway. It is likely the detail of the arrangements will differ considerably from what is currently included within the SLA. The review will, however, take into consideration the points noted above.

   The review of the SLA will include contributions from City of Edinburgh Council, Midlothian Council and East Lothian Council, and will be presented to the Edinburgh Health and Social Care Partnership Executive Management Team for review and approval.

Owner: Judith Proctor, Chief Officer Edinburgh Health and Social Care Partnership (EH&SCP) **Contributors:** Tony Duncan, Interim Head of Strategic Planning EH&SCP; Colin Beck, Strategy Planning & Quality Manager EHSCP; Alistair Gaw, Executive Director of Communities & Families CEC; Jackie Irvine, Chief Social Work Officer CEC; Fiona Benzies, Access and Emergency Social Care Services Manager; Brian Henderson, Acting Access and Emergency Social Care Manager	**Implementation Date:** 30.11.2019

2. Agreed, once the Service Level Agreement (SLA) is finalised, a Partnership Protocol will be developed in conjunction with Customer Contact Centre colleagues.

Owner: Judith Proctor, Chief Officer Edinburgh Health and Social Care Partnership (EH&SCP) **Contributors:** Alistair Gaw, Executive Director of Communities & Families; Stephen Moir, Executive Director of Resources; Nicola Harvey, Head of Customer and Digital Services; Tony Duncan, Interim Head of Strategic Planning EH&SCP; Neil Jamieson, Customer Senior Manager; Lisa Hastie, Customer Contact Manager; Jennifer Wilson, Deputy Contact Centre Manager; Elspeth Thompson, Customer Contact Manager; Fiona Benzies, Access and Emergency Social Care Services Manager; Brian Henderson, Acting Access and Emergency Social Care Manager.	**Implementation Date:** 28.2.2020

3. Partnership engagement protocols	Low

An internal Partnership Working Protocol was developed in 2017 for transferring out of hours support for the homelessness service to the Contact Centre, however, this has not been subject to review and contains call data relating to 2015 (such as volumes of calls).

Additionally, similar protocols have not been developed for Emergency Social Care Services; Social Care Direct and Emergency Home Care services. Management has advised that informal partnership working arrangements have been established and are working effectively.

Risks

Absence of effective controls may result in:

- Working protocols not reflecting current working arrangements and operations.
- Parties not being aware of and therefore do not fulfil, respective responsibilities and obligations.
- Areas of individual and shared responsibility not being clearly defined, with no legal basis for delineation.
- Internal funding and recharging for providing services not reflecting current volumes and demand, and the costs of the services provided may not be fully recovered.

3. Recommendations: SLAs – third party service provision

1. Internal partnership protocols should be developed and implemented for Emergency Social Care Services; Social Care Direct and Emergency Homecare Services provided by the Contact Centre. These should include (but not be limited to):
   - scope of services to be provided that are aligned with service delivery requirements and Contact Centre services;
   - clearly defined roles and responsibilities;
   - information and data sharing/security arrangements;
   - key performance measures and indicators to support ongoing performance monitoring;
   - ongoing performance monitoring arrangements including governance forum responsibility for review, reporting formats and frequency of review meetings.
2. Partnership protocols and key performance measures / indicators should be reviewed at least every two years to ensure they remain aligned with service delivery, operational processes and relevant regulatory and professional standards.
3. Governance arrangements to support ongoing performance monitoring should be designed and implemented to ensure that both service areas and the Contact Centre are satisfied with the quality of services provided.
4. The partnership protocol for the out of hours homelessness service should also be reviewed to ensure points 1-3 above apply to arrangements in place.

Agreed Management Actions

1. The Contact Centre meets regularly with the service areas, with a monthly service pack created for Social Care Direct. We will review other parts of the services for out of hours arrangements and establish if there is a need for further service packs.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Nicola Harvey; Head of Customer and Digital Services; Neil Jamieson, Customer Senior Manager; Lisa Hastie, Customer Contact Manager;	**Implementation Date:** 31.10.2019

Jennifer Wilson, Deputy Contact Centre Manager; and Elspeth Thompson, Customer Contact Manager.	
2. Service Packs are reviewed quarterly, and changes made as required. The arrangements for reviewing partnership protocols to be agreed as part of the revised Service Level Agreement set out in finding 2 above.	
Owner: Stephen Moir, Executive Director of Resources **Contributors:** Nicola Harvey; Head of Customer and Digital Services; Neil Jamieson, Customer Senior Manager; Lisa Hastie, Customer Contact Manager; Jennifer Wilson, Deputy Contact Centre Manager; Elspeth Thompson, Customer Contact Manager; Fiona Benzies, Access and Emergency Social Care Services Manager; and Brian Henderson, Acting Access and Emergency Social Care Manager.	**Implementation Date:** 31.10.2019
3. As per action 1, Service Packs are already in place for Social Care Direct and are discussed monthly. This process will be replicated across other areas we support to ensure we maintain a consistent relationship management approach with our customers.	
Owner: Stephen Moir, Executive Director of Resources **Contributors:** Nicola Harvey; Head of Customer and Digital Services; Neil Jamieson, Customer Senior Manager; Lisa Hastie, Customer Contact Manager; Jennifer Wilson, Deputy Contact Centre Manager; Elspeth Thompson, Customer Contact Manager; Fiona Benzies, Access and Emergency Social Care Services Manager; and Brian Henderson, Acting Access and Emergency Social Care Manager.	**Implementation Date:** 31.10.2019
4. To align with current arrangements in practice, a Homelessness Out of Hours' Service Pack will be created and reviewed on a quarterly basis.	
Owner: Stephen Moir, Executive Director of Resources **Contributors:** Nicola Harvey; Head of Customer and Digital Services; Neil Jamieson, Customer Senior Manager; Lisa Hastie, Customer Contact Manager; Jennifer Wilson, Deputy Contact Centre Manager; Elspeth Thompson, Customer Contact Manager; Brian Stewart, Homelessness and Housing Support Service Manager	**Implementation Date:** 31.10.2019

Appendix 1: Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on the operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or*** • ***Critical*** impact on the reputation of the Council which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or*** • ***Significant*** impact on the reputation of the Council.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation of the Council.
Low	A finding that could have a: • ***Minor*** impact on operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***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.

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 were:

Roles & Responsibilities

- The roles and responsibilities for Contact Centre staff in relation to handling of emergency requests on behalf of Service areas have been clearly defined;
- The roles and responsibilities of Service area team members out of hours is clearly defined;
- Service level agreements are in place for the work undertaken by the Contact Centre on behalf of Service areas, and include handling of emergency requests and any associated additional duties undertaken by the Out of Hours Service, and any Service area response times, regulatory or legislative requirements;
- There is a clear handover between the Contact Centre and Service area staff in relation to progression of emergency requests, and a record of this handover maintained; and
- The citizen making the emergency request is provided with a named point of contact within the Service area responsible for managing the request.

Methodology

- Clear processes and procedures are in place for handling of emergency requests by the Contact Centre and the Service areas they are referred to, and any complaints received in relation to these requests;
- All emergency requests received are logged and recorded in sufficient detail to provide a comprehensive end to end record of actions taken;
- There is regular engagement between the Contact Centre and Service areas to establish current & emerging issues, and discuss any service changes & proposed improvements that will require changes to service delivery; and
- The channels available for citizens making emergency requests to the Council are well communicated and easily accessible.

Prioritisation & Escalation Processes

- There are clear processes and procedures in place to assist staff in determining how all types of emergency requests received should be escalated by the Contact Centre, and within the Service areas that they are referred to, including to other agencies such as the Police, ambulance service and NHS 24;
- There are clearly defined Service area response times for progressing and actioning emergency requests;
- Service areas support the Out of Hours Contact Centre service with sufficient standby personnel and contact details to ensure that an effective response to emergency requests is provided;
- Escalation processes are well understood by all staff involved,
- Emergency requests received via standard channels are subject to appropriate response times; and
- Specific channels for receiving emergency requests are subject to enhanced response times.

Skills & Experience

- The skills and experience required of Call Handling staff dealing with emergency requests have been clearly identified and included in team role specifications;
- Call Handling staff are provided with appropriate training to enable them to manage any emergency requests and crisis situations that arise in the course of their duties;
- Experienced staff are provided with training across a range of service areas to ensure that they can be redeployed to under resourced areas as required;
- Enhanced training is delivered to Call Handling staff dealing with requests received via emergency social care phone lines / channels; and
- Enhanced training is delivered to Call Handling staff operating out of hours services where additional duties may be required.

Follow Up

- Outcomes / Actions taken by Service areas to address emergency requests referred by the Contact Centre require to be recorded in the system in which they were logged, prior to the request being closed as completed;
- Monitoring systems are in place to ensure that all emergency requests have been actioned; and
- Where monitoring systems have identified instances where emergency requests could have been managed more effectively, a lessons learned exercise is used to improve processes in place.

Performance Review & Reporting

- Key performance indicators (KPIs) have been established to monitor effective service delivery by the Contact Centre and Service areas in respect to receipt, prioritisation and progression of emergency requests;
- There is robust, consistent and accurate reporting of actual performance against KPIs;
- Regular performance reports are provided to Committee to update members on Contact Centre service delivery against targets, planned improvements and emerging issues; and
- Call handling services provided by the Council to third parties are supported by established arrangements including appropriate service standards and performance measures and are subject to robust monitoring and review.
- Customer feedback is obtained to establish any service issues, and is reviewed to establish if any improvements can be made to service delivery across the City and in Localities; and
- Any customer feedback which constitutes a complaint is managed and resolved in line with the Council's corporate complaints policy and procedures.

Complaints Handling

- Any complaints received in respect of Contact Centre or Service area handling of emergency requests are managed and resolved in line with the Council's corporate complaints policy and procedures and Service level agreements in place;
- Complaints received in respect of Contact Centre or Service area handling of emergency requests are consolidated and reported;
- The channels available for citizens making complaints in relation to the handling of emergency requests are well communicated and easily accessible;

- Any complaints of a serious nature in relation to handling of emergency requests are subject to review by the Council Strategic Complaints Officer; and
- There are clear processes for handling of complaints received in respect of emergency requests that ensure that the complaints provide a source of feedback and learning, help drive service improvements, and restore positive relationships with customers who feel let down by poor service.

The City of Edinburgh Council

Internal Audit

Final Report

GDPR (Gap Analysis) Follow-up

8 August 2019

CW1805

Overall report rating:

Generally adequate but with enhancements required	Areas of weakness and non-compliance in the control environment and governance and risk management framework that that may put the achievement of organisational objectives at risk

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

Contents

This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2018/19 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2018 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

Legislative requirements

The General Data Protection Regulation (GDPR), together with the UK Data Protection Act 2018, introduced widespread changes to data protection legislation on 25 May 2018. These included increased financial sanctions for non-compliance, and stronger direction in relation to roles and responsibilities and how personal data should be processed and stored by organisations both within and outwith the EU.

In advance of the 25th May 2018, organisations processing and storing personal data were expected by the Information Commissioner's Office (ICO) to conduct a programme of work to prepare for the new legislation. This included performing a gap analysis to identify areas of non-compliance and risk, and ensuring that appropriate implementation plans and supporting timeframes were established by 25h May 2018 to address the gaps identified.

GDPR Readiness Programme

The City of Edinburgh Council's (The Council's) Information Governance Unit (IGU) within Strategy and Communications developed and implemented a risk based GDPR readiness programme (the Programme) that assessed the extent of GDPR readiness across the Council. This programme included 20 workstreams addressing all areas of preparations for the new legislation. At a corporate level, these included establishing roles and responsibilities, new and revised guidance and procedures, establishment of new documentation such as the Record of Processing, privacy notices, and revised contract provisions, as well as an extensive communications and training programme.

One of the workstreams was a service gap analysis which identified areas of improvement to support services in achieving better compliance.

Outcomes of the 2017/18 GDPR Readiness Programme Internal Audit review

The 2017/18 audit of the of the GDPR readiness programme (performed between March and May 2018) confirmed that the programme was appropriately designed to identify key GDPR readiness risks and control gaps across the Council, with High risk service areas prioritised, and significant focus on awareness and training.

The review also highlighted that completion of the programme had been delayed due to IGU resourcing challenges that could also potentially impact the IGU's ability to validate effective implementation of GDPR findings raised, and their capacity to support ongoing and increasing volumes of operational IGU activities and other general enquiries generated as a result of the new regulations.

Gap analysis outcomes

Prior to commencement of the gap analysis, an initial information risk priority assessment was performed by IGU across all service areas. This was based on an assessment of the privacy impact and processing risks associated with the information being processed and retained. The outcomes were then combined, and a priority ranking of High; Medium; or Low allocated to each service area.

Following completion of the gap analysis in April 2018, a total of 94 GDPR action plans with 715 supporting recommendations were issued by the programme across Council Service areas. These included 4 service areas with an overall 'red' report rating assessment; 78 with 'amber'; and 12 with

green. Of the 715 supporting recommendations 118 were assessed as 'high' priority; 473 'medium'; and 124 as low, with the following definitions applied:

- High - address as quickly as possible and before 25th May 2018 if at all possible
- Medium - address when possible, if not prior to 25th May 2018 then as quickly as possible thereafter.
- Low - address within usual business practices.

A number of holistic Council wide GDPR related risks were also identified by the programme (for example third party; contracts; and shadow (non-centrally hosted) IT) and communicated to the Council's Corporate Leadership Team (CLT) and Directorate risk committees. The IGU also proposed that a Council working group should be established to ensure that these risks are effectively managed though Directorate risk committees, with local plans developed and implemented to ensure that they are addressed.

IGU GDPR readiness follow-up

Given their limited resources; increasing workload; and the volume of GDPR action plans and recommendations, the IGU adopted a self-attestation process to confirm with service areas that their GDPR actions had been addressed, and progress has been reported to individual Directors. In some instances, evidence of implementation was provided to IGU, however, for the reasons outlined above, no assurance testing was performed to confirm that the actions had been effectively implemented and sustained.

Information governance maturity model

IGU has also developed a GDPR maturity model (an assessment tool) that has been designed to enable services to assess the maturity of their established information governance processes in comparison to GDPR regulations and information governance more widely, to identify any potential risks and areas of non-compliance. The maturity assessment was issued across the Council in March 2019.

The model is based on the Generally Accepted Record Keeping Principles (GARP) developed by the Association of Records Managers and Administrators (ARMA). The eight GARP principles 8 include accountability; transparency; integrity; protection; compliance; availability; retention; and disposal.

Within the model, each principle has a set of questions with 5 answers attributed to each question. The responses are then matched to a graded maturity assessment that determines the maturity of information governance across the Council.

Information Board

A new Information Board has been established (the inaugural meeting was March 2019) with the objective of providing dedicated oversight of GDPR implementation; providing assurance to the Council's Corporate Leadership Team that appropriate frameworks have been established to support Directorates and service areas in effective management of information governance risk; and driving and supporting information management across the Council.

IGU management has advised that they now plan to close the Programme based on the self - attestation responses received from service areas, with ongoing assurance provided through a combination of reliance on the Council's established risk management framework to record and manage any remaining GDPR gap analysis actions that have not yet been addressed, and ongoing business as usual activity of the IGU which includes training and awareness, data protection impact assessments, records management assessments, the information maturity model, handling of

information requests and breach management. All of which support the identification of information risks across the Council and reinforces the IGU's role as a second line of defence.

Scope

As the GDPR readiness programme was reviewed in 2017/18, the scope of our current review was limited to an assessment of the design adequacy of the IGU validation process to confirm that services had either closed their actions, or were making adequate progress towards completion

The review was also designed to provide assurance in relation to the following Corporate Leadership Team (CLT) risk:

Information Governance - A major loss of data from the Council's control could result in fines, claims, loss of public trust and reputational damage. This includes both physical records (papers, files, folders etc) and data lost as a result of cyberattacks. This risk takes into account new requirements under the new General Data Protection Regulation.

Approach

Sample testing of completed GDPR actions and recommendations

A total of nine GDPR reports and their 98 supporting recommendations (25 High; 66 Medium; and 7 low) were selected by Internal Audit for testing. This represents 10% of the 94 GDPR action plans issued by the IGU across the Council. All red rated reports were included in the sample, and five (6%) of the amber reports.

We reviewed service area action plans to confirm that they were aligned with GDPR recommendations; interviewed service area representatives; and requested evidence to determine whether actions had been effectively implemented and sustained.

Our sample covered the following Directorates and service areas:

Directorate	Service	IGU Initial Risk Ranking	GDPR Report Priority Rating
Communities and Families	Early Years and Childcare	**Medium**	**Red**
	Residential Care	**High**	**Red**
	Community Safety	**Medium**	**Amber**
Place	Parks, Greenspaces, and Cemeteries	**Low**	**Red**
Resources	Facilities Management	**Medium**	**Red**
	Human Resources	**Medium**	**Amber**
	Legal Services	**Medium**	**Amber**
	Transactions: Assessment & Finance	**Medium**	**Amber**
	Lothian Pension Fund	**Medium**	**Amber**

Review of risk registers

We also reviewed risk registers for each of the services and Directorates noted above to establish whether any GDPR actions that had not been completed were recorded on the risk registers; and that the holistic risks identified by IGU had also been recorded (where relevant).

Discussions were also held with the Chief Risk Officer to understand how Programme outcomes had been reflected in, and were being managed through, the Council's established risk management framework.

We also reviewed the IGU Maturity Model to assess whether it is adequately designed to support ongoing identification and management of information governance risks.

Further details on the scope of our review are included at Appendix 2 – Areas of Audit Focus

A summary of the testing outcomes for each service area reviewed are included at Appendix 3.

2. Executive summary

Total number of findings: 3

Summary of findings raised	
High	1. Implementation of GDPR gap analysis actions
Medium	2. Ongoing management of information governance risks
Low	3. Information Governance maturity model – design and implementation

Further detail on the basis of the classifications applied to our findings is included at Appendix 1.

Opinion

Our review established that there is currently insufficient evidence available to confirm effective implementation and sustainment by service areas of General Data Protection Regulations (GDPR) gap analysis actions raised by the GDPR readiness Programme (the Programme) to address gaps identified between current Council information governance processes and the new GDPR regulations

Additionally, the Council's risk management framework cannot be relied upon to confirm that the information risks associated with all remaining GDPR gaps (including holistic Council wide risks) have been recorded and are being effectively managed. It is therefore likely that the gaps identified that need to be addressed across the Council to progress towards GDPR compliance and meet the expectations of the Information Commissioner's Office have not been addressed, and could potentially result in loss of data and significant breach of applicable regulations.

Whilst the Council could have explored alternative options to confirm that GDPR actions had been effectively implemented and would be sustained across Service Areas, reliance was placed on the Information Governance Unit (IGU) to complete this exercise. Given the limited resources and capacity of the IGU (as highlighted in the High rated finding raised in the GDPR Readiness Programme report issued in August 2017) IGU adopted a self attestation approach that was not designed to obtain and review evidence from services confirming effective implementation.

IGU intend to close the GDPR Programme and obtain ongoing assurance on information governance risk management by first line service areas via the risk management framework and newly launched information governance maturity model, with oversight provided by the recently established Information Board. The proposed information governance assurance framework is well designed and could potentially be a leading approach across the public sector. As with the gap analysis, it is, however, dependent on service areas providing factual responses to the maturity model assessment, and identifying; managing; and addressing their information governance risks effectively.

It is Internal Audit's opinion that the Programme should not be closed until further assurance has been obtained to confirm that all significant GDPR actions have been implemented and will be sustained by services; remaining and holistic information governance risks effectively managed through the risk management framework; the maturity model effectively embedded and used as a tool to assess information maturity and identify any significant risk and control gaps; and the Information Board's authority and oversight responsibilities clearly established.

Consequently, three findings, one High; one Medium; and one Low have been raised.

Our detailed findings and recommendations are laid out at Section 3 below.

3. Detailed findings

1. Implementation of GDPR gap analysis actions	High

Implementation of GDPR actions

Our review of a sample of nine GDPR reports and their 98 supporting recommendations confirmed that:

1. Services have not attested to IGU that all recommendations have been addressed. Of the 98 recommendations included in our sample (25 High; 66 Medium; and 7 low), only 38% (38) have been self attested as closed; and
2. Supporting evidence of implementation was available for only 50% of the 38 actions where services had confirmed closure;

The recommendations where no evidence could be provided to support implementation covered the following GDPR themes highlighted by the IGU in their reports:

- *Storage limitation* – teams should be consistently applying Council record retention policies and schedules to both hard copy and electronic records. A disposal record should be created and maintained for records that have been destroyed in line with the Council Records Management Policy requirements;
- *Security, Integrity, and Confidentiality* – employees should be aware of and consistently applying Clear Desk and Acceptable Use Policies designed to support effective information governance and GDPR compliance;
- *Collection and Purpose limitation* - ensuring that online privacy notices are updated with links included on hard copy forms. Additionally, where privacy notices have been published online, they are not consistently linked to the customer's online journey. This was a consistent theme across all services with the notable exception of Human Resources.
- *Lawfulness, fairness, and transparency* – information sharing with third parties.

Further details on our sample testing outcomes and associated themes are included at Appendix 2.

Discussions with service area representatives highlighted a number of reasons for implementation delays and their inability to provide evidence to support closure. Whilst Internal Audit has not performed testing to validate these reasons, they have been included at Appendix 4 for information.

Risks

The potential risks associated with our findings are:

- The Council is unable to demonstrate that all High and Medium rated service priority actions identified by the Information Governance Unit (IGU) GDPR readiness programme have been effectively implemented and will be sustained as per the Information Commissioner's Office (ICO) expectations, and is unable to close the GDPR readiness programme;
- Potential risk of non-compliance with applicable legislation and internal information governance policies; resulting in potentially breaches; loss of data and potential penalties.

1.1 Recommendation – Implementation of GDPR gap analysis actions

An appropriate risk based approach to confirm satisfactory implementation of all actions identified by the gap analysis should be designed and implemented.

The approach should consider the limited resources within the Information Governance Unit (IGU), and should include, but not be restricted to obtaining independent assurance and supporting evidence from services and Directorates that the all high and medium rated actions included in GDPR action plans have been effectively implemented and sustained.

1.1 Agreed Management Action - Implementation of GDPR gap analysis actions

The Information Governance Unit will adopt an evidence-based methodology and meet with service area representatives to assess and update (when appropriate) that current recommendations have been met and progressed. Progress and on-going risks will be monitored by the Information Board.

Owner

Laurence Rockey, Head of Strategy and Communications

Contributors

Kevin Wilbraham, Information Governance Manager

Sarah Hughes-Jones, Information Compliance Manager

Donna Rodger, Executive Assistant

Agreed Implementation Date

31 December 2019

2. Ongoing management of information risks **Medium**

Our review of the risk management framework established to support ongoing management of information risk across the Council confirmed that:

1. The Corporate Leadership Team (CLT) risk register refers to controls such as the information Security and Information Governance policies; laptop and media encryption; Internal Audit testing of phishing; GDPR implementation tracked by IGU; and cyber essentials accreditation.

   These do not reflect the necessary controls required to effectively manage information risk across the Council by either preventing data breaches and losses or detecting them once they have occurred;
2. There is no clear link between the IGU GDPR gap analysis reports and the risks included in Directorate and service area risks registers;
3. Where risks are recorded and scored on the Pentana system, there is insufficient detail supporting the risk and describing the relevant controls;
4. Not all teams that own GDPR actions have established risk registers. It is acknowledged that Risk Management team is working proactively with service areas to establish risk registers where gaps have been identified;
5. The inaugural meeting of the Information Board was March 2019. At the time of our review, the Board terms of reference was in draft. Review of the draft terms of reference highlighted the opportunity to improve the scope of the Board in relation to the following areas:
   - Inclusion of Risk Management;
   - Inclusion of arm's organisations such as the Lothian Pension Fund; and
   - Ensuring that the service areas roles and responsibilities for managing and providing assurance on their management of information governance risk is clearly articulated.

Risk

The potential risks associated with our findings are:

Information governance risks are not being effectively managed through the established risk management process, and holistically across the Council within agreed and accepted risk tolerance parameters.

2.1 Recommendation – roles, responsibilities, and membership of the Information Board

1. Risk management should be invited to attend the new Information Board;
2. The Information Board should review and agree the appropriate wording and rating of all Council wide information risks, and supporting controls to be included in the Corporate CLT risk register in conjunction with risk management, and present this for consideration at the CLT risk committee;
3. The roles, responsibilities, and expectations of first line services; the second line Information Governance Unit (IGU) and the Information Board in relation to managing information governance and risks across the organisation should be clearly articulated in the Information Board's terms of reference.

   This should include (be not be restricted to) responsibility for providing ongoing assurance to the Board that services are compliant with applicable both applicable legislation and internal Council policies;
4. The Board should consider whether arm's length organisations should be included within membership (for example, the Lothian Pension Fund and the Lothian Valuation Joint Board);
5. The Board terms of reference should include responsibility for ongoing monitoring of service progress with implementation of GDPR gap analysis actions, enabling the Board to make a risk based recommendation to the CLT as to when the GDPR gap analysis validation process should be closed; and ongoing monitoring of the information governance maturity assessment model completion rates and outcomes to identify services who have not completed the questionnaire ensure that that failure to complete and any significant risk areas are communicated to services, with any significant themes or trends reported to the CLT.

2.1 Agreed Management Action – roles, responsibilities, and membership of the Information Board

1. Risk and assurance representation are already included within the Information Board's Terms of Reference.
2. The Information Board will review identified Council-wide information risks (and controls) from existing sources for presentation to the Corporate Leadership Team (CLT);
3. The Information Board's Terms of Reference will be reviewed to provide clarity around respective responsibilities and roles in relation to risk management, assurance and reporting.
4. Existing governance arrangements between the Council and its arm's length companies will be used to provide assurance that information legislation is compiled with.
5. The Information Board's Terms of Reference already provides for work stream monitoring and assurance. Specific projects and progress will be referenced through board documentation and papers.

Owner

Laurence Rockey, Head of Strategy and Communications

Contributors

Kevin Wilbraham, Information Governance Manager

Sarah Hughes-Jones, Information Compliance Manager

Donna Rodger, Executive Assistant

Agreed Implementation Date

30 June 2020

2.2 Recommendation – communication of requirements to implement outstanding GDPR actions and ongoing management of information risk

1. The Information Governance Unit (IGU) should issue a communication to all Directorates and service areas highlighting the need to:
    - Ensure that all GDPR agreed actions are progressed and implemented;
    - Retain appropriate evidence to confirm implementation of agreed actions (providing examples of evidence requirements), and ensure that the actions (once implemented) are sustained;
    - Record any unimplemented actions and any relevant holistic GDPR risks on their risk registers, and ensure that supporting implementation action plans have been developed with responsibility allocated to appropriate owners within their service;
    - Proactively advise the IGU when actions have been implemented; and
2. Information Governance should continue to maintain a tracker of all completed GDPR actions (as advised by services) and present this to the Information Board for their review and consideration of which actions should be included in the independent risk based assurance process recommended in Finding 1 in this report.

a. Agreed Management Action - communication of requirements to implement outstanding GDPR actions and ongoing management of information risk

Further communications will be incorporated into the current Information Governance annual communications plan to take account of the above recommendations.

The Information Governance Unit will continue to track completed GDPR actions and report to the Information Board.

Owner

Laurence Rockey, Head of Strategy and Communications

Contributors

Kevin Wilbraham, Information Governance Manager

Sarah Hughes-Jones, Information Compliance Manager

Donna Rodger, Executive Assistant

Agreed Implementation Date

30 December 2019

2.3 Recommendation – ongoing information risk management

To ensure effective ongoing management of information risks across the Council, Risk Management should obtain copies of the General Data Protection Regulation (GDPR) gap analysis action plans issued by the Information Governance Unit (IGU) and:

1. Review them in comparison to Directorate and service area risk registers to identify any risks that have not been included, and ensure that these are raised and discussed at risk committees; and
2. Identify any services with information governance risks and GDPR readiness gaps that do not currently have an established risk register, and ensure that their development is either prioritised, or the risks reflected in the risk register at the next level.

2.3 Agreed management action - ongoing information governance risk management

Through the quarterly risk committees and risk management group cycles, the Corporate Risk Management Team will ensure that Service Areas are advised, with specific reference to their GDPR gap analysis action plans, to identify and consider inclusion and escalation as appropriate, of any information risks that are not yet included in their risk registers.

Owner
Stephen Moir, Executive Director of Resources
Contributors
Nick Smith, Head of Legal and Risk; Rebecca Tatar, Principal Risk Manager; Michelle Vanhegan, Business Support Executive; Layla Smith, Business Manager
Agreed Implementation Date
31 December 2019

3. **Information Governance maturity model – design and implementation**	**Low**

Whilst the Generally Accepted Record Keeping Principles (GARP) that form the basis of the maturity model questionnaire have been adapted for relevance to the Council, our review of the launch and content of the model established that:

1. Limited guidance was provided to support the users expected to complete the questionnaire. Prior to launch, senior management teams were briefed and advised that the questionnaire would be sent to information asset owners (generally tier 4 managers) on a phased basis from December 2018;
2. The questions are technical and may not be easily understood by all asset information owners across the Council. Whilst some guidance was provided with the distribution e mail, individuals would need to have a strong knowledge and understanding of information governance principles to support completion; and
3. The questionnaire does not include a 'non applicable' response to questions and forces selection from a range of pre determined responses. A good example is the question on whether services have created and published privacy notices, which may not be relevant for teams who do not deal directly with customers (for example second and third line assurance teams) and instead place reliance on the overarching Council privacy notice in relation to the data that the process and retain.

Risk

The potential risks associated with our findings are:

Responses received may not accurately represent the effectiveness of information governance maturity across the Council.

3.1 Recommendation - Information Governance maturity model – design and implementation

The information Governance Unit (IGU) should

1. Produce guidance to support completion of the model, explaining why the model has been developed and launched; frequency of completion; and how the responses will be analysed and used / reported to governance forums.
2. Review and simplify the questions included in the assessment (where possible) and consider inclusions of examples for the answer options and 'non applicable' responses. Where non applicable responses are included, the survey should force respondents to provide supporting rationale; and
3. Include a question to determine whether services are including information risks on their risk registers and managing them effectively.

3.2 Agreed management action - Information Governance maturity model – design and implementation
1. The Information Governance Unit will revise the model guidance and provide further details to support services in completing the survey. 2. The Information Governance Unit will review the assessment form and give consideration to the use of 'non-applicable' responses. 3. Questions on risk and risk management will be included in the next version of the maturity model.
Owner Laurence Rockey, Head of Strategy and Communications
Contributors Kevin Wilbraham, Information Governance Manager Henry Sullivan, Information Asset Manager Donna Rodger, Executive Assistant
Agreed Implementation Date 31 December 2019

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or*** • ***Critical*** impact on the reputation or brand of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or*** • ***Significant*** impact on the reputation or brand of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation or brand of the organisation.
Low	A finding that could have a: • ***Minor*** impact on the organisation's operational performance ; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***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.

Appendix 2 – Areas of Audit Focus

The audit areas and related control objectives that were tested in detail were:

Audit Area	Control Objectives
IGU Validation Process and Maturity Model	Review the IGU validation process and maturity model and confirm that: • a clear methodology has been developed to support the validation and maturity assessment process, and is consistently applied; • arms length external organisations associated with the Council (for example, Lothian Pension Fund) are included in scope of the validation and maturity assessment process; • where validation or maturity assessment outcomes identify areas where further action is required, these are communicated to service areas; and • GDPR action plan implementation progress (including areas where lack of progress is evident) is monitored and regularly reported to the CLT and relevant executive committees.
Management of GDPR risks	• Confirm whether a Council working group was established to address key generic GDPR corporate risks; • Obtain a copy of the terms of reference for the working group and confirm that the roles and responsibilities of the committee have been clearly defined; • Confirm that ownership of these risks has been appropriately allocated; • Confirm that the full population of risks has been discussed at Directorate risk committees and reflected in Directorate and Corporate Leadership Team risk registers, where applicable; • For a sample of risks, establish progress with defining and implementing key controls, and confirm that (where implemented) effectiveness of the controls has been assessed and recorded in risk registers; and • Review the CLT risk register and confirm whether appropriate controls have been established to manage information governance / GDP risks, and their effectiveness appropriately assessed.

Appendix 3 – Testing Outcomes

The following table summarises our testing outcomes across the 9 service areas included in our sample.

				Recommendations					
Sample	**Area**	**IGU Initial Risk Ranking***	**IGU GDPR Readiness Report Priority Rating**	**Total in report**	**High address pre 28/5/18**	**Medium address as soon as possible post 28/5/18**	**Low address as part of business as usual processes**	**Recs completed per self-attestation to IGU**	**Recs completed with supporting evidence**
1	Residential Care	**High**	**Red**	10	8	2	0	6	1
2	Early Years and Childcare	**Medium**	**Red**	15	7	8	0	8	0
3	Parks, Greenspaces and Cemeteries	**Low**	**Red**	19	5	14	0	0	0
4	Facilities Management	**Medium**	**Red**	15	4	9	2	8	3
5	HR	**Medium**	**Amber**	9	1	6	2	3	2
6	Legal Services	**Medium**	**Amber**	4	0	3	1	1	2
7	Community Safety	**Medium**	**Amber**	8	0	8	0	6	0
8	Transactions: Assessment & Finance	**Medium**	**Amber**	11	0	10	1	6	10
9	Lothian Pension Fund	**Medium**	**Amber**	7	0	6	1	During our audit this was currently being assessed by IGU as a wider review.	1
Totals				**98**	**25**	**66**	**7**	**38**	**19**

Appendix 3 – Testing Outcomes (cont.)

The following table summarises the themes (based on IGU classifications used in original GDPR reports) associated with recommendations where evidence was not provided to support actions that had been closed.

Sample	Area	IGU Initial Risk Ranking	IGU Report Rating	Themes associated with medium and high recommendations of recs where no evidence of closure could be provided
1	Residential Care	**High**	**Red**	Record retention and disposal **(Storage Limitation**) Clear desk policy, DP training on breaches **(Security, Integrity, and Confidentiality)** Record of updating personal data, privacy notices **(Collection and Purpose limitation)**
2	Early Years and Childcare	**Medium**	**Red**	Information sharing. (**Lawfulness, fairness and transparency)** Privacy notices **(Collection and Purpose limitation)** Record retention and disposal **(Storage Limitation**)
3	Parks, Greenspaces, and Cemeteries	**Low**	**Red**	Security of laptops used, risk assessments of premises, staff training **(Security, Integrity, and Confidentiality.** Privacy notices (**Collection and Purpose limitation)** A process for ensuring that access control data **(Accuracy)** Record retention **(Storage limitation)** Transferring data **(Security, Integrity, and Confidentiality)**
4	Facilities Management	**Medium**	**Red**	**Collection and Purpose limitation.** (**Data Minimisation)** A process for ensuring that access control data **(Accuracy)** Suitable controls for the transmission of personal data electronically, removable media **(Security, Integrity, and Confidentiality)**
5	HR	**Medium**	**Amber**	Record retention **(Storage limitation)** Alternative use to personal data used in training **(Data Minimisation)**
6	Legal Services	**Medium**	**Amber**	Process used by team members for retention of data (**(Storage Limitation**)
7	Community Safety	**Medium**	**Amber**	Privacy notices; CCTV signage **(Collection and Purpose limitation)** A regular review of the siting and range of CCTV cameras **(Data Minimisation)** A process for ensuring that access control data **(Accuracy**

Sample	Area	IGU Initial Risk Ranking	IGU Report Rating	Themes associated with medium and high recommendations of recs where no evidence of closure could be provided
8	Transactions: Assessment & Finance	**Medium**	**Amber**	Privacy notices **(Collection and Purpose limitation)**
9	Lothian Pension Fund	**Medium**	**Amber**	Privacy notices **(Collection and Purpose limitation)** A process for ensuring that access control data **(Accuracy)** Disposal record **(Storage limitation)** Security of papers in transit **(Security, Integrity, and Confidentiality)**

Appendix 4 - Reasons provided by Service Areas for implementation delays and lack of evidence to support closure of GDPR actions

Discussions with service area representatives highlighted the following reasons for implementation delays and inability to provide evidence to support closure:

1. IGU did not provide guidance on the evidence required to support completion of actions. A number of services confirmed that this was discussed verbally by IGU when GDPR reports were issued;
2. Where services did provide evidence to IGU, there was limited response to confirm that the evidence provided was adequate. It is understood that this was attributable to the limited resources available within IGU;
3. Lack of clarity regarding team member completion rates of CECil online GDPR and information governance learning modules, as completion is not proactively tracked. Whilst completion reports are available from the system, these are not consistently used.

   Additionally, there is also no single source of employee data that accurately replicates the current Council organisational structure making completion difficult to track within Service Areas (this was also identified in the Phishing Resilience Internal Audit report finalised in July 2018. Management are currently implementing agreed actions to ensure that this is resolved).

Changes in team members responsible for implementation of GDPR actions with insufficient handover performed. Examples provided included changes in Business Support, or new Managers starting after GDPR action plans had been agreed.

The City of Edinburgh Council

Internal Audit

Payments and Charges

Final Report

8 August 2019

CW1803

Generally adequate but with enhancements required	Areas of weakness and non-compliance in the control environment and governance and risk management framework that that may put the achievement of organisational objectives at risk

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

Content

This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2018/19 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2018. 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

Guidance

Audit Scotland published guidance on charging for services for Councils in October 2013, which includes guidance on why charges are important; managing charges; and the cycle for managing charges as well as two appendices outlining questions for both councillors and officers when considering setting and approving fees and charges.

A summary of the key messages included in the guidance is included at Appendix 1.

Sources of Income

The City of Edinburgh Council (the Council) has a number of income streams in addition to the three main income sources (Council Tax; Non Domestic Rates; and General Revenue Grant) that are used to support provision of services.

This additional income (circa £75 million for the first ten months of the 2018/19 financial year) is generated by application of statutory and discretionary charges by a number of different Council service areas, although the majority of the income streams are managed within Place.

These charges are reviewed annually and subsequently published in the Fees and Charges schedule published on the Council website.

Analysis of the Council's income

Analysis of the Council's income for the first ten months of 2018/19 confirmed that the two largest sources of additional income were: Parking Fees and Charges (£22.9 million); and Older People's Residential Care Fees (£14.3 million), with Licence Fees and Permits also generating £7.6 million.

Parking Fees and Charges

There are three main types of parking fees and charges:

1. On-street parking charges;
2. Parking permits; and
3. Parking tickets

Fees are set to recover the costs associated with provision of service for the first two of these, whilst parking ticket fees are set by statute.

The Council operates a contract with NSL Ltd for the collection of on-street parking income.

Older People's Residential Care Fees

Section 22 of the National Assistance (Assessment of Resources) Regulations 1992 (SI No: 2977) requires local authorities to set the standard rate for local authority homes (gross fees) at an amount equivalent to the full cost of providing the accommodation. Fees are determined in line with this legislation and the Charging for Residential Accommodation Guidance (CRAG) guidance prepared by the Health and Social Care Integration Directorate of Scottish Government that is distributed to all Scottish Local Authorities.

Residents with capital of £27,250 or more pay these fees in full (gross fees), whilst those with less than £27,250 pay a net amount (net fees) determined via a means-tested calculation performed by

the Council's Customer team on behalf of the Health and Social Care Partnership using the SWIFT system.

Gross Fees

A change to the gross fee calculation method was introduced in 2018/19, following approval by the Corporate Policy and Strategy Committee (February 2018) to change the basis of the calculation as there was no clear correlation between fees charged and the operational costs incurred. This resulted in the calculations being rebased to reflect the estimated unit costs of care provision in the forthcoming year, with application from the following April.

The Council had historically approved a policy in where most discretionary charges are increased annually at rate of 2% over the prevailing Retail Price Index (RPI). As at March 2018, the RPI rate was 3.3%. Recognising that care home charges had not been increased since April 2016, Finance and Resources Committee approved a further increase of 5% in June 2018, effective from 1 September 2018, for existing self-funding (gross fee) residents. This proposal was then ratified by full Council on 28th June 2018 as part of the established budget motion process.

The gross fee calculation considers the employee and other costs (equipment, etc.) at each individual home. A number of assumptions are then applied to the calculated cost is to determine the relevant fee for each type of care provided by each individual care home. The following assumptions are determined by the Council:

- An occupancy rate percentage of 95% to offset the cost of beds being unoccupied;
- A capital charge added to recover the cost of the building of the care home. This is only for certain properties and is currently set at £200 per week;
- An overhead charge, currently set at 12.69%, to cover the cost of service overheads within the Health and Social Care Partnership, such as Senior Management; Planning and Commissioning the Service Matching Unit; and central services within the Council, such as Business Support, Finance, and Human Resources.

Net fees

The 1992 Regulations also require all Scottish Local Authorities in Scotland to consider and calculate an individual's ability to pay any residential care home fees, as well as outlining the basis of the calculation These requirements are also reflected in the CRAG.

The CRAG defines the basis for the calculation process, and there is also provision in the Regulations for the Council to elect not to apply many elements of the calculation, when considered reasonable.

Assessments are performed by the Financial Assessments Team within Customer and Digital Services for all new care home applications, and an annual assessment is performed for all existing care home residents who receive financial assistance to determine the value of ongoing support to be provided and their contribution levels. The annual assessment is performed each April to coincide with the annual uprating of state pensions and benefits, as well as the revised annual allowance and capital rates specified in the CRAG, which are also refreshed annually.

Reassessments for existing care home residents are also performed following significant changes in circumstances when advised by the resident or their representative.

Following completion of assessments, residents are notified of the outcome and are advised to contact the Financial Assessments team if there are differences between the assessment and their actual financial circumstances.

Resident fees are then invoiced annually via the Council's Accounts Receivable (Proiv) system. Payments are generally made via monthly Standing Order, although some residents pay in full each year on receipt of the annual invoice.

Licence Fees and Permits

The Council currently administers 47 different types of licences and permits. Fees for some licences are set at a statutory level, whilst others are discretionary. For those where the Council has discretion, the level of fee increase based on the amount required to cover the costs of the service.

The basis of the calculation of licensing fees was reviewed and approved by the Regulatory Committee in February 2015 with the objective of setting fees at a level that would enable the Council to recover reasonable costs. Consequently, some fees were increased to reflect the costs of licences with significant enforcement costs.

A separate review of HMO fees was approved by the Regulatory Committee in April 2017, and was designed to achieve a more equitable split of costs in relation to the number of occupants within a property.

When setting fees employee and other direct and indirect costs associated with each category of licence is considered.

Reserve Balances

Reserve balances accumulate when the income generated from licence fees and charges exceeds the costs associated with preparing; issuing; administering; and enforcing the licences. Reserve balances for HMO and taxi licensing are ring fenced and can only be used to cover either ongoing operational service delivery costs and / or investment and cannot be used for general expenditure. Reserve balances are reviewed and reported to relevant Council Executive Committees annually.

Scope

This review focused on assessing the design adequacy and operating effectiveness of the key controls in place to support the annual review; approval; and processing (raising and issuing invoices, and processing payments received) of the fees, charges and payments received in the 2018-19 financial year for the following significant charges generating additional income (circa £54M per annum) for the Council:

- Parking Permits (Place):
- Older People's Residential Care (Health and Social Care) fees; and,
- Licences (Place).

Data analytics were used to compare the full population of fees applied during the period 1st April 2018 to 31st March 2019 with published fee schedules and support sample for testing.

Limitations of Scope

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

- cash management and banking;
- debt management;
- income accounting arrangements; and
- system access rights to the system used to process fees and charges.

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

Reporting Date

Our audit work concluded on 6 June 2019 and our findings and opinion are based on the outcomes of our testing at that date.

2. Executive summary

Total number of findings: Five

Summary of findings raised	
Medium	1. Authorisation and reporting of fees and charges
Medium	2. Older People's Residential Care Fees – Gross Charge
Medium	3. Older People's Residential Care Fees – Net Charge
Medium	4. Processing and recording of Licensing fees
Medium	5. Processing and recording of Parking permits

The basis for classification of IA findings raised is included at Appendix 1.

Opinion

Generally adequate but with enhancements required

The Council generates circa £54M per annum from fees and charges in relation to parking permits; residential care; and numerous types of licences

Our review of the design adequacy and operating effectiveness of the key controls established to support the annual review; approval; and processing of these fees and charges confirmed that they generally adequate but with enhancements required to ensure that the Council can demonstrate consideration of and ongoing alignment with Audit Scotland guidance on charging for services.

We identified some moderate weaknesses in the design of the processes supporting calculation, approval, and application of fees and charges. These related to lack of process documentation and rationale supporting initial fee calculations; the requirement to design, implement, and agree processes for fee waivers and refunds; and the need to implement ongoing risk based quality assurance processes to confirm that fees and charges are completely and accurately processed.

We also identified some minor differences between the fees and charges included in the approved budget motion and those published in the fees and charges schedule on the Council's website and noted that there is limited information published in relation to the costs of residential care.

Additionally, a number of parking permit fee increases were implemented 22 days after the date noted in the Council's budget motion, management has advised that the delay was attributable to the legislative requirements to provide sufficient notice of the change, and the practical (parking) impacts associated with advertising a significant number of permit fees simultaneously.

Use of data analytics enabled extraction from source systems and analysis of fee data for the full 2018/19 financial year for parking permits and licences. These were compared to the approved fees included in the 2018/19 budget motion to identify any anomalies. Review of care home fees was performed via sample testing.

Whilst some anomalies were identified (for example non alignment with approved fees; waived fees and £0 fees) none of the differences identified were considered significantly material from a financial perspective on either an individual or combined basis.

It should be noted that the rationale supporting anomalies in relation to licensing fees is currently being investigated by management.

Consequently, five Medium rated findings have been raised and are included at section 3 below.

3. Detailed findings

1. Review, authorisation, and publication of applicable Council fees and charges	Medium

Process documentation supporting review of fees and charges

Whilst a Council corporate charging policy has been established, there was limited process documentation available within the service areas we reviewed to support their ongoing review of fees and charges.

Budget motion and published schedule of fees and charges

Annual changes to fees and charges proposed by service areas are approved by the Council through the established budget motion process. A full schedule of fees and charges is also published on the Council's website at: schedule of fees and charges.

Details of fees and charges applied by services are also included in the relevant service area sections of the Council's external website.

Comparison between the approved 2018/19 budget motion and the published schedule of fees and charges highlighted that:

- the schedule of fees and charges was incomplete as a number of charges detailed in the budget motion were not included. Further detail is included at Appendix 3;
- some fee changes included in the schedule were not included in the budget motion;
- parking permits for retail, trade and businesses and the multiple permits associated with these for different City zones were noted in the budget motion and schedule as due to change on 1st April 2019. These were not revised until 23rd April; and
- two charges included in the budget motion and fee schedule could not been implemented due to legislative restrictions where amendments to Traffic Regulation Orders (TROs) were required. As a result, these fees will not be implemented during the current financial year.

Review, approval, and publication of residential care fees and charges

Review of the process applied to determine and approve residential care fees, and comparison with the fee information and published on the Council's website established that:

- **Review of residential care charges** - whilst the basis for the calculation of residential care charges was reviewed and approved by the Council's Corporate Policy and Strategy Committee in February 2018, final approval of the actual charges was provided by the EIJB Chief Finance Officer with no subsequent review and approval by either a Council or Edinburgh Integration Joint Board (EIJB) executive committee;

- **Budget approval** for residential care homes was achieved through the 2019/20 Coalition Budget Motion, however, this did not include details regarding resident charges applied at each Care Home;
- **Advice on financial assistance** for potential Council care home residents is published on the website, however, no specific information on applicable resident fees and the varying rates for different levels of care in Council care homes is provided;
- **Published assistance threshold** – the current published assistance threshold figure for resident savings of £28,000 (or less) is incorrect, as the current savings threshold applied to determine whether financial assistance should be provided is £27,250.

Licencing Reserves

Significant HMO and taxi licencing reserve balances remain for the 2017/18 financial year (£1.42M and £0.57M respectively). Whilst the HMO fees were reviewed in 2017 and the reserve balance was reduced in year the Taxi reserve increased by £0.24M, which suggests that costs are potentially being under and over recovered based on the fees applied.

Risks

Potential non alignment with Audit Scotland guidance on charging for services as:

- The rationale supporting calculation of fees and charges cannot be explained or provided to citizens;
- Fees and charges published on the Council's website and included in the schedule of fees and charges may not accurately reflect the charges that are being applied in practice;
- Adequate scrutiny and an appropriate level of approval is not applied to residential care home fees;
- The Budget Motion could potentially be incomplete and / or inaccurate; and
- Licencing fees and charges applied are not be aligned with demand and may result in under or over recovery of costs associated with service delivery.

1.1 Recommendation – process documentation supporting calculation of fees and charges including review of reserve balances

- The rationale and processes applied when calculating fees and charges should be documented and retained for all licences charged across the Place directorate;
- Reserve balances within Licensing should be regularly reviewed and monitored to determine whether surplus reserves should be used for service investment or to fund future licencing fees.

1.1 Agreed Management Action - process documentation supporting calculation of fees and charges including review of reserve balances

Response from Licencing

Any new fees or proposed adjustments are presented to the Committee for scrutiny and agreement.

The rationale for Taxi, Civic and Houses in Multiple Occupation (HMO) licencing fees was reviewed and agreed by Regulatory Committee in 2015 and 2017 respectively and no further changes are planned at this time.

As part of the annual budget process, the Place Directorate makes recommendations on any inflationary uplifts that should be applied to fees based on projected costs and the Licencing reserves position.

In 2018/2019 there was no increase in the Licencing budget which reflected the reserves position at that time.

In the 2019/20 budget Taxi and Civic discretionary licence fees were increased by 2.5% to reflect increased costs associate with the local government pay settlement for 2018/19 and 2019/2020. In comparison, the increase applied to fees supporting generation of other types of income across the Council was circa 5%. This demonstrates that Licencing is proactively managing both fees and reserves.

For HMO Licences, the Regulatory Committee approved a revised fee structure in 2017, and there is planned reduction of current reserve balances over a 3 year period. Consequently, HMO fees for 2019/2020 were not increased. For budget 2020/2021 a review of HMO reserves will be performed with Finance and recommendations made either to the Regulatory Committee or Full Council on any further fee adjustments required to ensure the planned reduction of the reserve is achieved.

There are also unplanned factors that impact the final reserves position. These include increased application volumes; the impact of vacancies and recruitment; and repairs or replacement of property or equipment (for example a replacement ramp at the Taxi Examination Centre in 2016/17 at the cost of £90K). These unplanned factors are also considered when revised fees are proposed during the budget process.

The Taxi reserve increase is largely driven by increased application volumes. The reserve is also being allowed to increase in the medium term to offset planned capital spend on relocation of the Taxi Examination Centre when the Council closes the Murrayburn depot site in the next 2-3 years to avoid potential capital budget pressures.

Licencing is working with Finance to ensure there is greater certainty in setting fees when taking account of the impact of the Central Support Charges levied.

In 2018 the Directorate introduced financial reporting to the Regulatory Committee in addition to the established financial reporting provided to the Finance and Resource Committee.

http://www.edinburgh.gov.uk/download/meetings/id/58887/item_72_-_licence_income_for_fees_2017-2018

http://www.edinburgh.gov.uk/download/meetings/id/59029/minute_of_the_regulatory_committee_of_221018

Response from Finance

At present, the allocation of central support costs in line with accountancy conventions is not finalised until after the licensing charges for the future year have been set. A mechanism to approximate allocation of central support charges in advance to allow for more considered analysis of reserve balances and costs within each budgetary process will facilitate this.

There is already a framework in place to apportion income and costs across licence categories and calculate additions to or withdrawals from licensing reserves. This populates the annual City of Edinburgh Licensing Board Financial Report as required under Section 9B of the Licensing (Scotland) Act 2005. This framework where appropriate will be developed to add to existing transparency in respect of rationale and processes.

The combination of both actions above will enable regular review and monitoring of reserve positions and related decision making. The implementation date allows for 2020-21 budget setting and 2019-20 final accounts processes to be completed allowing for audit evidence.

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Michael Thain, Head of Place Development; Andrew Mitchell, Regulatory Services Manager; Alison Coburn, Operations	**Implementation Date:** 31 July 2020

Manager; Sandra Harrison, Executive Assistant; Stephen Moir, Executive Director of Resources; Hugh Dunn, Head of Finance; John Connarty, Business Partnering Senior Manager; Susan Hamilton, Principal Accountant; Layla Smith, Business Manager; Annette Smith, Executive Assistant.	

1.2 Recommendation – approval and publication of residential care home fees

- A governance process for review and approval of annual changes to residential care home fees (and any significant 'in year' increases) should be agreed and consistently applied in advance of final agreement of fees via the Council's budget motion; and
- These rates for each care home should then be published on the Council's website and accurately reflected in the Council's schedule of fees and charges.

1.2 Agreed management action - approval and publication of residential care home fees

(i) A governance process for the review and approval of annual changes to residential care home fees will be agreed;

(ii) The agreed governance process for the review and approval of annual changes to residential care home fees will be applied for approval of annual fees for 2020/21; and

(iii) Rates for each care home will be published annually on the Council's website and accurately reflected in the Council's schedule of fees and charges.

Owner: Judith Proctor, Chief Operating Officer, Health and Social Care Partnership **Contributors:** Stephen Moir, Executive Director of Resources, Hugh Dunn, Head of Finance; Moira Pringle, Chief Finance Officer, Health and Social Care Partnership; John Connarty, Business Partnering Senior Manager; Karen Dallas, Principal Accountant; Kenny Raeburn, Senior Accountant; Sara MacDonald, Accountant; Cathy Wilson. Operations Manager, Health and Social Care; Layla Smith Resources Business Manager; Annette Smith, Executive Assistant.	**Implementation Date:** 1 June 2020

1.3 Recommendation – budget motion and schedule of fees

- Appropriate checks should be implemented prior to submission of the budget motion to Council to confirm that all actions required to support implementation of fee increases by the agreed dates have been completed by service areas;
- The schedule of fees and charges should be reconciled to the budget motion and also details of fees and charges maintained by services on the Council's external website prior to its publication.

1.3 Agreed management action – budget motion and schedule of fees

The fees and charges-related content of the approved budget motion is developed with service areas and, following approval by Council, Departmental Business Managers are asked by the Corporate Accounts team to cascade these decisions to relevant areas to ensure that they are implemented accordingly.

Timescales-permitting, however, a draft fees schedule will be circulated in advance of the publication of papers for the budget-setting meeting to serve as an additional opportunity both to undertake any

necessary preparatory work and identify any inconsistencies between the consolidated list and service-specific schedules maintained by relevant service areas on other areas of the Council's website.

A communication will be issued to Services together with the draft fees schedule requesting them to ensure that all necessary steps are taken to support implementation of the revised fees immediately following approval of the budget, and to ensure that the content of their pages on the Council's external website is aligned with the finally approved fees and charges schedule.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Hugh Dunn, Head of Finance; Fraser Rowson, Principal Accountant (Corporate Accounts); Layla Smith, Resources Business Manager; Annette Smith, Executive Assistant	**Implementation Date:** 29 May 2020

2. Older People's Residential Care Fees – calculation of gross charges — Medium

Our review of gross residential care home fee calculations highlighted that:

1. The 95% occupancy rate assumption applied to calculate the fees is based upon a budgetary defined target for the Council's care homes. Recent statistics provided by NHS Scotland's Information Services Division on the last ten year's average occupancy rate for care homes in Scotland and specifically in Edinburgh however suggest an average occupancy rate of circa around 89% for the last ten years.
2. The 12.69% overhead charge was calculated by the Health and Social Care Finance team; however, details of the calculation could not be provided at the time of our review. Management has advised that the calculation had been based on estimates provided by the Principal Accountant circa 5 years ago.
3. Management has advised that the capital charge of £200 per week is based on the cost of borrowing to fund capital investment but no evidence could be provided to support the basis of this assumption. Management advised that the Council chose to apply a generic figure of £200 for this charge rather than produce a calculation for each care home following legal advice from the Council's Legal Services team.

Risks

Potential non alignment with Audit Scotland guidance on charging for services as:

- Income for residential care homes is insufficient to meet the full cost to the authority of providing the accommodation;
- The gross charge for residential care homes is potentially incorrectly calculated; and
- Details of the charging methodology applied cannot be provided to citizens upon request.

2.1 Recommendation – calculation of gross charges

The calculation of the gross charge for Council run care homes should be revisited to ensure that the rate charged for each home reflects an amount equivalent to the full cost to the authority of providing the accommodation, specifically in terms of the three variable elements of the calculation:

1. occupancy rates – should be based on the average historic actual occupancy rate data across the care homes appropriately adjusted to reflect any non routine operational impacts that has resulted in temporary closures;

2. capital charge – manage should reconfirm with legal whether the capital charge should continue to be applied to specific homes, and should revisit the basis for the charge applied;
3. overheads – the basis for calculation of overhead charges should be reviewed and recalculated (where appropriate); and
4. Once calculated, the process supporting calculation of the charges should be documented and supporting evidence retained.

2.1 Agreed Management Action – calculation of gross charges

Health & Social Care Finance will review the methodology for the calculation of the gross charge and the identified constituent elements and then document these as evidence of the methodology applied as follows

1. Management's view is that the 95% occupancy rate as applied to the calculation is robust and will remain in place (subject to regular review), any decrease in this rate risks overcharging clients for their care;
2. Re-establish the basis for the capital charge for each care home and apply any changes as required;
3. Recalculate the overhead calculation and apply any changes as required; and
4. Seek confirmation from legal services on the basis for not applying the capital charge to the entire suite of care homes.

Owner: Judith Proctor, Chief Operating Officer, Health and Social Care Partnership **Contributors:** Stephen Moir, Executive Director of Resources, Hugh Dunn, Head of Finance; Moira Pringle, Chief Finance Officer, Health and Social Care Partnership; John Connarty, Business Partnering Senior Manager; Karen Dallas, Principal Accountant; Kenny Raeburn, Senior Accountant; Sara MacDonald, Accountant; Cathy Wilson. Operations Manager, Health and Social Care; Layla Smith Resources Business Manager; Annette Smith, Executive Assistant.	**Implementation Date:** 31 January 2020

3 Older People's Residential Care Fees – calculation of net charges **Medium**

Guidance for calculation of net charges

Other than the Charging for Residential Accommodation Guidance (CRAG) guidance prepared by the Health and Social Care Integration Directorate of Scottish Government that is distributed to all Scottish Local Authorities, there is no specific City of Edinburgh Council guidance that encapsulates the details of any local decisions made in relation to calculation of net charges.

Annual calculation of net charges – sample testing outcomes

Calculation design

Our review of a sample of 20 financial assessments performed in 2018/19 highlighted the following weaknesses in the design of the calculation:

- unlike state pensions, there is no consideration of any uplift in a resident's private pension as part of the annual recalculation process;
- the resident's initial declaration of capital is not reviewed in subsequent years, even where:

- Residents initially declared capital at a level close to the threshold at the time of their initial application (for example, £17,000 in 2018/19);
- Residents initially declared capital which has subsequently been disregarded under Schedule 4 of The National Assistance (Assessment of Resources) Regulations 1992, i.e. where the resident retains joint ownership of a property at the point at which they move into the care home, a situation which may subsequently have altered.

Calculation accuracy

The outcomes of our recalculation of the 20 financial assessments included in our sample highlighted the following inaccuracies in performing the calculations that had not been identified by management:

- 6 were completely accurate;
- 10 were inaccurate but by less than 2% of the total amount due – mainly due to small differences in the amounts of private pensions and state pension credits
- 4 were inaccurate in excess of 2% of the total amount due.

The four more significant inaccuracies were attributable to:

- Incorrect treatment of capital;
- Incorrect disregard of income;
- Life insurance disregarded from the calculation without being evidenced; and
- Differing housing costs being used than were shown to be in payment.

Risks

- Regulatory requirements are not followed.
- Income due is inaccurately calculated.

3.1 Recommendation – calculation of net charges

1. The current Charging for Residential Accommodation Guidance (CRAG) should be consolidated together with all relevant local Council decisions into a guidance document outlining the process to be applied when calculating net fees;
2. All decisions implemented as a consequence of CEC decisions should be documented within each individual case file.
3. All new applications and a risk based sample of annual recalculations should be reviewed and approved by an officer other than the officer processing the application.
4. All residents who have initially declared capital of £15,000, i.e. within £2,000 of the tariff income threshold (£17,000 in 2018/19) should be identified and their current amounts of capital validated to ensure the correct amount of capital is included within the calculation.
5. Similarly, all residents who initially declared capital which has been disregarded under Schedule 4 of The National Assistance (Assessment of Resources) Regulations 1992 should also be identified and confirmation obtained that this capital should continue to be disregarded

3.1 Agreed Management Action – calculation of net charges

1. The Customer Transactions Assessment and Finance team will design a process in consultation with the relevant parties (including the Health and Social Care Finance team and the EIJB Chief Finance Officer) that consolidates all relevant local Council decisions and CRAG requirements

into a guidance document outlining the decision making process to be applied when calculating net fees;

2. The final revised process will be reported to the Health and Social Care Partnership Management Team for information and comment;
3. Decisions implemented for each client will be documented in the Swift Case Notes or if lengthy paperwork may be appropriate to be in the paper file. In a future enhancement this will be stored electronically following implementation of Civica Workflow 365, which will provide capability to store all documents and notes going forward.
4. All new applications for assessment are already reviewed and approved by an officer other than the office processing the application. A risk-based sample of annual recalculations will be carried out by Team Leaders. This will be implemented following consultation with colleagues within the wider customer team as to the appropriate delivery of this process.
5. For clients in care homes with managed finance programmes, the team already contact the care homes annually to determine level of capital and if this has increased beyond £10k. In these cases, capital is monitored throughout the year to reduce the risk of overpayment of financial support and to ensure a new assessment takes place to reflect the increased capital resulting. This is likely to result in client contribution towards care where appropriate income levels have been breached.

   Currently there are no plans to carry out this process where the Council does not manage client income. Citizens are advised they are obligated to inform us where their income reaches tariff levels at the point of assessment. However, a small sample process to ensure changes are reported will be undertaken. The volume will be determined when the process is drawn up.
6. There is no current technology to identify cases with disregards of income or capital. It is the case that the team rarely take the decision to disregard capital. Disregards are mainly involved in disregarding income, for example, when half of an Occupational Pension is disregarded to benefit a spouse remaining in the family home. Again, the obligation sits with the claimant representative to notify of any changes in circumstances which would have an impact on level of financial support. As with point 4, a small sample process to ensure changes are reported will be undertaken. The volume will be determined when the process is drawn up.

Owner:	**Implementation Date:**
Judith Proctor, Chief Officer, Edinburgh Health and Social Care Partnership **Contributors:** Stephen Moir, Executive Director of Resources; Layla Smith, Business Manager, Resources; Nicola Harvey, Head of Customer and Digital Services; Julie Rosano, Business Support Executive; Neil Jamieson, Customer Senior Manager; Sheila Haig, Customer Manager (Assessment and Finance Team, Customer and Digital Services); Liz Davern, Team Manager (Assessment and Finance Team, Customer and Digital Services); Cathy Wilson, Operations Manager, Health and Social Care Partnership	27 December 2019

4. Processing and recording Licensing Fees	**Medium**

Our review of a sample of 220 licence applications processed on the Civica APP system confirmed that they were generally completely and accurately processed with some moderate exceptions. The following exceptions were identified for ten (4.6%) of the applications reviewed:

- One fee was in excess of the maximum fee permitted by legislation;
- payment records that do not match the fee list;
- necessary documents not linked to applications; and
- unsigned one-time payment forms.

Two of the exceptions noted above had been identified by management and corrected prior to completion of our review.

It was also noted that the APP payment action screen was not completed for 28 (12.8%) of the applications reviewed.

Difficulty was also experienced with allocating bulk licence applications payments (the main application including bulk payment recorded in APP against individual applications) as they were not consistently linked in the APP system. We identified one instance where the value deducted from one application did not match the value transferred to the other application.

Quality checking

While review of the quality of licencing applications within the APP system has been established quality checking is performed on an ad hoc basis, and the results and corrective actions completed are not always recorded.

Risks

- Fees and charges may not be completely, accurately, and consistently recorded.
- Income received for licence applications is not allocated to the correct ledger code.

4.1 Recommendation – procedures supporting processing and recording licencing fees

- procedures detailing the processes to be applied when processing and recording licencing fees should be reviewed and updated. This should include (but not be limited to) ensuring that fees charged are aligned with the current fee list (unless management has agreed that the fee can be waived or reduced); all relevant documents are linked to applications; all one time payment forms are signed; the requirement to complete the APP system payment action screen; and the need to accurately reconcile and allocate bulk payments received against individual licences; and
- the refreshed procedures should be shared with team members and training / further guidance provided where required.

4.1 Agreed Management Action - procedures supporting processing and recording licencing fees

The Licensing Service processes approximately 21,000 applications per annum and the Internal Audit sample reviewed represents approximately 1% of the overall number of applications.

Internal procedures will be reviewed to ensure that that they adequately cover the issues raised and all staff will receive refresher training to reinforce the importance of consistent application of the procedures.

Longer term upgrades to the APP Civica Licencing system should also offer enhanced capability with mandatory sections for each licence type processed.

Owner: Paul Lawrence; Executive Director of Place **Contributors:** Michael Thain, Head of Place Development; Andrew Mitchell, Regulatory Services Manager; Alison Coburn, Operations Manager; Sandra Harrison, Executive Assistant	**Implementation Date:** 20 Dec 2019

4.2 Recommendation - quality checking
A risk based quality assurance process should be designed; implemented and consistently applied at an appropriate frequency (e.g. weekly; monthly; or quarterly) to confirm the completeness and accuracy of licence applications and payments processed via the APP system. This should include (but not be restricted to): • a clearly defined sample selection methodology that is linked to volume; payment value; complexity of processing; and skills and experience of team members; • clear guidance on the checks to be performed (for example, use of a checklist) and how the testing outcomes should be recorded; and • consolidation and review of outcomes to identify any potentially significant or systemic themes that should be addressed either through training or ongoing performance management.
4.2 Agreed management action – quality checking
Licencing has existing assurance procedures for monitoring non compliance with core procedures and processes. These will be reviewed to identify whether additional quality assurance is required proportionate to the level of risk. Any revision of the procedures will be focused on those aspects of the processes which present higher levels of legal risk and will use existing assurance data to identify areas that would benefit from more robust scrutiny. Longer term upgrades to the APP Civica Licencing should reduce the risks in this area. The review and proposed revision of assurance procedures will be agreed with Internal Audit to ensure that this risk is fully addressed.
Owner: Paul Lawrence; Executive Director of Place **Contributors:** Michael Thain, Head of Place Development; Andrew Mitchell, Regulatory Services Manager; Alison Coburn, Operations Manager; Sandra Harrison, Executive Assistant **Implementation Date:** 20 Dec 2019

5. Processing and recording of Parking Permit fees	Medium

Since March 2019, residents parking permit applications (including those received in person from customers at the Customer Hub) have been processed online using the NSL Apply system.

Process design

Our review of the design of the parking permit application and payment process confirmed that:

- there is no documented process to support changes to fee data in the Apply system following the Council's annual budget motion and Traffic Regulation Order amendments. Management has confirmed that revised fees are provided by the Council to NSL who make the relevant changes in the Apply system;
- formal procedures have not yet been established to support the monitoring of parking permit payments in the Apply system, including authority for approval of fee waivers and / or reductions by the Transport team. Our sample testing highlighted that small outstanding payment balances have been written off;
- management information is provided by NSL from the Apply system and management has advised that their intention is to use this for sample checking on the completeness and accuracy of fee processing, however this quality assurance process has not yet been fully implemented; and

- management has advised high level reconciliations to confirm completeness of parking fee income received from NSL are performed between NSL and the Council's general ledger by the Finance team, however these have not been performed for parking permits following implementation of the NSL Apply system in March 2019.

Sample testing outcomes

As the Apply system was introduced in March 2019, two different data sources were available before and after the system change.

Consequently, our sample testing was performed across the period April 2018 to February 2019 from the Si-Dem system (26,883 transactions), with separate testing performed on data for March 2019 (2,368 transactions). The outcomes of our testing highlighted that:

- fees for 16 parking payment permits processed in March (0.7% of all transactions) via the Apply system did not match the fee contained in the fee schedule; and
- for fees processed between April 2018 and February 2019, 3,024 payments (11% of all transactions) did not match the fee schedule transactions.

A sample of 70 of the 3,024 anomalous transactions identified were selected for further discussion with the payment processing teams. These included transactions where payment values were less than the list of approved fees, and duplicate transactions.

A further sample of 25 fee refunds and 8 fee exemptions were also selected and passed to the team for feedback.

Management has reviewed the transactions and has advised that for payments processed in March via the NSL Apply system:

- some of the source fees recorded in the NSL Apply system were inaccurate and have now been corrected;
- some test data also remained in the live NSL Apply system post implementation, and will be removed; from its launch and this is to be removed;
- the fee recorded for two transactions could not be explained; and
- two permits appear to be duplicated with a £0 value (the correct fee is recorded in separate transactions within the system.

For payments processed between April 18 and February 19 in the Si-Dem system:

- the majority of the exceptions identified are as a result of a change of vehicle, change of address, partial refund for unused months or split payments.
- instances were also identified where small balances were written off and incorrect fees were applied by the system;
- one exemption could not be explained from the details recorded, however this permit has now been cancelled.
- refunds issued could not be explained for the majority of the items in the sample, however only one of these is of a material value.

Risks

- Fees and charges data maintained in the Apply system may not be correctly set, resulting in inaccurate application of fees and charges;
- Inaccurate fees and charges may be processed and not identified;

- Fees and charges could be waived without an appropriate level of approval; and
- Incomplete and inaccurate payments could be received from NSL, and the errors may not be detected.

5.1 Recommendation – process for updating fees and charges in the Apply system

- The process for advising NSL of changes to fees and charges to be updated in the Apply system should be documented and agreed by both parties; and
- These should include the requirement for a review of the charges in the system by the relevant Council team to confirm that they have been accurately entered, prior to uploading them into the live system operating environment.

Agreed Management Action – process for updating fees and charges in the Apply system

Current processes and UAT (User Acceptance Testing) mechanisms do exist for updating permit prices. However, these will be reviewed and enhanced with better recording of processes and outcomes. A new procedure regarding the change of permit price process on NSL Apply will be implemented.

Owner: Paul Lawrence; Executive Director of Place **Contributors:** Michael Thain, Head of Place Development; Ewan Kennedy, Policy and Planning Manager; Gavin Graham, Parking Enforcement Contract Manager; Gavin Sherriff, Acting Senior Transport Team Leader; Joanne Yorkston, Transport Officer; Alison Coburn, Operations Manager; Sandra Harrison, Executive Assistant	**Implementation Date:** 29 May 2020

5.2 Recommendation – procedure for authorising payments

- Procedures should be designed; implemented; and consistently applied to support review and authorisation of parking permit payments in the Apply system; and
- These should include details of the authority required from the Transport team to either waive or reduce fees in addition to established arrangements for blue badge permit holders.

5.2 Agreed Management Action - procedure for authorising payments

NSL Apply offers improved control mechanisms by automating many processes and tasks, including payments. These are currently not being used. Implementations of these controls, along with a formalised payment acceptance procedure will ensure correct payments are received and further reduce any anomalies. The payment acceptance procedure will confirm that the Council does not accept part payment for parking permits and only reduces the price when the applicant is a disabled persons' blue badge holder. The procedure will establish a quality assurance payment sampling processes for implementation across Business Support teams who administer parking permits.

Owner: Paul Lawrence; Executive Director of Place **Contributors:** Michael Thain, Head of Place Development; Ewan Kennedy, Policy and Planning Manager; Gavin Graham, Parking Enforcement Contract Manager; Gavin Sherriff, Acting Senior Transport Team Leader; Joanne Yorkston, Transport Officer; Alison Coburn, Operations Manager; Sandra Harrison, Executive Assistant	**Implementation Date:** 31 March 2020

5.3 Recommendation – ongoing risk based quality assurance

A risk based quality assurance process should be designed; implemented and consistently applied an appropriate frequency (e.g. weekly; monthly; or quarterly) to confirm the completeness and accuracy

of parking permit payments processed via the Apply system. This should include (but not be restricted to):

- a clearly defined sample selection methodology that is linked to volume; payment value; complexity of processing; and skills and experience of team members;
- clear guidance on the checks to be performed (for example, use of a checklist) and how the testing outcomes should be recorded; and
- consolidation and review of outcomes to identify any potentially significant or systemic themes that should be addressed either through training or ongoing performance management.

5.3 Agreed Management Action - ongoing quality assurance

A quality assurance payment acceptance procedure will be developed to ensure the accuracy of parking permit payments. This process will be based on the Internal Audit recommendations.

Owner: Paul Lawrence; Executive Director of Place **Contributors:** Michael Thain, Head of Place Development; Ewan Kennedy, Policy and Planning Manager; Gavin Graham, Parking Enforcement Contract Manager; Gavin Sherriff, Acting Senior Transport Team Leader; Joanne Yorkston, Transport Officer; Alison Coburn, Operations Manager; Sandra Harrison, Executive Assistant	**Implementation Date:** 31 March 2020

5.4 Recommendation – NSL income reconciliation

The financial reconciliations between the NSL Apply system and the Council's general ledger to confirm completeness and accuracy of parking permit fee income received from NSL should be completed.

5.4 Agreed Management Action – NSL income reconciliation

The recommendation is accepted.

Financial reconciliations between the systems have commenced reinstatement. Work is underway to build a management information suite which will augment the control attributes of the reconciliation as a standalone mechanism.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Hugh Dunn, Head of Finance; John Connarty, Business Partnering Senior Manager; Susan Hamilton, Principal Accountant; Douglas Linton, Senior Accountant; Layla Smith, Resources Business Manager; Annette Smith, Executive Assistant; Gavin Graham, Parking Enforcement Contract Manager; Gavin Sherriff, Acting Senior Transport Team Leader	**Implementation Date:** 28 February 2020

Appendix 1: Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or*** • ***Critical*** impact on the reputation of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or*** • ***Significant*** impact on the reputation of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation of the organisation.
Low	A finding that could have a: • ***Minor*** impact on operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***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.

Appendix 2: Areas of audit focus

The audit areas and related control objectives that were tested in detail were:

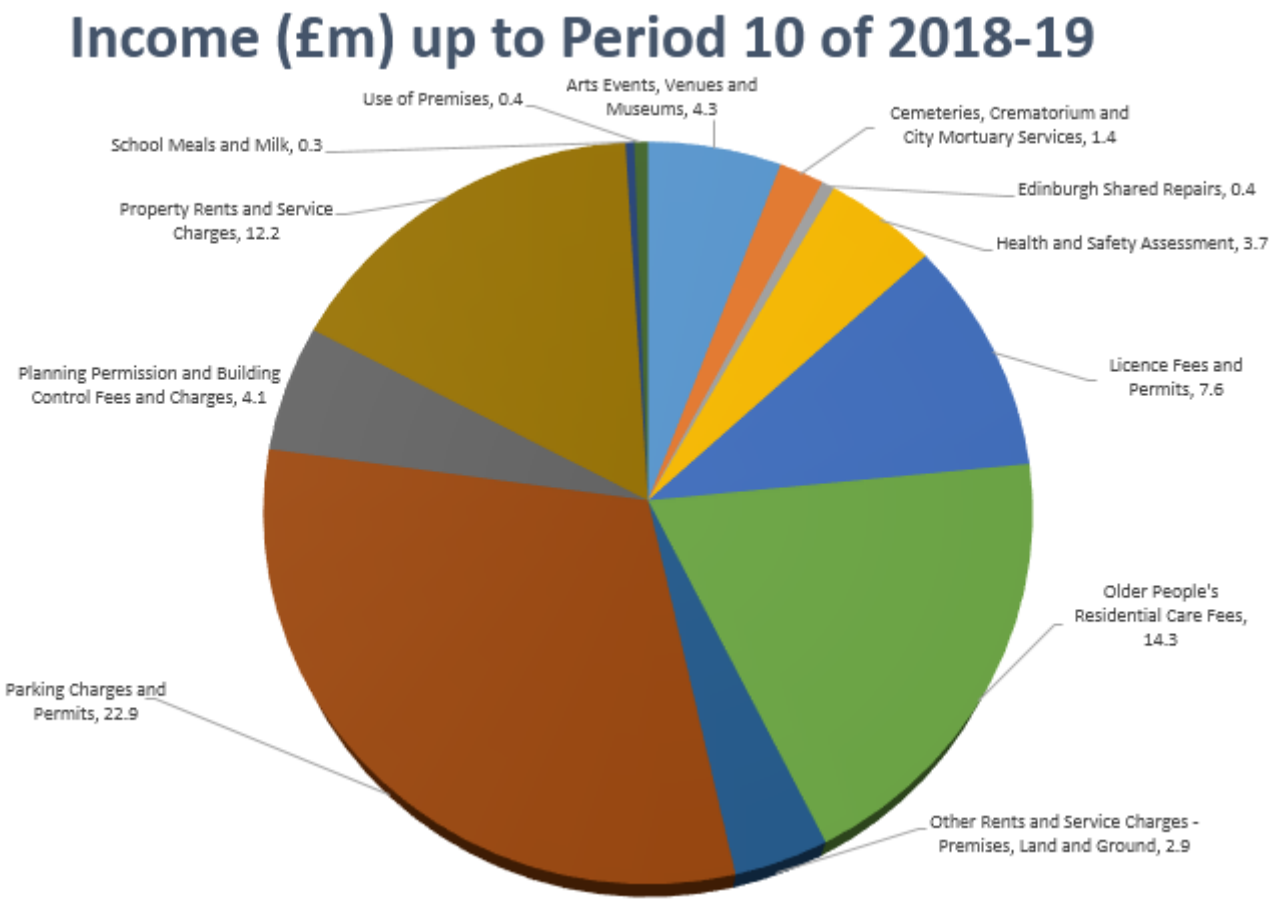
Audit Area	Control Objectives
Annual review and approval of fees and charges	• responsibility for annual review of fees and charges has been allocated to an appropriately senior employee within the relevant service areas; • annual review dates have been established for fees and charges, and they are reviewed within the relevant time frames; • the process for reviewing fees and charges is clearly defined, and includes an assessment of demand for the service, comparisons with the fees and charges applied by other local authorities and the private sector (where relevant); and an inflationary increase; • there are established and approved processes that clearly define when fees can be waived or reduced; and partial payment accepted that have been communicated to all teams involved in processing fees and charges; • the fees and charges schedule published on the Council website is updated in a timely manner to reflect changes refreshed fees and charges; and • fees and charges standing data in core technology systems used to support processing is updated completely; accurately; and in a timely manner.
Processing fees and charges	Select a representative sample of fees and charges and confirm that: • rates / fees applied are aligned with the fees and charges schedule published on the Council website; • any fee waivers; reductions; or partial payments have been applied in line with approved processes; that supporting rationale has been recorded; and that management approval (where required) has been obtained; • a process has been established to ensure that all fees and charges generated are recorded on the relevant systems; • invoices (where required) have been raised at the correct time (for example, monthly; quarterly; annually); issued; and accurately recorded on relevant systems; • payments received have been accurately processed and allocated against the correct charges recorded on the system; • there is clear segregation of duties to ensure payments are recorded intact and charges are not removed from the relevant systems without payment; • there is a clearly established process for ensuring that payments made directly into Council bank accounts (for example internet banking payments; standing orders; and direct debits) or by cash are allocated completely and accurately against the fees and charges raised in core systems, with any discrepancies investigated and resolved; • where payment has not been received by the expected date, details of outstanding fees are completely and accurately transferred across to the debt management team; and • where fees have not been paid, service is not provided without the relevant management approval.

Appendix 3: Audit Scotland Guidance: Charging for services: are you getting it right?

Key messages

1. Councils should have clear policies in place for charges and concessions. They should regularly review charges to ensure that they are appropriate and meet their intended objectives.
2. Councillors should take a lead role in determining charging policies. They should be involved and consulted over the design of charges and concessions.
3. Charges can be used to influence behaviour to help meet councils' objectives. They should not be seen solely as a means to generate income.
4. Councils should improve their use of cost information, including unit costs. This is essential for councils to design charges and understand the extent to which they will recover costs.
5. Charges for services vary markedly between councils, reflecting local circumstances and policy priorities. This may be appropriate, but councils should be aware of any significant differences in their charges. They should be transparent in how they set charges and be able to explain their charging decisions to the public.
6. Councils should consider charging as part of their overall financial management. Councils should understand the contribution that charges make to their overall financial position, and the extent to which individual services are subsidised. This can help councils to target subsidy to priority areas.
7. Many factors must be taken into account when designing charges. To assist in this, councils should follow the good practice set out in this report. This includes identifying charging options, assessing their impact on services and the people that use them, and making comparisons with other providers.

Appendix 3 – analysis of Council income: 1 April 2018 to 31 January 2019 (period 10)



Appendix 4 – Analysis of differences between the budget motion; schedule of fees and charges; and published service area fee lists

Ref	Fee type	Budget motion	Schedule of fees and charges	Service Area Fee List
1.	Residential Care Fees	Economic rate – actual charges are not included	Economic rate – actual charges are not included	Not published
2.	Licencing - cinema	N/A	£124	£1 difference
3.	Licencing – change of manager	N/A	£99	£4 difference
4.	Licencing - HMO	Up to 40 occupants	Up to 40 occupants	Up to 600 occupants plus increases per 100 occupants above this value
5.	Licencing - Hypnotism	N/A	Within 28 days not included	20% surcharge for applications received within 28 days of the start of the licence
6.	Licencing - Late hours catering	N/A	Within 28 days not included	20% surcharge for applications received within 28 days of the start of the licence
7.	Licencing – Public Entertainment	Variation (not change of capacity) and Community/Charitable/Religious or Political Group Events which are free to enter not included	Variation (not change of capacity) and Community/Charitable/Religious or Political Group Events which are free to enter not included	Variation (not change of capacity) and Community/Charitable/Religious or Political Group Events which are free to enter included in the service area fee list
8.	Licencing - Skin piercing / tattooing	N/A	1 year renewal not included	Includes a fee for a 1 year renewal
9.	Licencing – Theatre	N/A	Variation (not change of capacity) and live animal supplement not included	Variation (not change of capacity) and live animal supplement included in division fee list

The City of Edinburgh Council

Internal Audit

Organisational Change

Final Report

8 August 2019

CW1804

Overall report rating:

Generally Adequate with enhancements required	Areas of weakness and non-compliance in the control environment and governance and risk management framework that that may put the achievement of organisational objectives at risk

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

Contents

This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2018/19 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2018. 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) has saved circa £240m since 2012 by improving the way services are managed; enhancing access to services online; prioritising services; transforming its structure and operations; and implementing operational efficiencies.

Even with these substantial savings, the Council continues to face challenges from long-term budget pressures due to reduced or constrained funding; increasing costs; and rising demand for services, and estimates that it will need to save a further £150m by 2023.

These savings will be achieved by ongoing transformational changes including increasing income; improving the efficiency and performance of service delivery and operations; effective supplier and contract management; and maximising use of existing assets.

When implementing transformational change, it is essential that the Council's procedures for the conduct of reviews and pay protection policy (both last updated in March 2011) are consistently applied to ensure that organisational change is effectively managed, and the impact of the changes are closely monitored to ensure that they continue to deliver the expected service delivery benefits and anticipated cost savings post implementation.

Scope

The scope of this audit assessed whether recent organisational changes across three Council areas (listed below) were effectively planned and implemented; post implementation reviews were performed to confirm that expected efficiency improvement benefits and anticipated cost savings had been achieved; and consider whether support provided by the Council to the Health and Social Care Partnership (the Partnership) and Edinburgh Integration Joint Board (EIJB) had been adversely impacted as a result of the transformation.

It should be noted that there are no specific requirements in the Council's procedures for the conduct of reviews and pay protection policy in relation to completion of post implementation reviews and the requirement to consider the impacts of the proposed change on the Partnership and Integration Joint Board. These expected governance controls have been included in scope based on Internal Audit's independent assessment of the risks associated with organisational change.

The three organisational changes reviewed were:

1. Business Support – early consultation phase
2. Place – Waste and Cleansing – Waste four day week (4DW) shift change – six months post completion
3. Strategy and Communications – twelve months post completion

The review also considered the following Corporate Leadership Team (CLT) risk:

- **Change** – key deliverables, benefits and timescales for achieving change across the Council may not be achieved in line with business expectations, requirements, budgets and resources. This may result in adverse impacts on service delivery, the Council's finances and reputation, the anticipated need for further savings to deliver balanced budgets may create additional pressure on our infrastructure, capital and revenue funding and affect the execution of the Council's business plan, adverse reputational impact, and industrial relations.

Limitations of Scope

As the Business Support review was in the early consultation phase at the time of our review, our scope was limited to the planning and consultation stages.

It should also be noted that Waste and Cleansing does not provide support services to the Partnership or the EIJB.

Further details on the scope of our review are included at Appendix 2 – Areas of Audit Focus.

Reporting Date

Our audit work concluded on 5 April 2019 and our findings and opinion are based on the conclusion of our work as at that date.

2. Executive summary

Total number of findings: 1

Summary of findings raised	
Medium	1. Organisational change management and governance

Further detail on the basis of the classifications applied to our findings is included at Appendix 1.

Opinion

Generally Adequate with enhancements required

Our review established that the framework established to support implementation of organisational change is generally adequate with enhancements required.

We confirmed that the Council's procedures for the conduct of reviews and pay protection policy were consistently considered as part of the planning process and applied across all three reviews. There was also a clear understanding of the desired outcomes; the costs and benefits associated with the proposed changes; and appropriate consultation was performed (with both employees and unions) prior to implementation of the change.

However, there were some inconsistencies in the management and implementation of each of the changes. Whilst some variation is expected (each organisational change has its own unique challenges and nuances), given the financial; operational; and reputational risks associated with organisational change, some consistency is required.

A key point to note is that impact assessments were not performed to assess the potential impact of the proposed changes on support services provided by the Council to Health and Social Care Partnership (the Partnership) and the Integration Joint Board (EIJB). Additionally, whilst there was no evidence of engagement with Partnership senior management to discuss the impact of the planned changes, management has advised that the change proposals were discussed.

The management and governance processes supporting the Waste and Recycling four day week (4DW) review were well designed and effectively applied, with a clear audit trail of all key considerations supporting design of the proposed change and its subsequent implementation, and completion of a post implementation review. The only area for improvement noted with this change is that the business case had not been signed.

It should also be noted that (as at the conclusion of our review in April 2018s) a new Managing Change policy had been developed and was scheduled for presentation to the Finance and Resources Committee on 23 May 2019. If the new Managing Change policy is approved, it is likely that the Council's procedures for the conduct of reviews will require to be refreshed to support the new policy changes, as they were last updated in March 2011.

Consequently, one medium rated finding has been raised. Further information is included in Section 3.

Management responses

Business Support

The Business Support Review was approved by the Executive Director of Resources and taken to both the Corporate Leadership Team and Change Board for formal approval. Both meetings are attended by stakeholders from the Health and Social Care Partnership who receive meeting minutes and actions.

Strategy and Communications

It should be noted that the financial delivery of the savings as a result of the review was reported consistently through the quarterly monitoring report to Finance and Resources with the Division delivering a balanced at year end in 2018/19. Whilst a formal post implementation review was not undertaken, management has stressed that very significant follow up work has been undertaken to ensure staff feel engaged, motivated, financial savings are delivered and that the Division is delivering high quality outputs. Management advise that in their view the purpose of a post implementation review has been carried out though this work.

Human Resources

All organisational changes were presented; discussed; agreed; and minuted at the Corporate Leadership team. There is considered sufficient as there is no requirement for a 'wet' signature.

Additionally, the new organisational change policy and guidance (with supporting template and process maps) have already been finalised and agreed in consultation with the Trade Unions and approved by the Finance and Resources Committee in May 2019. Human Resources is now working towards implementation of the revised policy.

3. Detailed findings

1.1 Organisational change management and governance	Medium

Our review of the three organisational changes identified the following areas where organisational change management and governance should be improved:

- whilst business cases for each change had been prepared, there was no evidence of approval and signature by the appropriate Executive Directors; Heads of Service; Finance and Human Resources (HR).

  The Executive Director of Resources provided evidence of approval of the Business Support business case following completion of the audit, and management and Human Resources advised that all business cases were approved by the Corporate Leadership Team, and that there is no requirement for a 'wet' signature.

- there was no evidence available to support completion of impact assessments by Business Support and Strategy and Communications in relation to the support and services that they provide to Health and Social Care Partnership (the Partnership) and Edinburgh Integration Joint Board (EIJB); and no evidence of engagement with Partnership senior management to discuss the

planned changes. Management has advised that (whilst not recorded), the impacts of the proposed changes were discussed with Partnership senior management.

- strategy and communications had no established plan or actions log to support their change process;
- monitoring of risks; issues; and dependences, assigning ownership of and tracking actions to address risks and issues had not been established for the Strategy and Communications change; and
- no post implementation review has yet been performed by Strategy and Communications in the twelve months post completion of the change. Management has advised that whilst no post implementation review has been performed, effectiveness of the new structure is routinely considered as part of the ongoing management of the service.

The table below summarises the key governance documents prepared to support each organisational review that were reviewed as part of this audit:

Key Change Management Documents	Business Support	Waste – 4DW	Strategy and Communications
Current and Planned Structure	Yes	Yes	Yes
Cost vs Benefit	Yes	Yes	Yes
Signed Business Case	Management has advised (and Human Resources has confirmed) that each business case was reviewed and approved by the Corporate Leadership Team.		
Partnership Impact Assessment	No	N/A*	No
Consultation	Yes	Yes	Yes
Plan / Actions Log	Yes	Yes	No
Risks, Issues and Dependencies	Yes	Yes	No
Post-implementation Review	N/A*	In progress	No

* Note. As the Business Support review is in the early consultation phase and Waste and Cleansing provides no support to the Health and Social Care Partnership or Edinburgh Integration Joint Board, these have been marked as not applicable.

Risks

The potential risks associated with our findings are:

- organisational changes begin without the appropriate evidence of approval of business cases;
- support provided to the Partnership and / or Edinburgh Integration Joint Board is potentially adversely impacted as a result of transformation, and Partnership senior management are not made aware of the planned changes;
- where plans are not used to support the change process, changes may not be effectively managed and implemented, resulting in potential delays; inefficiency; or objectives not being achieved;
- risks, issues and dependencies associated with the changes are not identified and managed with appropriate mitigating actions taken; and
- where post implementation reviews are not performed, it is not possible to confirm whether the expected benefits; efficiencies; and cost savings have been achieved.

1.1 Recommendation - Organisational Change Management Framework

The Council's procedures for the conduct of reviews should be refreshed to include (but not be restricted to) the requirement to:

- develop a business case that includes details of current and planned structures, and details the costs and benefits associated with the proposed change, that is approved and signed by Directors and Heads of Service in line with applicable Council standing orders;
- complete a business impact assessment for support services provided to the Health and Social Care Partnership / Edinburgh Integration Joint Board and any other external organisations or partnerships supported by the Council, and ensure that the proposed changes and their impacts are discussed and agreed prior to final approval of the business case;
- develop and maintain a plan / actions log to support effective management and implementation of the change;
- ensure that risks; issues; and dependencies are identified; recorded; and appropriately allocated and managed throughout the change; and
- complete and record the outcomes of a post implementation review to confirm that the change has been delivered within budget and that the expected benefits have been realised.

Agreed Management Action

Recommendation accepted.

The guidance supporting the new organisational change policy that was approved by the Finance and Resource Committee in May 2019 will be updated to incorporate these Internal Audit recommendations prior to implementation across the Council.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Katy Miller, Head of Human Resources; Layla Smith, Resources Operations Manager; Adam Fergie, Executive Assistant	**Implementation Date:** 31 March 2020

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or*** • ***Critical*** impact on the reputation of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or*** • ***Significant*** impact on the reputation of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation of the organisation.
Low	A finding that could have a: • ***Minor*** impact on operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***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.

Appendix 2 – Areas of Audit Focus

The audit areas and related control objectives that were tested in detail were:

Audit Area	Control Objectives
Planning	Obtain copies of change plans, and confirm that: • details of planned service changes and associated benefits are included; • appropriate consultation (internal and external) has been performed in relation to planned service delivery changes; • 'as is' and 'to be' processes have been mapped, reflecting details of planned efficiency improvements and their impact on key operational controls; • planned changes have considered all relevant risks and the requirement to comply with Council policies; • details of expected benefits; anticipated implementation costs and subsequent cost savings (including payback timeframes); and planned headcount reductions are included; • proposed implementation timeframes reflect dependencies on projects delivering key process efficiencies and changes (for example implementation of new or changes to existing systems); • where required, plans have been approved by the Head of Finance; Head of Human Resources; Corporate Leadership Team; and relevant Council executive committees; and • responsibility for the implementation of change was allocated at an appropriate level within the Service.
Impact on the Health and Social Care Partnership support	• implementation plans considered the impact of proposed changes on support provided to the Health and Social Care Partnership; • support services provided were ring fenced and not impacted by the proposed changes (where possible); and • where changes did impact upon Partnership support, they were discussed and agreed with the Partnership Chief Officer and senior management team.
Implementation (not applicable to Business Support)	• all changes specified in change plans were effectively implemented; • any significant variations from plan were approved prior to implementation by the relevant and appropriate senior management; • implementation costs incurred were monitored during the implementation process and all significant cost variations approved; and • established processes were applied (specifically standard HR redundancy and recruitment processes) when implementing the changes.
Post implementation reviews (not applicable to Business Support)	• a benefits tracking process was developed and maintained until the end of the expected payback period to ensure that all expected benefits were on track and ultimately delivered. Any significant variances were highlighted to senior management; and

	• regular post implementation reviews were performed / are scheduled following completion of transformation to consider what went well; lessons learned; and whether anticipated benefits will be realised.

The City of Edinburgh Council

Internal Audit

Public Services Network Accreditation

Customer and Digital Services

Final report

1 August 2019

Project Code
RES1807

Overall report rating:

Significant enhancements required	Significant areas of weakness and non-compliance in the control environment and governance and risk management framework that puts the achievement of organisational objectives at risk

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This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2018/19 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2018 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 Public Services Network (PSN) is the UK government's high-performance network that enables public sector organisations to share resources. It unifies the provision of network infrastructure across the UK public sector into an interconnected "network of networks" to increase efficiency and reduce overall public expenditure. The PSN is part of the UK Government Digital Service and is managed by the Cabinet Office.

Public sector information carried across the PSN is rated 'official' under the Government Security Classification (GSC) Policy, which covers the majority of information that is created or processed across the public sector and is the lowest rating in the UK Government security classifications.

The PSN applies a 'walled garden' approach, to the control of internet content and shared services, as the security of any one user connected to the PSN affects the security of all other users, and the network itself.

Consequently, the PSN compliance framework was established to provide PSN users with assurance that network services will operate effectively; that their data is protected; and that network issues can be promptly resolved.

Compliance framework requirements are designed to defend against common threats such as opportunistic hackers and abuses of business processes, whilst remaining proportionate and aligned with wider business goals. All PSN users are required to hold a valid PSN connection compliance (CoCo) certificate that ensures that all bodies connected to the network meet basic UK Government security requirements.

Compliance certificates submission process

PSN users are normally required to renew their compliance certificates annually. To obtain their certificates, users must:

- demonstrate that they comply with the Information Assurance (IA) requirements detailed in the PSN Code of Connection (CoCo);
- provide a network diagram;
- provide an independent IT health check report (completed within the last 12 months) and a supporting remediation action plan for any significant unresolved weaknesses; and
- sign the PSN commitments.

Appendix 2 includes details of the Code of Connection Information Assurance requirements. The security controls required to demonstrate ongoing compliance with these requirements are operated for the Council by its technology partner, CGI.

The Government reserves the right to withdraw a connection compliance certificate at any time if the certified organisation no longer meets the required standards.

The Council's 2018 PSN accreditation submission

The Council's last submission for PSN reaccreditation was based on an external IT Health Check (ITHC) performed in December 2017 and was submitted in January 2018.

Based on the ITHC results, the government's PSN Compliance Team (the Accreditor) confirmed that the Council does present risks to the ongoing security of the PSN by (for example) operating out of support software such as Windows 2003.

Consequently, the application was not accepted, and the Council's compliance certificate now expired.

Whilst the Council's PSN access has not been restricted by the Government, The Accreditor requested that the Council submit monthly update reports detailing progress with the remediation activities being delivered by CGI to resolve the weaknesses identified in the ITHC.

One of the key remediation activities is completion of the ongoing Council wide technology refresh programme that is expected to complete by the end of August 2019. This programme will replace end user devices across the estate and enhance security controls by ensuring that only fully supported software is installed, and effective ongoing patch management controls implemented.

Scope

The review assessed the adequacy and effectiveness of the processes applied to identify infrastructure vulnerabilities that impact upon PSN compliance; confirm that these are communicated to CGI for resolution; and ensure that they are included in the PSN remediation plan.

We also evaluated the effectiveness of governance and oversight of the PSN compliance remediation plan to ensure that the PSN compliance resubmission is ready by the target date of May 2019.

Limitations of Scope

Our original terms of reference also included review the arrangements in place to identify and replace out of support technology systems. This area was subsequently not covered as this would have required access to CGI. Additionally, the ongoing device refresh programme (scheduled for completion by the end of August 2019) should address aspects of unsupported technology, and the vulnerabilities associated with unsupported technology will be included in vulnerability scans.

Our work does not guarantee that the organisation will be fully compliant with Public Services Network connection compliance certificate.

Reporting Date

Our audit work concluded on 8th February 2019, and our findings and opinion are based on the conclusion of our work as at that date.

The delay in finalising the report is attributable to late finalisation of the terms of reference (2 April 2019).

2. Executive summary

Total number of findings: 3

Summary of findings raised	
High	1. Public Services Network governance framework
High	2. Public Services Network contingency arrangements
Medium	3. Public Services Network remediation action plan - scope and submission review and delivery timeframes

Opinion

Significant enhancements required

Whilst the Council has established a PSN governance framework that is appropriately designed, our review identified a number of significant weaknesses in the effectiveness of the framework that limits the Council's ability to ensure that key services required to identify and address potential network vulnerabilities (ongoing vulnerability scanning and patch management) are delivered by CGI, and effectively oversee CGI's preparation of the PSN accreditation submission.

These weaknesses could significantly impact upon the volume and age of network vulnerabilities included in the submission; the planned application submission date (May 2019); and could potentially result in failure to achieve PSN accreditation from the UK Government.

There is also a risk that the Government could revoke PSN access in the event of a PSN security incident that originated from known vulnerabilities in the Council's network. If this did occur, there are currently no established contingency plans to ensure that key Council services could continue to be delivered without PSN access.

Digital Services management has advised that compensating intrusion prevention and detection system (IPS and IDS) controls are in place that should either prevent intrusion, or detect a successful intrusion, enabling implementation of timely remediation actions.

It should be noted that compensating IPS and IDS controls are not considered by the Government when awarding PSN accreditation; are not included in the scope of the independent IT Healthcheck that supports the accreditation submission; and have not been reviewed by Internal Audit.

Consequently, 2 High and 1 Medium rated findings have been raised and are included at section 3 below.

Management Response

Digital Services Management has advised that whilst revocation of PSN access would have a significant adverse impact on the Council's ability to deliver services, they believe that there is a low probability of the risk crystallising and becoming an issue based on informal discussions with Cabinet Office officials in April and May 2019.

Additionally, Digital Services management consider (based on the discussions noted above) that it is likely that the Government would accept a further delay in relation to submission of the PSN

application, and that implementation of existing programmes of work, such as the end user device refresh, targeted improvements in patching and ongoing vulnerability scanning that identifies new vulnerabilities with supporting remediation plans to ensure that they are addressed in a timely manner, will be sufficient to meet the Government's expectations for CoCo compliance and PSN accreditation.

As detailed in our Public Sector Action Plan for Cyber Resilience completed August 2018 and finalised in April 2019, ongoing vulnerability scanning has yet to be implemented by CGI as a service as specified under the terms of their contract.

3. Detailed findings

1. Public Services Network governance framework	High

Our review of the Public Services Network (PSN) governance arrangements established that:

1. Despite escalation to the Partnership Board (which is the most senior governance forum within the established CGI governance framework), CGI has not yet implemented the ongoing vulnerability scanning and patch management services required to identify and address potential network vulnerabilities. These services are specified as key deliverables in the CGI contract. This point has also been raised in our review of the Public Sector Action Plan for Cyber Resilience completed August 2018 and finalised in April 2019;
2. Separate arrangements have been established to support the Council's governance and oversight of CGI plans to achieve the Scottish Government's Cyber Essentials Plus accreditation and UK Government PSN accreditation, although the improvements to network security controls required to achieve both are predominantly the same (for example, ongoing vulnerability and patch management, and effective user access management);
3. The format and content of weekly CGI PSN progress reports is aligned with Cyber Essentials Plus accreditation progress reports, and are used as the basis for upward reporting to PSN governance forums

   Our review of the Public Sector Action Plan for Cyber Resilience (completed August 2018 and finalised in April 2019) established inconsistencies in CGI progress report formats and confirmed that there is limited validation of their accuracy.

   Digital Services Management has advised that CGI and Digital Services have been working together to establish consistent formats, and that the issues with progress reporting have been escalated to the Partnership Board; and
4. Whilst some high level PSN risks have been recorded on the Pentana risk management system, the risks associated with potential failure to achieve PSN accreditation, or revocation of access by the Government have not been fully considered and recorded.

Risks

- There may be duplication of governance activities (including reporting) between the forums established provide oversight of progress towards the Scottish Government's Cyber Essentials Plus and Public Services Network (PSN) accreditation;
- Decision making across the two separate governance structures and forums may be inconsistent;

- Inappropriate decisions may be made by governance forums based on inconsistent management information; and
- PSN risks may not be effectively managed through to resolution.

1.1 Recommendation - Public Services Network governance framework

- Management should consolidate and streamline the Scottish Government's Cyber Essentials Plus and Public Services Network (PSN) accreditation governance arrangements (including risk registers); and
- The risk register should be reviewed and refreshed to include all relevant PSN risks, with actions allocated to appropriate owners to ensure that they are managed through to resolution.

1.1 Agreed Management Action - Public Services Network governance arrangements

Digital Services Management has recognised the need to review governance arrangements around PSN /CyberSecurity. This will include

- Adapting the Security Working Group (SWG) Assurance report, in conjunction with CGI, to be the single report for all security assurance and accreditation matters encompassing PNS, Cyber Essentials/Cyber Essentials Plus, PSCAP and progress against Internal Audit findings.
- Working with CGI to change the Security Management Plan to have separate fortnightly SWG meetings to cover Operations and Assurance:
  - SWG Operations Group will review the Security Operations Centre (SOC) and Security Operations Reports (SOR)
  - SWG Assurance Group will review Assurance, PSN, Cyber Essentials/Cyber Essentials Plus and Audit Actions.

  To enable this approach, we will work with the Commercial teams from CGI and the Council to ensure that this approach is acceptable under the terms of the Contract
- Ensuring that PSN risks are included and highlighted in the Public Sector Network Plan B report. These risks will also be added to the Council/CGI partnership security risk log and reviewed as part of this.

Owner

Stephen Moir, Executive Director of Resources

Contributors

Nicola Harvey, Head of Customer and Digital Services; Heather Robb, Chief Digital Officer; Neil Dumbleton, Enterprise Architect; Alison Roarty, Commercial Team Lead; Layla Smith, Resources Operations Manager; Julie Rosano, Executive Assistant

Agreed Implementation Date

31st December 2019

2. PSN contingency arrangements — High

Digital Services management advised that details of alternative PSN connection solutions have been provided to CGI to enable completion of a feasibility study to identify suitable contingencies in the event that accreditation is not achieved, and / or Government revokes the Council's access in the event of a significant security incident.

However, no change request has been submitted to CGI for delivery of this work, and no timeframes for identification and implementation of alternative solutions provided.

Digital Services has identified all services that are dependent on use of the PSN and management has advised that these services have been contacted and made aware of the potential risk that accreditation may not be achieved.

Risks

The Council may be unable to deliver key services such as Revenue and Benefits and may be unable to provide information securely to other local authorities and government bodies (for example, the Department of Works and Pensions) if access to the PSN is revoked and alternative contingency solutions are not readily available.

2.1 Recommendation – Public Services Network contingency arrangements

- A change request should be prepared and submitted to CGI requesting them to perform a feasibility study to identify potential alternative contingent Public Services Network solutions, and their associated implementation timeframes; and
- The change request should specify the timeframes required for completion of the feasibility study and request that a report detailing the alternative options is provided to the PSN Board.

2.1 Agreed Management Action - Public Services Network contingency arrangements

- A change request has been raised with CGI to:
  - Confirm formally the viable contingency plan options and;
  - Provide a Rough Order of Magnitude proposal (ROM) detailing the cost of work associated with potential contingency solutions.
- When the ROM proposal and feasibility assessment is received for the change request to build the contingency environment, it will be considered by the PSN Board and Executive Director of Resources and a decision will be made whether to proceed with creation of a contingency environment based on the risk of possible disconnection from the Public Services Network.
- If it is agreed to progress with the proposed option, a second change request will be raised requesting CGI to provide a full implementation plan including costs and timeframes.

Owner

Stephen Moir, Executive Director of Resources

Contributors

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Agreed Implementation Date

31st October 2019

3. Public Services Network remediation action plan scope, and submission review and delivery timeframes	Medium

We identified the following weaknesses in relation to the scope of the CGI Public Services Network remediation action plan (RAP) and the timeframes for review and delivery of the final submission that could potentially have a significant impact on the UK Government's decision to award PSN accreditation:

Scope of the PSN accreditation application

1. The vulnerability remediation activity progress reports currently provided to the Cabinet Office are based on the vulnerabilities identified in the independent PSN IT Health Check (ITHC) completed in December 2017, and do not include any new vulnerabilities identified from the phased (manual) network vulnerability scan completed by CGI between July and October 2018, with the results presented to the Council and reviewed / analysed in November 2018;
2. A current network diagram is required to support the accreditation application. Whilst CGI has provided various iterations of a high level wide area network and data centre architecture diagram, and have shown Digital Services management (on screen) a detailed version, management confirmed that a final copy has not yet been provided;
3. The content of the PSN gap analysis prepared by CGI in January 2018 and the supporting remediation action plan (RAP) have not been reviewed by the PSN Board and working group to confirm that it includes the full population of network vulnerabilities.

   Additionally, the Council currently has no view of the ageing profile of the vulnerabilities that require to be addressed and cannot confirm how long the Council has been exposed to these potential security risks.

   Digital Services management has advised that CGI has confirmed that the PSN gap analysis and RAP were originally based on the independent PSN IT Health Check completed in December 2017 and have not yet been updated to reflect new vulnerabilities. However, Digital Services management has not yet seen copies of the revised documentation, although progress reporting to the PSN Board includes new vulnerabilities identified in the November 2018 vulnerability scan;
4. As CGI has not yet implemented ongoing vulnerability scanning across the Council network, it has not been possible to confirm whether any new and significant vulnerabilities have been identified since the November scan (note that lack of ongoing vulnerability scanning was highlighted in our review of the Public Sector Action Plan for Cyber Resilience completed August 2018 and finalised in April 2019);

   Management has advised that CGI is expected to complete a further vulnerability scan prior to resubmission of the PSN accreditation, with the results to be provided one week prior to initiation of the independent external IT health check assessment required to support the application;

PSN accreditation submission timeframes

5. CGI progress reports have consistently highlighted that key remediation actions will not be completed before the target May 2019 PSN submission date. Review of the PSN Working Group and Board packs for January/February 2019, highlighted a red rated planning forecast to address known vulnerabilities by March-May 2019, whereas an amber status had been reported from September 2018 onwards.

   This is mainly attributable to a key dependency on the ongoing Council wide technology refresh programme that is expected to complete in August 2019; and

Review of the application prior to submission

6. Review of the January 2019 PSN board pack established that the CGI PSN application submission timeline includes only five working days for the Council to review the application. Additionally, the review process and responsibilities for final approval have not yet been clarified.

Risks

- Public Services Network (PSN) accreditation may not be awarded if the Council cannot demonstrate that processes have been established to identify vulnerabilities that present a significant risk to PSN security (as determined by the UK Government) and demonstrate that they have been addressed;
- PSN access may be may be revoked if the Council does not achieve accreditation, or if a significant cyber security incident occurs due to vulnerabilities that have not been remediated prior to achieving accreditation.

  Management has advised that whilst this risk has a high impact, there is a low probability of the risk crystallising and becoming an issue based on informal discussions with the Cabinet Office;
- The Council has limited assurance that the remediation action plan (RAP) that forms the basis of ongoing progress reporting to the Government and the final accreditation application is aligned with Government expectations.

  Management has advised that Government expectations would be fully met though implementation of ongoing vulnerability scanning that identifies new vulnerabilities with supporting remediation plans to ensure that they are addressed in a timely manner;
- As CGI has not yet provided a current network diagram, the Council has limited assurance that the manual vulnerability scan completed in November 2018 covered the entire network and has identified the full population of network vulnerabilities that need to be addressed;
- New vulnerabilities may be discovered as part of the planned CGI vulnerability scan and independent IT Health Check resulting in failure to achieve PSN accreditation; and
- The Government may not accept a further delay in relation to submission of the PSN application.

  Management has advised that informal discussions with the Cabinet Office suggest that this is unlikely.

3.1 Recommendation – scope of Public Services Network accreditation application

- A final network diagram should be provided to the Council and a joint review performed by both the Council and CGI to confirm that the November 2018 vulnerability scan covered the entire network (based on the final network diagram), and that these are included in the CGI remediation action plan (RAP);
- The refreshed RAP should be updated to include the ageing of the full population of known network vulnerabilities, and should be reviewed and approved by the PSN Board; and
- Vulnerability remediation activity progress reports currently provided to the Cabinet Office should be updated to accurately reflect progress against the full population of all known network vulnerabilities.

3.1 Agreed Management Action - scope of Public Services Network accreditation application

As part of the ongoing work for security compliance, work is underway on all the recommendations noted above. This includes:

- A refreshed remediation action plan (RAP) addressing new vulnerabilities identified from CGI network scans completed in November 2018 and March 2019. This is in draft as of July 2019.
- An aged vulnerability tracker which now forms part of the Public Services Network (PSN) Board report. The RAP to be sent to the PSN Accreditor as part of the PSN submission has been

amended to include the date vulnerabilities were identified and the proposed dates for their remediation.

- Output and remediation actions from the vulnerability scans carried out to date. From 16/04/2019 this has been included in the PSN Board Report. This provides full network vulnerability/remediation plan information as opposed to the information in the RAP which only relates to the vulnerabilities identified by the Independent Health Check.
- Confirmation that PSN Connection Compliance (CoCo) updates provided to the Cabinet office include details of the additional active monitoring measures applied by the Council.

Evidence is being compiled for these and will be provided to Internal Audit by the end of September 2019.

Owner

Stephen Moir, Executive Director of Resources

Contributors

Nicola Harvey, Head of Customer and Digital Services; Heather Robb, Chief Digital Officer; Neil Dumbleton, Enterprise Architect; Alison Roarty, Commercial Team Lead; Layla Smith, Business Manager; Julie Rosano, Executive Assistant

Agreed Implementation Date

30th September 2019

3.2 Recommendation - Public Services Network accreditation submission timeframes

- The PSN Board should consider whether the timeframes for the PSN submission remain realistic and achievable; and
- The revised submission timeframes should include sufficient time for the Council to review the final submission; provide feedback to CGI; and confirm that all required changes have been incorporated.

3.2 Agreed Management Action - Public Services Network accreditation submission timeframes

These actions have now been completed. The following evidence will be provided to Internal Audit.

- Details of Public Services Network independent IT healthcheck received by the Council's Digital Services function on 24th April
- The PSN Code of Connection (CoCo) submission created by CGI and Council from 26th April until 13th May
- Initial review of remediation action plan by Council and CGI between 6th may and 14th May
- Daily meetings held by Council CGI between 29th April and 13th May to refine submission
- CGI has prepared updated documents for the formal Submission of the CoCo with accompanying Remediation Action Plan for review by the Executive Director of Resources in July 2019.

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Contributors

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Agreed Implementation Date

30th September 2019

3.3 Recommendation - Review and final approval of the Public Services Network accreditation final submission
Responsibility for review and final approval of the final Public Services Network accreditation submission should be confirmed by the PSN Board.
3.3 Agreed Management Action - Review and final approval of the Public Services Network accreditation final submission
Evidence will be provided that shows: • The Public Services Network submission is written by CGI and the Council. • The PSN Board provides fortnightly review (latterly weekly). • Updates were submitted to the Council and CGI weekly executive review meeting for approval (15th March,12th April). • The Council and CGI partnership Executives will provide final approval of the Code of Connection (CoCo) submission.
Owner Stephen Moir, Executive Director of Resources
Contributors Nicola Harvey, Head of Customer and Digital Services; Heather Robb, Chief Digital Officer; Neil Dumbleton, Enterprise Architect; Alison Roarty, Commercial Team Lead; Layla Smith, Business Manager; Julie Rosano, Executive Assistant
Agreed Implementation Date 30th September 2019

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***;*** *or* • ***Critical*** impact on the reputation or brand of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***;*** *or* • ***Significant*** impact on the reputation or brand of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation or brand of the organisation.
Low	A finding that could have a: • ***Minor*** impact on the organisation's operational performance ; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***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.

Appendix 2 - PSN Code of Connection (CoCo)

To achieve Public Services Network compliance, organisations must demonstrate that their infrastructure is sufficiently secure and that connecting to the PSN would not present an unacceptable level of risk to the network.

As part of the application process, organisations must complete a Code of Connection (CoCo) application form which outlines the UK Government's Information Assurance (IA) requirements.

Organisations must then demonstrate ongoing compliance with the following CoCo Information Assurance (IA) requirements to obtain their connection compliance certificates.

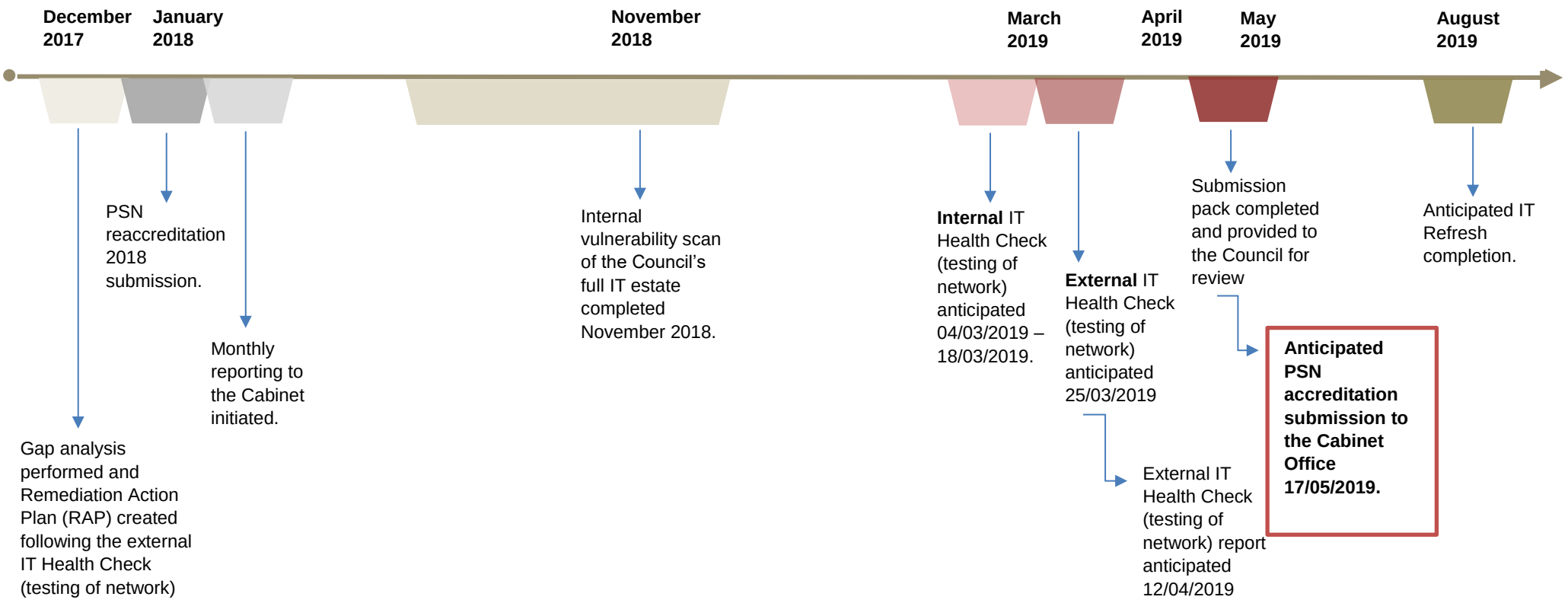
The following outlines the IA requirements:

1. **Operational Security**
    - Vulnerability and patch management
    - Secure configuration
    - Physical security
    - Protective monitoring and intrusion detection
    - Security incident response
2. **Authentication and access control**
    - Authentication access controls to ensure devices and services are protected against unauthorised access.
3. **Boundary protection and interfaces**
    - Appropriate security controls to protect boundaries between networks and the internet (e.g. Firewalls with appropriately configured rule sets).
4. **Protecting data at rest and in transit**
    - Data is protection within organisation's infrastructure or between other environments.
5. **User and administrator separation of data**
    - Access based on the principle of least privilege for minimum level of access necessary to perform their role.
6. **Users**
    - Implementing security controls (e.g. The Baseline Personnel Security Standard) on staff
7. **Testing your security**
    - Ongoing regular IT Health Checks (ITHCs) to test for infrastructure vulnerabilities. Results from independent testing to be provided within the PSN application.

Security gaps

If organisations do not meet any of the IA requirements, the PSN Compliance team must be contacted to enable assessors to work with organisations to close security control gaps or mitigate risks (where appropriate).

Appendix 3 – PSN Timeline 2018/2019 – as at February 2019



Appendix 4 – Areas of Audit Focus

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

Audit Focus	Review Approach
Public Services Network connection compliance	• Confirm that a gap analysis has been performed to identify any gaps between the Council's established cyber security controls and the Government's information assurance requirements for the PSN; • Evaluate remediation plans that have been developed by the Council, to confirm that they will address the gaps identified, and include all key dependencies; • Establish whether regular independent Information Technology Health Checks (ITHC) are in place to test the security of the Council's network infrastructure, and confirm that any significant actions have been addressed; and • Confirm there is an up to date network diagram of the Council's network infrastructure.
Governance and oversight of PSN remediation plan	• Confirm that an appropriate governance framework has been established to ensure effective operational and senior management oversight of PSN remediation progress; • Confirm that any emerging delivery issues are communicated to the governance forum; senior management; and the Partnership Board, with clear timeframes specified for remediation; • Confirm that the current PSN compliance position has been reflected in the relevant risk registers in line with the Council's established risk management framework.
Infrastructure vulnerabilities	• Review the procedures in place to identify infrastructure vulnerabilities and ensure that they are communicated to CGI and included in the PSN remediation plan; • A register of all hardware and software is maintained, and includes details of the end of supplier support arrangements; • Appropriate action is taken to arrange for implementation of upgrades or alternative versions prior to the expiry date; • Where upgrades or alternative versions cannot be implemented prior to expiry dates, arrangements are established with suppliers to provide short term ongoing support (including patch management where possible); and

	• A comprehensive list of out of support hardware and software is maintained and the security risks associated with these reflected in both services and ICT risk registers.

The City of Edinburgh Council

Internal Audit

Public Services Network Accreditation

Customer and Digital Services

Final report

1 August 2019

Project Code
RES1807

Overall report rating:

Significant enhancements required	Significant areas of weakness and non-compliance in the control environment and governance and risk management framework that puts the achievement of organisational objectives at risk

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

Contents

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Consequently, the application was not accepted, and the Council's compliance certificate now expired.

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Scope

The review assessed the adequacy and effectiveness of the processes applied to identify infrastructure vulnerabilities that impact upon PSN compliance; confirm that these are communicated to CGI for resolution; and ensure that they are included in the PSN remediation plan.

We also evaluated the effectiveness of governance and oversight of the PSN compliance remediation plan to ensure that the PSN compliance resubmission is ready by the target date of May 2019.

Limitations of Scope

Our original terms of reference also included review the arrangements in place to identify and replace out of support technology systems. This area was subsequently not covered as this would have required access to CGI. Additionally, the ongoing device refresh programme (scheduled for completion by the end of August 2019) should address aspects of unsupported technology, and the vulnerabilities associated with unsupported technology will be included in vulnerability scans.

Our work does not guarantee that the organisation will be fully compliant with Public Services Network connection compliance certificate.

Reporting Date

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High	2. Public Services Network contingency arrangements
Medium	3. Public Services Network remediation action plan - scope and submission review and delivery timeframes

Opinion

Significant enhancements required

Whilst the Council has established a PSN governance framework that is appropriately designed, our review identified a number of significant weaknesses in the effectiveness of the framework that limits the Council's ability to ensure that key services required to identify and address potential network vulnerabilities (ongoing vulnerability scanning and patch management) are delivered by CGI, and effectively oversee CGI's preparation of the PSN accreditation submission.

These weaknesses could significantly impact upon the volume and age of network vulnerabilities included in the submission; the planned application submission date (May 2019); and could potentially result in failure to achieve PSN accreditation from the UK Government.

There is also a risk that the Government could revoke PSN access in the event of a PSN security incident that originated from known vulnerabilities in the Council's network. If this did occur, there are currently no established contingency plans to ensure that key Council services could continue to be delivered without PSN access.

Digital Services management has advised that compensating intrusion prevention and detection system (IPS and IDS) controls are in place that should either prevent intrusion, or detect a successful intrusion, enabling implementation of timely remediation actions.

It should be noted that compensating IPS and IDS controls are not considered by the Government when awarding PSN accreditation; are not included in the scope of the independent IT Healthcheck that supports the accreditation submission; and have not been reviewed by Internal Audit.

Consequently, 2 High and 1 Medium rated findings have been raised and are included at section 3 below.

Management Response

Digital Services Management has advised that whilst revocation of PSN access would have a significant adverse impact on the Council's ability to deliver services, they believe that there is a low probability of the risk crystallising and becoming an issue based on informal discussions with Cabinet Office officials in April and May 2019.

Additionally, Digital Services management consider (based on the discussions noted above) that it is likely that the Government would accept a further delay in relation to submission of the PSN

application, and that implementation of existing programmes of work, such as the end user device refresh, targeted improvements in patching and ongoing vulnerability scanning that identifies new vulnerabilities with supporting remediation plans to ensure that they are addressed in a timely manner, will be sufficient to meet the Government's expectations for CoCo compliance and PSN accreditation.

As detailed in our Public Sector Action Plan for Cyber Resilience completed August 2018 and finalised in April 2019, ongoing vulnerability scanning has yet to be implemented by CGI as a service as specified under the terms of their contract.

3. Detailed findings

1. Public Services Network governance framework	High

Our review of the Public Services Network (PSN) governance arrangements established that:

1. Despite escalation to the Partnership Board (which is the most senior governance forum within the established CGI governance framework), CGI has not yet implemented the ongoing vulnerability scanning and patch management services required to identify and address potential network vulnerabilities. These services are specified as key deliverables in the CGI contract. This point has also been raised in our review of the Public Sector Action Plan for Cyber Resilience completed August 2018 and finalised in April 2019;
2. Separate arrangements have been established to support the Council's governance and oversight of CGI plans to achieve the Scottish Government's Cyber Essentials Plus accreditation and UK Government PSN accreditation, although the improvements to network security controls required to achieve both are predominantly the same (for example, ongoing vulnerability and patch management, and effective user access management);
3. The format and content of weekly CGI PSN progress reports is aligned with Cyber Essentials Plus accreditation progress reports, and are used as the basis for upward reporting to PSN governance forums

   Our review of the Public Sector Action Plan for Cyber Resilience (completed August 2018 and finalised in April 2019) established inconsistencies in CGI progress report formats and confirmed that there is limited validation of their accuracy.

   Digital Services Management has advised that CGI and Digital Services have been working together to establish consistent formats, and that the issues with progress reporting have been escalated to the Partnership Board; and
4. Whilst some high level PSN risks have been recorded on the Pentana risk management system, the risks associated with potential failure to achieve PSN accreditation, or revocation of access by the Government have not been fully considered and recorded.

Risks

- There may be duplication of governance activities (including reporting) between the forums established provide oversight of progress towards the Scottish Government's Cyber Essentials Plus and Public Services Network (PSN) accreditation;
- Decision making across the two separate governance structures and forums may be inconsistent;

- Inappropriate decisions may be made by governance forums based on inconsistent management information; and
- PSN risks may not be effectively managed through to resolution.

1.1 Recommendation - Public Services Network governance framework

- Management should consolidate and streamline the Scottish Government's Cyber Essentials Plus and Public Services Network (PSN) accreditation governance arrangements (including risk registers); and
- The risk register should be reviewed and refreshed to include all relevant PSN risks, with actions allocated to appropriate owners to ensure that they are managed through to resolution.

1.1 Agreed Management Action - Public Services Network governance arrangements

Digital Services Management has recognised the need to review governance arrangements around PSN /CyberSecurity. This will include

- Adapting the Security Working Group (SWG) Assurance report, in conjunction with CGI, to be the single report for all security assurance and accreditation matters encompassing PNS, Cyber Essentials/Cyber Essentials Plus, PSCAP and progress against Internal Audit findings.
- Working with CGI to change the Security Management Plan to have separate fortnightly SWG meetings to cover Operations and Assurance:
  - SWG Operations Group will review the Security Operations Centre (SOC) and Security Operations Reports (SOR)
  - SWG Assurance Group will review Assurance, PSN, Cyber Essentials/Cyber Essentials Plus and Audit Actions.

  To enable this approach, we will work with the Commercial teams from CGI and the Council to ensure that this approach is acceptable under the terms of the Contract
- Ensuring that PSN risks are included and highlighted in the Public Sector Network Plan B report. These risks will also be added to the Council/CGI partnership security risk log and reviewed as part of this.

Owner

Stephen Moir, Executive Director of Resources

Contributors

Nicola Harvey, Head of Customer and Digital Services; Heather Robb, Chief Digital Officer; Neil Dumbleton, Enterprise Architect; Alison Roarty, Commercial Team Lead; Layla Smith, Resources Operations Manager; Julie Rosano, Executive Assistant

Agreed Implementation Date

31st December 2019

2. PSN contingency arrangements — High

Digital Services management advised that details of alternative PSN connection solutions have been provided to CGI to enable completion of a feasibility study to identify suitable contingencies in the event that accreditation is not achieved, and / or Government revokes the Council's access in the event of a significant security incident.

However, no change request has been submitted to CGI for delivery of this work, and no timeframes for identification and implementation of alternative solutions provided.

Digital Services has identified all services that are dependent on use of the PSN and management has advised that these services have been contacted and made aware of the potential risk that accreditation may not be achieved.

Risks

The Council may be unable to deliver key services such as Revenue and Benefits and may be unable to provide information securely to other local authorities and government bodies (for example, the Department of Works and Pensions) if access to the PSN is revoked and alternative contingency solutions are not readily available.

2.1 Recommendation – Public Services Network contingency arrangements

- A change request should be prepared and submitted to CGI requesting them to perform a feasibility study to identify potential alternative contingent Public Services Network solutions, and their associated implementation timeframes; and
- The change request should specify the timeframes required for completion of the feasibility study and request that a report detailing the alternative options is provided to the PSN Board.

2.1 Agreed Management Action - Public Services Network contingency arrangements

- A change request has been raised with CGI to:
  - Confirm formally the viable contingency plan options and;
  - Provide a Rough Order of Magnitude proposal (ROM) detailing the cost of work associated with potential contingency solutions.
- When the ROM proposal and feasibility assessment is received for the change request to build the contingency environment, it will be considered by the PSN Board and Executive Director of Resources and a decision will be made whether to proceed with creation of a contingency environment based on the risk of possible disconnection from the Public Services Network.
- If it is agreed to progress with the proposed option, a second change request will be raised requesting CGI to provide a full implementation plan including costs and timeframes.

Owner

Stephen Moir, Executive Director of Resources

Contributors

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Agreed Implementation Date

31st October 2019

3. Public Services Network remediation action plan scope, and submission review and delivery timeframes	Medium

We identified the following weaknesses in relation to the scope of the CGI Public Services Network remediation action plan (RAP) and the timeframes for review and delivery of the final submission that could potentially have a significant impact on the UK Government's decision to award PSN accreditation:

Scope of the PSN accreditation application

1. The vulnerability remediation activity progress reports currently provided to the Cabinet Office are based on the vulnerabilities identified in the independent PSN IT Health Check (ITHC) completed in December 2017, and do not include any new vulnerabilities identified from the phased (manual) network vulnerability scan completed by CGI between July and October 2018, with the results presented to the Council and reviewed / analysed in November 2018;
2. A current network diagram is required to support the accreditation application. Whilst CGI has provided various iterations of a high level wide area network and data centre architecture diagram, and have shown Digital Services management (on screen) a detailed version, management confirmed that a final copy has not yet been provided;
3. The content of the PSN gap analysis prepared by CGI in January 2018 and the supporting remediation action plan (RAP) have not been reviewed by the PSN Board and working group to confirm that it includes the full population of network vulnerabilities.

   Additionally, the Council currently has no view of the ageing profile of the vulnerabilities that require to be addressed and cannot confirm how long the Council has been exposed to these potential security risks.

   Digital Services management has advised that CGI has confirmed that the PSN gap analysis and RAP were originally based on the independent PSN IT Health Check completed in December 2017 and have not yet been updated to reflect new vulnerabilities. However, Digital Services management has not yet seen copies of the revised documentation, although progress reporting to the PSN Board includes new vulnerabilities identified in the November 2018 vulnerability scan;
4. As CGI has not yet implemented ongoing vulnerability scanning across the Council network, it has not been possible to confirm whether any new and significant vulnerabilities have been identified since the November scan (note that lack of ongoing vulnerability scanning was highlighted in our review of the Public Sector Action Plan for Cyber Resilience completed August 2018 and finalised in April 2019);

   Management has advised that CGI is expected to complete a further vulnerability scan prior to resubmission of the PSN accreditation, with the results to be provided one week prior to initiation of the independent external IT health check assessment required to support the application;

PSN accreditation submission timeframes

5. CGI progress reports have consistently highlighted that key remediation actions will not be completed before the target May 2019 PSN submission date. Review of the PSN Working Group and Board packs for January/February 2019, highlighted a red rated planning forecast to address known vulnerabilities by March-May 2019, whereas an amber status had been reported from September 2018 onwards.

   This is mainly attributable to a key dependency on the ongoing Council wide technology refresh programme that is expected to complete in August 2019; and

Review of the application prior to submission

6. Review of the January 2019 PSN board pack established that the CGI PSN application submission timeline includes only five working days for the Council to review the application. Additionally, the review process and responsibilities for final approval have not yet been clarified.

Risks

- Public Services Network (PSN) accreditation may not be awarded if the Council cannot demonstrate that processes have been established to identify vulnerabilities that present a significant risk to PSN security (as determined by the UK Government) and demonstrate that they have been addressed;
- PSN access may be may be revoked if the Council does not achieve accreditation, or if a significant cyber security incident occurs due to vulnerabilities that have not been remediated prior to achieving accreditation.

  Management has advised that whilst this risk has a high impact, there is a low probability of the risk crystallising and becoming an issue based on informal discussions with the Cabinet Office;
- The Council has limited assurance that the remediation action plan (RAP) that forms the basis of ongoing progress reporting to the Government and the final accreditation application is aligned with Government expectations.

  Management has advised that Government expectations would be fully met though implementation of ongoing vulnerability scanning that identifies new vulnerabilities with supporting remediation plans to ensure that they are addressed in a timely manner;
- As CGI has not yet provided a current network diagram, the Council has limited assurance that the manual vulnerability scan completed in November 2018 covered the entire network and has identified the full population of network vulnerabilities that need to be addressed;
- New vulnerabilities may be discovered as part of the planned CGI vulnerability scan and independent IT Health Check resulting in failure to achieve PSN accreditation; and
- The Government may not accept a further delay in relation to submission of the PSN application.

  Management has advised that informal discussions with the Cabinet Office suggest that this is unlikely.

3.1 Recommendation – scope of Public Services Network accreditation application

- A final network diagram should be provided to the Council and a joint review performed by both the Council and CGI to confirm that the November 2018 vulnerability scan covered the entire network (based on the final network diagram), and that these are included in the CGI remediation action plan (RAP);
- The refreshed RAP should be updated to include the ageing of the full population of known network vulnerabilities, and should be reviewed and approved by the PSN Board; and
- Vulnerability remediation activity progress reports currently provided to the Cabinet Office should be updated to accurately reflect progress against the full population of all known network vulnerabilities.

3.1 Agreed Management Action - scope of Public Services Network accreditation application

As part of the ongoing work for security compliance, work is underway on all the recommendations noted above. This includes:

- A refreshed remediation action plan (RAP) addressing new vulnerabilities identified from CGI network scans completed in November 2018 and March 2019. This is in draft as of July 2019.
- An aged vulnerability tracker which now forms part of the Public Services Network (PSN) Board report. The RAP to be sent to the PSN Accreditor as part of the PSN submission has been

amended to include the date vulnerabilities were identified and the proposed dates for their remediation.

- Output and remediation actions from the vulnerability scans carried out to date. From 16/04/2019 this has been included in the PSN Board Report. This provides full network vulnerability/remediation plan information as opposed to the information in the RAP which only relates to the vulnerabilities identified by the Independent Health Check.
- Confirmation that PSN Connection Compliance (CoCo) updates provided to the Cabinet office include details of the additional active monitoring measures applied by the Council.

Evidence is being compiled for these and will be provided to Internal Audit by the end of September 2019.

Owner

Stephen Moir, Executive Director of Resources

Contributors

Nicola Harvey, Head of Customer and Digital Services; Heather Robb, Chief Digital Officer; Neil Dumbleton, Enterprise Architect; Alison Roarty, Commercial Team Lead; Layla Smith, Business Manager; Julie Rosano, Executive Assistant

Agreed Implementation Date

30th September 2019

3.2 Recommendation - Public Services Network accreditation submission timeframes

- The PSN Board should consider whether the timeframes for the PSN submission remain realistic and achievable; and
- The revised submission timeframes should include sufficient time for the Council to review the final submission; provide feedback to CGI; and confirm that all required changes have been incorporated.

3.2 Agreed Management Action - Public Services Network accreditation submission timeframes

These actions have now been completed. The following evidence will be provided to Internal Audit.

- Details of Public Services Network independent IT healthcheck received by the Council's Digital Services function on 24th April
- The PSN Code of Connection (CoCo) submission created by CGI and Council from 26th April until 13th May
- Initial review of remediation action plan by Council and CGI between 6th may and 14th May
- Daily meetings held by Council CGI between 29th April and 13th May to refine submission
- CGI has prepared updated documents for the formal Submission of the CoCo with accompanying Remediation Action Plan for review by the Executive Director of Resources in July 2019.

Owner

Stephen Moir, Executive Director of Resources

Contributors

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Agreed Implementation Date

30th September 2019

3.3 Recommendation - Review and final approval of the Public Services Network accreditation final submission
Responsibility for review and final approval of the final Public Services Network accreditation submission should be confirmed by the PSN Board.
3.3 Agreed Management Action - Review and final approval of the Public Services Network accreditation final submission
Evidence will be provided that shows: • The Public Services Network submission is written by CGI and the Council. • The PSN Board provides fortnightly review (latterly weekly). • Updates were submitted to the Council and CGI weekly executive review meeting for approval (15th March,12th April). • The Council and CGI partnership Executives will provide final approval of the Code of Connection (CoCo) submission.
Owner Stephen Moir, Executive Director of Resources
Contributors Nicola Harvey, Head of Customer and Digital Services; Heather Robb, Chief Digital Officer; Neil Dumbleton, Enterprise Architect; Alison Roarty, Commercial Team Lead; Layla Smith, Business Manager; Julie Rosano, Executive Assistant
Agreed Implementation Date 30th September 2019

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***;*** *or* • ***Critical*** impact on the reputation or brand of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***;*** *or* • ***Significant*** impact on the reputation or brand of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation or brand of the organisation.
Low	A finding that could have a: • ***Minor*** impact on the organisation's operational performance ; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***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.

Appendix 2 - PSN Code of Connection (CoCo)

To achieve Public Services Network compliance, organisations must demonstrate that their infrastructure is sufficiently secure and that connecting to the PSN would not present an unacceptable level of risk to the network.

As part of the application process, organisations must complete a Code of Connection (CoCo) application form which outlines the UK Government's Information Assurance (IA) requirements.

Organisations must then demonstrate ongoing compliance with the following CoCo Information Assurance (IA) requirements to obtain their connection compliance certificates.

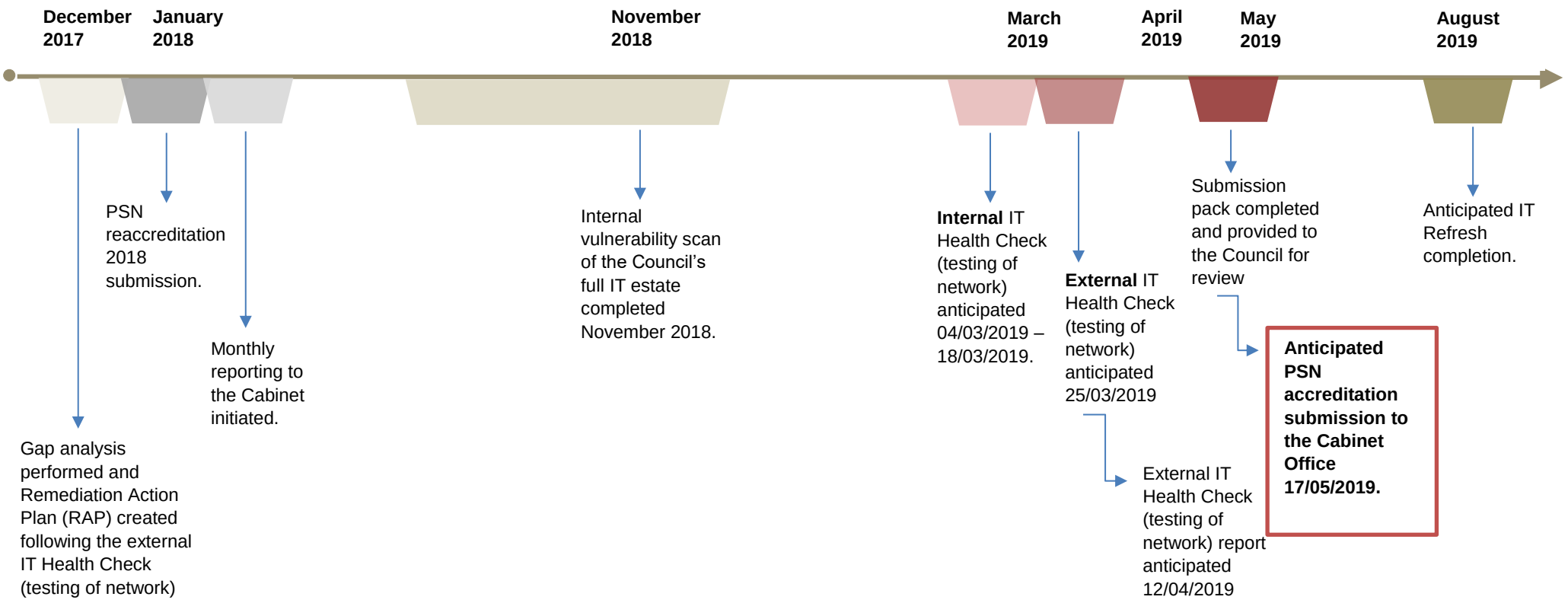
The following outlines the IA requirements:

1. **Operational Security**
    - Vulnerability and patch management
    - Secure configuration
    - Physical security
    - Protective monitoring and intrusion detection
    - Security incident response
2. **Authentication and access control**
    - Authentication access controls to ensure devices and services are protected against unauthorised access.
3. **Boundary protection and interfaces**
    - Appropriate security controls to protect boundaries between networks and the internet (e.g. Firewalls with appropriately configured rule sets).
4. **Protecting data at rest and in transit**
    - Data is protection within organisation's infrastructure or between other environments.
5. **User and administrator separation of data**
    - Access based on the principle of least privilege for minimum level of access necessary to perform their role.
6. **Users**
    - Implementing security controls (e.g. The Baseline Personnel Security Standard) on staff
7. **Testing your security**
    - Ongoing regular IT Health Checks (ITHCs) to test for infrastructure vulnerabilities. Results from independent testing to be provided within the PSN application.

Security gaps

If organisations do not meet any of the IA requirements, the PSN Compliance team must be contacted to enable assessors to work with organisations to close security control gaps or mitigate risks (where appropriate).

Appendix 3 – PSN Timeline 2018/2019 – as at February 2019



Appendix 4 – Areas of Audit Focus

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

Audit Focus	Review Approach
Public Services Network connection compliance	• Confirm that a gap analysis has been performed to identify any gaps between the Council's established cyber security controls and the Government's information assurance requirements for the PSN; • Evaluate remediation plans that have been developed by the Council, to confirm that they will address the gaps identified, and include all key dependencies; • Establish whether regular independent Information Technology Health Checks (ITHC) are in place to test the security of the Council's network infrastructure, and confirm that any significant actions have been addressed; and • Confirm there is an up to date network diagram of the Council's network infrastructure.
Governance and oversight of PSN remediation plan	• Confirm that an appropriate governance framework has been established to ensure effective operational and senior management oversight of PSN remediation progress; • Confirm that any emerging delivery issues are communicated to the governance forum; senior management; and the Partnership Board, with clear timeframes specified for remediation; • Confirm that the current PSN compliance position has been reflected in the relevant risk registers in line with the Council's established risk management framework.
Infrastructure vulnerabilities	• Review the procedures in place to identify infrastructure vulnerabilities and ensure that they are communicated to CGI and included in the PSN remediation plan; • A register of all hardware and software is maintained, and includes details of the end of supplier support arrangements; • Appropriate action is taken to arrange for implementation of upgrades or alternative versions prior to the expiry date; • Where upgrades or alternative versions cannot be implemented prior to expiry dates, arrangements are established with suppliers to provide short term ongoing support (including patch management where possible); and

	• A comprehensive list of out of support hardware and software is maintained and the security risks associated with these reflected in both services and ICT risk registers.

The City of Edinburgh Council

Internal Audit

Software Licenses and Certificates Management

Final Report

1 August 2019

RES1805

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 2018/19 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2018. 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

Software Licenses

The City of Edinburgh Council (the Council) uses an extensive range of proprietary software applications to support both service delivery and operations, and most of these software applications will require to have a software license to support their ongoing use.

A software license is essentially an end user agreement that specifies the terms and conditions that apply to the use and distribution of the software within an organisation.

There are three main different types of proprietary software licenses:

1. Per device licenses – applies to one installation of the software in a service; computer; phone; or another device;
2. Concurrent licenses – enables more than one user to use the software simultaneously, and is limited to a specified number of users;
3. Site licenses – are much less restrictive and typically allow as many users as required to use the software at one location.

There can also be many different combinations of bespoke (specifically tailored) license agreements.

Certificates

Certificates are used to verify the identity of a user or system before permitting access to, and establishing secure connections with, networks; applications; websites; interfaces or devices.

Use of certificates applies to Council employees connecting to internal networks (including remote access), and citizens accessing services provided via the Council's external website.

Security certificates are digital certificates that are used to sign and encrypt e mail messages. This process verifies the sender and prevents unauthorised tampering as only the intended recipient can decrypt and read the e mail.

Licensing and Certificate Management

Given the importance of having current and valid software licenses and certificates to enable ongoing access to the key systems and software applications used across the Council, it is essential that adequately designed software license and certificate management processes have been established and are consistently and effectively applied.

Management of software licenses and certificates for the main ICT contract is performed on behalf of the Council by their technology partner, CGI.

CGI Contractual Obligations

Licenses

It should be noted that CGI is not responsible for the ongoing management of all software licenses used across the Council, as some licenses continue to be managed by Council service areas. Digital Services management has advised that the allocation of license management responsibilities was agreed at the start of the contract, although there is reliance on CGI to maintain and provide

management information on the consolidated population of Council licenses for systems and applications on the Council's network.

The CGI contract includes the following output based specification (OBS) within End User Infrastructure requirements (OBS_20 section 20.22) in relation to the ongoing management of the Council's population of software licenses:

1. A regular (or automated) license monitoring system reporting the number of licenses permitted minus those in use. The Supplier shall fully meet this requirement providing a license monitoring, reporting and compliance system through Microsoft's SCCM product.
2. As well as fully meeting this requirement, the Supplier shall enhance the requirement providing reports which detail:

- How many copies of a particular software program have been deployed to the computers in the Authority and determine how many users actually run the program;
- How many licenses of a particular software program are needed when the license agreement is renewed;
- Whether users are still running a particular software program, and if the program is not being used, whether the system can be retired;
- Which times of the day a software program is most frequently used.

Certificates

Schedule 2.4 of the contract details security management services to be provided by CGI, including the requirement to manage certificates for deployment, and update and revoke certificates. Digital Services management has advised that a certificate error would be a CGI service failure, as certificates are a means by which CGI provide their services to the Council.

Scope

The review assessed the design adequacy of the key controls applied by CGI to support ongoing management of licenses and certificates for the systems that they support on behalf of the Council; and the adequacy of oversight applied by the Council to ensure that license and certificate management is performed effectively.

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

Testing was performed across the period 1 February 2018 to 31 March 2019.

Limitations of Scope

This review focused only on licenses and certificates for Council systems managed under the main CGI contract. Management of licenses and certificates for shadow IT systems that have been separately procured by services and are not centrally supported were specifically excluded from scope.

Our initial scope also included testing the effectiveness of key CGI license and certificate management controls, however, due to late provision of information to support sample selection, it has not been possible to perform effectiveness testing. Consequently, our review has been limited to an assessment of the design adequacy of CGI license and certificate management controls.

Reporting Date

Our audit work concluded 5 July 2019, 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. Governance and Oversight of Licenses and Certificates
High	2. CGI certificate and Licenses Management

Opinion

Significant Improvement Required

The scope of our review was limited to an assessment of the adequacy of governance and oversight applied by the Council to ensure that license and certificate management is performed effectively by CGI; and the design adequacy of key CGI license and certificate management processes and controls due to late provision of information by CGI to support completion of effectiveness testing

We identified significant control weaknesses in both governance and oversight, and the design of CGI licenses and certificates processes and controls.

Consequently, only limited assurance can be provided that the risks associated with licenses and certificates are being effectively managed; that employees have current and valid licenses and certificates enabling access to the necessary systems and applications required to perform their roles; and that the costs associated with unused licenses are identified and minimised.

Governance and oversight

License and certificate management requirements are detailed in the contract agreed with CGI in (2016) and were not subject to change in the 2018 contract refresh. These include the requirement for CGI to produce ongoing licencing monitoring reports.

Whilst Digital Services management has been escalating the lack of license information provided by CGI since the inception of the contract and has recorded a risk in relation to ongoing license management in the Digital Services risk register, license inventory reports were only provided by CGI to the Council in May 2019.

Consequently, Digital Services management has been unable to apply fully effective governance and oversight of CGI license management processes since the inception of the CGI contract in 2016.

We established that the format of license inventory reports prepared by CGI and provided to Digital Services are not aligned with OBS requirements and that their content is incomplete. Most notably, the reports do not include details of ongoing license usage, and the Council is unable to identify instances where unused licenses are incurring significant costs and address the position by making appropriate adjustments to contractual license arrangements with suppliers.

Additionally, the scope of the Council's governance meetings with CGI currently does not cover ongoing management of certificates. Digital Services management has advised that a risk based approach is being adopted with their initial focus on hardware and software licenses.

CGI License and Certificate Management Processes

As the license inventory reports provided to the Council by CGI are currently incomplete it is likely that either source license and certificates data maintained by CGI is incomplete, or the process applied to generate the license inventory report is not adequately designed.

Additionally, Internal Audit was unable to reconcile license data for two suppliers between the license report used by CGI (the software asset report), and the license inventory report provided to the Council.

A recent incident where users were unable to access the Council's intranet pages via both Internet Explorer or Google Chrome and received error messages confirming that the website's security certificate was not valid or had expired suggests that the CGI certificate management process is not operating effectively and as designed.

We also confirmed that incident reports are not reviewed to identify and address any potentially systemic themes or issues in relation to ongoing management of licenses and certificates. Review of these reports and provision of this information to the Council would provide additional assurance in relation to the effectiveness of CGI's ongoing license and certificate purchases; renewals; and implementation processes.

Consequently, two High rated Internal Audit Findings have been raised.

3. Detailed findings

1. Governance and Oversight of Certificates and Licences	High

License inventory report contents

Whilst Digital Services management has been escalating the lack of license information provided by CGI since the inception of the contract and has recorded a risk in relation to ongoing license management in the Digital Services risk register, monthly license inventory reports were only provided by CGI in May 2019.

Our review of the license inventory reports confirmed that they do not include any detail in relation to ongoing license usage, which prohibits the Council from making appropriate adjustments to license agreements to reduce the costs associated with unused licenses.

CGI has advised that provision of usage data is not required as per OBS requirements detailed in the contract, however review of the contract confirmed that provision of license usage information is a contractual requirement.

Additionally, the following data fields in the report provided to the Council are incomplete:

- Number of users;
- License version and quantities;
- Supplier name
- OBS reference
- License expiry date
- Purchase order reference (where applicable)
- License / contract number

The Commercial team has provided evidence supporting their identification and escalation of these reporting inaccuracies to CGI on 27 May 2019) and have agreed 4 High priority actions (number of users; license quantity; product version and license measurement unit); 12 Medium; and 3 Low actions that require to be addressed to improve the quality of the License inventory reports.

These issues had not been addressed during the course of our review, and no specific timeframes have yet been agreed with CGI for their resolution.

Ongoing certificate and license governance

Whilst governance meetings have been established between the Council and CGI that includes focus on ongoing management of licenses, there is currently no focus on CGI's ongoing management of the Council's population of certificates.

The Commercial team has advised that this is due to the lower risk profile associated with management of certificates in comparison to licenses, and ongoing focus on hardware and software license management.

Additionally, details of license and certificate related incidents (for example, inability of users to access system applications due to expired licenses or certificates) reported to the CGI helpdesk are not provided at governance meetings. This would provide additional assurance on the effectiveness of CGI's license and certificate purchase and renewal processes.

Risks

- CGI is not meeting their contractual obligations in relation to licenses;
- As accurate license usage data is not yet provided by CGI, the Council is unable to identify and adjust license arrangements with suppliers and reduce unnecessary spending on software licenses that are no longer required;
- The Council has only limited assurance that license terms and conditions of use are not breached; and users will be able to access the applications required for their respective roles; and
- Significant themes arising from reported incidents may not be identified; escalated; and appropriately resolved.

1.1 Recommendation - Governance and Oversight of Certificates and Licenses

1. Reporting requirements in relation to license usage and associated costs should be specified and agreed with CGI together with implementation timeframes for their provision.
2. Completion timeframes for implementation of the CGI actions required to address current license inventory reporting gaps should be defined and agreed with CGI;
3. Reporting requirements in relation to the ongoing management of Council certificates should be specified and agreed with CGI together with implementation timeframes for their provision;
4. The scope of ongoing governance meetings between the Council and CGI should be extended to include oversight of ongoing CGI certificates management, and discussion on any thematic issues related to certificates and licenses identified from incident reports;
5. Operational reporting to senior management on the effectiveness of CGI management of licenses and certificates should be designed and implemented.

1.1 Agreed Management Action (Council) - Governance and Oversight of Certificates and Licenses

Both Digital Services Management and CGI agree that the issues relating to Certificates and Licenses must be addressed.

1. Digital Services Management will:
   - ensure improved Governance of the processes around this are undertaken, reporting any issues through the Executive Board; and
   - ensure licenses are reduced/savings are realised where reduction or improved management of licenses is practicable.
2. Although not directly part of this action, more explicit requirements and governance around certificates and licenses will form part of any new or revised outsourcing contract.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Nicola Harvey, Head of Customer and Digital Services; Heather Robb, Chief Digital Officer; Jackie Galloway, Senior Manager (commercial); Alison Roarty, Commercial Team Lead; Layla Smith, Resources Operations Manager; Julie Rosano, Executive Assistant	**Implementation Date:** 31 January 2020

1.2 Agreed Management Action (CGI) - Governance and Oversight of Certificates and Licenses

1. CGI will
   - Provide improved reporting on licenses and usage to Council Asset meetings. This will start no later than October 2019;

- At these meetings, also provide updates on certificate management, highlighting any service impact/incident reports caused by certificate issue; and
- Work with Council to provide a relevant update for the Partnership Board/Executive meeting on certificate and license management.

Owner: Steve Smart, Senior Vice President and Business Unit Leader for CGI Scotland. **Contributors:** Alan Dickie, Vice President Consulting Services CGI; Stephen Moir, Executive Director of Resources; Nicola Harvey, Head of Customer and Digital Services; Heather Robb, Chief Digital Officer; Jackie Galloway, Senior Manager (commercial); Alison Roarty, Commercial Team Lead; Layla Smith, Resources Operations Manager; Julie Rosano, Executive Assistant	**Implementation Date:** 31 January 2020

2. CGI certificate and licenses management — High

Production of license inventory reports

As the license inventory reports provided to the Council by CGI are currently incomplete (refer finding 1 for further details), it is likely that either the source data included in the CGI Configuration Management Database (CMDB), the central repository used to record and maintain the Council's licenses, is incomplete, or the process applied to extract data for inclusion in the license inventory report generated using the Microsoft SCCM reporting module is not adequately designed.

Internal Audit attempted to reconcile license data between the CGI software asset report and the license inventory report for two suppliers (Adobe and SAP) that are widely used across the Council and were unable to match the types and volumes of licenses for these suppliers between both reports.

We were also unable to establish whether CGI performs a reconciliation between the CMDB; CGI software asset report; and the license inventory report provided to the Council. However, our testing has confirmed that license data in the reports cannot be reconciled.

Ongoing management of certificates and licenses

Whilst CGI has established processes supporting the purchase and renewal of certificates and licenses that (based on a walkthrough performed by Internal Audit) appear to be adequately designed, an incident occurred during our review where users were unable to access the Council's intranet (https://orb.edinburgh.gov.uk/) through either Internet Explorer or Google Chrome. The error message provided to users was that 'the website's security certificate is not yet valid or has expired'.

Whilst the helpdesk was able to resolve this issue by enforcing website security, this did cause disruption for employees, and suggests that the site's certificate was either not renewed on time or had not been effectively installed.

This incident suggests that the established CGI certificate management process is not consistently operating correctly.

Risk

- Where licenses or certificates have expired and have not been renewed or correctly implemented, users will be unable to access the applications required to support their roles; and
- Potential security risks associated with failure to renew or install certificates for both the Council's intranet and external website.

2.1 Recommendation - Completeness and accuracy of license inventory reports

- CGI should perform reconciliations between the Configuration Management Database (CMDB); the CGI software asset report; and the license inventory report provided to confirm their completeness and accuracy prior to providing to the Council;
- Any significant differences and unexplained reconciling items identified should be investigated and resolved.

2.1 Agreed Management Action - Completeness and accuracy of license inventory reports

CGI will:

- Use the Microsoft SCCM Product to ensure that all software installed in appropriately licensed
- Ensure that the license report is reconciled back to source system data (where applicable) and gain Council confirmation that they are satisfied with the completeness and accuracy of the license inventory.
- Update the Council at the fortnightly asset meetings of any differences between installed and licensed software and agree a course of action e.g. removal, reduction in licenses, discussion with Services on usage
- This should start by the end of October 2019.

Owner: Steve Smart, Senior Vice President and Business Unit Leader for CGI Scotland. **Contributors:** Alan Dickie, Vice President Consulting Services CGI; Stephen Moir, Executive Director of Resources; Nicola Harvey, Head of Customer and Digital Services; Heather Robb, Chief Digital Officer; Jackie Galloway, Senior Manager (commercial); Alison Roarty, Commercial Team Lead; Layla Smith, Resources Operations Manager; Julie Rosano, Executive Assistant	**Implementation Date:** 31 January 2020

2.2 Recommendation - Thematic certificates and licenses incidents

- CGI should monitor and identify the volume and frequency of reported incidents that relate to certificates and licenses that have either not been renewed or correctly implemented;
- CGI should provide the Council with details of the themes identified from incident reports and the actions implemented to address them; and
- If significant volumes of incidents are reported, CGI should review and refresh the design of their license and certificates management processes; make any necessary changes; and ensure that the process is consistently applied;

2.2 Agreed Management Action - Thematic certificates and licenses incidents

- CGI will report to the Council on service incidents that have been caused by license or certificate issues where the root cause is non/late renewal or incorrect implementation.
- This should start no later than the end of October 2019 and will be discussed at the monthly Partnership Forum.
- CGI and Digital Services will then determine if the issues identified require a process review.

Owner: Steve Smart, Senior Vice President and Business Unit Leader for CGI Scotland. **Contributors:** Alan Dickie, Vice President Consulting Services CGI; Stephen Moir, Executive Director of Resources; Nicola Harvey, Head of Customer and Digital Services; Heather Robb, Chief Digital Officer; Jackie Galloway, Senior Manager (commercial); Alison Roarty, Commercial Team Lead; Layla Smith, Resources Operations Manager; Julie Rosano, Executive Assistant	**Implementation Date:** 31 January 2020

Appendix 1: Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on the operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or*** • ***Critical*** impact on the reputation of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or*** • ***Significant*** impact on the reputation of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation of the organisation.
Low	A finding that could have a: • ***Minor*** impact on operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***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 that were included in the review are:

Audit Focus	Review Approach
Software License Management	• Review the procedures in place to monitor software licenses to ensure compliance with license requirements and prevent spending on unnecessary licenses; • Confirm if CGI maintains a central repository or management tool to track key software licenses including application licenses and cloud subscriptions; • Confirm the CGI maintains an IT asset inventory including software license deployments; • Review the availability and management of information included in license agreements and license conditions including purchase, maintenance, and service costs; and • Determine the Council's ability to prove its entitlement to use key software licenses.
Enterprise Certificate Management	• Confirm if the CGI maintains an inventory of its certificates; and • Review the processes in place to monitor certificates as well as identify and renew expiring certificates before these impact security or delivery of Council services.
Group Policy Update	• Review the process for providing group policy updates to users to ensure they are able to access the Council's network remotely.
Council Oversight	• Confirm that C&DS has established an effective process to ensure that CGI meet their contractual obligations in relation to software license and certificate management.

The City of Edinburgh Council

Internal Audit

Implementation of the asset management strategy and CAFM system

Final Report

31st July 2019

RES1813

Overall report rating:

Significant enhancements required	Significant areas of weakness and non-compliance in the control environment and governance and risk management framework that puts the achievement of organisational objectives at risk

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

Contents

This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2018/19 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2018. 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) has a significant operational portfolio of buildings that are managed by the Property and Facilities Management Division of the Resources Directorate. In addition, the Council owns a commercial property investment portfolio of buildings and land which it leases to generate income or uses to support strategic development activities for the City.

Development of the Asset Management Strategy

In 2015, Deloitte was engaged to perform a review of how effectively the Council manages its operational and investment property portfolios. The outcome of their review was a set of proposals that included leasing and disposal of assets where possible and consolidating existing services.

These proposals were then further developed into an Asset Management Strategy (AMS), aimed at achieving cost savings and delivering an improved property management service through a new operating model. The AMS is a five year programme that aims to:

- create a credible, focused, and sustainable delivery plan for property and facilities management;
- provide a fit-for-purpose, right-sized and safe Council property estate;
- provide an appropriate level of service at an acceptable cost; and
- act in a commercial manner in pursuit of maximising value.

This AMS was approved by the Finance and Resources Committee on 24 September 2015 and Anturas Consulting (Anturas) was engaged to assist in its implementation.

Delivery of the Asset Management Strategy

Anturas helped establish the plans to support delivery of the AMS strategy prior to conclusion of their work in December 2017, when a handover document was provided to the Council, with the expectation that Property and Facilities Management (P&FM) would implement the remaining elements of the 3 key AMS objectives (service delivery optimisation; estate rationalisation; and investment portfolio optimisation) together with new service delivery plans and the Computer Aided Facilities Management (CAFM) system.

Progress with AMS implementation

Whilst significant progress is evident with implementation of some of the recommendations included in the original Asset Management Strategy (AMS) approved in 2015, some elements have not yet been implemented, and the savings targets that have been achieved were not wholly attributable to AMS delivery.

Management is aware of the delays with AMS implementation and has advised that this is due to inaccurate and unachievable assumptions that underpin the strategy. Specifically:

- The original business case assumed that ongoing revenue costs associated with new buildings within the operational portfolio would be calculated and included in business cases, ensuring that they were subsequently reflected in future revenue budgets. This process to reflect the revenue cost of new buildings within future budgets was not established until March 2019, leaving over a three-year gap where revenue costs were not included in either asset business cases or future revenue budgets, resulting in significant dilution of proposed savings and pressures on existing budgets;

- The original property closure and disposal assumptions proposed by Deloitte have proven not to be accurate. The operational estate has grown, and disposal and rationalisation decisions could not be progressed without political and/or client services agreement.
- The original assumptions from Deloitte in respect of reducing the volumes of concessionary lets did not adequately consider legal; political; operational; and community considerations. Consequently, the volume of lets has not significantly reduced, and expected financial targets have not been achieved;
- The commercial property investment portfolio assumptions were predicated on the disposal of a significant number of properties with the proceeds reinvested into a portfolio of a smaller number of superior quality assets that would generate a similar level of rental return. These assumptions from Deloitte did not take cognisance of the budget pressures associated with adopting such an approach; and the costs and difficulties involved in acquiring new investment assets in such a buoyant and active property market.
- The timeframes for CAFM system implementation assumed that that all relevant Council data sets were complete; accurate; and could be easily migrated to the new system. This was not the case.

Management recognises the need for investment in a team to support the onboarding of services and drive forward delivery of the strategies contained in the original Blueprint.

Computer Aided Facilities Management (CAFM) system implementation

One of the key objectives associated with implementation of the Computer Aided Facilities Management (CAFM) system are to replace the historic Asset Inventory System (AIS) and provide a single source for all Property and Facilities Management (P&FM) data and the production of performance management information.

CAFM is an off the shelf, cloud based package purchased from and maintained by an external supplier (Technology Forge). It is proposed that the application will be supported by the Council's technology partner (CGI) and hosted on the Council's corporate network.

The CAFM modules that have been implemented to date are facilities management (janitorial services); operational property surveys; and asbestos surveys. Modules have yet to be implemented to support investments and the operational (leased) aspects of the property portfolio.

Scope

The purpose of this review was to consider progress of delivery of the remaining aspects of the asset management strategy and CAFM implementation progress; assess progress with implementation of agreed management actions to address the reopened historic Internal Audit findings; and provide assurance in relation to the following Corporate Leadership Team (CLT) risk:

- **Capital Asset Management -** Due to the age of a number of properties across the Council's operational estate, there is risk that properties are not of a sufficiently safe and sustainable standard for their continued use, potentially resulting in structural failures and/or negative health and safety consequences for staff, service users or members of the public. Associated with this, the Asset Management Strategy requires that decisions are made to dispose of properties in a planned manner. The risk associated with the implementation of the strategy is that disposal decisions are not made in a timely manner, which results in additional costs pressures for both the capital and revenue budgets and consequently demographic pressures cannot be responded adequately to by the property portfolio, particularly for education and health and social care services.

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

Reporting Date

Our audit work concluded on the 29 March 2019 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	1. Council Property Strategy
High	2. Computer Aided Facilities Management (CAFM) system Project
High	3. Property and Facilities Management Data Completeness; Accuracy; and Quality
Advisory	4. Computer Aided Facilities Management (CAFM) – property survey scheduler

The basis for classification of IA findings raised is included at Appendix 1.

Opinion

Significant enhancements required

To ensure that financial savings targets and service delivery improvements are achieved across the Council's property portfolio and facilities management services, it is essential that a realistic and achievable property strategy has been established to enable effective management of the property portfolio in the short; medium; and longer term, and that portfolio is supported by complete and accurate data and management information on the occupancy status; market and lease values; and condition of the Council's property assets.

Our review confirmed that significant enhancements are required to address weaknesses identified in the original strategy and existing control environment established to manage the Council's property portfolio and deliver facilities management services. Consequently, three high rated and one Advisory (no risk efficiency improvement) findings have been raised.

Council Property Strategy

The first High rated finding reflects the need to develop a new Council Property Strategy that outlines how the Council's operational property portfolio will be managed; maintained; optimised; and used to deliver savings across the short; medium; and longer term. This finding also highlights the importance of ensuring that Properties and Facilities Management (P&FM) are involved in the development and approval of all business case proposals that involve new property developments and / or requests for space from the existing operational property portfolio to ensure that the proposals are aligned with a new property strategy, and that property maintenance lifecycle and running costs are factored into both future capital and revenue budgets.

Computer Aided Facilities Management (CAFM) system project

The full implementation of the Computer Aided Facilities Management (CAFM) system is also essential to establish a single source of the truth for all property related data and enable the generation of

complete and accurate management information to support ongoing portfolio monitoring and effective management decision making. The CAFM system project commenced in 2015 and whilst three of the five system modules are now live, the system has not yet been fully implemented. Our second High rated finding highlights the areas where improvements are required to support completion of the project, and notes the need to review project resources to ensure that key person dependency risk is addressed, and sufficient resources are available to support delivery.

Data Completeness; Accuracy; and Quality

The Internal Audit review of Management Information Quality within Facilities Management completed in January 2016 resulted in one High and two Medium rated findings being raised in relation to data architecture; data quality; and production of management information. These findings were subsequently closed then reopened in June 2018 following confirmation from management that the agreed management actions to address the control weaknesses identified had not been effectively implemented and sustained.

Our current review identified a number of issues in relation to the completeness; accuracy; and quality of property and facilities management data that require to be addressed. Consequently, the historic issues will be closed and replaced with the new High rated finding (refer finding 3 below) that will be reported as overdue based on the outcomes and timescales of this audit report.

Our detailed findings and recommendations are included at section 3 below.

Management response

From 2016 onwards, as the original Asset Management Strategy (AMS) programme was put into practice, the underlying assumptions behind the key components of CAFM, Investment Portfolio (including concessionary lets), property rationalisation and FM Services became increasingly inaccurate and obsolete. The impacts of this are described above and has resulted in a mid-point review, to effectively refresh the Council's AMS.

Notwithstanding the above, significant progress has been made in delivering key elements of the strategy, and where assumptions have shown to be undeliverable as originally envisaged – particularly in regard to the investment portfolio and rationalisation of the property estate – service areas have altered their strategic approach to accommodate these realities.

The AMS involved work streams largely carried out by three Property and Facilities Management teams: Investments, Strategic Asset Management, and Facilities Management.

The Investments team oversees a large commercial property investment portfolio extending to over 1,150 interests within 10 asset classes.

Investment Portfolio performance over the last 5 years has been strong with rental income increasing from £10.7m in 2015/15 to £14.9m in 2018/19. The target for the team set through the originally approved AMS was to secure rental growth of 2.5% per annum for 3 years, reducing to 1.5% thereafter. The target level of growth has been exceeded and the team continue to identify additional opportunities for income maximisation through an in-house developed disposals and acquisitions strategy. The revised strategy in this area (to replace the original AMS) was approved by the Finance and Resources Committee on 23 May 2019.

The major staff transformation part of the AMS has taken place in the Facilities Management service where security, janitorial and cleaning staff (some 10% of the total Council workforce) underwent organisational reviews between 2015 and the present day. This transformation has seen the introduction of mobile devices to a staff team where IT use in day to day work was previously non-existent. Greater detail on this aspect of the AMS is seen in the Implementation and Application of the new Facilities Management SLA audit. The proposed savings (under AMS) in this area have been commuted to cover

the cost of new floor space built between 2015 and 2019, as reported to the Finance and Resources Committee on 23 May 2019.

The Asset Condition and Estate Rationalisation work streams are carried out by the Strategic Asset Management Team. A central part of the AMS was to improve the Council's management information and forward planning capability. As such, all 590 of the buildings in the Council's operational estate were subject to a comprehensive condition survey between 2016-2017, all stored in the CAFM system as its first major "single source of truth" output. The outcome of this process was the approval of a total budget of £153m over five years to address building condition issues and to deliver a new planned preventative maintenance programme. The first year of this programme, 2018-19, has seen 27 projects completed across primary schools and other operational buildings including the City Chambers. Works are varied in nature and range from external and internal fabric enhancement to mechanical and electrical improvements. This element is ahead of target as reported to the Finance and Resources Committee on 23 May 2019.

The rationalisation work stream has required a strategic re-think. Original assumptions in respect of the reduction of the operational estate do not mirror the reality that since 2015 the Council has built over 70,000 square metres of new floorspace. While some of this replaced older stock, the equivalent of three new high schools have been added to the operational estate. This has resulted in higher revenue costs including non-domestic rates, cleaning and janitorial services and repairs and maintenance expenditure. The practical result of this is that operational property budgets have been increasingly pressurized year on year. While the operational property estate has been growing significantly, there has been no corresponding decrease across the remainder of operational property portfolio, although notable achievements have been made in respect of office accommodation, particularly the exit of Lothian Chambers, 329 High Street, 1a Parliament Square and Bonnington Resources Centre. As part of these closures, restacks of Waverley Court and three local offices have also been undertaken, implementing a 7:10 desk allocation ratio as part of the estate optimisation strategy.

As the rationalisation workstream of the AMS developed, it was increasingly recognised by those involved in its delivery that attempting to close property brings with it practical political, social and community issues which could not be successfully bridged through the original approach. As such, the team sought approval from the Finance and Resources Committee in September 2018 to adopt a service led design approach to rationalisation which is both participatory and which seeks to focus on service needs and outcomes desired at a local level and then match buildings to these. In effect, service design has replaced the original AMS rationalisation workstream.

While the audit identifies three High rated findings, these do **not** fall under the parameters of "Significant areas of weakness and non-compliance in the control environment and governance and risk management framework". The component parts of the AMS were created using industry recognised project and risk management processes and these have been applied and maintained throughout the life of the work streams. Governance arrangements, both internally and politically through regular political group briefings and formal reporting to the Finance and Resources Committee have been consistently applied.

3. Detailed findings

1. Council Property Strategy	High

As highlighted in the background section of this report, management has advised that they have been unable to deliver aspects of the Asset Management Strategy (AMS) as some of the original underlying business assumptions have proven to be inaccurate and not achievable, and there was a lack of political support for some proposals. This has been reported to the Finance and Resources Committee on a regular basis.

Whilst management has delivered current year Property and Facilities Management savings targets (£2M), our review confirmed that this has been achieved by other initiatives (for example, acquisition of Housing Revenue Account properties and generation of additional rental income from assets in the existing property portfolio), instead of delivery of AMS proposals.

We identified the following AMS recommendations that have not yet been completely implemented:

- **concessionary lets** - review of a sample of concessionary lets with a rental value below £1000 per annum that were due for review and renewal in 2018/2019 confirmed that only 2 out of 23 were in the process of being renegotiated. It is also acknowledged that existing data quality issues (refer finding 3 below) has presented challenges in identifying the full population of concessionary lets maintained on the historic Asset Information System (AIS);

  Management has advised that there are a number of lets defined as 'concessionary' where it is not possible to increase the rental values due to decisions made by the Council in relation to, for example, care homes where operators are delivering subsidised services on behalf of the Council; charitable organisations occupying operational properties; or where the leases support sport and other community activities. Consequently, the approach applied has been to increase rental income where possible.
- **operational estate rationalisation** - the original AMS identified the need for rationalisation of the operational estate. Whilst an asset management board and asset investment groups for Place; the Health and Social Care Partnership; and Communities and Families have been established, there is limited progress with rationalisation of the existing Council estate.

  Management has advised that the properties identified for rationalisation in the AMS included properties that accommodated services for which there is now increased demand due to population growth (for example primary schools).
- **available capacity** - regular reviews of available capacity across all Council properties are not routinely performed to identify areas that could be externally leased. Instead, reviews are included as part of ongoing service redesign proposals.
- **lifecycle costs** – our review of the Council's Portfolio Governance Framework (completed May 2019) highlighted the need to include whole of life costing in project business cases and ensure that they are reported to the Asset Management Board. Additional recommendations have been included in this review to ensure that Property and Facilities Management are fully engaged in this process.

Risk

- The Asset Management Strategy (AMS) does not recognise the extent of the challenges faced by the Council in relation to delivery of savings from the property portfolio; political expectations; and future demand for Council properties. Consequently, its implementation will not deliver the expected financial and operational service delivery benefits and is unlikely to do so for the reasons set out in this report; and
- Inability to accurately assess the changes in demand for council properties, leading to financial loss to the council

1.1 Recommendation – Requirement for a new 'Council Property Strategy'

Property and Facilities Management (P&FM) should produce a new Council Property Strategy that will detail how the Council's operational and investment property portfolios will be managed; maintained; and used to deliver savings across the short; medium; and longer term. The strategy should include, but not be restricted to:

- a clearly defined process that will be applied to assess current and future property and capacity demands to support current and future delivery of Council services (including services provided by the Health and Social Care Partnership) on an ongoing basis;
- revised assumptions and plans for rationalisation and replacement of the existing Council property estate; and
- plans to maximise rental income where Council properties are leased externally, including clear proposals for the ongoing treatment of concessionary lets.

Agreed Management Action – Requirement for a new 'Council Property Strategy'

The Strategic Asset Management Team is refreshing the current Corporate Asset Strategy 2014-2019 over the course of 2019/20. This will cover the key themes of how the estate will be managed, which will address some of the elements set out above.

The development of a demand strategy, which sets out cross directorate requirements, for each directorate is a shared responsibility between Property and Facilities Management (P&FM) and the directorates. Some directorates are at a greater stage of maturity than others, for example school roll forecasting gives a good indicator of property changes required in the future, and Council corporate office requirements are clearly set out. Other directorates require more support to develop their demand strategy before that can be translated into property needs, and P&FM are assisting with this through, for example, taking forward a suitability assessment for the current properties in the Health and Social Care Partnership so that the partnership can make informed judgements about the type of space it requires in the future.

The updated Corporate Asset Strategy will set out key themes and direction of travel, such as employing service led design processes, but will not present a property list of plans for rationalisation. The service led design process is predicated on having no preconceived notions of what the asset base might look like to serve a local community, until engagement with the community has been undertaken and options start emerging. The Council already has a defined repairs and maintenance programme as a result of the additional funding approved by Council in February 2018, and this new approach will be reflected in the updated Corporate Asset Strategy.

As a subset of this Corporate Asset Strategy, a new Council Property Strategy will be developed and implemented that will cover the areas noted above. Additionally:

- clear definitions will be established for the Council's commercially leased investment property portfolio and the voluntary and charitable lets included within the investment portfolio; and

- a report detailing the full population of voluntary and charitable lets, and the supporting background for these arrangements will be prepared and presented to the Council's Finance and Resources Committee. The committee will be requested to make a risk based decision on whether the rental charges applied to these lets should be regularly reviewed and potentially increased, or whether they should be frozen with no increases applied for a specified period.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Peter Watton, Head of Property and Facilities Management; Lindsay Glasgow, Strategic Asset Management Senior Manager; Graeme McGartland, Investments Senior Manager; Gohar Khan, Performance and Audit Officer; Layla Smith, Business Manager; Audrey Dutton, Executive Assistant.	**Implementation Date:** 30 May 2023

1.2 Recommendation – Property Aspects of Major Projects

1. The requirement for Property and Facilities Management (P&FM) to be consulted when preparing business cases for major projects that will involve either construction of a new property or a request for space from the existing property portfolio should be communicated across all Directorates; Divisions; to project managers; and included in the Strategic Change and Delivery project management toolkit;
2. Where new major projects for inclusion in the Council's major projects portfolio include a requirement for new property or space from the existing portfolio, P&FM and Finance should also sign the business case to confirm that the proposal is aligned with the Council's property strategy; that they are comfortable with the ongoing repairs and maintenance lifecycle costs included in the business case; and that future revenue funding will be available to support ongoing lifecycle costs and
3. Strategic Change and Delivery and the Change Board should confirm that P&FM and Finance have been consulted in all business cases that involve property requirements prior to their final approval.

Agreed Management Action - Property Aspects of Major Projects

P&FM will recommunicate the requirement for business cases to be developed through the Asset Investment Groups; request that Strategy and Communications include it in the Strategic Change and Delivery project management toolkit; and have oversight of ensuring P&FM have input into any property changes at the Change Board. P&FM will comment on all known business cases and provide estimates of property whole life costs (not just R&M costs).

For smaller projects, such as the siting of a portacabin on school grounds to accommodate increased pupil numbers, Properties and Facilities Management will design a process and supporting funding protocols to ensure that P&FM are consulted at an early stage to enable revenue costing to be prepared for the client service (for example, where additional janitorial and cleaning services are required) and for the source of funding to be established and agreed.

The process and supporting funding protocols will be shared with all Directorates and Heads of Service for discussion and agreement.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Peter Watton, Head of Property and Facilities Management; Andrew Field, Senior Manager, Property and Facilities Management; Gohar Khan, Performance and Audit Officer; Layla Smith, Business Manager; Audrey Dutton, Executive Assistant	**Implementation Date:** 31 March 2020

2. Computer Aided Facilities Management (CAFM) system project — High

Whilst the facilities management (janitorial services); operational property surveys; and asbestos surveys Computer Aided Facilities Management (CAFM) system modules have been implemented, the investment and operational estates modules are not yet live.

Management has advised that delivery of the remaining two modules has been impacted by a combination of project resource constraints, and the significant extent of operational support provided by the project following implementation of the janitorial services module.

Our review has established that:

- The CAFM project has not been independently assessed as a major project for inclusion within the Council's major projects portfolio and is currently reported as part of the Asset Management Strategy (AMS) implementation.

  Whilst CAFM and the AMS are inextricably linked (CAFM is a key enabler for AMS delivery), the scope of each are significantly different;
- The CAFM project appears to be significantly under resourced in comparison to similar projects that involve system implementation, and data cleansing and migration;
- There is a key person dependency on an external contractor and one internal senior manager, who also has ongoing service delivery responsibilities for CAFM implementation;
- No evidence is available to confirm that three live CAFM modules were tested, and that all significant testing issues identified were resolved prior to implementation, with an action plan developed to address any less significant testing issues that were accepted as part of the 'go live' implementation decision;
- A basic user access process has been established to manage requests for new user CAFM access; confirm that user access is allocated based on appropriate user access profiles; and ensure that leaver access is revoked. This could be improved.

Risk

- Limited oversight of the Computer Aided Facilities Management (CAFM) system implementation project by senior management and the Change Board;
- The CAFM system will not be fully and effectively implemented within expected timeframes;
- Implementation issues have not been identified and resolved through testing; the new modules do not operate as expected; and service delivery requirements are not met; and
- User access is not effectively managed, and users could be allocated inappropriate system access rights.

2.1 Recommendation - Computer Aided Facilities Management (CAFM) project governance; delivery; and resourcing

- The Computer Aided Facilities Management (CAFM) project should be reassessed as a stand - alone project for inclusion in the Council's major projects portfolio by completing the project prioritisation matrix and providing this to Strategic Change and Delivery for their review and feedback;
- Project plans for delivery of the remaining aspects of CAFM implementation should be refreshed to include requirements for data cleansing and quality, and delivery of the remaining two modules;
- Management should consider the adequacy of available project resources based on the aspects of CAFM implementation to be delivered and the required implementation timeframes; and

- Opportunity for sharing or pooling resources with similar projects (for example, ERP to support data cleansing) to support delivery should be considered.

Agreed Management Action - Computer Aided Facilities Management (CAFM) project governance; delivery; and resourcing

The project prioritisation matrix will be completed based on the refreshed CAFM business plan (see below) and the outcomes shared with the Executive Director of Resources and the Strategic Change and Delivery team for a final decision regarding inclusion in the Council's major projects portfolio.

Effective implementation of the CAFM system and improving data quality is a key priority for P&FM given plans to outsource both preventative repairs and routine maintenance over the next 18 months as CAFM will be utilised to support these new arrangements.

Consequently, a CAFM business plan has been developed that focuses on the priorities of the business in relation to the CAFM project and ongoing responsibilities for the operational support of CAFM moving forward.

The CAFM Business Plan covers a period of 3 years and includes:

- Hard FM Re-Procurement
- Data Quality Strategy
- Business Analysis
- Onboarding new process and services onto CAFM
- Resource requirements and costs

A re-baselined project implementation document; risks, issues and dependencies log; and project plan has also been developed in line with the business plan which will be tabled at the CAFM project board in July 2019.

The sharing of resources with other similar projects will be explored in cognisance of the risk that where there is a need for both projects to have resource, prioritisation of one over another may affect project timescales.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Peter Watton, Head of Property and Facilities Management; Andrew Field, Senior Manager, Property and Facilities Management; Brendan Tate, CAFM Project Manager; Gohar Khan, Performance and Audit Officer; Layla Smith, Business Manager; Audrey Dutton, Executive Assistant	**Implementation Date:** 31 December 2019

2.2 Recommendation - Computer Aided Facilities Management (CAFM) testing plans

A risk based decision should be taken to decide on the extent of testing to be performed in comparison to associated testing costs. Appropriate testing plans should be established that to support future Computer Aided Facilities Management (CAFM) module implementation. The testing plans should include details of:

- tests to be performed, covering all aspects of module functionality;
- detail how testing outcomes should be recorded, including prioritisation of testing exceptions;
- note the acceptable level of testing exceptions to support a 'go live' implementation decision; and
- detail responsibility for resolution and subsequent testing of any post implementation issues.

Agreed Management Action - Computer Aided Facilities Management (CAFM) testing plans

We have concerns over some of the recommendations above.

Detailed testing with defined UAT scripts requires dedicated resource to undertake. This is a significant cost that is unbudgeted for at present. The rate card of a Test Manager from our incumbent ICT supplier is £625/day.

Previous modules have been tested successfully through a close working relationship with the business areas migrating over to CAFM. This has approach to testing is appropriate for the resources available.

On CAFM Business Case approval, we will accommodate significantly more control over formal testing of CAFM through the Project Manager, working closely with the Operations Manager, by creating a set of generic User Acceptance Test Scripts which will be documented and aligned with the processes being migrated to CAFM and used to approve the go/no-go decision by the relevant business areas.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Peter Watton, Head of Property and Facilities Management; Andrew Field, Senior Manager, Property and Facilities Management; Brendan Tate, CAFM Project Manager; Gohar Khan, Performance and Audit Officer; Layla Smith, Business Manager; Audrey Dutton, Executive Assistant	**Implementation Date:** 31 December 2019

2.3 Computer Aided Facilities Management (CAFM) – user access management

A CAFM user administration process should be designed; communicated; and implemented. This should include, but not be restricted to:

- ownership and ongoing responsibility for consistent application of the process;
- details of how new user access requests should be submitted (for example to a central e mail box);
- details of the user profiles to be allocated to new users, depending on their operational roles and responsibilities;
- the requirement to perform regular (for example quarterly or six monthly) user access reviews to confirm that user access rights remain appropriate and are aligned with available system licences;
- the requirement for line managers to provide details of leavers and request that their system access rights are revoked.

Agreed Management Action - Computer Aided Facilities Management (CAFM) – user access management

Property and Facilities Management will own and administer the CAFM user administration process. This will include allocation of CAFM user profiles that are aligned with user roles and responsibilities, and ongoing annual user access reviews.

A new CAFM site on the intranet (Orb.edinburgh.gov.uk/CAFM) has now been introduced that contains details of the processes to be applied by line managers for starters/leavers and change of circumstance staff.

This includes the forms that are required to be completed and relevant user guides for Facilities Management in order that the Orb becomes a central location to keep all documentation stored and up to date.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Peter Watton, Head of Property and Facilities Management; Andrew Field, Senior Manager, Property and Facilities	**Implementation Date:** Completed. A date of 30 October 2019 has been

Management; Brendan Tate, CAFM Project Manager; Gohar Khan, Performance and Audit Officer; Layla Smith, Business Manager; Audrey Dutton, Executive Assistant	allocated for Internal Audit validation

3. Property and Facilities Management Data Completeness; Accuracy; and Quality	High

Whilst a data cleansing exercise has been performed on the Computer Aided Facilities Management (CAFM) system, management has advised that there are still data integrity issues as data was not cleansed prior to transfer from the historic Asset Information System (AIS) and other source systems on to CAFM. Management estimates that CAFM data is circa 70% accurate.

Property and Facilities Management (P&FM) currently has no established data steward who has ongoing responsibility for the completeness; accuracy; and quality of both historic and current data used by P&FM to manage the Council's property portfolio and deliver facilities management services. Management has identified the need for a data steward and has produced a job specification, however the role has not yet been recruited.

Additionally, there are no established controls to confirm the completeness and accuracy of data maintained in both the AIS and CAFM systems. We confirmed that ad-hoc reviews are performed to identify changes made to AIS data, with the CAFM system manually updated to reflect these changes.

Review of Property and Facilities Management (P&FM) data used to support ongoing property management activities established that:

- there were discrepancies between the population of properties maintained by the operational estate team, and the population of properties to be surveyed by the property survey team;
- the historic Asset Interface System (AIS) does not differentiate between concessionary and non-concessionary leases in the Investment Portfolio. Consequently, an assumption has been made that concessionary leases will be less than £1K in value, and this threshold is being applied to identify potential concessionary leases for renegotiation.

  Review of a sample of leases identified one concessionary lease with a value in excess of £1K that had not been identified for inclusion in the review process;
- data in relation to vacant and disposed properties had not been updated correctly for 3 out of 20 properties included in our sample; and
- management information on unpaid rental invoices available from accounts receivable is not shared with the investments property team, enabling them to remind landlords that payment is due, or withhold renewal of leases (where appropriate).

  Our testing identified one leasehold property where outstanding rental invoices amounted to £50,000 for a period of 2 years.

Risks

- The Computer Aided Facilities Management (CAFM) system is not yet the established single source of truth for Property and Facilities Management (P&FM) data;
- Incomplete and inaccurate data could result in production of inaccurate management information and uninformed or inappropriate management decisions;
- Lack of visibility of repairs and maintenance requirements across the Council estate resulting in

potential health and safety consequences; and

- Income generation potential is not optimised and rental income not received within expected timeframes.

3.1 Recommendation - Property and Facilities Management Data Completeness; Accuracy; and Quality

- A Properties and Facilities Management (P&FM) data steward should be established to support the Computer Aided Facilities Management (CAFM) system implementation and ongoing P&FM service delivery by ensuring that data transferred to or recorded on the CAFM system is complete and accurate.

  It is expected that this role would include (but should not be limited to) ongoing data cleansing; data quality checks; and reconciliation of data between CAFM and source systems.

- P&FM management should explore the option of sharing data steward responsibilities with other projects or services where data steward roles have been established.

Agreed Management Action - Property and Facilities Management Data Completeness; Accuracy; and Quality

Current CAFM users have access to the operational data they need in the system to perform their roles and are also updating the CAFM system with new data.

Whilst the vision is to have all property data in CAFM, the volume of property data that could be captured and recorded is near infinite, therefore property data that will retained in CAFM has to be focused on the effort and cost to collect versus the value it provides.

The CAFM Business Case includes requirement for a Data Quality Manager, who will be the responsible data steward for Property and Facilities Management (P&FM) data. Their role is not necessarily to collect the data but to ensure rigor and control over it. This will involve ensuring regular reviews of data within the system and ensuring that data is managed and maintained in line with the established CAFM data hierarchy and agreed Council information management policies and procedures.

Sharing data steward responsibilities across services is problematic, as they hold responsibility and accountability for the data under their remit. It would be highly unlikely that a data steward from another service would want to take on the additional accountability of data from P&FM. We recommend that P&FM establish their own data steward.

The CAFM Business Case includes the delivery of a Data Quality Strategy for P&FM. The objective of the data quality strategy is to attribute risk and value to the data maintained in the system. Additionally:

- data change processes and procedures that capture data processing and management in CAFM will be designed and implemented.
- processes for reviewing data quality, for example, review of condition survey data run in tandem with review of property data every five years, will be designed and implemented.
- data validation controls within CAFM will be applied; and
- data quality audit controls for individual data fields available in CAFM will be applied, and audit reports run at an appropriate frequency to identify any significant changes to key data.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Peter Watton, Head of Property and Facilities Management; Andrew Field, Senior Manager, Property and Facilities Management; Brendan Tate, CAFM Project Manager; Gohar Khan,	**Implementation Date:** 31 March 2022

Performance and Audit Officer; Layla Smith, Business Manager; Audrey Dutton, Executive Assistant	

3.2 Recommendation – resolution of known data quality issues

- A reconciliation should be performed between the list of properties between the population of properties maintained by the operational estate team, and the population of properties to be surveyed by the property survey team, and all discrepancies resolved to ensure that both teams are basing their work on an accurate list of properties;
- A referencing system for concessionary lets should be developed and applied to lease details maintained on both the Asset (AIS) and Computer Aided Facilities Management (CAFM) systems to enable identification of and reporting on the volume and value concessionary lets across the Council Estate;
- The volume and value of concessionary lets across the Council Estate should be monitored and reported to the relevant Council executive committee;
- System data in relation to vacant and disposed properties should be reviewed and updated.

Agreed Management Action - resolution of known data quality issues

- A reconciliation of the two lists has been performed and there are no obvious discrepancies other than properties which are out with the scope of the survey team.
- The viability of establishing a referencing system for concessionary lets in the CAFM system will be explored.
- The volume and value of known concessionary lets across the Council Estate will form part of the Annual Investment Portfolio update which is reported to the Finance and Resources committee.
- There is an ongoing work stream looking at vacant and disposed properties and the systems updates required.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Peter Watton, Head of Property and Facilities Management; Andrew Field, Senior Manager, Property and Facilities Management; Graeme McGartland, Investments Senior Manager; Brendan Tate, CAFM Project Manager; Gohar Khan, Performance and Audit Officer; Layla Smith, Business Manager; Audrey Dutton, Executive Assistant	**Implementation Date:** 31 March 2022

3.3 Recommendation – review of overdue rental payments

- Management information on unpaid rental invoices should be requested (at least quarterly) from accounts receivable and reviewed to identify any significant overdue payments (value and age); and
- Where appropriate, action should be taken to advise tenants that withhold leases will be revoked or not renewed where payment has not been received.

Agreed management action - review of overdue rental payments

This risk is accepted by management as it is not always possible to recover unpaid rent during the tenancy on the basis of the points noted below, and that all rental debts written off are subject to approval by Committee. Additionally, the proportion of rental income debt write off has not been significant in the context of the actual sums involved.

- information on unpaid rental invoices has been requested on a quarterly basis from Accounts

Receivable. This has been agreed and such reports will form part of the ongoing Investments reporting schedule.

- where Property and Facilities Management identify unpaid rent, the tenant will be contacted with a reminder (in addition to standard accounts receivable debt management processes) until it has been paid;
- it is not always possible to revoke leases given the length of their term. Some leases could be for ten years. The Council would have to take the tenant to Court to have the lease revoked; and
- at the end of lease, where the tenant has not fulfilled legal and financial obligations, the option for the tenant to renew the lease is removed.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Peter Watton, Head of Property and Facilities Management; Andrew Field, Senior Manager, Property and Facilities Management; Brendan Tate, CAFM Project Manager; Gohar Khan, Performance and Audit Officer; Layla Smith, Business Manager; Audrey Dutton, Executive Assistant	**Implementation Date:** N/A – management action has been risk accepted

4. Computer Aided Facilities Management (CAFM) – property survey scheduler	**Advisory**

Whilst the CAFM operational property survey module is being used to record and retain evidence of completed property surveys, the CAFM scheduler is not being used to highlight when subsequent surveys are due to be completed.

Management has confirmed that there is property survey scheduling process is iterative, and that an established process is maintained outwith the CAFM system. This process has not been subject to IA review and testing.

Recommendation - Computer Aided Facilities Management (CAFM) – property survey scheduler

The property survey scheduler within the Computer Aided Facilities Management (CAFM) system should be implemented and used to support scheduling of future property surveys. The implementation process should include:

- pre-implementation testing and recording of the outcomes to confirm that the scheduler operates as expected;
- provision of training and guidance notes to surveyors to ensure that they understand how to use the system; and;
- a post implementation review to confirm that the scheduler is being effectively and consistently used.

Agreed Management Action - Computer Aided Facilities Management (CAFM) – property survey scheduler

The property survey scheduler did not form part of the CAFM scope and did not form part of the Requirements. This is because there is an already established process for carrying out surveys across the Council Estate. The process is an iterative one and needs to be flexible in nature. For example, if a report is received of loose masonry on a Council building then that will demand an immediate surveying response regardless of where such a building may be in a schedule.

As a rule, buildings are surveyed every five years and any new management action in respect of this approach will be considered on a bi-annual basis.	
Owner: N/A – advisory findings are not subject to Internal Audit follow-up **Contributors:** N/A	**Implementation Date:** N/A

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or*** • ***Critical*** impact on the reputation of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or*** • ***Significant*** impact on the reputation of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation of the organisation.
Low	A finding that could have a: • ***Minor*** impact on operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***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.

Appendix 2 - Areas of audit focus

The audit areas and related control objectives were tested in detail were:

Audit Area	Control Objectives
AMS and CAFM project management framework	• An appropriate project governance framework has been established to support delivery of the remaining aspects of the AMS, that is aligned with the Council's established project management framework; • Project Management expertise and supporting resources have been secured to support delivery through to project completion; • Project delivery is supported by an established project plan that is regularly reviewed and refreshed to reflect progress; • Progress reporting has been established and is provided to the AMS Steering Group, Asset Management Board; the Council's Change Board (if AMS meets the definition of a major project for the Council); and the Finance and Resources Executive Committee; and • Progress reporting includes an overall project RAG assessment; details of project costs; benefits tracking (including delivery of savings); and monitoring and reporting of project risks; issues; and dependencies. • Review (to the extent possible) the delivery of AMS financial targets benchmarked against the original AMS assumptions.
Property strategy and Management	• A register of Council properties has been established in CAFM and accurately maintained, with assets accurately recorded as either Investment or Operational and correctly valued (historical cost and current market value); • CAFM includes the latest property condition surveys for all Council properties; details of the next scheduled survey; and details of completed and required repairs; • A register of leases is maintained in CAFM and is proactively managed to ensure that they are either renewed in advance of expiry date, or marketed to identify new tenants in advance of the lease expiry date; • Assets initially leased at concessionary rates have been renegotiated to market rates (where lease renewals have taken place); • Appropriate action is taken to address properties that are currently vacant, or will soon be vacated, to ensure that a timely decision is made to either lease or sell; • Assets identified for disposal have been marketed and sold in a timely manner; • The Task Force with Property; Life Long Learning; and Locality Managers that was established to assess potential combination of services to support property rationalisation has been reconvened or refreshed; • A comprehensive assessment of likely demand for new assets to be managed and maintained by Properties and Facilities Management and associated capital and revenue costs (for asset lifecycle repairs and maintenance) over the short, medium and long term, has been performed, and reflected in the capital and revenue budgeting process; • A process has been established to ensure that internal demand for space within Council properties from service areas and external third parties are appropriately assessed and prioritised;

Audit Area	Control Objectives
	• Regular reviews are performed to ensure that Council use of properties is maximised so that surplus floor space and / or assets can be leased or sold.

Implementation of the CAFM system	• Data migrated from the legacy Asset Information System (AIS) is complete and accurate and has been fully reconciled, and cleansed where required;
	• Appropriate system testing was completed prior to 'go-live' of the new CAFM system. This includes:
	  ○ Core system testing (including system functionality and production of management information); and
	  ○ User acceptance testing (UAT)
	• All significant errors identified from system testing were graded; recorded; prioritised; resolved; and retested prior to system implementation;
	• The legacy AIS system and new CAFM system were run in parallel and data between the two systems was consistent (if applicable);
	• The project plan includes ongoing testing of any remaining system modules prior to implementation;
	• All system customisations are documented and were appropriately tested prior to implementation; and
	• A training program for the new CAFM system is in place and has been rolled out to appropriate personnel.

CAFM Operation	• A process has been established to support ongoing management of CAFM user access and user profiles;
	• CAFM management information requirements have been agreed with stakeholders; and
	• Complete and accurate MI is produced from the CAFM system and used to support Properties and Facilities Management operations. It is expected that this would include:
	  ○ volume and value of investment properties;
	  ○ volume and value (historic and market) of operational properties;
	  ○ volume; value and expiry dates of leases;
	  ○ total property capacity and spare capacity;
	  ○ repairs and maintenance scheduled analysed between capital and revenue expenditure;
	  ○ total repairs and maintenance completed and associated costs incurred;
	  ○ volume and value of work performed by contractors.

Third party supplier management	Confirm that the CAFM contract with Technology Forge for provision of ongoing support and administration of the CAFM system covers the following areas: • Resilience and business continuity arrangements, including recovery time and recovery point objectives; and the requirement to test these at an appropriate frequency; • System security controls to prevent inappropriate access; potential cyber attacks; and loss or theft of data; • User access and licence management arrangements; • Process for requesting; managing; and implementing system changes

The City of Edinburgh Council

Internal Audit

Implementation and application of new Facilities Management Service Level Agreement

Property Facilities & Management

Final Report

1 August 2019

RES1814

Overall report rating:

Generally Adequate with enhancements required	Areas of weakness and non-compliance in the control environment and governance and risk management framework that that may put the achievement of organisational objectives at risk

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

Contents

This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2018/19 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2018. 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's (the Council) Property and Facilities Management (P&FM) service is responsible for maintaining the Council's property portfolio and delivering facilities management services (for example catering; security; janitorial; and cleaning) to support their day to day management.

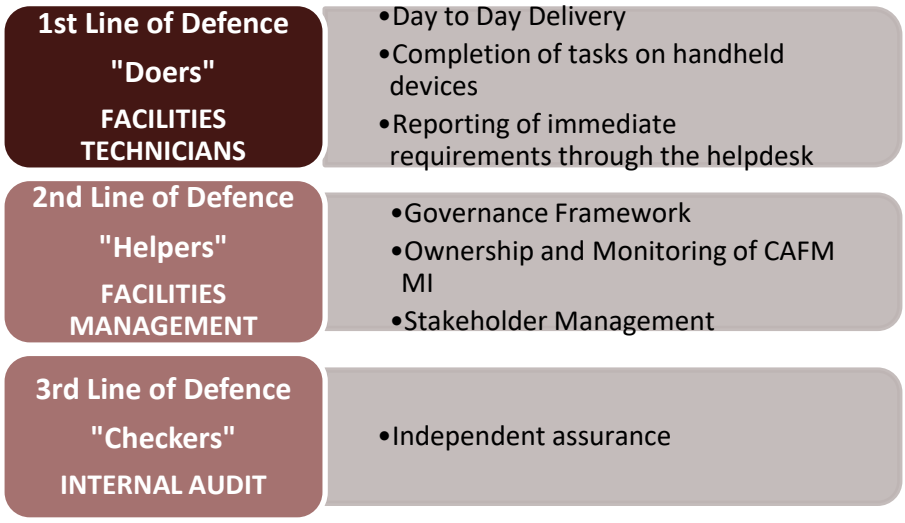
P&FM's main internal client is the Communities and Families Directorate, which includes schools; nurseries; children's homes; libraries; and community centres.

The Council's Asset Management Strategy (the Strategy) was approved by the Finance & Resources Committee on 24 September 2015, and Anturas Consulting (Anturas) were engaged to manage its implementation.

Whilst several of the Strategy's objectives were achieved prior to conclusion of the Anturas contract in December 2017, facilities management service levels and supporting key performance indicators had not yet been defined, making it difficult to manage both service and employee performance, and ascertain whether the service provided was aligned with customer expectations.

Consequently, P&FM agreed to defined and implement an FM Service Level Agreement (FM SLA). The FM SLA for Janitorial Services was agreed with Communities and Families (C&F) and implemented in October 2018. Management has advised that this SLA is the first to be implemented across Scottish Local Authority Property Group.

The Three lines of defence model can be applied to the delivery of FM services, where the 'First line' are the facilities technicians responsible for service delivery; the "Second line" Facilities Management who are responsible for applying a governance framework to ensure effective delivery of services included in the SLA by reviewing performance management information (MI) available from the Computer Aided Facility Management (CAFM) system; and ongoing stakeholder management. The 'third line' (for example, Internal Audit) provides independent assurance on the design and ongoing effectiveness of the controls established to support ongoing delivery of facilities management services.



Scope

This review assessed the adequacy of the design of the FM SLA and the effectiveness of key controls established to confirm that FM services are delivered as designed; efficiently; and effectively.

Our review also validated whether the remaining Medium rated finding raised in the 2016/17 review of Property Maintenance had been effectively resolved.

Our audit work concluded on 22 March 2019 and our findings and opinion are based on the conclusion of our work as at that date.

2. Executive summary

Total number of findings: 1

Summary of findings raised	
High	1. Facilities Management Janitorial Services Governance Framework

Opinion

It is essential to ensure that a governance framework is established and operates effectively to confirm the ongoing consistency and quality of janitorial services provided by Facilities Management (FM) to Communities and Families (C&F) following implementation of the new Facilities Management Service Level Agreement (FM SLA) in October 2018.

Our review has confirmed that whilst management recognises the need to implement a governance framework; has acknowledged that key performance indicators (KPIs) are required to support ongoing assessment of the quality of service delivery; is actively progressing development of a framework, and has already established some elements (for example weekly stakeholder management meetings and production of management information (MI)), further enhancements are required to improve both the framework design and its operating effectiveness.

These enhancements include the need to define and implement KPIs; develop and produce MI that is aligned with the KPIs; confirm the accuracy of performance information currently produced from data recorded on the Computer Aided Facility Management (CAFM) system; develop and implement ongoing quality assurance reviews; communicate existing performance issue escalation guidance, and clarify responsibilities for their ongoing management and resolution; and improve the effectiveness of established stakeholder management processes.

Consequently, one High rated finding has been raised (refer section 3 below).

It should be noted that FM management are aware of the need to implement an appropriate governance framework to support ongoing monitoring of the services provided to Communities and Families, although implementation plans have not yet been developed, and have provided a management response (refer below) that outlines some of the challenges that have impacted progress. It should also be recognised that the new service delivery model is in the early stages of implementation.

Appendix 2 also includes a diagram that illustrates a suggested design for an FM janitorial services governance framework, based on our recommendations.

2016/17 Property Maintenance review – progress with implementation of remaining findings

An Internal Audit review of Property Maintenance completed in February 2017 raised a Medium rated finding highlighting that no formal guidance was available to the Facilities Management helpdesk detailing how property maintenance issues reported should be prioritised.

A guidance document has now been developed and provided to FM Helpdesk teams that categorises issues reported into groups and provides appropriate response times based on these groups. Consequently, this finding can now be closed.

Management response

The original Deloitte recommendation in relation to the Facilities Management (FM) model was that the service should be outsourced, however a decision was made at the Council's Finance and Resources Committee (September 2015) that an in house model should be developed.

This resulted in the transfer and transformation of an established direct labour organisation service model from Communities and Families to Properties and Facilities Management in 2015/16 that had not been reviewed in circa 30 years.

The transformation involved changing to an 'in house' strategic partner model that is now designed to meet the needs of the services that FM support. These changes have been implemented by management, with limited project management support, in addition to their ongoing service delivery responsibilities. They also involved an extensive review of the service (circa 18 months) and subsequent recruitment (circa 33 full time equivalent employees were recruited across a six month period, and the management structure has been changed) to address service delivery gaps.

Consequently, FM has been on a journey that involves significant cultural change for employees in relation to how they think about and approach their roles.

There has also been significant challenge with implementation of the new technology required to enable production of management information to support ongoing monitoring service delivery performance, with a number of employees retiring and many not yet using the new technology accurately despite the availability of extensive ongoing support and training.

The requirement for additional support and training required involved significant management time and effort both from FM and other areas such as Human Resources. This has impacted management's ability to design and implement an appropriate governance framework to confirm the ongoing consistency and quality of janitorial services provided, although there has been ongoing informal engagement with Head Teachers in relation to the quality of service delivery.

It should also be noted that implementation of a governance framework that includes assessing performance against established key performance indicators is dependent on developing a strategy for the Computer Aided Facility Management (CAFM) system, given known issues with the quality of CAFM system data.

There is a direct relationship between the speed of implementation of the management actions detailed in this review and resources availability within the Facilities Management service.

3. Detailed findings

1. Facilities Management Janitorial Services Governance Framework	High

The Facilities Management Service Level Agreement (FM SLA) for provision of Janitorial Services between Facilities Management (FM) and Communities and Families (C&F) was signed and implemented on the 31st of October 2018.

However, no second line governance framework has yet been established to confirm that the full range of agreed services continue to be delivered effectively, and that all service delivery issues raised are satisfactorily resolved.

Our review identified the following areas where governance arrangements supporting ongoing delivery of FM services require to be established and / or improved:

1. Implementation of Key Performance Indicators (KPIs)

KPIs have not yet been established to assess whether the services detailed in the FM SLA are being delivered effectively.

FM management has advised it was agreed at the time of initial implementation of the FM SLA that KPIs would be established 6 months post implementation.

Whilst a timeline to finalise KPIs has now been agreed between FM and C&F, their format and content has not yet been discussed and agreed.

2. Completeness and accuracy of CAFM performance management information

Review of management information (MI) produced from the Computer Aided Facility Management **(**CAFM) system identified that facilities management performance issues are not consistently and accurately closed by janitors using their handheld devices, resulting in production of inaccurate MI from CAFM.

3. Ongoing quality assurance reviews

Implementation of the FM SLA was supported by a janitorial handbook that provides operational guidance for janitorial employees in relation to the services provided under the FM SLA.

Review of the handbook established inclusion of the requirement for ongoing ‘second line’ quality assurance or “internal audit plan” designed to confirm the quality of both the services provided, and the content of the Quality Management System used as the basis for production of performance management information (MI).

Whilst evidence has been provided of one completed site review, an ongoing risk based quality assurance plan that identifies the sites and services to be reviewed and their review frequency has not yet been developed and implemented.

4. Clear guidance on escalation of performance issues

The FM SLA does not include detail on how performance issues should be escalated. The escalation process is included in the janitorial handbook, however there is no reference from the FM SLA to the janitorial handbook. Additionally, the handbook does not define responsibilities for ongoing management and resolution of escalated performance related issues.

5. Stakeholder relationship management and feedback

Weekly meetings with C&F stakeholders have been established with the objective of discussing ongoing service delivery performance, however, no structured agenda is applied; performance

management information available from the CAFM system is not provided for review and discussion; and follow up actions are not recorded and tracked through to implementation.

Risks

The potential risks associated with our findings are:

- FM management does not have adequate and effective second line oversight of the quality of janitorial services provided;
- Performance issues and associated risks (for example health and safety risk) are not identified and resolved in a timely manner;
- Inappropriate and uninformed management decisions are made based on inaccurate management information; and
- Performance issues identified at weekly stakeholder meetings are not investigated and resolved.

1.1 Recommendation - Implementation of Key Performance Indicators

1. An appropriate set of Key performance indicators (KPIs) should be developed by Facilities Management (FM); agreed with Communities and Families (C&F); implemented and monitored to confirm that janitorial services (as detailed in the Facilities Management Service Level Agreement (FM SLA) and janitorial handbook) continue to be effectively delivered. The KPIs should be:

- aligned with service delivery objectives and targets included in the SLA and janitorial handbook;
- SMARTER – specific; measurable; achievable; relevant; time-bound; explainable (easily understood); and relative (should use relative values such as percentages) to enable comparisons over time;
- linked to FM performance data recorded in the Computer Aided Facility Management (CAFM) system (where possible); and
- linked to the outcomes of quality assurance reviews (refer recommendation 1.2 below);

2. The KPIs should be communicated to all employees responsible for delivering the janitorial services specified in the FM SLA and janitorial handbook; and
3. Reports should be designed and implemented that highlight performance against the agreed KPIs (for example, using red; amber; and green RAG ratings) and an overall performance assessment for delivery of services for the period (for example month or quarter) under review.

Agreed Management Action – Implementation of key performance indicators

A suite of KPI's is currently being developed in conjunction with the Communities & Families. While an element of these are service led, Facilities Management are keen to ensure a customer led component to these. These KPI's will be based on industry standards and will be linked to Facilities Management performance data and the outcomes of quality assurance reviews.

Once agreed, KPI's will be communicated through training sessions, web updates and included in the SLA and janitorial handbook which is distributed both to staff and to our customers and key stakeholders.

Monthly dashboards will be produced highlighting performance against indicators. These will be both for internal service use and for customer reporting.

Owner: Stephen Moir, Executive Director of Resources Contributors: Peter Watton, Head of Property and Facilities Management; Mark Stenhouse Facilities Management Senior Manager; FM locality managers; Gohar Khan, Performance and Audit Officer; Layla Smith, Operations Manager; Audrey Dutton, Executive Assistant	Implementation Date: 31/03/2020

1.2 Recommendation - Completeness and accuracy of Computer Aided Facility Management (CAFM) performance management information

- Sample checking should be performed on open and closed tasks recorded in the CAFM system to confirm that the status recorded on the system is accurate; and
- The requirement for janitors to record closure of tasks using handheld devices should be reinforced and included as a specific objective in their 'looking forward' conversations.

Agreed Management Action - Completeness and accuracy of Computer Aided Facility Management (CAFM) performance management information

Sample CAFM checking is underway to sense check the accuracy of status as recorded on the system.

A final stage of face to face additional training of janitorial staff is nearing completion and management reinforcement of the requirement for staff to properly utilise hand held devices is a standing agenda item at team meetings.

This training will also include the requirement for managers to include effective use of handheld devices in annual employee looking forward conversations.

Owner: Stephen Moir, Executive Director of Resources Contributors: Peter Watton, Head of Property and Facilities Management; Mark Stenhouse Facilities Management Senior Manager; Gohar Khan, Performance and Audit Officer; Layla Smith, Operations Manager; Audrey Dutton, Executive Assistant	Implementation Date: 29/11/2019

1.3 Recommendation - Implementation of ongoing quality assurance reviews

Facilities Management (FM) should implement a proportionate, risk based, ongoing quality assurance review process across the sites that receive janitorial services specified in the Facilities Management Service Level Agreement.

The process should include (but should not be restricted to):

- a clear methodology for site selection that is linked to performance outcomes detailed in ongoing performance reports (refer recommendation 1.1 above);
- 'themed' reviews across a range of sites that focus on high risk areas. For example, health and safety risk, and the requirement to complete ongoing checks on stair treads; window restrictors; and suspended ceilings;
- clear guidance on how to complete the review; identify and assess any potential gaps; and report the outcomes; and
- a review process to identify systemic weaknesses, ensuring that they are communicated to management and subsequently resolved.

Agreed Management Action - Implementation of ongoing quality assurance reviews

Ongoing quality assurance reviews will be established as described above. In addition to using these to measure the efficacy of our SLA delivery, these are required as part of the ISO 9001/45001 certification process and designed to give us comfort over the robustness of our policies, procedures and supporting documentation.

Owner: Stephen Moir, Executive Director of Resources Contributors: Peter Watton, Head of Property and Facilities Management; Mark Stenhouse Facilities Management Senior Manager; Gohar Khan, Performance and Audit Officer; Layla Smith, Operations Manager; Audrey Dutton, Executive Assistant	Implementation Date: 31/03//2020

1.4 Recommendation - Guidance for escalating performance related issues

- The Facilities Management Service Level Agreement should be updated to include a reference to the escalation of performance issues process detailed in the janitorial handbook;
- The janitorial handbook should be updated to confirm management responsibilities for resolution of escalated performance issues.

Agreed Management Action - Guidance for escalating performance related issues

The Facilities Management SLA will be updated and cross-referenced to the Janitorial Handbook to describe the performance escalation process. An interim measure will see a paragraph added to the SLA and handbook which describes an escalation process pre KPI and dashboard roll-out.

The janitorial handbook will be updated, and staff sessions held, to confirm management responsibilities for resolution of performance issues.

Owner: Stephen Moir, Executive Director of Resources Contributors: Peter Watton, Head of Property and Facilities Management; Mark Stenhouse Facilities Management Senior Manager; Gohar Khan, Performance and Audit Officer; Layla Smith, Operations Manager; Audrey Dutton, Executive Assistant	Implementation Date: 30/08/2019

1.5 Recommendation - Formalising weekly meetings with Communities and Families

Weekly meetings held with Communities and Families should be formalised to include:

- a standing agenda;
- review of performance information currently available from the Computer Aided Facility Management **(**CAFM) system; review of performance management information against key performance indicators (once established and implemented as per recommendation 1.1 above); review of themes reported through the Facilities Management helpdesk; and review of outcomes from quality assurance reviews (once established and implemented as per recommendation 1.3 above);
- allocation of agreed actions from the meeting together with responsibility for addressing and agreed implementation dates; and
- ongoing review of the actions log at each meeting.

Agreed Management Action

A weekly meeting is currently held with Communities & Families. This will be formalised and have a standing agenda to include a review of performance information and outcomes of quality reviews. This meeting will also serve to log and consider agreed actions and outcomes.

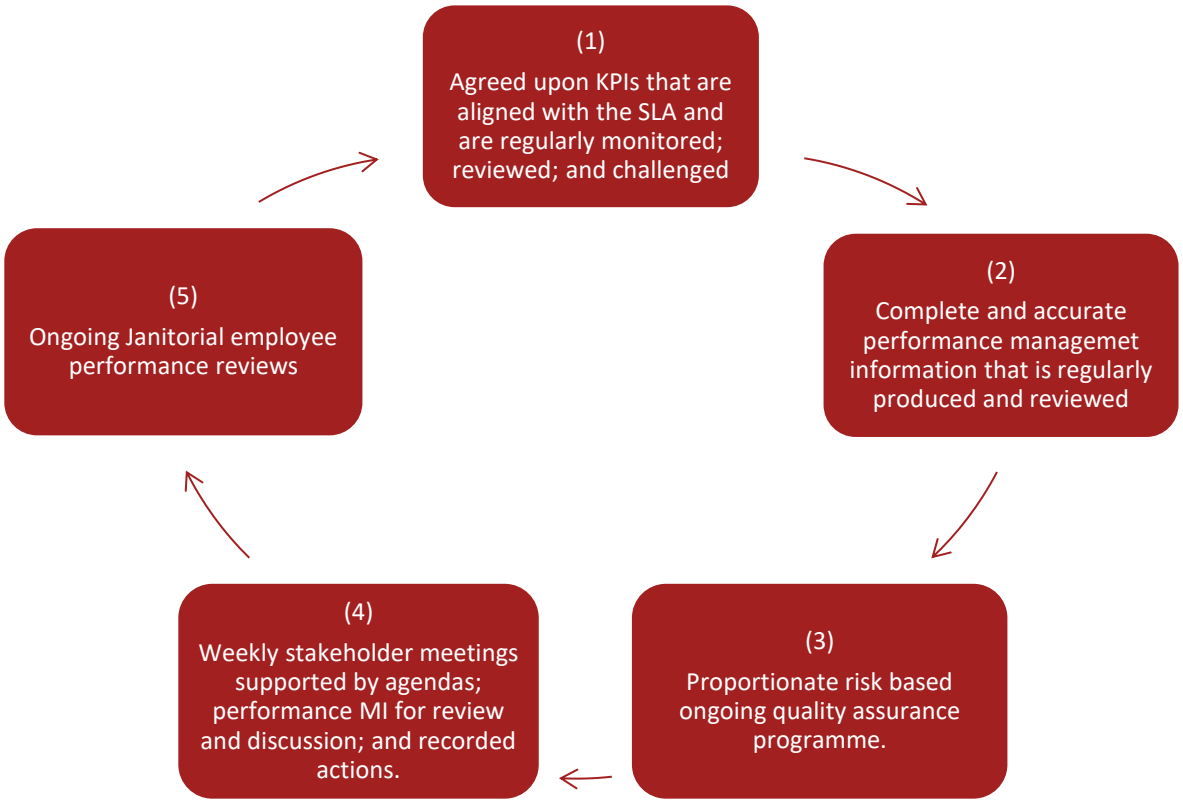
Owner: Stephen Moir, Executive Director of Resources Contributors: Peter Watton, Head of Property and Facilities Management; Mark Stenhouse Facilities Management Senior Manager;	Implementation Date: 31/03/2020

Gohar Khan, Performance and Audit Officer; Layla Smith, Operations Manager; Audrey Dutton, Executive Assistant	

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or*** • ***Critical*** impact on the reputation of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or*** • ***Significant*** impact on the reputation of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation of the organisation.
Low	A finding that could have a: • ***Minor*** impact on operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***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.

Appendix 2 – Suggested Facilities Management Janitorial Services Governance Framework



Appendix 3 – Areas of Audit Focus

The audit areas and related control objectives that were tested in detail were as follows:

Audit Area	Control Objectives
Design and Implementation	• There was appropriate consultation with stakeholders and employees prior to finalising the design of the FM SLA to agree on the nature and costs of services to be provided; • Roles and responsibilities of FM employees and stakeholders have been agreed and documented within the SLA; are documented in role descriptions; and have been incorporated in employee objectives (looking forward conversations); • The SLA includes guidance for an established process for escalating performance issues; • The costs and benefits associated with the FM SLA have been considered and recorded; • The FM SLA was reviewed and approved by senior management; • The FM SLA was signed by both Facilities Management and service areas (including Communities and Families) prior to implementation; • The FM service restructure was performed in line with applicable HR organisational review; redeployment; and redundancy policies and processes, with support provided by HR (where required); • An effective employee engagement and communication process was applied throughout the process; • Training has been provided to FM employees and Contact Centre teams who support the FM helpdesk in relation to new operational processes; • Details of the new FM SLA and the process for engaging with Facilities Management to initiate requests for service or provide feedback have been communicated across the Council; • Performance management information enabling an assessment of ongoing performance has been designed and implemented; • A process has been established to ensure that Council staff initially engage with FM for requests for service prior to sourcing alternative suppliers; and • A change management process has been established to support arrangements where FM provide additional services outside of the agreed services included in the FM SLA.
Governance, Monitoring and Reporting	• An appropriate governance framework (including regular stakeholder meetings) has been established to monitor ongoing FM performance and obtain feedback from stakeholders; • Ongoing management of FM services, and engagement with stakeholders has been allocated to an appropriate senior manager; • Consolidated performance MI is regularly produced and reviewed by management; • Plans have been designed to support implementation of quality control processes to assess the quality of FM services delivered to stakeholders; and • Performance issues are escalated and resolved on a timely basis;
Post-Implementation review	• A post-implementation review of the FM SLA has taken place to identify any potential lessons learned and opportunities for improvement, with clear plans established to support implementation of agreed changes;

Audit Area	Control Objectives
	• Ongoing benefits monitoring is performed to confirm that expected benefits (financial and non financial) have been / will be achieved; and • Reports are provided to the Finance and Resource Committee on implementation progress; realisation of expected benefits; and stakeholder feedback.

The City of Edinburgh Council

Internal Audit

Homelessness Services

Final Report

8 July 2019

CW1808

Significant enhancements required	Significant areas of weakness and non-compliance in the control environment and governance and risk management framework that puts the achievement of organisational objectives at risk.

Contents

This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2018/19 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2018. 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

In accordance with the Housing (Scotland) Act 1987 as amended by the Housing (Scotland) Act 2001; the Homelessness Etc. (Scotland) Act 2003; and the Homeless Persons (Unsuitable Accommodation) (Scotland) Order 2004; and the Housing (Scotland) Act 2010, the Council has a legal duty to assist people presenting as homeless or at risk of homelessness.

Homelessness position in Edinburgh

The number of people presenting as homeless to the Council has reduced by 32% over the last decade, from 4,881 applications in 2008/09 to 3,290 in 2018/19. Assisting the homeless, remains a significant challenge for the Council, with 3,061 applicants (93%) assessed as homeless or at risk of homelessness in the last year.

Homelessness cases are assessed and managed by housing officers in localities; temporary accommodation services and the Access Point. Housing officers manage individual cases until the Council's duties have been fully discharged. As at 31 March 2019, there were 24.5 full time equivalent Housing Officers managing a total of 3,876 open homeless cases. Throughout the year caseloads vary per officer from 130 – 190, dependent on demand, resources and absences.

In 2018/19, the average case length for homelessness applications was 365 days, up from 293 days in 2017/18. The Service has advised this increase is due to a lack of permanent or settled housing and increased presentations from private rented sector tenants (up from 17% in 2013 to 24% in 2018).

Advice and Assessment Services

Advice on housing options and the availability of services is provided free of charge at the Council's four locality offices (during office hours); through the customer contact centre (outwith office hours); and via the Council's website. Dedicated services for vulnerable applicants are also available through The Access Point (TAP).

The Council must carry out an assessment to decide if a statutory homelessness duty is owed and must ensure applicants are eligible for assistance and have recourse to public funds. The Council aims to complete its enquiries and inform the applicant of the outcome within 28 days.

The Council must make enquiries and record its decisions in line with the three tests of homelessness, which are as follows:

1. Is the applicant homeless, or threatened with homelessness?
2. Is the applicant intentionally homeless?
3. Does the applicant have a local connection to the City of Edinburgh?

The Council operates a duty appointment system for applicants who are at immediate risk of homelessness or have nowhere to stay that night. An interview should be carried out the same day or temporary accommodation provided until the next available appointment.

The Council also has a duty to inquire whether an applicant (or any other person residing with the applicant) has housing support needs, and where identified, must develop a support plan and make referrals to support services as required. Gold priority can be awarded to people presenting as homeless, should they be assessed as requiring specific housing e.g. ground floor, wet floor shower, or ramped/level access. This is carried out by the advice and assessment service.

Temporary Accommodation

The Council should provide temporary accommodation to applicants who require it, until its statutory duty is discharged. The Council's temporary accommodation consists of furnished flats; bed and breakfast accommodation; shared houses; and hostels.

Under the Homeless Persons (Unsuitable Accommodation) (Scotland) Amendment Order 2017, pregnant women and families can be only be placed in unsuitable accommodation for a maximum of 7 days, unless exceptional circumstances apply. The Council records and monitors any breaches daily, taking action to resolve.

Over the past 12 months the Council has reduced the number unsuitable accommodation breaches from 166 in Q1 2018/19 to 43 in Q2 2019/20. This is a result of a number of initiatives including:

- Allocating an extra 40 council properties for temporary accommodation;
- Investing in extras funding for private sector leasing (PSL) properties; and
- Working with partner Registered Social Landlords (RSLs) to secure a further 75 properties.

Allocation of permanent accommodation

The Council advertises homes available to rent from the EdIndex partnership (the City of Edinburgh Council and 19 Housing Associations) through the online 'Key to Choice' system.

As at 31 March 2019, there were 21,000 applicants on the EdIndex waiting list. Properties are allocated according to the Council's Letting Policy. Statutory homeless applicants are awarded 'Silver Priority, which are ranked by the date silver priority awarded and then by date of application. In 2018/19, circa 1,404 allocations were made to homeless applicants from a total of 3,002 available lettings, with an average of 187 bids per property. The Council lets 7 out of 10 homes to homeless households.

Homelessness case management

Case Management Procedures require Housing Officers to review progress with cases every 12 weeks to confirm that applicants' details remain accurate and they are consistently bidding for available properties.

Processes are also in place for managing 'lost contact' cases'. These are defined as a protracted absence of any sign that a person remains homeless and is actively seeking rehousing by placing bids and maintaining contact with the service.

Quality Assurance

The Council has developed a case management checklist which covers all key areas in the assessment and case management process. Team Leaders required to undertake case file reviews and discuss outcomes at one to one meetings with housing officers.

An audit section is also included within the Homelessness Information System (HIS) database to record the date and name of officer performing the review and any comments regarding the outcomes of the case file review.

Statutory Reporting

The Council is required to report performance and data on statutory homelessness duties and outcomes to the Scottish Government and Scottish Housing Regulator quarterly and annually. Due to known limitations with the Homelessness Information System (HIS) database, data extraction and preparation of reports is a predominantly manual process mainly reliant on one experienced team member, who performs data cleansing checks to ensure the data is complete, relevant and in the correct format in line with documented processes.

Scope

The objective of this review was to assess the adequacy of design and operating effectiveness of the key controls established to ensure the Council meets its statutory homelessness duties, through review of key documents and testing of key processes, and discussions with key members of staff.

We also reviewed a sample of 146 homelessness case files across all four localities for the period 1 April 2018 to 31 December 2018. This included homeless assessment cases; lost contact cases and cases where the applicant had received an offer of permanent accommodation.

Limitations of Scope

The scope of this review was limited to the operational processes in place to ensure the Council meets it statutory homeless duties. The following areas were specifically excluded from the scope of this review:

- Access to out of hours homelessness services – this is included within the scope of the Emergency Prioritisation and Complaints audit.
- Homelessness management strategies - the Council's Rapid Rehousing Transition Plan (RRTP) was approved by the Council's Housing and Economy Committee in March 2019. A review of the RRTP and the supporting delivery framework will be considered within the scope of the Prevention Services review included in the 2019/20 Internal Audit annual plan.
- Whilst this review considered how the Council is meeting its statutory duty to provide interim accommodation, it does not consider the Council's overall approach to use of interim accommodation, as this was subject to review in 2017, and will also be included in the scope of the review above.

Reporting date

Our audit work concluded on 5 June 2019 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	1. Homelessness performance and quality assurance
High	2. Data quality and performance reporting
Medium	3. Provision of homelessness advice and information

Opinion

Significant enhancements required

Our review confirmed there are significant control weaknesses in relation to the design and operating effectiveness of key controls established to ensure the Council meets it statutory homelessness duties.

Consequently, two high and one medium rated findings have been raised.

The two High rated findings reflect the need to ensure that appropriate performance standards and measures are established, and an effective first line (service) quality assurance process implemented to provide ongoing assurance that that homelessness policies and procedures are consistently applied across the Council in line with applicable legislation; regulations; Scottish Government and Scottish Housing Regulator expectations; and other relevant internal Council policies.

Whilst management recognises and acknowledges the limitations of the Homelessness Information System (HIS) database use to record and manage homeless applications and is taking appropriate action to replace the system (a project is underway to migrate HIS to the Northgate system). Implementation of the new system has been delayed to September 2020 due to a series of issues related to the build and data loading. A project board is in place to ensure governance and monitoring of the migration and includes representatives from the service area, ICT services and CGI.

To ensure effective security of personal sensitive data stored and processed in the HIS and prevent unauthorised access, it is essential that HIS user access profiles are reviewed and updated to ensure that all users have unique user log on IDs and passwords, and that a data protocol is designed; implemented; and monitored as part of the quality assurance process to support accurate recording, processing, and extraction of homelessness data. These interim measures should improve compliance with General Data Protection Regulation (GDPR) requirements until the new Northgate system is implemented.

Whilst homelessness service operational performance is reported to senior management, there is currently no performance reporting provided to the Council's Housing and Economy Committee, although management has advised that this is currently under development. Additionally, limited performance information is reported publicly to customers, in comparison to other Scottish Local Authorities.

The medium rated finding highlights the importance of ensuring that appropriate and timely information and advice is available through multiple communication channels to help people and / or their advocates make the right choices to address their housing situation. If customers can access relevant information at the right time, this should reduce the extent of initial contact and support required from the Council, alleviating demand and pressures on the Homelessness service.

Our detailed findings and recommendations are included at Section 3 below.

Management response

Management acknowledge the issues raised during the audit and will commit to implementing improvement actions to address these. The Homelessness Service is facing increasing pressure with a lack of affordable housing options and move on accommodation available for applicants presenting in Edinburgh. This has resulted in a significant increase in Housing Officers workload due the extremely high number of open homelessness cases and the increase in average time taken to rehouse an applicant in to permanent accommodation. Average Housing Officer caseload is between 130-190 cases, which impacts ability to carry out the full requirements of our case management procedures effectively.

There are over 3,000 homeless households that apply to the Council each year for whom it has a duty to find a settled home. The number of homeless applications has been decreasing due to the Council and its partner's extensive homelessness prevention work, but pressure on temporary housing is increasing with people spending longer in temporary accommodation due to the length of homeless cases. This is caused by the limited settled housing options relative to the scale of demand.

The housing market pressure experienced in Edinburgh is fundamentally different to any other housing market in Scotland. This has led to high housing costs, high need for affordable housing, and high unmet need, which has a significant impact on the ability to rehouse homeless households. Household income inequality is growing, and the already pressured housing market is expected to be under increasing pressure as the city grows at a faster pace than elsewhere in Scotland.

The following issues are also impacting demand for services:

- Between 2016-2026 the population of Edinburgh will increase by 7.7%, double the projected growth rate for the whole of Scotland at 3.2%, and household population is projected to increase by 11.5%, almost twice the projected increase of 6.4% for Scotland as a whole.
- Demand for new homes in Edinburgh is between 38,000 and 46,000 over the next ten years, of which over 60% needs to be affordable.
- Only 15% of Edinburgh's overall housing stock is available for social rent, compared to Scottish average of 25%.
- Private rents in Edinburgh average over £1,000 a month, this well above current Local Housing Allowance and is not affordable for a majority of applicants; the national average is £800.
- In 2017/18, around 800 people presented as homeless from a private rented sector tenancy, a customer group that has begun to increase year on year.
- Increased loss of private rented sector properties to the short term lets market.
- To buy a home in Edinburgh costs over 6 times the average income.
- 111% of all social lets in Edinburgh would be required to meet all homeless needs through the social rented sector, i.e. even if all available social lets are to homeless households there would still be a supply gap and it would not allow for needs of other priority groups to be met.
- The Council's Business Plan 2017-2022 includes a commitment to deliver 20,000 affordable homes by 2027; one of the largest council-led house building programmes in the UK. There is a significant shortfall of settled housing available for all housing needs groups in Edinburgh.

3. Detailed findings

1. Homelessness performance and quality assurance — High

Our review of existing homelessness policies, procedures and operational processes established that:

1.1 Homelessness policies and procedures

- **Review of policies and procedures** - a range of policies and procedures aligned to best practice and relevant legislation are in place, but have not been subject to regular review, with several last reviewed in 2013/14;
- **Standard templates** – are not used to ensure the format of policy and procedures documentation is consistent and subject to appropriate version control;
- **Local interpretation of policies and procedures** – Locality Team Leaders issue instructions via email that result in local interpretation of policies and procedures; inconsistent application; and variances in approach; and
- **A 'Housing Options Protocol for Care Leavers'** was drafted and shared with the Council's Young People's Services in January 2019, however, feedback is yet to be received to allow the protocol to be finalised, implemented and communicated.

Management has advised that a review of all policies and procedures is currently in progress and due to be completed by 30 September 2019.

1.2 Homelessness Operational Processes

- **Records Management and retention –** paper case files could not be located for 17 cases chosen as part of our sample. Business Support advised these files were not recorded as archived.
- **Average appointment waiting times** where emergency assistance was not required was 11.6 working days in 2018/19. The average waiting time has subsequently increased, averaging 21.9 working days in March. Management has advised this is due to staff absence and mandatory training for new ICT system, including the delivery by officers.
- **Capacity** - Housing Officers advised that limited capacity is available to manage cases in line with the timescales set out in the Council's procedures. It was noted the average caseload per officer was 138 cases. Management advised that, officers generally have one day per week for casework, which makes providing support to all cases challenging so prioritisation from officers is on a case by case by case basis.
- **Homelessness assessments** reportedly often take longer than the allocated one-hour slot, resulting in multiple interviews; which impacts waiting times;
- **Duplication of effort when recording information** - for example, taking handwritten notes in interviews, and then transferring to system (laptops and computers are available for use during interviews);
- **Completion of Action Plans** following interview, rather than during the interview with the applicant;
- **Inconsistent approach to scheduling regular reviews** - for example using calendar reminders or Excel logs**,** with a number of officers managing caseloads through paper lists.
- **Eligibility checklists and applicant identification –** only 72% of cases files (59 of 82 cases) sampled had completed eligibility checklists and copies of applicant identification on file, to evidence that the applicant was eligible for assistance and had recourse to public funds;
- **Recording applicant circumstances**, **advice given and final decision** - 21% (17 of 82 cases) of case files did not include a clear record of the applicant's circumstances; the advice given; and the reason for the Council's final decision;

- **Application of the 'Three Tests of Homelessness'** - 11% of case files (9 of 82 cases) could not evidence that the Council had considered and documented in sequence, its decisions in line with the 'Three Tests of Homelessness';
- **Applicant declaration** – applicants are required to sign a declaration pro-forma to demonstrate they understand their legal duty to disclose accurate information. Testing found the pro-forma was only completed in 2% of cases (2 of 82 cases) reviewed. Housing Officers advised this was due to ambiguity on whether the proforma meets the requirements of the General Data Protection Regulations (GDPR).

  Consultation with the Council's Information Governance Unit, and Legal department confirmed that the declaration proforma should be revised;
- **Action plans** - evidence of completed action plans that were provided to the applicant was available in only 24% of the case files (20 of 82 cases) reviewed;

  Housing Officers advised that some action plans had been emailed to applicants, however we were unable to confirm as this was not noted on the electronic file, or a copy of the email retained in the paper case file;
- **Written decision letters** – there was no evidence of copies of decision letters for 20% of case files (16 of 82 cases) reviewed;
- **12 weekly case review process** - for 96% of cases (79 of 82 cases), there was no evidence to demonstrate the housing officer had regularly followed the Council's 12 weekly case review process. with several instances of limited contact for periods of 6 to 12 months.
- **Lost contact -** in 72% of cases (23 of 32 closed cases sampled), housing officers did not consistently follow the Council's 'Lost Contact' procedures to ensure all efforts were made to contact applicants prior to closing their case, again with several instances of no contact attempts being made for 6 to 12 months.
- **Pre-allocation advice and support** - in 87% of cases (13 of 15 cases sampled), there was limited evidence to demonstrate the housing officer had contacted the applicant to provide pre-allocation advice and support, prior to an offer of permanent accommodation.

1.3 Quality Assurance

Our sample testing across 82 case files found no evidence of completion of case file reviews, with no documentation retained on file, and the audit section on Homelessness Information System (HIS) database incomplete.

We also reviewed a system report which recorded completion of the audit section on HIS and noted the audit field had not been complete on any case files since February 2017.

Risks

- Housing officers are not operating in line with the Councils policies and procedures;
- Failure to meet statutory and regulatory duties in relation to homelessness;
- Assistance may be provided by applicants who are not eligible, and with no recourse to public funds;
- Applicants who need to wait up to four weeks for an appointment may be provided with insufficient information to prevent homelessness occurring or reoccurring for example, where a customer is served a two-month Notice to Quit/Section 33 notice by a landlord;
- Applicants are not aware of their legal duty to disclose accurate information;
- Inaccurate record keeping for evidencing decision making and to support statutory appeals;
- Non-compliance with records management policies and General Data Protection Regulations (GDPR);
- Applicants are not aware of decision outcome and their legal right to appeal; and

- Inability to demonstrate the applicant was provided with relevant information, such as benefits advice and support; to help sustain their tenancy and prevent repeat homelessness.

1.1 Recommendations: Policies and procedure framework

Management have advised all policies and procedures are currently being reviewed. As part of that review the following should be considered:

1. A policy and procedure review schedule should be developed and maintained to ensure all documents are reviewed at least every three years or earlier where required due to legislative or operational changes;
2. Use of a standard template for all policies and procedures to ensure all documents:
   - Clearly state the Title of the document and whether it is a policy, procedure or process note;
   - Clearly state how the policy or procedure ensures compliance with applicable legislation;
   - Include a Version Control table, stating creation date; version number; policy owner and date next review due;
   - Include within the footer, the title, date and version number; and
   - Appendix to reference links to other relevant policies and procedures.
3. All policies and procedures should be stored in a controlled and centrally managed location, with clear responsibilities for reviewing and updating documents, and previous versions should be archived;
4. Implementation of a protocol for communicating updates to policies and procedures by a Senior Officer only, to ensure consistent application of policies and procedures across all localities and other offices; and
5. The Housing Options Protocol for Care Leavers should be finalised in conjunction with Young People's Services; approved and communicated.

Agreed Management Actions

1. A full policy and procedure review schedule will be developed and maintained to ensure all documents are reviewed at least every three years or earlier where required due to legislative or operational changes. An initial review of all policies and procedures will take place this year.

Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Debbie Herbertson, Homelessness Services Manager; Brian Stewart, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 31 January 2020

2. Agreed, the recommendation will be implemented in full.

Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Debbie Herbertson, Homelessness Services Manager; Brian Stewart, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 31 January 2020

3. Agreed, the recommendation will be implemented in full.

Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Debbie Herbertson, Homelessness Services Manager; Brian Stewart, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 31 January 2020

4. The Service Manager will implement a protocol for communicating updates to policies and procedures relating to Homelessness Prevention and Housing Options Team, to ensure consistent application of policies and procedures across all localities and other offices

Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Debbie Herbertson, Homelessness Services Manager.	**Implementation Date:** 30 September 2019

5. We will, in conjunction with Young People's Services, finalise the Housing Options Protocol for Care Leavers. It will be approved by the Council's Housing, Homelessness and Fair Work Committee and communicated by the end of this financial year.

Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Scott Dunbar, Looked After Children Senior Manager; Debbie Herbertson, Homelessness Services Manager; Steve Harte, Young People's Services Team Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 30 April 2020

1.2 Recommendations: Review of appointment waiting times and increased efficiencies

The current appointment system should be reviewed with the aim of reducing appointment waiting times for non-emergency applicants. In doing so, management should consider

1. Introducing measures to provide applicants with relevant information at the time of first contact; whether that is in person or on the telephone. This should include:
    - Working with Customer Service and Business Support staff to ensure applicants are advised what documents they will be required to bring to their interview;
    - Review of current interview processes and time allocated to identify where efficiencies can made, for example through better use of technology, to allow assessments to be complete in one appointment in the majority of cases;
    - Early intervention for applicants threatened with homelessness within two months to enable the Council to take steps to prevent the homelessness occurring where possible.
2. Introduction of a service standard for conducting interviews within a specified number of days from point of initial contact, with associated performance monitoring and reporting to management in place.

Agreed Management Actions

1. Staff will provide relevant information at initial point of contact, whether that is in person or on the telephone.

   A script will be provided for Customer Service and Business Support staff to ensure that that applicants are advised on the documents they are required to bring to their interview; a follow up appointment letter will also clarify what documentation is required when attending appointment.

   Current interview processes and time allocated will be reviewed to identify where efficiencies can be made. This will involve reviewing the current interview space availability and the use of technology to support staff to complete assessments in one appointment wherever possible.

   The continued delivery of early intervention and prevention work will be supported through the review of processes and the service is currently recruiting four additional officers, to ensure increase capacity to deliver high quality prevention work.

Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Debbie Herbertson, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 31 January 2020
2. Agreed, a service standard for conducting interviews within 14 days from point of initial contact will be introduced, with associated performance monitoring and reporting to management put in place.	
Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Debbie Herbertson, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 31 October 2019
1.3 Recommendations: Review of legal duty to disclose declaration	
1. The legal declaration proforma should be revised in consultation with the Council's Information Governance Unit and Legal department to ensure it accurately sets out the applicant's legal duties and any action which could be taken in line with relevant legislation; the Homelessness Code of Guidance; and General Data Protection (GDPR) regulations. The form should be regularly reviewed in line with the policy review schedule (refer recommendation 1.1) to ensure it remains up to date; 2. Housing officers should ensure all applicants are advised of their legal duties and a copy of the signed declaration should be retained within the case file. Completion of legal declarations should be checked as part of Case files reviews.	
Agreed Management Actions	
1. Agreed, the recommendation will be implemented in full.	
Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Debbie Herbertson, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 31 October 2019
2. Housing Officers will ensure that all applicants are advised of their legal duties and a copy of the signed declaration will be retained within the case file. Completion of legal declaration will be checked as part of case file reviews.	
Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Debbie Herbertson, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 31 October 2019
1.4 Recommendations: Monitoring compliance with policies and procedures	
1. A communication should be issued to all Housing Officers and Business Support staff to remind them of their responsibility for managing and storing records including electronic files and emails. Communication should include links to the Council's Records Management Policy, Retention Schedule and Records Management factsheets available via the Orb. 2. A communication should be issued to all Team Leaders and Housing Officers to reinforce the requirement to comply with the Council's policies and procedures and advise that ongoing	

compliance with policies and procedures will be monitored and reported.

3. A regular case file review process for new assessments; open cases; and closed cases should be implemented to monitor compliance with policies and procedures and identify any training and development needs.

   The process should be documented and should include, but not be limited to the following:

   - clearly defined roles and responsibilities for the both senior officer performing the case file review, and the housing officer managing the case;
   - defined frequency and sample size of case file reviews to be performed;
   - appropriate coverage of team members, with focus on new team members, or those where results of previous case file reviews indicate that improvement is required;
   - requirement to document completion of the case file review using the Case Management Checklist;
   - requirement to record the date; name of officer carrying out the case file review; and a summary of the review outcomes and subsequent actions to be taken within the 'Audit' section of the Homelessness Information System (HIS) system;
   - retention of completed checklist within the case file;
   - process for addressing follow-up actions; and
   - monitoring and reporting arrangements, including any significant and / or systemic themes identified that need to be addressed.

4. Compliance with policies and procedures should be a performance objective for all Team Leaders and Housing Officers. Completion of case file reviews and outcomes should be discussed at regular performance meetings and annual looking back/forward conversations. Any training needs identified should be recorded and addressed, and improvement actions clearly set out.

Agreed Management Actions

1. Agreed, a communication will be issued to all Housing Officers and Business Support staff to remind them of their responsibility for managing and storing records including electronic files and emails. Communication will include links to the Council's Records Management Policy, Retention Schedule and Records Management factsheets available via the Orb.

Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Debbie Herbertson, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 30 September 2019

2. A communication will be issued to all Team Leaders and Housing Officers to reinforce the requirement to comply with the Council's policies and procedures and advise that ongoing compliance with policies and procedures will be monitored and reported.

Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Debbie Herbertson, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 30 September 2019

3. Agreed, the recommendation will be implemented in full.

Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Debbie	**Implementation Date:** 31 October 2019

Herbertson, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	
4. Agreed, the recommendation will be implemented in full.	
Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Debbie Herbertson, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 30 November 2019

2. Data quality and performance reporting — High

The Homelessness Information System (HIS) database contains significant amounts of personal sensitive information in relation to homeless applicants.

Management acknowledges that there are limitations with the Homelessness Information System (HIS) database use to record and manage homeless applications and has advised that whilst a project to migrate HIS to the Northgate system commenced in 2015, implementation has been delayed to September 2020 due to a series of issues related to the build and data load of the new system.

Our review identified a number of areas where the quality and accuracy of data recorded in and reported from HIS requires improvement:

- **user access profiles -** system users do not use unique usernames and passwords to access the database. Furthermore, the same shared username and password has been used to access the system since circa 2011 and is documented within the HIS user manual;
- **case records** - can be accessed and amended by all users and no audit trail is in place to record any changes made and by whom;
- **data fields** - can be bypassed data and incomplete or inaccurate data entered; and
- **electronic records** - are not destroyed within 5 years in line with the Council's records retention schedule, with system records dating back to 2002.

The requirement to cleanse and audit the data in HIS was also raised in a previous internal audit in 2017 on Short Term Homelessness provision. This finding is outstanding pending migration to Northgate.

Service Standards and public performance reporting

Whilst the Council has publicised high level figures such as reductions in homelessness presentations due to housing options and prevention advice, it does not regularly report performance information relating to homelessness service provision and outcomes to its customers. In addition, there are no Service Standards setting out what customers can expect from the service in terms of timescales and how the Council is performing against these.

A review of other local authorities including Glasgow City Council, Perth and Kinross Council, West Dunbartonshire Council and South Lanarkshire Council noted regular performance reporting and established Service Standards in place.

Committee Reporting

The Council does not currently report homelessness and housing options performance information to the Housing and Environment Committee. Management has advised that a suite of performance

measures and reporting is currently under development and proposals will be presented to the Committee in August 2019.

Risks

- Potential non-compliance with General Data Protection Regulations (GDPR) Article 5(1)(f) and Article 32 in relation to information security and security of processing;
- Potential non-compliance with the Council's internal information governance policies;
- The Council cannot rely on the quality and accuracy of data collected and reported both internally and externally as reflected in the specific findings in this audit;
- Inaccurate data recording on service needs, demand and outcomes may impact informed decision making on service delivery, investment and funding;
- The Council cannot provide assurance it is providing an efficient and effective statutory service.

2.1 Recommendations: Improving data quality and accuracy of reporting

1. A review of HIS user access profiles and rights should be completed to control access to the system. Where possible unique user log on IDs and passwords should be provided for all users, with a requirement to change passwords on a regular basis;
2. An interim 'Data Protocol' should be established and implemented until the migration of data from the Homelessness Information System to Northgate is completed, with the objective of controlling input and processing of homelessness data in the HIS and reducing interim data quality issues. The protocol should set clear rules in relation to the quality, format, and completion of data input and processed;
3. Data input quality checks should also form part of regular case file reviews as set out in recommendation 1.4;
4. A risk-based approach should be taken and documented to determine if data quality checks will be performed on historic data held within the system; and
5. Records held within HIS should be managed within the Council's Records Retention Policy and Schedule. This should a detailed plan for destruction of records over 5 years old.

Agreed Management Actions

1. Unique user log on IDs and passwords will be provided for all users, with a requirement to change passwords on a regular basis to improve system security.

Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Emma Morgan, Senior Change and Delivery Officer; Debbie Herbertson, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 31 January 2020

2. An interim 'Data Protocol' will be established and implemented until the migration of data from the Homelessness Information System to Northgate is completed, with the objective of controlling input and processing of homelessness data in the HIS and reducing interim data quality issues. The protocol will set clear rules in relation to the quality, format, and completion of data input and processed.

Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Emma Morgan,	**Implementation Date:** 31 January 2020

Senior Change and Delivery Officer; Debbie Herbertson, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	
3. Data input quality checks will also form part of regular case file reviews as set out in recommendation 1.4.	
Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Emma Morgan, Senior Change and Delivery Officer; Debbie Herbertson, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 31 January 2020
4. Agreed, a risk-based approach will be taken and documented to determine if data quality checks will be performed on historic data held within the system.	
Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Emma Morgan, Senior Change and Delivery Officer; Debbie Herbertson, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 31 January 2020
5. Records held within HIS will be managed within the Council's Records Retention Policy and Schedule. The ongoing management and deletion of historical records will form part of the data cleansing project as HIS migrates to Northgate.	
Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Emma Morgan, Senior Change and Delivery Officer; Debbie Herbertson, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 31 October 2020

2.2 Recommendations: Service Standards and performance reporting

1. The Council should consider developing Service Standards which set out what customers can expect the Council in relation to homelessness advice and assistance. Service Standards should be SMART (specific; measurable; achievable; relevant; time bound; and evaluated regularly) and clearly defined. Suggestions for Service Standards include, but should not be limited to:
   - appointment waiting times
   - % assessment decisions with 28 days
   - % applicants provided with temporary accommodation
2. The Council should report performance information in relation to Service Standards and key homelessness outcomes regularly on the Council's website and other forums such as social media; and
3. Proposals for performance reporting to the Housing and Economy Committee should consider (but not be restricted to) monitoring areas highlighted in finding 1; performance against agreed service standards (if implemented), compliance with applicable regulations, policies, and procedures; and data quality protocols.

Agreed Management Actions

1. We will develop Service Standards which set out what customers can expect in relation to homelessness advice and assistance. Service Standards should be SMART (specific; measurable; achievable; relevant; time bound; and evaluated regularly) and clearly defined. Proposed Service Standards include:

• appointment waiting times • % assessment decisions with 28 days • % applicants requiring and eligible for temporary accommodation receiving an offer	
Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Debbie Herbertson, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 30 November 2019
2. We will report performance information in relation to Service Standards and key homelessness outcomes regularly on the Council's website and other forums such as social media	
Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Emma Morgan, Senior Change and Delivery Officer; Debbie Herbertson, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 31 March 2020
3. We will report performance information through a dashboard to the Housing and Economy Committee, officers are currently working with elected members to finalise the key performance indicators required.	
Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Emma Morgan, Senior Change and Delivery Officer;	**Implementation Date:** 31 January 2020

3. Provision of homelessness advice and information — Medium

Review of homelessness information, advice, and support provided by the Council noted the following areas where this could be improved:

Homelessness Webpages

The Council's webpages include only basic information relating to homelessness, such as contact details for locality offices and out of hours assistance. Limited information is provided on the range of homelessness services provided by the Council such as housing options, homelessness assessments and temporary accommodation. The website does not detail and signpost customers to other support and advice agencies who may be able to offer specialist help and assistance.

Additionally, the Council's website does not provide information for landlords and creditors (such as mortgage providers) on their legal duty to disclose any actions or proceedings which may put a household in the City of Edinburgh area at risk of homelessness in line with Section 11 of the Homelessness Etc (Scotland) Act 2003.

During our review management provided updated website content which is currently in draft. The service is currently working with Customer and Digital Services to progress this.

Information Leaflets

The Council provides a range of leaflets relating to Homelessness and Temporary Accommodation including how an applicant can keep in touch; how to bid on property; advice of storage or property and guidance on priority status.

Review of the leaflets confirmed that they only provide further advice to those who have already contacted the service for assistance, with limited written information available to those contacting the service for the first time.

Self-serve facilities

Customers who require housing options advice and information from the Council must attend an interview in person during office hours. No facility is currently available to allow applicants to receive advice and information based on their circumstances at a time convenient to them.

As part of our review, we considered information provided by other local authorities, and note a number including Fife Council have developed online self-service housing advice tools which can be accessed by applicants 24 hours a day, 7 days a week.

Risks

- Customers are not aware of the range of homelessness advice and assistance available;
- Information is not readily available to vulnerable and hard to reach groups;
- Information is not available in a timely manner to prevent homelessness occurring; and
- Service demands are impacted through provision of advice in relation to ongoing non-emergency enquiries.

3.1 Recommendations: Communication and provision of information

The Council should introduce a range of communication methods to ensure customers are aware of the information and support services available. This should include:

1. Consultation with current and previous applicants, and other agencies to understand information requirements and communication preferences for receiving information.
2. The Council's website should be updated to include the following:
    - Information on the range of advice and support available from the Council and what customers can expect including:
        - emergency homelessness assistance;
        - temporary accommodation;
        - housing options advice – including other housing providers;
        - homeless assessments;
        - signposting to other support and advice agencies including financial/debt/legal advice; foodbanks; health services; and drug/substance addiction services; and
        - Inclusion of a frequently asked questions (FAQs) section
    - Legal duties of landlords and creditors such as mortgage providers in relation to issuing a Homelessness Section 11 Notice.
    - Webpages should be subject to regular review to ensure the information remains up to date and in line with policies and legislation.
3. The Council should also develop a leaflet for applicants based on the information set out above. The leaflet should be made available in all Council offices, locality offices, libraries, health centres, Citizen Advice Bureaus, charities and other local support and advice agencies.
4. The Council should consider development of an online self-service housing options advice tool which can be accessed via the Council website and smart phone. The tool would allow applicants to enter details about their circumstances and receive advice on pre-defined outcomes.

The tool would not replace the right for applicants to request information and advice in person, however, would allow applicants to receive person centred advice at a time convenient to them.

Agreed Management Actions

1. A series of engagement events will take place over the remainder of 2019, linked to the development of the Council's Rapid Rehousing Transition Plan. These events will allow the opportunity to engage with all partners including, service users, statutory partners and third sector providers. A focus of these events will include how and what we communicate.

Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Debbie Herbertson, Homelessness Services Manager; Brian Stewart, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 31 March 2020

2. Following the engagement events with key stakeholders, the Council's website will be updated to include the information set out within the recommendation, and any other information relevant to key stakeholders.

   Webpages will be subject to regular review to ensure the information remains up to date and in line with policies and legislation.

Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Rapid Rehousing Transition Plan Lead Officer (currently recruiting); Debbie Herbertson, Homelessness Services Manager; Brian Stewart, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 30 April 2020

3. Following the engagement events with key stakeholders**,** we will develop a leaflet for applicants based on the information set out above, and any other relevant information.

   The leaflet will be made available in all Council offices, locality offices, libraries, health centres, Citizen Advice Bureaus, charities and other local support and advice agencies.

Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Rapid Rehousing Transition Plan Lead Officer (currently recruiting); Debbie Herbertson, Homelessness Services Manager; Brian Stewart, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 30 April 2020

4. This may be a longer-term option for the service, we are dependent on CGI/Digital Services to progress this option. The current delay in implementing Northgate for our service as well as developing an online EdIndex housing application form has impacted progressing this further.

   It is our aim to develop an online self-service housing options advice tool which can be accessed via the Council website and smart phone.

Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Jackie Irvine, Head of Safer and Stronger Communities; Nicky Brown, Homelessness and Housing Support Senior Manager; Rapid Rehousing Transition Plan Lead Officer (currently recruiting); Debbie Herbertson, Homelessness Services Manager; Brian Stewart, Homelessness Services Manager; Nichola Dadds, Senior Executive Assistant	**Implementation Date:** 31 January 2023

Appendix 1: Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on the operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or*** • ***Critical*** impact on the reputation of the Council which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or*** • ***Significant*** impact on the reputation of the Council.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation of the Council.
Low	A finding that could have a: • ***Minor*** impact on operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***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.

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 were:

Advice and Information
• The Council has developed a range of policies and procedures for homelessness and housing support which are aligned to best practice including the Code of Guidance on Homelessness; • The Council publicises information in a range of ways and places to ensure maximum accessibility; including in person, online, in other languages and formats; and to people with disabilities; • Information provided includes how Council services (including emergency assistance) can be accessed; details of the Council's duties and case management processes; what is required of the applicant; and what the applicant can expect; and • The Council provides housing options advice and support including advice on maintaining the applicant's current home (where possible); signposting to other support and advice agencies (including mediation); and details of other housing providers in Edinburgh.
Homelessness Assessment
• All applicants seeking homelessness advice and assistance are offered an appointment for an interview; • If the applicant has nowhere to stay that night, the interview is carried out the same day, or interim accommodation provided until the interview is arranged; • All interviews are conducted in private meeting rooms, with the individual's requirements considered, including provision of same sex officers; interpretation or translation services; and arrangements for hard of hearing or visually impaired applicants; • The Council undertakes eligibility checks to establish if the applicant is eligible for homelessness assistance prior to offering accommodation and/or an assessment; • The Council's processes ensure that all homelessness assessments consider the three tests of homelessness in line with relevant legislation and the Code of Guidance on homelessness; • Interviewing officers advise applicants of their legal duty to disclose accurate information relevant to their assessment, and all applicants sign a proforma to demonstrate their understanding; • The Council retains a clear record of the circumstances; advice given; and reasons for the final decision, with all appropriate evidence recorded; • Information recorded during interviews and assessments is limited to that required to make an assessment, with consideration given to the General Data Protection Regulations (GDPR); • The Council prepares an action plan detailing the options for each individual applicant, and a copy of this is provided to the applicant; • Applicants are provided with written notification of the Council's decision and right to request a review of the decision within 21 days; and

- Reviews are carried out by a senior officer, with the decision and reasons provided in writing; and
- Complete and accurate records are maintained, including evidence required to support completion of the three stages of the homeless assessment; copy of the outcome and action plan; decision letter (translated if required); signed declarations and any discharge of duty letters.

Housing Support and Advice

- A Care Leavers protocol is in place to ensure the Council meets its corporate parenting responsibilities and assist young people who are leaving care with accessing appropriate accommodation;
- The Council undertakes assessments to establish if an applicant or household has support needs, with the appropriate EdIndex priority ratings allocated. This includes providing advice and appropriate referrals and contacting other agencies and services;
- The Council provides information, advice, and services for storage of property and kennelling of pets including timescales for disposal and rehoming where necessary.

Temporary Accommodation

- Policies and procedures are in place which set out how the Council will meet its responsibilities to provide temporary accommodation to people who are homeless or threatened with homelessness in Edinburgh;
- The Council fulfils its duty to provide temporary accommodation to applicants who require it, and accurately records where this is not possible; and
- Use of shared house; bed and breakfast; and other unsuitable accommodation for pregnant women and families is limited to 7 days, and where this is breached is accurately recorded and reported to the Scottish Government.

Case Management

- Case management and regular review processes are in place to ensure the Council effectively manages cases until all statutory duties are discharged;
- Applicants are allocated a housing officer for the duration of their case, are provided information on how to contact their housing officer; and how often their housing officer will contact them to review their case, temporary accommodation position, benefits and support needs, and bidding activity;
- Applicants are provided with clear information on their responsibilities during the process, including keeping their contact details up to date, notifying their housing officer of any changes in circumstances, and how to actively bid for properties on a weekly basis as required;
- Silver Priority is awarded at date of award of priority and then by date of application for starters in line with the Council's letting policy;

- Housing Officers adhere to lost contact procedures, with a clear audit trail of efforts to contact, dates and reasons for closure and re-opening of cases evidenced by follow-up notes; and

Housing officers contact applicants prior to any offer of settled accommodation to explain the allocation and sign up process, any support or benefit requirements and to reinforce implications of refusing one offer, and discharge of duty.

Performance monitoring and reporting

- The Council undertakes regular case file audits and quality assurance reviews to ensure it is meeting its statutory duties effectively;
- Processes are in place to ensure the Council accurately gathers and reports data and information on homelessness and housing options as required by the Scottish Government and Scottish Housing Regulator; and
- The Council regularly monitors and reports at both a senior officer and Committee level on a wide range of homelessness processes and performance including compliance with statutory duties, case management, and outcomes.

The City of Edinburgh Council

Internal Audit

Quality, Governance, and Regulation

Final Report

5 July 2019

CW1802

Generally adequate but with enhancements required	Areas of weakness and non-compliance in the control environment and governance and risk management framework that that may put the achievement of organisational objectives at risk

Contents

This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2018/19 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2018. 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

Provision of social work services by local authorities is regulated by the Care Inspectorate who performs annual inspections to confirm ongoing compliance with applicable regulations and assess the quality of the services provided.

The City of Edinburgh Council (the Council) and the Edinburgh Health and Social Care Partnership (the Partnership) provides a total of 173 regulated social work services to adults, children and young people across the following areas:

- Communities and Families - children's social work (e.g. care homes and young people's centres);
- Safer and Stronger Communities - community justice social work, homelessness services and family and household support); and
- The Partnership - adult social work (e.g. care homes and care at home).

Local authorities are required to appoint a Chief Social Work Officer (CSWO) in line with section 3 of the Social Work (Scotland) Act 1968 requirements, and further supported by section 45 of the Local Government etc (Scotland) Act 1994. The CSWO is responsible for provision of appropriate strategic and professional leadership and advice; supporting overall performance improvement; and management of corporate risk in relation to statutory social work services delivered by both the Council and the Partnership.

This is achieved by providing the Chief Executive of the Council; the Council's Corporate Leadership Team (CLT); the Edinburgh Integration Joint Board (EIJB) that is responsible for direction and scrutiny of the Partnership; and elected members with updates on risks and issues that could impact upon the safety of vulnerable people and / or social work services and sharing the outcomes of relevant service quality and performance reports.

The CSWO is also required to publish an annual report for both the Council and the EIJB on the functions of the CSWO role, and an evaluation of the quality of delivery of the Council and HSCP's social work services. In Edinburgh, the Quality, Governance and Regulation (QGR) team is responsible for supporting the CSWO in performing their statutory role by providing ongoing review, support, and challenge in relation to delivery of adult and children social work services. QGR cover the following services: quality and compliance, regulation; public protection; family & household support; and the Syrian Refugee and Migration Programme.

QGR is also responsible for monitoring implementation of Care Inspectorate Improvement plans (issued following completion of annual inspections) to ensure that the weaknesses they have identified are addressed

Included within QGR, is the Quality Assurance and Compliance team (QAC). The remit of the QAC is to support services - highlighting strengths; areas for improvement; identifying and analysing trends and themes; and developing action plans (where required) to ensure that barriers preventing delivery of effective social work services in line with applicable regulatory requirements are removed.

QGR works closely with both Council and Partnership teams; in collaboration with external partner agencies; and also works with external regulatory bodies such as the Scottish Social Services Council; the Care Inspectorate; and the Healthcare Improvement Service.

The Three Lines of Defence model can be applied to delivery of social work services across the Council and Partnership, where the 'first line' is the teams responsible for delivery of social work

services; the ‘second line’ the CSWO supported by QGR and QAC who provide assurance on delivery and quality of social work services, and report to senior management and relevant Committees and Board through delivery of the CSWO annual report. The ‘third line’ provides independent assurance (for example, Internal Audit or the Care Inspectorate) on key controls established to manage social work risks.

An Audit Scotland coordinated governance forum, the Local Area Network (LAN) that includes the Care Inspectorate; Education Scotland; the Housing Regulator; Audit Scotland; and external audit (Scott Moncrieff); meets quarterly to discuss their scrutiny activities across the Council and Partnership, and areas of concern, in line with the Audit Scotland Code of Audit Practice 2016.

These quarterly discussions include focus on the quality of delivery of social work services.

Scope

This review assessed the design and operating effectiveness of the QAC assurance framework to confirm that it enables the CSWO to effectively discharge their statutory responsibilities across the Council and Partnership, and adequately supports the CSWO annual reports provided to the Council and the EIJB.

Sample testing was performed for the period 1 October 2017 to 31 October 2018. Our audit work concluded on 28 February 2019 and our findings and opinion are based on the outcomes of our testing at that date.

Limitations of Scope

There were no limitations of scope.

2. Executive summary

Total number of findings: 3

Summary of findings raised	
High	1. Quality Assurance and Compliance Assurance Framework
Medium	2. Quality Assurance and Compliance Methodology and Operational Processes
Low	3. Data Protection Impact Assessment

Opinion

Generally adequate but with enhancements required

The Council's Quality Assurance and Compliance (QAC) team is a highly skilled and experienced team that provides invaluable second line assurance in relation to the Council and Partnership's key social work risks; supports the CSWO's evaluation of the quality of delivery of social work services in their annual report; and also, the effective delivery of CSWO statutory obligations.

Our review confirmed that the design and operating effectiveness of the QAC is generally adequate with enhancements required, as we identified some areas of weakness in the QAC assurance framework that could have a potentially significant impact upon the quality of assurance delivered, and the content of the CSWO's annual report.

Consequently, one High; one Medium; and one Low rated findings have been raised.

Our High rated finding reflects the need for QAC to establish a Terms of Engagement that clearly defines how they will engage with both the Council and the Partnership, and the levels of access required to employees, systems, records and files to support delivery of their assurance reviews.

This finding also highlights that there are currently no established protocols to ensure that QAC assurance review outcomes are reported to, and subject to scrutiny by, appropriate Council; Partnership; and EIJB governance forums; and the importance of ensuring that QAC are engaged to review and where involved provide feedback on the quality of service improvement plans designed by service areas and submitted to external assurance providers prior to their submission.

Whilst QAC applies an established methodology to support delivery of their reviews that is subject to ongoing review to improve the quality of their review process, our Medium rated finding reflects a number of areas where the methodology should be further enhanced.

These include the need to develop and implement a risk based annual plan to confirm appropriate coverage of all high risk social work services; apply ratings to findings raised to reflect the risks associated with the weaknesses identified in the quality of social work practices; document the escalation process applied to significant findings identified prior to completion of reviews or where immediate concerns relating to practice or conduct are highlighted; and implement a risk based follow up process to ensure that agreed management actions have been effectively implemented and sustained.

The Medium rated finding also reflects the need for QAC to develop and maintain a risk register that captures the potential risks that could impact upon their assurance delivery, and the key controls established to ensure that these risks are effectively managed.

Our Low rated finding highlights that there is currently no Data Protection Impact Assessment covering the processes applied by QAC in relation to the personal data they obtain; review; process; and retain to support completion of their assurance reviews, to ensure that they are compliant with applicable data protection legislation and principles.

3. Detailed findings

1. Quality Assurance and Compliance Assurance Framework	High

Quality Assurance and Compliance (QAC)Terms of Engagement

QAC Service level agreements (SLAs) have been recently drafted and are supported by revised template scoping and procedural documents covering the key types of assurance review undertaken. Our review noted, that while the SLAs provide an overview of the team's assurance responsibilities & engagement approach, they are not supported by an overarching Terms of Engagement to support their ongoing engagement with, and rights of access to, employees and records of the Council; the Health and Social Care Partnership (the Partnership); and the Edinburgh Integration Joint Board (EIJB), enabling them to deliver their ongoing assurance, and discharge their responsibility to provide professional advice in relation to any planned significant social work service changes.

Management has confirmed that their direct reporting line to the CSWO and existing (informal) escalation processes would be applied if required in the event of any access issues that could potentially impact upon assurance delivery.

Review and scrutiny of QAC assurance outcomes

There are currently no established protocols to ensure that QAC planned assurance activities and outcomes (with the exception of public protection) are reviewed and scrutinised by appropriate governance forums on an ongoing basis, to confirm that appropriate coverage of all significant social work risks is planned, and enable early identification and resolution of significant issues and / or recurring themes in advance of receiving the Chief Social Work Officer's (CSWO's) annual report.

Review of the 2016/17 CSWO annual report found only limited reference to specific QAC reviews and links to EIJB; Children's Services; and Community Justice annual performance reports. In addition, the 2017/18 CSWO annual report did not include any detail on QAC assurance reviews. Management advised that this was the result of an oversight.

Ongoing CSWO engagement with senior management and external assurance providers

Whilst the CSWO has regular meetings with the Chief Executive of the Council; reports directly to the Executive Director of Communities and Families (CF); and attends quarterly CF Risk and Assurance Committee meetings, ongoing engagement with Partnership senior management Team is currently limited to invitation from the Chief Officer to attend Partnership senior management meetings.

We also confirmed that the CSWO does not attend and is not represented at Local Area Network (LAN) meetings.

Review of quality improvement plans to address external assurance actions

There is currently no requirement for QAC to perform an independent second line review of the quality of improvement plans designed by service areas and submitted to external assurance providers (for example the Care Inspectorate). Our review noted that improvement actions submitted by Service Managers generally included short term solutions rather than the longer term strategic improvements required to address the root causes of the concerns raised.

The Regulation Service is currently piloting a programme of continuous improvement with three Care Homes to track progress with implementation of Care Inspectorate improvement plans, using Pentana, the Council's performance and risk management system. The processes being set up, aim to encourage managers to consider the root causes of quality issues identified, and each action will have

to be validated before being signed off as completed in Pentana. Responsibility for validation is still to be determined.

Risks

- Insufficient second line assurance coverage of all Council and Partnership significant social work risks.
- Inability to provide assurance to the Council; the Partnership and the EIJB on significant social work risks.
- Significant issues and holistic themes are not identified and addressed in a timely manner.
- The Chief Social Work Officer annual report could potentially be incomplete and / or inaccurate.
- The Chief Social Work Officer is unable to fulfil their statutory obligations in relation to providing professional advice on planned significant social work service changes.

1.1 Recommendation - Terms of Engagement

A Terms of Engagement, should be developed and agreed with Council and Health and Social Care Partnership (Partnership) senior management and where appropriate, relevant Council Executive and Edinburgh Integration Joint Board (EIJB) committees to support ongoing delivery of second line social work services assurance activities, and discharge of Chief Social Work Officer (CSWO) responsibilities to provide professional advice. The Terms of Engagement should include, but should not be limited to:

1. CSWO statutory obligations;
2. Roles and responsibilities of the second line Quality Governance and Regulation teams and how the team supports the CSWO in discharging their statutory obligations and the CSWO annual report;
3. The requirement for Quality Assurance and Compliance (QAC) to prepare and deliver an annual, risk-based assurance plan that provides coverage of all significant Council and Partnership social work risks on an ongoing basis;
4. Right of access to all relevant Council; Partnership; and EIJB employees and records (including ongoing engagement with senior management and external assurance providers), and a supporting escalation process where potential blockages arise;
5. Details of relevant governance forums responsible for approving the proposed QAC annual plan and reviewing and scrutinising assurance review outcomes, as agreed in consultation with key stakeholders;
6. Involvement in any planned significant changes to delivery or registration requirements of social work services across the Council and Partnership to provide professional advice; and
7. Responsibility for review of service improvement plans prior to submission to external assurance providers.

Agreed Management Action

The service has prepared a Service Charter, which sets out the role and wider function of the service devolved under the Chief Social Work Officer. This will act as a vehicle to deliver audit activity and a framework which will be supported by a Service Level Agreement to ensure the focus, scope and frequency of audit activity is agreed with key stakeholders and customers on a rolling annual basis.

These documents are now available for internal audit to review, with a launch planned for August 2019.

Owner: Alistair Gaw, Executive Director Communities and Families **Contributors:** Jackie Irvine, Chief Social Work Officer, Jon Ferrer Senior Manager Quality, Governance and Regulation, Keith Dyer Manager, Quality and Compliance	**Implementation Date:** Service Charter – 31 August 2019 Directorate level SLAs – 31 October 2019

1.2 Recommendation - Review of service improvement plans

Quality Assurance & Compliance (QAC) should develop a process to support review and challenge of service improvement plans to address external social work services assurance finding raised across the Council and the Health and Social Care Partnership (the Partnership) prior to their submission.

The process should include, but not be limited to:

1. Confirming that the root causes of external assurance recommendations have been identified by service areas;
2. Confirming that improvement plans will address the root causes identified and satisfy the relevant external assurance provider
3. Confirming that ownership is appropriate and that implementation dates are realistic and achievable; and
4. Detailing the expected evidence to be retained and any follow up work to be performed by QAC to confirm satisfactory implementation advance of the next planned visit from the external assurance provider.

This could be achieved through formalising the approach used for the Care Homes pilot project currently underway.

The process should be agreed with relevant service areas; the Corporate Leadership Team (CLT) and Council Executive and Edinburgh Integration Joint Board (EIJB) Committees prior to implementation.

Agreed Management Action

The Quality Assurance and Compliance (QAC) Service would not have sufficient capacity or coverage to actively support, review and challenge all improvement plans generated from external assurance activity due to the overall size of the service compared with the volume and scale associated with many of the plans and improvement actions generated from activity.

Some areas of development may require several phases of work over a number of years. It is also the case that improvement plans become the responsibility of a recognised governance forum, such as the Integration Joint Board, Public Protection Committee's and Senior Management Teams who are responsible and accountable for oversight. The Service Managers and Chief Social Work Officer (CSWO) hold membership at these forums.

The following processes will however be developed where QAC is overseeing progress of assurance actions from self-evaluation/audit activity:

- Where service improvements and/or recommendations have been generated as part of self-evaluation and/or audit activity, tracking of progress and/or monitoring against agreed implementation dates/targets will be undertaken by a nominated officer at 3, 6 and 12-month intervals.

- The process for recording and reporting progress will be agreed at the point in which the Terms of Engagement are signed. Any change or deviation from this agreement will require agreement by both parties.
- Each improvement action will be assigned a lead officer or nominated point of contact and completion or target end date.
- Where tracking and monitoring reveal limited progress, or in cases where concerns have been raised by the lead officer and no discernible action taken, the matter will be escalated by the CSWO to the Director, Chief Officer or in some cases directly to the Chief Executive.
- These processes will be set out in the Directorate Level Service Level Agreements.

Owner: Alistair Gaw, Executive Director Communities and Families **Contributors:** Jackie Irvine, Chief Social Work Officer, Jon Ferrer Senior Manager Quality, Governance and Regulation, Keith Dyer Manager, Quality and Compliance	**Implementation Date:** 31 October 2019

2. Quality Assurance and Compliance methodology and operational processes	**Medium**

Annual Planning Process

Our review established that Quality Assurance and Compliance (QAC) do not have an established risk based annual plan to determine their coverage of both the Council's and Health and Social Care Partnership's most significant social work risks.

Currently, QAC annual work plans are determined by Quality Governance and Regulation (QGR) and approved by the Chief Social Work Officer (CSWO).

Quality Assurance and Compliance (QAC) review methodology

Review of a sample of four QAC assurance reports completed between 1 October 2017 to 31 October 2018 highlighted the need to improve the QAC methodology in the following areas:

1. Findings raised in reports are not currently rated to reflect the risks associated with the weaknesses identified in the quality of social work practices;
2. Significant issues identified during an assurance review that could adversely impact the quality of services delivered or result in a regulatory breach are immediately highlighted to Quality Assurance management; the CSWO; and senior management. However, this escalation process is not documented. Concerns were also noted that outcomes and actions taken by management are not always fed back to QAC to evidence satisfactory resolution;
3. Service areas are not required to provide management responses detailing the actions that they will take to address findings raised or provide dates for implementation of these action. Management has advised that QAC methodology is currently being refreshed and will include implementation of terms of reference detailing the work to be performed in individual reviews; and the requirement for management to develop and deliver improvement plans that will be reviewed by a Quality Assurance Officer at 3, 6 and 12 monthly intervals, with the CSWO kept informed of progress.

   This approach was noted for one of the reviews tested: Management actions to address findings raised in the review of Community Justice Services Practice Evaluation completed in September 2018 have been recorded in an improvement plan and the service has committed to providing

regular progress updates. It was noted however, that some of the QAC report recommendations outlined in the plan are in the format of statements rather than actions;

4. No consistent follow up approach was applied to confirm that agreed management actions have been implemented and effectively sustained.

In, addition, the QAC Manager provided details of seven assurance reports issued between October 2017 and April 2018 where there was either no action or limited action taken by Service Areas in response to findings raised. Four of these reports covered 69 recommendations or proposals. Three further reports were in respect of extensive quality improvement work undertaken in Locality Offices. This feedback was in line with the results of the IA review of four reports.

It is recognised that not all recommendations or proposed actions will be prioritised and/or taken forward by the service area, however, in such cases, a record of the decision should be noted and held.

Risk Register

QAC does not currently maintain a risk register that captures the potential risks in relation to the quality of assurance provided, and availability of resources required to ensure appropriate coverage of social work risks across the Council and Partnership to support the CSWO's annual report.

Skills and Experience

Whilst QAC roles, responsibilities, and reporting lines are clearly defined and recorded in job descriptions and role specifications, they are not currently used as the basis for setting employee performance objectives as part of their annual 'looking forward' conversations.

Management advised that the requirement for Quality Assurance Officer to hold a social work qualification and have relevant social work experience was revised in 2017, however the revised job description could not be located, and the original job description was used for recruitment in Autumn 2018.

Risks

- Assurance outcomes do not cover all significant social work risks and do not fully support the Chief Social Work Officer's annual report;
- Findings raised do not include a rating indicating the significance of the associated risks;
- A risk-based approach checking that a sample of management actions have been effectively implemented cannot be applied if findings are not rated;
- There is no assurance that gaps identified in social work services have been addressed by both Council and Partnership management;
- Quality Assurance and Compliance (QAC) assurance risks have not been identified and recorded, and management cannot demonstrate that they are being effectively managed; and
- QAC team objectives do not reflect roles and responsibilities as detailed in job descriptions and role specifications.

2.1 Recommendation - Risk based annual planning

A risk based annual plan should be developed and implemented to support delivery of Quality Assurance and Compliance (QAC) assurance across both the Council's and Health and Social Care Partnership's (the Partnership's) key social work service delivery risks. This should include, but not be restricted to:

1. Establishing an 'assurance universe' of the full population of social work services delivered by the Council and the Partnership;
2. Performing an annual risk assessment of Council and Partnership social work services to ensure that all high-risk services are reviewed on an ongoing basis (for example, once every three years); and
3. A process supporting changes to the plan in response to new risks, or changes in existing risk profiles.

Annual Programmes of Activity should be generated in consultation with customers and partners and reviewed by the Corporate Leadership Team (CLT) and the relevant Council executive and Edinburgh Integration Joint Board (EIJB) committees.

Agreed Management Action

Each Directorate will in partnership with the Quality Assurance and Compliance (QAC) Service generate a Programme of Work or Activity Plan for the forthcoming 12 months. This Programme of Work will detail areas of interest and scrutiny, the approach, model and methodology to be used, timescale for completion, reporting arrangements and agreed frequency of monitoring/tracking.

This expectation will also be set out in the Service Level Agreements (SLAs) between QAC and Communities and Families; the Health and Social Care Partnership (the Partnership) and Community Justice. It is not envisaged that programmes of work will be reviewed by the Corporate Leadership Team (CLT) or the relevant Council executive/Edinburgh Integration Joint Board (EIJB) committees.

Governance for reporting and escalation processes will reside with the Chief Social Worker Officer (CSWO) and Head of Service/Director, and will be delivered through the Senior Management Teams, Public Protection committee's and Health and Social Care Partnership (the Partnership).

QAC will ensure high risk services and areas of social work delivery, particularly Public Protection and the focus of decision making with regard removal of liberty are prioritised within each plan and are subject to scrutiny at least once every two years. The Programme will also consider and absorb activity as generated and commissioned by each relevant Public Protection Committee or Partnership.

Activity commissioned by or generated from Public Protection and Safeguarding Partnerships will corelate directly to the capacity available to the respective service areas (i.e. Child Protection Committee commissioned child protection audit linked to Communities and Families Annual Programme of Activity.)

The QAC Manager will be responsible for ensuing there is sufficient time, capacity and resource allocation available and where/if necessary remove or delay other areas of work detailed on the programme to this end. If required medium/low risk work will be carried over to the following year or at a point in time where capacity becomes available.

Activity generated from unplanned/unpredictable events, episodes or incidents, such as death and serious harm, findings from SCR's or LSI's, outcomes following SSSC investigation or recommendations following external scrutiny/inspection may where appropriate replace pre-agreed activity/work where required. Where additionality is not possible due to lack of capacity, the Department/Chief Officer will be notified of the need for planned work to be cancelled, scaled back or rescheduled. The CSWO reserves the right to commission activity in response to any of the above scenarios as required to ensure they are able to dispense their statutory duties accordingly.

Owner: Alistair Gaw, Executive Director Communities and Families	**Implementation Date:** 31 October 2019

Contributors: Jackie Irvine, Chief Social Work Officer, Jon Ferrer Senior Manager Quality, Governance and Regulation, Keith Dyer Manager, Quality and Compliance	

2.2 Recommendation - QAC methodology

Existing QAC methodology should be reviewed and refreshed to include:

1. Application of ratings to findings raised that reflect the significance of the control gaps identified and the associated risks;
2. The requirement to record the process applied where significant issues have been escalated to senior management prior to completion of a review; and
3. Implementation of a risk based follow up process to confirm that management has implemented and sustained their agreed actions to address the findings raised.

Agreed Management Action

1. Quality Assurance and Compliance (QAC) does not propose to apply ratings to findings. The rationale for this is, that the QAC methodology and the presentation and interpretation of the findings generated is often subject to a number of variables. Evaluation can comprise of and include the use of both qualitative and quantitative evidence that can offer insight of patterns, trend and trajectory. Other methods of intelligence/evidence gathering, such as the use of testimonials and people's stories provide a user experience that may not necessarily reflect prescribed changes or improvements to policy, procedure, process or practice. The impact of change to service provision, practice approaches and legislation can shift the balance of care and focus within the social work and public protection sphere, impacting on data and performance that can potentially present artificial and/or flawed interpretation.

   It is important that each service area has a degree of autonomy and independence to prioritise work/activity and in certain situations reject proposed activity in favour of an alternative yet equally effective approach. Such decisions are important for social work services to retain a degree of control.

   However, where proposed areas of improvement are identified and subsequently rejected, the decision, rationale and alternative approach, if any, will be recorded and held by the commissioning service and QAC.
2. The following escalation processes will be developed:

   <u>During Activity</u>

   Should concerns be raised that relate to an individual's immediate safety or protection or where the service becomes aware of evidence of (gross) misconduct whilst undertaking any commissioned work, the matter will be immediately escalated in writing to the Quality Assurance and Compliance Manager or Senior Manager Quality, Governance and Regulation or the Chief Social Work Officer (CSWO). The matter will be raised/escalated to the Director or Commissioning Manager for immediate action as required. This escalation process is detailed in the Service Level Agreement.

   <u>Post Activity</u>

   For escalation post activity (concerned with monitoring and tracking of service improvements and recommendations) we will follow this process outlined at management action 1.2.
3. For recommendation 3 – we will apply the follow-up process for monitoring progress with actions, as set out in the management action for 1.2.

Owner: Alistair Gaw, Executive Director Communities and Families	**Implementation Date:** 31 October 2019

Contributors: Jackie Irvine, Chief Social Work Officer, Jon Ferrer Senior Manager Quality, Governance and Regulation, Keith Dyer Manager, Quality and Compliance	

2.3 Recommendation - QAC Risk register

A Quality Assurance & Compliance (QAC) risk register should be established and maintained in the Pentana risk management system that includes all relevant QAC assurance risks and supporting controls,

The risks and controls should be allocated to appropriate owners who will be responsible for ensuring that the risks are regularly re assessed and the controls remain effective.

The register should be regularly reviewed to establish if any risks require to be escalated to the Quality, Governance and Regulation risk register.

Agreed Management Action

Quality Assurance and Compliance (QAC) recognise the need for a service Risk Register. Version 1 of the register was generated on 16 April 2019 and will be monitored through QAC Management within Safer and Stronger and reported to Communities and Families Wider Management Team in accordance with current reporting requirements.

Owner: Alistair Gaw, Executive Director Communities and Families **Contributors:** Jackie Irvine, Chief Social Work Officer, Jon Ferrer Senior Manager Quality, Governance and Regulation, Keith Dyer Manager, Quality and Compliance	**Implementation Date:** 31 August 2019

2.4 Recommendation - Skills and experience

Job descriptions and role specifications should be used as the basis for setting Quality Assurance and Compliance (QAC) employee performance objectives as part of their annual 'looking forward' conversations.

In addition, the qualifications and experience required for the Quality Assurance Officer role should be clarified; the role description updated to reflect the requirements; and the revised role description used to support all future recruitment activity

Agreed Management Action

The 'essential requirements' and qualifications deemed necessary for the role of Quality Assurance Officer (QAO) and Regulation Officer will be reviewed and amended as required within the existing job descriptions and Job Specification.

Whilst the Service acknowledges the need to reflect and align the work of the QAO role with the existing job description, skills, experience and knowledge are gained through ongoing professional development, training and directed learning opportunities.

QAO's are required to work across a range of disciplines ands areas of social work practice and legislation, this requires a broad knowledge, yet successful delivery of activity is subject to competency-based project management, time management, clarity of role and function and a predetermined set of parameters. The QAC service adopts a variety of approaches which include quality improvement, quality assurance, evaluation and scrutiny, each deployed to meet the needs of the approach, identified model or the questions generated by the service.

Owner: Alistair Gaw, Executive Director Communities and Families	**Implementation Date:** 31 October 2019

Contributors: Jackie Irvine, Chief Social Work Officer, Jon Ferrer Senior Manager Quality, Governance and Regulation, Keith Dyer Manager, Quality and Compliance	

3. Data Protection Impact Assessment	**Low**

There is currently no Data Protection Impact Assessment (DPIA) covering the processes applied by Quality Assurance and Compliance (QAC) in relation to the personal data they obtain; review; process; and retain to support completion of their assurance reviews.

A DPIA must be completed to confirm that appropriate controls have been established to ensure ongoing compliance with General Data Protection Regulation (GDPR) legislation; Data Protection principles; and the Council and Partnership's records management policies.

Risks

- Non-compliance with the data protection principles set out in the Data Protection Act 1998, General Data Protection Regulation, and the new Data Protection Act 2018.
- Failure to safeguard personal data, resulting in reputational, and potentially financial, damage to the Council.

3.1 Recommendation - QAC Data Protection Impact Assessment

1. A Data Protection Impact Assessment (DPIA) should be prepared to cover the processes applied to all data obtained; reviewed; processed; and retained by Quality Assurance and Compliance (QAC).
2. The completed document should be submitted to the Information Governance Unit (IGU) for review and assessment.
3. Following receipt of a DPIA assessment report from the Information Governance Unit (IGU), QAC should implement the recommended improvement actions then submit the assessment report, and evidence of completed improvement actions to their Information Asset Owner for the processing to be authorised.

Agreed Management Action

The Quality Assurance and Compliance Manager has completed a Data Protection Impact Assessment which was signed off by the Information Governance Unit on 9 April 2019. This is now available for Internal Audit to review.

Owner: Alistair Gaw, Executive Director Communities and Families **Contributors:** Jackie Irvine, Chief Social Work Officer, Jon Ferrer Senior Manager Quality, Governance and Regulation, Keith Dyer Manager, Quality and Compliance	**Implementation Date:** 31 August 2019

Appendix 1: Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or*** • ***Critical*** impact on the reputation of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or*** • ***Significant*** impact on the reputation of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation of the organisation.
Low	A finding that could have a: • ***Minor*** impact on operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***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.

Appendix 2: Areas of audit focus

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

Roles and responsibilities

- The roles and responsibilities and reporting lines for the QG&R team have been clearly defined, and are reflected in the team's 'looking forward' performance objectives;
- An appropriate independent reporting line through to the CSWO and elected members has been established;
- There is clear alignment between team objectives; the Chief Social Work Officer's responsibilities; and applicable regulatory requirements;
- Terms of reference detailing the team's assurance responsibilities and engagement approach has been prepared; agreed with; and approved by the Executive Director of Communities and Families; the Chief Officer for the H&SCP; the Corporate Leadership Team; and relevant Council and EIJB Executive Committees;
- The scope of work provides QG&R with right of access to all relevant personnel and documentation in relation to delivery of social work services by the Council and the H&SCP; and
- The scope of work includes the requirement to engage the CSWO and QG&R for professional advice in relation to any planned significant changes to delivery of social work services across the Council and the H&SCP.

Skills and experience

- Skills and experience required for all roles within the QG&R team have been clearly defined and included in team role specifications; and
- The current team is suitably qualified and are required to ensure that continuing professional development (CPD) requirements for their relevant professional bodies are maintained.

Methodology

- A QG&R methodology has been defined and is consistently applied across all reviews performed;
- The methodology includes guidance on understanding key social work risks and controls; preparing the annual plan; planning, performing and reporting on individual assurance reviews; follow-up; and reporting to governance committees; and
- Key performance indicators have been established to manage both QG&R team delivery and ensure effective engagement with relevant Council and H&SCP teams.

Planning

- A risk based annual assurance plan detailing QG&R focus for the financial year is prepared and approved by the CLT; the H&SCP and the relevant Council and EIJB Executive committees;
- The annual assurance plan is based on an assessment of the key risks that could impact delivery of social work services across the Council and the H&SCP;
- The annual plan considers whether available team resources are sufficient to provide assurance on all key social work service delivery risks;

- The plan provides an appropriate level of coverage across all social work services provided by the Council and the H&SCP, and includes an appropriate balance between service delivery and thematic reviews;
- Planning for reviews includes sufficient time to understand social work services processes applied;
- Any process design issues that could impact the quality of services delivered are immediately highlighted and escalated; and
- An appropriate sample selection methodology is applied to ensure that representative samples are selected and tested for assurance reviews.

Fieldwork

- Any significant issues that could result in a regulatory breach or adversely impact quality of social care services is immediately escalated to the CSWO and senior management within the Council and the H&SCP;
- The outcomes of sample based testing performed is recorded, with any testing and emerging themes identified and recorded; and

  Further testing is performed (where required) to identify the extent of any significant or system issues.

Reporting and follow-up

- Reports are prepared detailing the outcomes of all QG&R reviews, raising issues / findings where issues have been identified;
- Management responses detailing the actions that will be taken to address findings raised are obtained, together with agreed implementation dates;
- An appropriate risk based follow-up approach is applied by QG&R to confirm that all agreed management actions have been implemented and effectively sustained; and

The follow-up process includes an assessment of progress with implementation of findings raised by external regulatory / scrutiny bodies.

Governance and reporting

- There is a clearly established independent reporting line for reporting QG&R assurance outcomes to appropriate H&SCP governance forums; the CLT and relevant Council and EIJB executive committees;
- Governance and Committee reporting include progress with delivery of the QG&R plan; assurance review outcomes; and progress with implementation of agreed management actions to address the findings raised;
- QG&R reports are shared with the Care Inspectorate and other regulatory bodies upon request;
- Either the CSWO or QG&R are represented at relevant Council and H&SCP risk committees to ensure that any risks relating to quality and delivery of social work services are highlighted and included in risk registers (where appropriate); and

  Either the CSWO or QG&R are represented at the Local Area Network meeting hosted by the Council and attended by all assurance providers (including the Care Inspectorate) to ensure that plans and outcomes are shared and discussed (where appropriate).

The City of Edinburgh Council

Internal Audit

Emergency Prioritisation & Complaints - Telecare

Final Report

23 July 2019

CW1806

Generally adequate but with enhancements required	Areas of weakness and non-compliance in the control environment and governance and risk management framework that may put the achievement of organisational objectives at risk

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 Edinburgh Health and Social Care Partnership's Assistive Technology Enabled Care Hub (ATEC 24) provides a 24-hour 365-day emergency telecare and response service to approximately 9,000 citizens across the City who use personal alarms; pull cords; movement sensors; monitors; and smoke alarms to keep them safe in their homes.

A full service is provided that includes installation and maintenance of telecare equipment; call handling; and attendance at the client's home. When an alarm is activated, an electronic alert is sent to the ATEC 24 call handling team via the Jontek telecare system. ATEC 24 then contact the client (or nominated family and friends), to ensure they are safe and initiate appropriate action.

Where it is clear that immediate medical assistance is required an ambulance will be requested. If there is no response from a client when an alarm has activated, or if a number of repeat calls are made, a mobile responder is sent to the client's home. Call handlers in the ATEC 24 control room allocate work to mobile teams responding to calls.

In response to increasing service demand and complexity of user needs (400,000 calls were handled in 2018 with 12,000 visits made to clients), an additional 30 team members are currently being recruited, including two management posts.

Performance data is produced by ATEC 24 which includes, percentage of incoming alarm calls answered within 1 and 3 minutes against target, and emergency response visits met within 45 and 60 minutes.

Management has advised that all complaints are logged and managed in line with applicable Council processes. Complaint levels are historically low, and mostly relate to client expectations. Two serious complaints were received in 2018 and improvement plans were developed and implemented.

Following a recent organisational review, management has advised that all call handlers and mobile responders are being trained to work generically to achieve greater flexibility and effectiveness, and a learning development plan is in place to support the new working arrangements.

The Technology Enabled Care Services Association (TSA), the industry body for technology enabled care (TEC), has developed a quality standards framework. TEC Quality, the TSA's independent standards arm audits and certifies organisations against these standards.

TEC Quality performed an independent external audit of ATEC 24's performance against the quality standards framework in March 2019.

Scope

This review focused on monitoring and response services provided by ATEC 24, with the objective of assessing the design adequacy and operating effectiveness of processes and key controls established to ensure that emergency Telecare requests received from citizens are prioritised and addressed. The process supporting complaints received in relation to emergency requests was also reviewed.

Sample testing was performed for the period 1 December 2018 to 31 May 2019.

Further detail on our areas of audit focus is included at Appendix 2.

Reporting Date

Our audit work concluded on 30 May 2019, 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	
Medium	1. ATEC 24 operational framework
Low	2. ATEC 24 customer engagement

Opinion

Generally adequate but with enhancements required

Our review has identified moderate areas of weaknesses in the Health and Social Care Partnership's Assistive Technology Enabled Care Hub (ATEC 24) control environment and governance and risk management frameworks that could impact the service's ability to ensure that emergency support requests received from citizens are effectively prioritised and addressed.

This opinion is supported by the outcomes of the independent external audit performed by the Technology Enabled Care Services Association (TSA) industry in March 2019 to assess ATEC 24's ongoing compliance with TSA quality standards framework, as comparison between their draft report and the findings raised from this review confirms that they are aligned.

Consequently, one medium and one low rated finding have been raised.

The first finding highlights that ATEC 24's operational processes require to be reviewed and refreshed, with specific focus on emergency call prioritisation; risk-based decision making in relation to leaving clients once support has been provided; and provision and installation of client key safes to ensure timely access to client properties in emergencies.

This finding also highlights the importance of establishing a first line service area performance monitoring and quality assurance framework to confirm that services are delivered effectively and in line with established performance targets, and the need to provide ongoing service delivery performance reporting to senior management for review.

Our second finding raised reflects the need to establish a continuous improvement approach to support ongoing service delivery based on customer feedback, and that publicly available documentation detailing the services available to potential customers is out of date and should be refreshed.

Management has confirmed that a number of service improvements have been implemented during a recent period of significant change and acknowledge and recognise that further improvements are required. Initiatives implemented to date include:

- initiating a number of projects to realise improvements and efficiencies across the service.
- establishing Hub coordinators to facilitate supervision and support linked to training and performance management.
- implementation of revised job descriptions and the move to holistic working practices across teams to increase the capacity, flexibility, and skills of staff handling calls and assisting service users.
- implementation of an essential training programme for all employees.
- management and resolution of complaints in line with Council policy, with lessons learned exercises undertaken and reported.

3. Detailed findings

1. ATEC 24 operational framework	Medium

Our review of existing telecare policies, procedures and operational processes established that:

1.1 Operational processes

- **Call flows** that guide ATEC 24 team members on how to deal with clients are in place, however they have not been reviewed since 2015 and instances were noted where details were out of date. The Technology Enabled Care Services Association (TSA) recommend that response call flows are reviewed every 3 years.
- **Call prioritisation procedures** have not been established to prioritise responses to multiple calls. The current approach is inconsistent with priority varying from a first come basis to call handler or responder judgement. We identified one instance where a call was received, and a client had fallen. Attendance at a subsequent call was prioritised on the basis of client location. As a result, the response time for the first call was 1 hour 35 minutes against the specified 45 minutes target.
- **Emergency calls** are also received through a general telephone number which is not integrated with the Telecare alarm call system, and calls received via this channel are not recorded, prioritised, and monitored against key performance indicators. Management has recognised this and advise that a project is underway to establish an integrated emergency call line. In the short term there are plans to apply interactive voice response to this line to filter emergency calls and re-direct non-emergency calls.
- **Emergency response visits** – we identified one instance where a customer was assessed as requiring medical treatment following a telecare visit, and the telecare responders did not remain with the client until the ambulance arrived, as a carer was in attendance. A family member later noted that the carer had also not stayed with the customer until the ambulance arrived. Management has advised that a risk-based approach is taken when deciding whether a responder will remain with the client, however the service user agreement does not outline the criteria for these risk-based assessments.
- **Attendance by responders** is measured from the alarm activation time to when the responders confirm attendance by triggering the alarm system on arrival at a client's property, and then confirm the time of the end of the visit via the same process. We noted that on occasion, responders only trigger the alarm once to provide the end of visit update. Management advised this is often due to immediately providing emergency assistance to the client upon arrival.
- **Key safes** have been installed at circa 5,000 of 9,000 (55%) of clients' properties with the balance of keys currently stored centrally at ATEC 24 headquarters. Where client keys are held centrally, responders must return to headquarters to collect keys before attending an emergency call. Management recognise there are inefficiencies in this process, and a business case to install key safes across the remaining client properties is currently being developed.
- **Regular engagement with external partners** including the Scottish Ambulance Service; NHS24; and Social Care Direct has been established, however, engagement with Police Scotland and the Scottish Fire and Rescue Service, is less frequent. Management has advised that this is due to Council resourcing and capacity challenges.

1.2 Service Level Agreements

- **Service Level Agreements (SLAs)** are in place for monitoring response services provided by Telecare to external third parties including community alarms services provided to a number of housing associations. Review of three SLAs noted they have not been revised since 2016.
- The SLA between the Council and NHS Lothian for a Fallen Uninjured Person Service (FUPS) was last reviewed in 2015 and has not been revised to reflect the Health and Social Care Partnership's current arrangements.

1.3 Performance Reporting

- **Draft Health and Social Partnership Executive Management Team (EMT) scorecard data** includes volume of calls and responses, however, service performance in relation to call answer times or emergency response visit times against established performance targets are not included in the draft scorecard.
- **Operational key performance indicators** have been established to monitor service user response times where assistance is required. For three of the ten visits included in our sample, response times were in excess of the specified 45 minutes response time target, with one response time in excess of an hour.

  Management has advised that response time targets will be subject to review, as the TSA has set a revised indicator to monitor response times from the time when the need for a response is identified.

  Call response times are also manually recorded in a response report for each visit, submitted on return to headquarters. This data is then used to develop management reporting. Management has advised that hand held devices for automated reporting are currently being piloted
- **Service performance reports** detailing ongoing service performance in comparison to established key performance indicators is not currently provided to the Health and Social Care Partnership Executive Management Team. Management has advised that development of service performance reports is being considered with the Data, Performance & Business Planning team.

1.4 Quality Assurance

- **Quality assurance** for call handling is currently performed by some Hub Coordinators on an informal basis and is used to inform performance one to ones. We noted the quality assurance approach applied is inconsistent and is not supported by a clearly defined methodology. For example, frequency of checks and sample selection criteria have not been agreed and documented.

  Technology Enabled Care Services Association (TSA) guidance recommends that 5% quality monitoring samples are performed for each call handler.

  Management has advised that there are plans to formalise the quality assurance processes, and link the outcomes of these to training, development and support.

Risks

Absence of these controls may result in:

- Service delivery not being aligned with The Technology Enabled Care Services Association (TSA) quality standards framework.
- Inadequate or inappropriate response to an emergency situation.
- The service being held responsible for issues out with established client terms of engagement.
- Lack of oversight and scrutiny of service performance against targets.
- Performance, development and training issues not being identified and addressed.
- Service Level Agreements may not reflect current working arrangements and operations.
- Parties not being aware of and therefore not fulfilling, respective responsibilities and obligations.
- Areas of individual and shared responsibility are not clearly defined.
- Financial implications of providing services may not reflect increased demand and provision.
- Management are unaware of the issues impacting service delivery and the required planned improvement actions.
- Inconsistent service performance is not identified and remedied.
- Call handler and responder performance, development and training issues are not identified and addressed.

1.1 Recommendations: Review of operational processes

1. A review schedule aligned to the Technology Enabled Care Services Association (TSA) guidelines should be developed for all call flows, templates and any linked guidance documents to ensure they are reviewed at least every three years. All documents should include version control and clearly state date of last review, and the next scheduled review.
2. A call prioritisation process should be designed and implemented and supported (where required) by delivery of training. This should include (but not be limited to) the requirement to record the rationale for prioritising calls. The procedure should be subject to review at least every three years.
3. A call menu system should be designed and applied to the general telephone number to ensure that emergency calls can be identified and allocated the same level of priority as automatic alarm calls. Performance measures should be implemented to ensure service levels and response times are monitored for emergency calls received via this channel.
4. Management should consider updating the content of service user agreements to outline the approach to and limitations associated with services provided during home visits, for example, how responders assess the risk associated with leaving a client once assistance has been provided.
5. Responders should be reminded to consistently follow operational processes by logging attendance at both the start and end of all visits, and their compliance with this process monitored.
6. Roll out of hand held devices to allow automated reporting should be progressed.
7. The key safe business case should be progressed, and an installation programme implemented to allow the numbers of individual safes to be maximised.
8. A schedule of meetings and resources should be put in place to ensure regular engagement with all external responders. Consideration should be given to amalgamating meetings with external partners if capacity is an issue.

Agreed Management Actions

1. Call flows, templates and linked guidance documents will be reviewed and updated in accordance with TSA guidelines. A review schedule will be implemented with the last review date and date of next scheduled review clearly identifiable i.e. every 3 years.	
Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Lindsay Munro, ATEC 24 Service Manager (Lead Contributor); Craig O'Donnell, ATEC 24 Service Manager; Lisa McMahon, ATEC 24 Coordinator; Joanne Fowler ATEC 24 Coordinator; Urszula Siegieda, ATEC 24 Coordinator	**Implementation Date:** 29.11.2019
2. Call prioritisation procedures will be designed and implemented, including recording the rationale for call prioritisation and delivery of training to staff. A review schedule for these procedures will be implemented with the last review date and date of next scheduled review clearly identifiable i.e. every 3 years.	
Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Lindsay Munro, ATEC 24 Service Manager (Lead Contributor); Craig O'Donnell, ATEC 24 Service Manager; Lisa McMahon, ATEC 24 Coordinator; Joanne Fowler ATEC 24 Coordinator; Urszula Siegieda, ATEC 24 Coordinator	**Implementation Date:** 29.11.2019
3. Interactive voice/call menu system to be designed and applied to general telephone number to filter emergency calls and re-direct non-emergency calls. Emergency calls from the general telephone number will be allocated the same level of priority as automatic alarm calls. **The following exception will however apply:** Calls will be recorded, prioritised, and monitored against key performance indicators to ensure service levels and response times are monitored for emergency calls received via the general telephone number. As the calls from this general telephone number are within the corporate network and not within the Alarm Receiving Centre (ARC) Infrastructure, voice recording will be included as part of the longer-term procurement exercise for the ARC.	
Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Lindsay Munro, ATEC 24 Service Manager (Lead Contributor); Craig O'Donnell, ATEC 24 Service Manager; Lisa McMahon, ATEC 24 Coordinator; Joanne Fowler ATEC 24 Coordinator; Urszula Siegieda, ATEC 24 Coordinator	**Implementation Date:** 31.10.2019 **Exception:** Anticipated 31.03.2020
4. Management will consider updating the content of service user agreements to outline the approach to and limitations associated with services provided during home visits, for example, how responders assess the risk associated with leaving a client once assistance has been provided.	
Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Craig O'Donnell, ATEC 24 Service Manager (Lead Contributor); Lindsay Munro, ATEC 24 Service Manager	**Implementation Date:** 31.10.2019
5. Attendance by responders to be measured from the alarm activation time to when the responders confirm attendance by triggering the alarm system on arrival at a client's property. Responders will also confirm the time of the end of the visit via the same process. Training to staff will be delivered to ensure Responders consistently follow operational processes by logging attendance at both the start and end of all visits. Staff will be made aware that compliance with this process will be monitored.	

Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Lindsay Munro, ATEC 24 Service Manager (Lead Contributor); Craig O'Donnell, ATEC 24 Service Manager; Lisa McMahon, ATEC 24 Coordinator; Joanne Fowler ATEC 24 Coordinator; Urszula Siegieda, ATEC 24 Coordinator	**Implementation Date:** 31.10.2019
6. Roll out of hand held devices to allow automated reporting will be progressed.	
Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Craig O'Donnell, ATEC 24 Service Manager (Lead Contributor); Lindsay Munro, ATEC 24 Service Manager; Andy Jones, ATEC 24 Coordinator; Lisa McMahon, ATEC 24 Coordinator; Joanne Fowler ATEC 24 Coordinator; Urszula Siegieda, ATEC 24 Coordinator	**Implementation Date:** 30.04.2020
7. The key safe business case, or an alternative approach, will be progressed and an installation programme implemented to allow the numbers of individual safes to be maximised.	
Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Craig O'Donnell, ATEC 24 Service Manager (Lead Contributor); Lindsay Munro, ATEC 24 Service Manager; Andy Jones, ATEC 24 Coordinator	**Implementation Date:** 30.04.2020
8. Regular engagement with all external partners via six-monthly meetings and resources will be implemented i.e. SAS, NHS24, SCD, Police Scotland and the Scottish Fire and Rescue Service.	
Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Katie McWilliam, Strategic Planning & Quality Manager – Older People, H&SCP; Lindsay Munro, ATEC 24 Service Manager (Lead Contributor); Craig O'Donnell, ATEC 24 Service Manager	**Implementation Date:** 28.02.2020

1.2 Recommendations: Service Level Agreements

1. All third-party contracts and supporting Service Level Agreements (SLAs) should be reviewed and updated. This should include a review of financial arrangements to ensure ATEC 24 is adequately remunerated for the levels of service provided.
2. All Telecare SLAs should be reviewed every two years to ensure that they take account of service delivery and operational processes, changes to any applicable regulations and relevant professional standards.
3. A partnership protocol should be approved and implemented for the Fallen Uninjured Person Service to reflect the current operations, funding arrangements and any planned process improvements.

Agreed Management Actions

1. All third-party contracts and supporting Service Level Agreements (SLAs) will be reviewed and updated. This will include a review of financial arrangements to ensure ATEC 24 is adequately remunerated for the levels of service provided.

Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Craig O'Donnell, ATEC 24 Service Manager (Lead Contributor); Lindsay Munro, ATEC 24 Service Manager; Emma Szadurski, ATEC 24 Service Manager	**Implementation Date:** 31.01.2020

2. All Telecare SLAs will be reviewed every two years to ensure that they take account of service delivery and operational processes, changes to any applicable regulations and relevant professional standards.	
Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Craig O'Donnell, ATEC 24 Service Manager (Lead Contributor); Lindsay Munro, ATEC 24 Service Manager; Emma Szadurski, ATEC 24 Service Manager	**Implementation Date:** 31.01.2020
3. A partnership protocol will be approved and implemented for the Fallen Uninjured Person Service to reflect the current operations, funding arrangements and any planned process improvements.	
Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Lindsay Munro, ATEC 24 Service Manager (Lead Contributor).	**Implementation Date:** 29.11.2019

1.3 Recommendations: Performance Reporting

1. Key performance indicators included within the Health and Social Care scorecard should include percentage of calls answered within set targets; percentage of emergency response visits within target; and well as volumes of calls and responses.
2. The parameters used for monitoring call handling and response times should be reviewed and updated in line with Technology Enabled Care Services Association (TSA) guidance and used to inform capacity planning; to ensure that there are sufficient call handlers and responders to meet industry standards.
3. ATEC 24 Service performance should be reported and regularly scrutinised by the Health and Social Care Partnership Executive Management Team.

Agreed Management Actions

1. Key performance indicators included within the Health and Social Care scorecard will include percentage of calls answered within set targets; percentage of emergency response visits within target; and well as volumes of calls and responses.

Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Katie McWilliam, Strategic Planning & Quality Manager – Older People, H&SCP; Craig O'Donnell, ATEC 24 Service Manager (Lead Contributor); Philip Brown, Senior Change & Delivery Officer, Strategy & Comms; Rebecca Paterson, ATEC 24 Business Support	**Implementation Date:** 30.09.2019
2. The parameters used for monitoring call handling and response times will be reviewed and updated in line with Technology Enabled Care Services Association (TSA) guidance and used to inform capacity planning; to ensure that there are sufficient call handlers and responders to meet industry standards.	
Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Lindsay Munro, ATEC 24 Service Manager (Lead Contributor); Craig O'Donnell, ATEC 24 Service Manager	**Implementation Date:** 31.10.2019
3. ATEC 24 Service performance will be reported and regularly scrutinised by the Health and Social Care Partnership Executive Management Team.	

Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Katie McWilliam, Strategic Planning & Quality Manager – Older People, H&SCP (Lead Contributor); Craig O'Donnell, ATEC 24 Service Manager; Philip Brown, Senior Change & Delivery Officer, Strategy & Comms	**Implementation Date:** 30.09.2019

1.4 Recommendations: Quality Assurance Framework

1. A documented first line (service delivery) quality assurance process that is aligned to Technology Enabled Care Services Association (TSA) guidelines should be developed and communicated for call handling and response visits. The process should include (but not be limited to):
   - quality assurance roles and responsibilities;
   - frequency and scope of quality assurance checks; and
   - sampling methodologies to be applied (for example coverage across all team members on an ongoing basis; increased focus on new team members; and sample sizes linked to call and response volumes).
2. Quality assurance outcomes should be linked to supervision, training and performance objectives, with regular one to ones scheduled to ensure action is taken to address any competence issues or gaps identified.
3. Where systemic themes or trends are identified from quality assurance reviews, management should consider whether existing operational processes should be revisited.

Agreed Management Action	
1. A documented quality assurance process aligned to Technology Enabled Care Services Association (TSA) guidelines will be developed and communicated for call handling and response visits. The process will include quality assurance roles and responsibilities, frequency and scope of quality assurance checks, sampling methodologies to be applied.	
Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Lindsay Munro, ATEC 24 Service Manager (Lead Contributor); Craig O'Donnell, ATEC 24 Service Manager; Lisa McMahon, ATEC 24 Coordinator; Joanne Fowler ATEC 24 Coordinator; Urszula Siegieda, ATEC 24 Coordinator	**Implementation Date:** 30.04.2020
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Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Lindsay Munro, ATEC 24 Service Manager (Lead Contributor); Craig O'Donnell, ATEC 24 Service Manager; Lisa McMahon, ATEC 24 Coordinator; Joanne Fowler ATEC 24 Coordinator; Urszula Siegieda, ATEC 24 Coordinator	**Implementation Date:** 30.04.2020
3. Where systemic themes or trends are identified from quality assurance reviews, management will consider whether existing operational processes should be revisited.	
Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Craig O'Donnell, ATEC 24 Service Manager (Lead Contributor); Lindsay Munro, ATEC 24 Service Manager; Lisa McMahon, ATEC 24 Coordinator; Joanne Fowler ATEC 24 Coordinator; Urszula Siegieda, ATEC 24 Coordinator	**Implementation Date:** 30.04.2020

2. ATEC 24 customer engagement	Low

Our review of customer engagement and marketing materials established that:

Service improvements through use of customer feedback and lessons learned mechanisms is currently limited. Management advised this is due to resource and capacity constraints however planned improvements are in progress with two service user groups being established.

Customer information including website information and leaflets to promote the service are out of date and require to be rebranded from Community Alarm and Telecare Service to ATEC 24.

Management has advised that rebranding of materials is currently on hold due to a wider rebrand of the Health and Social Care Partnership, however, in the short term, a low cost local rebranding of personal protective equipment; and uniforms; site signage; and document templates is underway.

Risks

Absence of these controls may result in:

- Service design and delivery not being influenced by customer feedback.
- Service delivery not being effective in meeting customer needs.
- Customers not being aware of the range of available telecare services and assistance.

2.1 Recommendations: Customer Feedback

1. Feedback processes to obtain input from service users should be implemented. These should be incorporated into a continuous improvement programme for service delivery, with improvement actions appropriately allocated and monitored.
2. Benefits and service improvements made as a result of customer feedback should be tracked and communicated both externally to customers, and internally to the service.

Agreed Management Action

1. Feedback processes to obtain input from service users will be implemented. These should be incorporated into a continuous improvement programme for service delivery, with improvement actions appropriately allocated and monitored.

Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Craig O'Donnell, ATEC 24 Service Manager (Lead Contributor); Lindsay Munro, ATEC 24 Service Manager; Nicky Scally, ATEC 24 Supported Housing Team Lead	**Implementation Date:** 31.01.2020

2. Benefits and service improvements made as a result of customer feedback will be tracked and communicated both externally to customers, and internally to the service.

Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Craig O'Donnell, ATEC 24 Service Manager (Lead Contributor); Lindsay Munro, ATEC 24 Service Manager; Nicky Scally, ATEC 24 Supported Housing Team Lead	**Implementation Date:** 31.01.2020

2.2 Recommendations: Customer engagement

1. Short term planned improvement actions should be completed pending the launch of the wider rebranding exercise, ensuring there are effective and well communicated pathways to access the service.
2. ATEC 24 should actively be involved in the wider Health and Social Care Partnership rebrand, to ensure that service needs are communicated and considered, and that any issues or delays impacting access to service are escalated appropriately.

Agreed Management Action	
1. Short term planned improvement actions will be completed pending the wider rebranding launch, ensuring there are effective and well communicated pathways to access the service.	
Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Lindsay Munro, ATEC 24 Service Manager (Lead Contributor); Craig O'Donnell, ATEC 24 Service Manager; Emma Szadurski, ATEC 24 Service Manager	**Implementation Date:** 31.01.2020
2. ATEC 24 will be actively involved in the wider Health and Social Care Partnership rebrand, to ensure that service needs are communicated and considered, and that any issues or delays impacting access to service are escalated appropriately.	
Owner: Judith Proctor, Chief Officer, H&SCP **Contributors:** Tony Duncan, Interim Head of Strategic Planning, H&SCP; Craig O'Donnell, ATEC 24 Service Manager (Lead Contributor); Lindsay Munro, ATEC 24 Service Manager; Emma Szadurski, ATEC 24 Service Manager; Ann Duff, Senior Communications Officer, Strategy & Comms	**Implementation Date:** 30.06.2020

Appendix 1: Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on the operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or*** • ***Critical*** impact on the reputation of the Health and Social Care Partnership which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or*** • ***Significant*** impact on the reputation of the Health and Social Care Partnership.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation of the Health and Social Care Partnership.
Low	A finding that could have a: • ***Minor*** impact on operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***Minor*** impact on the reputation of the Health and Social Care Partnership.
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 were:

Roles & Responsibilities

- Roles and responsibilities for all staff handling emergency requests have been clearly defined;
- Service level agreements are in place for the work undertaken by ATEC 24 on behalf of third parties and other partners, and include handling of emergency requests and any associated additional duties undertaken and required response times, regulatory or legislative requirements;
- There is a clear handover between the call handlers and responders in relation to progression of emergency requests, and a record of this handover maintained; and
- The citizen making the emergency request is provided with a named point of contact responsible for managing the request.

Methodology

- Clear processes and procedures are in place for handling of emergency requests by ATEC 24 and any complaints received in relation to these requests;
- All emergency requests received are logged and recorded in sufficient detail to provide a comprehensive end to end record of actions taken;
- There is regular engagement between ATEC 24 and other partners to establish current & emerging issues, and discuss any proposed changes to service delivery; and
- The channels available for citizens making emergency requests to ATEC 24 are well communicated and easily accessible.

Prioritisation & Escalation Processes

- There are clear processes and procedures in place to assist staff in determining how all types of emergency requests received should be escalated both internally and externally including to other agencies such as Police Scotland, Scottish Ambulance Service and NHS 24;
- There are clearly defined response times for progressing and actioning emergency requests;
- ATEC 24 service staff are supported with sufficient standby personnel and contact details to ensure that an effective response to emergency requests is provided;
- Escalation processes are well understood by all staff involved,
- Emergency requests received via standard channels are subject to appropriate response times; and
- Specific channels for receiving emergency requests are subject to enhanced response times.

Skills & Experience

- The skills and experience required of Call Handling staff dealing with emergency requests have been clearly identified and included in team role specifications;
- Call Handling staff are provided with appropriate training to enable them to manage any emergency requests and crisis situations that arise in the course of their duties;
- Experienced staff are provided with training across a range of service areas to ensure that they can be redeployed to under resourced areas as required;
- Enhanced training is delivered to Call Handling staff dealing with requests received via emergency social care phone lines / channels; and

- Enhanced training is delivered to Call Handling staff operating out of hours services where additional duties may be required.

Follow Up

- Outcomes / Actions taken by Service areas to address emergency requests referred by the Contact Centre require to be recorded in the system in which they were logged, prior to the request being closed as completed;
- Monitoring systems are in place to ensure that all emergency requests have been actioned; and
- Where monitoring systems have identified instances where emergency requests could have been managed more effectively, a lessons learned exercise is used to improve processes in place.

Performance Review & Reporting

- Key performance indicators (KPIs) have been established to monitor effective service delivery by ATEC 24 in respect to receipt, prioritisation and progression of emergency requests;
- There is robust, consistent and accurate reporting of actual performance against KPIs;
- Regular performance reports are provided to Committee to update members on ATEC 24 service delivery against targets, planned improvements and emerging issues; and
- Call handling services provided by ATEC 24 to third parties are supported by established arrangements including appropriate service standards and performance measures and are subject to robust monitoring and review.

Complaints Handling

- Any complaints received in respect of ATEC 24 handling of emergency requests are managed and resolved in line with the Council's corporate complaints policy and procedures and Service level agreements in place;
- Complaints received in respect of ATEC 24 handling of emergency requests are consolidated and reported;
- The channels available for citizens making complaints in relation to the handling of emergency requests are well communicated and easily accessible;
- Customer feedback is obtained to establish any service issues, and is reviewed to establish if any improvements can be made to service delivery;
- Any complaints of a serious nature in relation to handling of emergency requests are subject to review by the Council Strategic Complaints Officer; and
- There are clear processes for handling of complaints received in respect of emergency requests that ensure that the complaints provide a source of feedback and learning, help drive service improvements, and restore positive relationships with customers who feel let down by poor service.

The City of Edinburgh Council

Internal Audit

Localities Operating Model

Final Report

9 August 2019

PL1801

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.

·EDINBVRGH·
THE CITY OF EDINBURGH COUNCIL

Contents

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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 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 Council's new Locality model was designed to meet the requirements of the Community Empowerment (Scotland) Act, 2015 in relation to services delivered by the Council's Place directorate. The new model also responds to concerns raised in an Audit Scotland report An overview of Local Government in Scotland 2014 regarding sustainability of Local Authority services given increasing demand for services and decreasing resources.

The new Localities model was approved by the Council's Communities and Neighbourhoods Committee, in November 2015, resulting in creation of four Localities (North East, North West, South East, and South West) across the City in April 2016.

The new localities model was both complex and ambitious, with services delivered across the locality geographies by the Council; partner organisations; and external bodies, with the objective of increasing responsiveness and relevance of service delivery; decentralising the Council decision making process; and increasing community participation in the democratic process.

The Edinburgh Partnership

The *Community Empowerment (Scotland) Act, 2015*, requires Local Authorities to establish and participate in Community Planning Partnerships that will work together to produce Locality Improvement Plans (LIPs). In Edinburgh, Community Planning is overseen by the Edinburgh Partnership (EP). The Council is one of a number of strategic partners represented on the EP Board which agreed that each locality should produce and deliver a 5-year strategic LIP with the objective of co-ordinating partnership activities to reduce poverty and inequality. Development and delivery of the LIPs is the main strategic activity for each locality.

In April 2019, the Partnership agreed a new structure to enable better focus for partnership working in the city that includes four city-wide partnership groups, four local community planning partnerships, and 13 new Neighbourhood Networks. Each group will take responsibility for a theme or plan to support achievement of the Partnership goal of a city where poverty and inequality are reduced and will feed into the Partnership Board. This new structure is in the process of being implemented.

Council Governance of Community Planning; Delivery of Council Locality Services; and LIP Actions

The Council established four Locality Committees (LCs) in February 2018 that were allocated responsibility for governance of community planning; development and delivery of the locality improvement plans and supporting actions; reporting on performance; and escalating service delivery challenges to the Partnership Board via the Council's nominated Board representative.

Management has advised that the remit of LCs includes leading and co-ordinating local community planning activities; monitoring local delivery of services by the Council, Police Scotland and the Fire and Rescue Service; approving the Neighbourhood Environment Programme and Community Grants Fund; and facilitating public engagement, consultation, participation and feedback on all areas within the LCs' remit.

Localities also have direct management responsibility for a range of Council services, including Housing, local Transport and Environment, and local Lifelong Learning services including branch and school libraries. Each of these services are delivered via a matrix management arrangement with strategic and policy support from central services within the Place Directorate, and in the case of Lifelong Learning, Communities and Families.

On 7 February 2019, a review of LCs was presented to a meeting of the full Council by resulting in dissolution of the LCs on 1 April 2019

Governance of Council services delivered across the four localities is provided by the appropriate Council Executive Committees. Oversight of community planning (which includes delivery of locality improvement plan actions by the Council) forms part of the remit of the Culture and Communities Committee, and policy matters that affect localities are the responsibility of the Policy and Sustainability Committee.

The Council established the following strategic objectives for Localities:

- Empower citizens and communities and improve partnership working;
- Implement a lean and agile locality operating model;
- Deliver better outcomes and improved citizen experiences; and
- Embed values and develop culture.

Additionally, implementation of the localities model was expected to deliver savings via flexible allocation and utilisation of resources within cross-functional teams; elimination of duplicate roles; and improved budget allocation due to closer linkages between decision-makers and service users, however, within the Council, the majority of services delivered across localities are managed centrally by divisional teams. Where localities have direct management responsibility for Council services, matrix management arrangements have also been established with the relevant divisional teams

Budgets to support delivery of Council services via the localities have not been established. Consequently, locality service delivery costs continue to be allocated to centralised budgets and managed by the relevant centralised divisions.

Council employees located in localities have delegated financial authorities to raise purchase orders via the Oracle financial system. One of the key controls built into Oracle is authorisation limits that prevent individuals from raising and approving purchase order in excess of their delegated authorities. Oracle users are required to submit an authorisation form approved by their line manager and a senior Finance officer to either gain access to the system or change their authorisation limit.

Scope

The scope of this review was to assess the design adequacy and operating effectiveness of key controls supporting the current Council localities operating and governance model.

The review also provided assurance on the following key risks:

- failure to deliver Locality strategic objectives in line with Council strategy and relevant Council pledges;
- statutory non-compliance; and
- failure to deliver projected cost savings.

Limitations of Scope

- Delivery of Health and Social Care Partnership services across the Localities and the requirements of the Public Bodies (Joint Working) (Scotland) Act, 2014 are specifically excluded from scope. The review focused only on Council services delivered across the Localities; and
- Edinburgh Partnership governance - the review was limited to the Council's governance and oversight of Council services delivered across localities, and delivery of Council Locality Improvement Plan (LIP) actions.

Further details on the scope of our review are included at Appendix 2 – Areas of Audit Focus.

Reporting Date

Our audit work concluded on 15 April 2019, and our findings and opinion are based on the outcomes of our testing at that date.

Consequently, a number of reports to both Council committees and the Edinburgh Partnership relating to Locality Improvement Plans provided to Internal Audit after this date have not been considered when preparing our report.

2. Executive summary

Total number of findings: 2

Summary of findings raised	
High	1. Localities Governance and Operating Model
Low	2. Oracle Financial System – Authorised Approval Limits

Further detail on the basis of the classifications applied to our findings is included at Appendix 1.

Opinion

Significant Improvement Required

It is acknowledged that the original design of the localities model was ambitious as the structure involved operation of a matrix model within the Council between the four locality teams and city wide services.

Our review highlighted that the initial localities operating model; governance; and risk management frameworks established by the Council were not adequately designed as they were not well enough integrated to fully support effective ongoing monitoring of Council service delivery performance across the four localities, and progress with delivery of the Council's strategic Locality Improvement Plan (LIP) actions, and we identified the significant control weaknesses detailed below.

Whilst locality improvement plans have been prepared, and clear strategic objectives set, no post implementation review has been performed to confirm that the localities model is operating as expected and has delivered the benefits anticipated by the Council.

Additionally, established locality service delivery performance measures are not appropriately designed to support ongoing monitoring and review of the effectiveness of Council services delivered, and financial performance across the Localities.

We also confirmed that not all Locality risk registers are regularly reviewed and updated to ensure that all risks have been identified; assessed; appropriate owners allocated; and that realistic timeframes have been set to ensure that appropriate controls are established to ensure that the risks are effectively managed.

Consequently, one high rated finding has been raised.

Management has advised that the Localities operating model and risk management frameworks are in the process of being redesigned following dissolution of the Localities Committees as a result of a decision taken by full Council in February 2019, and that the established Council governance framework supporting for oversight of services across the localities and progress with LIP actions will remain unchanged.

It is Internal Audit's opinion that the recommendations included in the High rated finding raised should be incorporated (where appropriate) in the revised Localities operating model and established Council locality governance arrangements to support ongoing delivery of Council services across localities; implementation of Council LIP actions; and effective ongoing monitoring of both service delivery performance and LIP action progress.

The Low rated finding raised reflects one instance where a manager's delegated authority limit within the Oracle financial system had been increased (from £10K to £100K) without his knowledge, and with no supporting authorisation or approval from his line manager to process the limit increase.

Management response from the Place Directorate and Strategy and Communications

It is recognised the Council's localities operating model has not been fully effective and that oversight of locality performance and delivery of locality improvement plan actions could be improved. This is mainly attributable to the ambitious and complex design of the original localities operating model.

The Localities operating model is in the process of being redesigned following dissolution of the Localities Committees as in February 2019, and the Internal Audit recommendations included in the first finding below will be considered and implemented (where appropriate) in the design of the new model and incorporated within reporting provided to established Council executive committees that are responsible for oversight of service delivery across the localities and monitoring progress with delivery of LIP actions.

Once the new locality model has been designed, details of the new design and implementation plan will be shared with Internal Audit by 31 March 2020 to demonstrate how their recommendations will be addressed and implemented. It has been agreed with Internal Audit that new management actions will be raised at that time to track implementation progress.

3. Detailed findings

1. Localities Governance and Operating Model	High

Our review of the established Council localities operating model and governance and risk management frameworks confirmed that:

1. a post-implementation review of the effectiveness of the localities operating model has not yet been performed;
2. the process supporting development of Council aspects of the Locality Improvement Plan (LIP) actions has not been documented. We also noted that:
   - The Council's LIP actions are not aligned with the locality budgets and operational capacity;
   - ownership of Council LIP actions is not clear; and
   - progress with delivery of actions is not monitored, and a number of actions have not yet been delivered.
3. whilst performance measures for Council services delivered across localities have been established and are reported to Localities Committees, they are not adequately designed to support effective ongoing monitoring of locality performance as they are based on centralised divisional performance measures that are split across each Locality;
4. there are no established engagement protocols and escalation processes between centralised divisions and localities, with ongoing engagement between divisions and localities performed on an informal basis;
5. as locality service delivery costs continue to be allocated to centralised division budgets managed by the relevant Heads of Service, budgets devolved to and managed by the localities is less than 1% of total expenditure within localities. Additionally, localities are not involved in, or consulted as part of, the annual budget planning process;
6. whilst some progress is evident with the migration of locality risk registers onto the Pentana risk management system, review of risk registers confirmed that that majority of locality risks have not been updated for some time; that several risks are not supported by action plans; and that owners have not been allocated to ensure that actions are implemented to address the risks identified;

7. there is currently no established succession planning process within localities to ensure that appropriate successors are identified and trained as contingent resources for key Council roles in the event of unplanned absence or unexpected resignations.

Risks

The potential risks associated with our findings are:

- the design of the current model may not support long term compliance with the *Community Empowerment (Scotland) Act, 2015*, and address the concerns raised by Audit Scotland in their 2014 report regarding sustainability of Local Authority services given increasing demand for services and decreasing resources;
- the Council's Locality Improvement Plan (LIP) actions may not be delivered;
- the Council cannot confirm that services are being coordinated and prioritised between services and localities and delivered effectively within budget; that locality customer expectations are being met; and the expected benefits for the localities operating model will be achieved;
- locality service delivery issues are not escalated and resolved in a timely manner;
- locality risks are not identified and effectively managed;
- operational risks associated with inefficient allocation of work; duplication of roles; and ineffective monitoring leading to potential financial loss; and
- potential reputational consequences in the event of failure of the Council's localities operating and established governance framework.

1.1 Recommendation - Localities Operating Model Post Implementation Review

- a post implementation review of the Council's localities operating model and established governance framework should be performed to confirm whether it has effectively supported and governed delivery of the Council services across the localities and delivery of the Council's LIP actions;
- The outcomes of the post implementation review should be documented; and
- Lessons learned from the post implementation review should be incorporated in the design of the future Council localities operating model and locality reporting provide to established Council governance forums.

1.1 Agreed Management Action - Localities Operating Model Post-Implementation Review

Not applicable – refer management response in section 2 above.

Owner: N/A **Contributors:** N/A	**Implementation Date:** N/A

1.2 Recommendation – Development and Delivery of Council Locality Improvement Plan Actions

The planning process supporting development and delivery of the Council's Locality Improvement Plan (LIP) action plans, should be documented; retained and agreed. This should include (but not be restricted to):

1. analysis of responses received in relation to delivery of Council services across localities and strategic objectives from all participants involved in the locality planning process;
2. roles; responsibilities; and accountabilities of all Council teams involved in supporting delivery of LIP actions;

3. documentation detailing how LIP actions (including appropriate prevention measures) have been selected and prioritised;
4. LIP actions should be discussed and agreed with all centralised divisions that will be involved in supporting their implementation;
5. consideration of capacity constraints; availability of resources; alignment of resources between the Council's locality and centralised division teams; and any other constraints that could impact delivery of LIP actions;
6. alignment of LIP actions with the Council's strategic objectives;
7. dependencies on other areas of the Council to support implementation of LIP actions;
8. the costs to the Council associated with delivery of LIP actions;
9. design and implementation of management information to enable monitoring of delivery progress with LIP actions; and
10. details of the Council's governance arrangements established to monitor delivery of Council LIP actions.

1.2 Agreed Management Action - Development and Delivery of Council Locality Improvement Plan Actions

Not applicable – refer management response in section 2 above.

Owner: N/A **Contributors:** N/A	**Implementation Date:** N/A

1.3 Recommendation - Locality Service Delivery Performance Measures

The current performance framework for Council services delivered across localities should be refreshed. This should include (but not be limited to):

- key performance indicators (KPIs) that are aligned with the Council service to be delivered across localities. These should be specific; measurable; achievable; relevant; time bound; explainable and relative to organisational change (SMARTER);
- agreement of KPIs between centralised divisions responsible for delivering locality services and localities;
- a consolidated view of locality performance that is provided to the Corporate Leadership Team (CLT) and relevant Council executive committees;
- review and challenge of locality performance at relevant Council governance forums; and
- inclusion of locality performance in performance objectives (looking ahead conversations) for managers of Council divisions; locality managers; and their teams.

1.3 Agreed Management Action - Locality Service Delivery Performance Measures

Not applicable – refer management response in section 2 above.

Owner: N/A **Contributors:** N/A	**Implementation Date:** N/A

1.4 Recommendation - Engagement with Council centralised divisions

Engagement protocols between localities and Council centralised divisions should be designed and implemented to support delivery of services across localities. This should include processes to ensure that:

- all service requests from localities are communicated completely; accurately; and in a timely manner to centralised divisions;
- services are delivered within the timeframes specified in the agreed locality key performance indicators (KPIs); and
- issues with service delivery are escalated and resolved in a timely manner.

1.4 Agreed Management Action - Engagement with Council centralised divisions

Not applicable – refer management response in section 2 above.

Owner: N/A **Contributors:** N/A	**Implementation Date:** N/A

1.5 Recommendation - Locality budget planning and financial management

- Finance should be engaged in the design of the new locality operating model to ensure that the proposed solution can be supported by an appropriate and effective locality financial operating model;
- The design of the new financial operating model should consider the benefits associated with allocating budgets and cost centres to localities and calculating and reporting locality costs on an ongoing basis;
- The rationale supporting the decisions in relation to the design of the new locality financial model should be recorded.

1.5 Agreed Management Action - Locality budget planning and financial management

Not applicable – refer management response in section 2 above.

Owner: N/A **Contributors:** N/A	**Implementation Date:** N/A

1.6 Recommendation - Risk Management

1. Centralised and individual localities risk registers should be reviewed and refreshed to ensure that:

- they include all operational and strategic risks (including risks associated with third parties) that could impact upon service delivery, or delivery of locality improvement plan (LIP) actions;
- that the impact and probability of the risks have been assessed;
- appropriate owners have been allocated to all risks; and
- action plans and delivery dates have been prepared to support implementation of appropriate controls to manage the risks.

2. Locality risk registers should be included in the information provided to relevant Council governance forums (for example, the Place Directorate Risk Committee).

1.6 Agreed Management Action- Risk Management

Not applicable – refer management response in section 2 above.

Owner: N/A **Contributors:** N/A	**Implementation Date:** N/A

1.7 Recommendation - Succession Planning

Locality roles with associated key person dependency risks should be identified and a succession planning exercise performed to identify potential successors who could fill these roles in the event of unplanned long-term absence or unexpected resignations.

The skills and experience of the potential successors should be considered in comparison to key Locality roles and training and support (including knowledge transfer) provided where required.

1.7 Agreed Management Action - Succession Planning

Not applicable – refer management response in section 2 above.

Owner: N/A **Contributors:** N/A	**Implementation Date:** N/A

2. Oracle Financial System – Authorised Approval Limits	**Low**

Our testing of the budgetary approval process in Localities identified one instance where the Transport and Environment Manager (the user) could potentially authorise a purchase order in excess of their approved £10K authorisation.

We confirmed that the user was initially allocated a £10k Oracle approval limit in December 2016, as per a signed authorisation form.

The approval limit was then increased to £100k in March 2018 with no supporting request from either the user or their line manager. Additionally, the user was not aware of this revised limit.

The Finance and Procurement Systems helpdesk within Finance was unable to provide any reason or supporting documentation for this unauthorised change.

The user's authorisation limit has now been restored to £10k.

Risks

Risk of financial approvals in excess of authorised approval limits that could potentially result in financial loss.

2.1 Recommendation - Authorisation Limits Review

- Finance and Procurement team should implement appropriate controls to ensure that limit changes are only processed when supported by request forms that have been authorised and approved by line managers;
- A review of existing limits within Oracle should be performed to establish whether this issue is limited to this one instance, or whether the problem is potentially more systemic; and
- If the issue is systemic, Finance should engage with Risk Management to ensure that appropriate controls are designed and implemented.

Agreed Management Action- Authorisation Limits Review

A large-scale exercise, involving over 500 changes to the structure, was undertaken during the winter months realigning Place, taking into account changes relating to Transformation. A review of all Oracle Requisition Approvers for the department of Place has been initiated and is currently underway.

More fundamentally, a rolling programme of all Oracle Requisition Approvers, across all divisions, has been reinstated. Prior to 2015 this was business as usual (BAU), however due to the proposed

introduction of the enterprise resource planning solution and other budget cuts and staff reductions this was suspended. The significance of this regular review was recognised and reinstated in 2018. This will be rigorously implemented until firmly re-embedded as part of BAU across the business	
Owner: Stephen Moir, Executive Director of Resources **Contributors:** Hugh Dunn, Head of Finance; Alison Henry, Corporate Finance Senior Manager; Layla Smith, Business Manager; Annette Smith, Executive Assistant; David Camilleri, Principal Accountant - Financial Systems; Brenda Brownlee, Senior Accountant	**Implementation Date:** 26 June 2020

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or*** • ***Critical*** impact on the reputation of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or*** • ***Significant*** impact on the reputation of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation of the organisation.
Low	A finding that could have a: • ***Minor*** impact on operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***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.

Appendix 2 – Areas of Audit Focus

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

Audit Focus	Control Objectives
Corporate strategy	A post implementation review has been performed to confirm that the Localities model: • has delivered the expected benefits detailed in the initial Localities implementation plan; • is operating as expected; and • remains aligned with the overall Council strategy and relevant Council pledges.
Governance and management oversight	• There is a clearly established localities governance model with reporting lines into the Place Senior Management Team; the Corporate Leadership Team; and relevant Council executive committees; • Delegated authorities have been established for each locality detailing their financial and service delivery decision making authorities; • Locality managers and employees have a clear understanding of their roles and responsibilities; • Service delivery responsibilities have been clearly defined between the Localities and functional Council service delivery teams; and • Reporting lines and communication channels are well defined, and clearly communicated to all employees.
Resource and Budget Management	Processes have been established to ensure that locality service demands are appropriately prioritised; resourced; and funded from functional service budgets.
Operational Performance	• Locality key performance indicators (KPIs) have been designed and implemented to support service delivery; • KPIs have been shared and agreed with central Council service delivery teams; • Progress against KPIs is regularly monitored and recorded to support operational management and reporting to relevant governance forums; • There is an established customer engagement process to ensure that all citizens can effectively engage and communicate with Locality teams to request services; • There is an established engagement process to ensure that all Locality requests are communicated to central service delivery teams; • There is an established escalation process applied in instances where Locality requests have not been delivered by centralised teams within established KPIs; • There is an established Locality customer complaint process; and • Performance against relevant KPI's is included in the Locality managers annual looking forward conversations; and is assessed a part of the looking backwards conversations.
Risk Management	• Locality risk committee meetings have been established; • Locality risk registers are maintained, and regularly updated, with any significant locality risks escalated and included in the Place Directorate risk register;

	• Constructive and measurable actions are designed for each of the risks identified; and • Actions are appropriately allocated, and their completion monitored.
Development and delivery of Local Improvement Plans	• A clear process has been established and is applied to support development of LIPs; • Responses from all participants are collected; reviewed and analysed, with emerging themes identified and included (where appropriate) in LIPs; • Resource availability and other constraints are considered when creating plan objectives; • Completed plans are made publicly available; and • Progress against plan is monitored and reported to the appropriate governance forums and executive committees.
Succession planning	• Key locality roles have been identified and appropriate succession plans established.

The City of Edinburgh Council

Internal Audit

HMO Licensing

Final Report

8 August 2019

PL1803

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.

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

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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's Licensing division operates as licensing authority for civic, taxi and private hire cars; and Houses in Multiple Occupation (HMOs) licences. The Council Regulatory Committee and Licensing Sub-Committee deal with policy issues and license applications arising from these functions.

The Licensing Service processes approximately 22,000 licence applications each year covering approximately 130 licence types. The Service generates around £5 million in licensing fees which pays for its operating costs. Internal Audit conducted a full Licensing audit in 2016 and reviewed controls relating to civic and liquor licensing. The last HMO Licensing audit was performed in May 2015 when the Licence processing and inspections team were in separate divisions of the Council; both the functions were merged in 2016 transformation exercise.

The owners of a House in Multiple Occupation (HMO) are required under the Housing (Scotland) Act 2006 to have an HMO licence issued by the local authority. A dwelling is classified as an HMO if it is:

- occupied by 3 or more unrelated persons, as their only or main residence; and
- is either a house, premises or a group of premises owned by the same person with shared basic amenities.

Additionally, the Scottish Ministers may also specify (by order) that an HMO licence is required for any other type of property.

This legislation therefore not only covers houses, flats and bedsits shared by 3 or more unrelated individuals but also dwellings such as hostels; student halls of residence; and separate dwellings that have communal facilities such as toilets, bathrooms, and kitchens.

The applicant needs to ensure that the accommodation is compliant with 18 HMO conditions designed to ensure minimum safety, quality, and management standards. It is a criminal offence to operate without a licence and under the Housing act, local authorities have enforcement powers[1]. Complaints about non-compliance in an HMO licensed accommodation are dealt by the Council's Enforcement division.

Following a consultation exercise, a new three years HMO licence and licence fee structure was approved by Council's Regulatory Committee on 21 April 2017. The new fee structure introduced broader fee bands based on occupancy.

HMO licence applications are received and recorded by the Customer team, along with supporting documents and fees accepted at the High Street Office. Applications received are recorded in the ACR system and then (if valid and complete) transferred to the licensing system (APP Civica), with daily reconciliations performed between the systems. ICT management has confirmed that both systems are hosted by CGI on behalf of the Council.

Applications and supporting documents are then reviewed by Licensing; followed by an internal and external consultation process; and inspection of the accommodation. The outcome of this process determines whether the licence application will be recommended for either approval or rejection (in line with delegated powers) or referred to the Council's Licensing Sub-Committee if cases are either contrary to policy or an objection has been received.

[1] Police Scotland also have enforcement powers should they wish to take action

Policy directs that all new licences (first grants) or cases sent to committee will be restricted to one year, otherwise a three years licence is awarded.

As required by the act, the Licensing division follows a statutory consultation process which involves the attendance of a fire officer at property inspections for first time applications and the submission of a consultation request to Police Scotland for all applications. A formal response is not always received from Police Scotland for these consultations, and if no response is received within the statutory notice period of 28 days then it is deemed a satisfactory response and the application is processed.

A further requirement placed on the Local Authority by the 2006 act is to publish and maintain a register of applications and the decisions made on them. This must exclude any information that may jeopardise the safety or welfare of any person or the security of the premises. The register must be readily accessible by the public at all reasonable times. The information required for publication of this register at the Council, is contained within the APP system. This system is used to process all licensing applications.

The most significant key Performance Indicators for the licensing division, as agreed with the Regulatory Committee, is to reach a decision within 72 days for 90% of HMO applications and (to support achievement of this timeframe) start processing at least 95% of applications within 7 days of their receipt.

The Council's Licensing service has used the APP system since April 2014 to process licences and provide management information to monitor service performance against agreed KPI's. There has been an ongoing issue with the stability and efficiency of this system which has had a detrimental impact on team productivity and performance. An upgrade is planned for APP system (to version 8.7), however Digital Services have confirmed that it is not going to improve Licencing module performance. An enhanced version of the system (Cx) is available and CGI, Digital Services and Licensing are currently working together to plan an upgrade to this version.

Scope

This review assessed the design adequacy and operating effectiveness of the key HMO licensing controls established to manage the following key risks:

- Compliance with Council policies, procedures, and HMO licensing legislative requirements;
- Ensuring that processes remain robust in terms of potential risk of bribery or conflicts of interest;
- Ensuring inspection routines and operational processes are delivered consistently; and
- Poor ICT system performance and outage impacting team performance and productivity

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

Testing was performed for the period of April 2018 to March 2019.

Limitations of Scope

The subject of this review is limited to HMO licences' application processing and determination. Processing of other types of licences, as well as licensing enforcement processes and key controls are excluded from the scope of this review but will be considered in future reviews.

Further details on the scope of our review are included at Appendix 2 – Areas of Audit Focus.

Reporting Date

Our audit work concluded on 3rd May 2019, 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. Licensing System – Data Integrity and Performance Issues
High	2. Collection and processing of HMO licence fees
Medium	3. Operational Performance and Reporting
Low	4. Training and guidance documentation

Further detail on the basis of the classifications applied to our findings is included at Appendix 1

Opinion

Significant improvement required

Whilst our review did not identify any significant breaches of applicable legislation; statutory obligations; or Council standing orders, we did identify gaps in both the design and operating effectiveness of the key operational controls established to mitigate the risks associated with processing HMO Licence applications and payments that are significantly impacting upon operational performance.

APP Civica system limitations

Most notably, there are a number of limitations with ongoing use of the APP Civica system that are impacting both user experience and the ability to completely; accurately and efficiently process HMO licencing applications and payments in line with applicable key performance targets, and effectively maintain the licencing register in line with applicable statutory requirements.

Management has advised that implementation of the latest version of the system (Cx) is planned, however there are currently no established plans to support this.

Completeness of income

We confirmed that there are currently no established procedures to support timely identification; matching; and allocation of BACS licencing fee receipts against applications received, with all unmatched BACS receipts retained in a general (non-Licencing) suspense account.

As the HMO licencing service is solely funded by income generated through application fees, it is essential to ensure that the full population of BACS licence fee payments are identified and processed in a timely manner.

Moderate control weaknesses

We also identified some control weaknesses that are having a moderate impact on Licencing's operational performance. These included lack of established procedures and guidance in relation to the number of inspection revisits to be performed for each application prior to granting an HMO licence; the need to improve the process for allocation of workload to inspections officers to address the risks associated with lone working, and ensure that inspection outcomes are consistently recorded on standard electronic proformas using iPads; lack of published guidance detailing the process for applicants to request refunds; the need to document and retain evidence of reconciliations performed to confirm that all applications received have been completely recorded on the APP Civica system; and the need to review existing and develop new HMO licencing performance measures to support ongoing performance reporting to the Regulatory Committee.

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

Areas of good practice

The Licencing Team has recognised the need to understand the skills of the inspections team, and are currently developing an inspections team skills matrix with the objective of identifying skills gaps.

Management has advised that training will be developed and delivered to address the skills gaps identified, ensuring that inspection team members are fully equipped to perform their roles to the required standard, and each member of the team feels confident in their ability to perform their role to the required standard, and ensure consistency of inspections.

Another area of good practice is the weekly protection of Tuesday mornings each week to share information that the team should be aware of (for example regulatory or legislative updates) and address any team queries.

3. Detailed findings

1. Licensing System – Data Integrity and Performance Issues — High

The current version of the APP system does not include protected system fields or in-built system milestones to support HMO licence applications' data integrity.

Management has also advised that there have been numerous instances of poor system performance including initial log on issues; slow processing; and system inaccessibility resulting in application backlogs.

Limitations of the current system impair the Council's ability to meet its performance targets and also to comply with the statutory requirement to maintain a licencing register. Although management has advised that the Council is currently compliant with this requirement, the limitations of the system makes it much more manually resource intensive to maintain and the format of the register published is not as accessible as it could be on mobile or portable electronic devices.

An updated version of APP system, Cx, is available and is tailor made for license processing. Digital Services has advised that plans are in place to consider the business case for the upgrade to Cx in August/ September 2019 however Internal Audit has not been provided with any timebound project plan to achieve this.

Licencing management has advised that the longer term plan is to move to APP version 8.7, although the Change request submitted to CGI is for an upgrade to APP Civica CX, and has also confirmed that the system issues have been reported to the Regulatory Committee.

Risks

The potential risks associated with our findings are:

- Key data altered in the system resulting in inaccurate or incomplete licence processing,
- Potential non-compliance with Article 5(1)(f) and Article 32 of the EU General Data Protection Regulations
- Critical steps of licence processing not completed and unmonitored,
- Delayed processing of applications
- Potential failure to continue to meet the requirements of part 5 of the Housing (Scotland) Act 2006 to maintain an up to date register of applications and decisions,
- Inefficient use of staff resources due to system performance issues,
- Key system issues leading to impact on the performance not appropriately reported to senior management and governance forums for visibility, scrutiny and remedial actions.

1.1 Project plan

Digital Services and Licensing division should jointly have a consultation with CGI to create a mutually agreeable timebound project plan for the implementation of APP Cx version.

1.1 Agreed Management Action – Project plan

Response from Digital Services

Digital Services resources have now been allocated to work with both the Licencing team and CGI to progress the change request for the upgrade to APP Civica CX, and this will involve developing a plan to support implementation of the system upgrade that includes details of all relevant activities to be completed and implementation timeframes.

Response from Licencing

The Place Directorate and Digital Services have made change requests for CGI to provide analysis on the business benefits, costs and risks of moving to the APP. These change requests are outstanding from CGI from 2018. Upon receipt of this analysis the Directorate will agree with the Resource Directorate a project plan for approval by senior managers,

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Nicola Harvey, Head of Customer and Digital Services; Heather Robb, Chief Digital Officer; Alison Roarty, Commercial Team Lead; Layla Smith, Business Manager; Julie Rosano, Executive Assistant	**Implementation Date:** 20 December 2019

1.2 Recommendation - Escalation of system issues

A paper, highlighting system issues with current version of the APP system along with a proposed plan to fix those, should be submitted to the relevant Licensing and ICT Executive Committees.

1.2 Agreed Management Action - Escalation of system issues

The Place Directorate has previously reported on operational performance issues to the Regulatory Committee in 2018. The Place Directorate will include a full assessment of system issues with APP within a wider performance report due to be submitted to Regulatory Committee in the last quarter of 2019/20. This report will include an update on proposed project plan for APP Cx

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Michael Thain, Head of Place Development; Andrew Mitchell Regulatory Services Manager; Alison Coburn, Operations Manager; Sandra Harrison, Executive Assistant.	**Implementation Date:** 31 March 2020

2. Collection and processing of HMO licence fees — High

There is currently no established procedural documentation or guidance to support identification and matching of funds to applications received; and processing of HMO application fees received via BACS payments directly into the Council's main bank account.

A considerable volume of licence fee payments are received via BACS (typically from agents and institutional applicants), with no licence application or property number reference numbers provided. It was not possible to quantify either the volume and value of BACS payments received, or those that remained unmatched to HMO applications received due to the lack of standardised referencing.

Lack of standard references result in difficulties matching and allocating funds received against a specific HMO licence application. The complexity of the process further increases when accumulated payments are received for more than one HMO application.

BACS payments received that cannot be matched or allocated against a licence are retained in a general Council bank account. Details of unallocated receipts are included in a general Council-wide exceptions list which is circulated to all departments by the Banking team for review and comparison with expected payments for pending applications.

Given the volume of Licensing applications (including HMO) and absence of clearly defined payment references, it is not always possible to identify and reconcile the exceptions list against the applications pending for payment.

Risk

The potential risks associated with our findings are:

- Licencing application fees may not be matched against the correct licencing application;
- The HMO application may not be processed due to outstanding payment;
- Application processing KPIs may not be achieved;
- Licencing fee income may not be allocated against the correct general ledger cost centre and reflected in Licencing reserves; and
- Financial performance targets may not be achieved due to understated income.

2.1 Recommendation - BACS Payment Reference

The Licensing team, in consultation with Banking team, should develop a procedure to support identification; matching of funds to applications received; and processing of HMO application fees received via BACS payments

This procedure should include (but not be restricted to)

- development and implementation of standard references to be provided with all BACS payments;
- details of the process to be applied to identify and match the fees against applications and / or properties;
- clarification regarding whether applications can be submitted electronically or should be submitted in hard copy only.

A customer guidance note should also be developed and published on the Council website for licence applicants, detailing the alternative ways to apply and make payment for licences.

2.1 Agreed Management Action - BACS Payment Reference

It should be noted that measure are in place to ensure that no application is progressed without the required fee being reconciled. This reflects the statutory process and the need to ensure that the Council treats applications for a renewal lawfully unless the reconciliation process can evidence a payment has not been made.

There is no evidence from directorate monitoring the level of income from HMOs licence applications which would demonstrate that fees are not being collected. Any unmatched fee not identified will in effect contribute to the Council's general revenue account and therefore there is no financial loss to the Council.

The Internal Audit recommendation outlined above is not accepted as it not believed to be achievable. Therefore Licencing; Customer; and Finance will investigate potential solutions re the BACS issue, (including any potential scope for a technology solution) to address this risk. These options will be reviewed with Internal Audit and a longer term solution identified and implemented.

It has been agreed with Internal Audit that (once the solution has been identified) another audit finding will be raised that will monitor implementation of the solution to confirm that it is operating effectively.

In the meantime, a statement will be added to the Licencing pages on the Council's external website and application forms advising customers of what reference must be used to successfully make a BACs payment.

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Michael Thain, Head of Place Development; Andrew Mitchell Regulatory Services Manager; Alison Coburn, Operations Manager; Sandra Harrison, Executive Assistant.	**Implementation Date:** 30 March 2020

3. Operational Performance and Reporting — Medium

Inspection Revisit policy

When inspection officers identify issues or anomalies during HMO property inspections, they may schedule a revisit for a later date to ensure that they have been addressed prior to granting the HMO licence. However, there is currently no documented policy stating the maximum acceptable number of revisits to be performed for each HMO application prior to refusal.

Internal Audit requested details of the volume of revisits performed for each application during the 2018/19 financial year, but this data could not be provided.

Management has advised that there are often multiple revisits for each application and that they are not consistently recorded on the system. Management has also confirmed that team briefings have been held and email guidance provided on revisits.

Allocation of Inspections

HMO inspections scheduled for the forthcoming week are reviewed one week in advance by a member of the inspection team to assign available time slots against the geographical location of each property. Team Leaders then allocate these time slots to each Inspection Officer.

Management has also advised that some inspection officers also reallocate the inspections amongst themselves without informing Team Leaders (TL) or management.

Inspection documentation

Site inspections for renewal applications should be performed using a standardised template on a Council iPad, enabling the Inspection Officer to prepare the inspection report on site and send it immediately to the applicant.

Review of a sample of 25 inspections established that 10 had been recorded on paper form. Licensing team were also unable to locate the supporting documentation for one inspection included in our sample.

We also noted that inspection officers record inspection outcomes for new applications on paper instead of using the iPad template. Team Leaders informed that it this is due to the requirement of fire inspection report in new applications which is manually prepared by the Fire Officer. The manual inspection report is subsequently combined with the manual Fire Officer's report.

Licence Fee Refunds

The Council's Licence Refund Request policy, available on the Council's external website, states the circumstances under which a refund of a licence fee can be made. It does not however provide the applicant with guidance on how to request a refund. Currently, customers request refunds directly from the Licensing officer who is processing their application, which is subsequently approved by either the Licensing Manager or next level manager.

Reconciliation - Paper Applications to APP records

Our review noted that Customer team's daily reconciliation between electronic application records created on the APP and paper applications is not documented. As there is no audit trail supporting this reconciliation, Internal Audit can therefore not confirm whether this control is effective in ensuring that all paper applications received have been processed via APP.

Reporting

The Licensing team provides performance reports against its two KPIs to the Regulatory Committee every six months. However, we noted that numbers related to HMO licensing are excluded for one of the two KPIs. The rationale supporting exclusion of the HMO performance data is not clearly stated in the performance report and is only referenced in the appendix.

Management has advised that the KPI for 90% applications to be processed within 72 days is an unrealistic expectation for HMO applications.

Risk

The potential risks associated with our findings are:

- Inefficient use of inspection resources; inefficient processes; increased application backlogs; and failure to achieve KPI performance targets,
- Revisit inspection costs result in unit cost (processing cost) per licence that are disproportionate to licencing fee income;
- Lone working health and safety risk when inspection officers reallocate inspections without informing TLs or management
- Poor customer experience in relation to refunds, and inconsistency in the nature of refund requests received;
- Potential conflict of interest or bribery risk with refund requests made directly to Licensing officers who are processing the application;
- Subjective inspection outcomes and decisions where the standard iPad pro forma is not used;
- HMO applications are not completely recorded in APP system and are not processed; and
- Performance against KPIs for HMO applications is not provided to the Regulatory Committee for scrutiny by the Committee, and underlying performance issues may not be identified and resolved.

3.1 Recommendation – Inspection Revisit Policy

The Licensing team should develop and implement an inspection revisit policy that should include (but not be limited to:

a) instance when a revisit is required prior to granting the licence;
b) the maximum number of revisits to be performed prior to the application being refused;
c) the minimum and maximum timeframes between revisits;
d) the approval procedure to applied for more than one revisit for an application;
e) processes supporting scheduling; and recording the results of revisits;
f) when an application should be refused based on successive unsatisfactory revisits and
g) the fee to be charged (if permitted under legislation) for any additional revisits requested by the applicants.

The procedure should be communicated to and appropriate checks established to ensure that it is consistently applied by all Team Leaders and Inspection Officers.

3.1 Agreed Management Action - Inspection Revisit Policy

It is not legally possible to refuse a licence application based on number of visits as legislation requires that each case is considered on its merits and any policy that removes discretion would be at high risk of legal challenge.

A new procedure is currently being drafted that will ensure a consistent approach and any decision on number of revisits is controlled by managers of the service to reduce the number of unnecessary revisits.

We will amend current codes used in the APP Civica licencing system to ensure a 3-stage process for inspection and revisit is applied going forward. This will include creation of:

- a new unique single action code for an Initial inspection
- a new unique single action code for a Revisit inspection to offer a 7,14 21 or max 28-day time frame to complete any outstanding works – only available after an initial inspection has taken place
- a new unique action for a single Team Leader/Manager Review Inspection – only available in exceptional cases where additional guidance is sought by the inspector and must be authorised by a team leader/manager

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Michael Thain, Head of Place Development; Andrew Mitchell Regulatory Services Manager; Alison Coburn, Operations Manager; Sandra Harrison, Executive Assistant.	**Implementation Date:** 31 Dec 2019

3.2 Recommendation – Allocation of Inspections

- Inspection officers should be encouraged to assign themselves to the available weekly inspections by Wednesday of the previous week. Team Leaders should then review the schedule to confirm that inspectors have been effectively allocated across the geographies; update (as required); and finalise the inspection schedule.
- Inspection Officers should be reminded that reallocation of inspection is not permitted, detailing the risks involved, and where required, the inspection officers should request the reallocation to Team Leaders.

3.2 Agreed Management Action – Allocation of inspections

This process has been revisited with all team members and they are reminded all changes to be approved by Team Leaders as per the existing procedure

Reports are being designed in APP which will further strengthen this. These will ensure that inspections are based on resources available for the coming week. The allocation of inspections will be electronically passed to the TLs for efficiently checking and sign off.

The new reports and process for running/allocating the inspections are scheduled to be implemented at the end of October 2019

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Michael Thain, Head of Place Development; Andrew Mitchell Regulatory Services Manager; Alison Coburn, Operations Manager; Sandra Harrison, Executive Assistant.	**Implementation Date:** 30 November 2019

3.3 Recommendation - Inspection documentation

Inspection Officers should consistently document their inspections outcomes (for both new and renewal applications) using the predesigned iPad template.

Team Leaders should review a sample of completed inspection reports to ensure that outcomes are being consistently recorded using the iPad template. Where exceptions are found, these should be discussed with the relevant inspection officers and included in their monthly performance discussions.

3.3 Agreed Management Action – Inspection documentation

A revised version of the electronic Inspection sheet for inspecting new properties is being prepared together with an electronic inspection sheet for the Fire Service and Public Safety teams. This will enable all officers involved in a new inspection to use iPADs to create and produce an inspection sheet using an electronic template. The revised procedure will put in place proportionate checks by the team leaders to ensure that the electronic template is being used.

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Michael Thain, Head of Place Development; Andrew Mitchell Regulatory Services Manager; Alison Coburn, Operations Manager; Sandra Harrison, Executive Assistant.	**Implementation Date:** 31 Oct 2019

3.4 Recommendation - Refund Request Policy

The refund policy should be updated to include: the process for an applicant to request a refund of their HMO licence fees. This should include:

a) how to request a refund (for example, by email/letter);

b) link to a refund request form; and

c) how the refund payment will be made (for example, cheque/electronic credit).

The updated refund policy should be published on the HMO License section of the Council website.

3.4 Agreed Management Action - Refund Request Policy

The established policy approved by Regulatory Committee is that refunds will only be authorised in very exceptional circumstances, for example, serious illness. Guidance on how to request a refund form is therefore not appropriate.

Licencing will ensure that the terms of the Policy are more clearly referenced on application forms and the Council website so that customers are aware of the terms of the policy, and will advise that in exceptional circumstances, refund requests should be made by letter to the Licensing Manager.

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Michael Thain, Head of Place Development; Andrew Mitchell Regulatory Services Manager; Alison Coburn, Operations Manager; Sandra Harrison, Executive Assistant.	**Implementation Date:** 20 September 2019

3.5 Recommendation – Reconciliation between physical applications and APP

The reconciliation between manual applications received and those recorded on the APP system should be documented on the APP report used to complete the reconciliation. This should include:

a) the details of individual(s) performing the reconciliation;

b) the date the reconciliation was performed;

c) the volumes reconciled; and

d) details of any discrepancies and their resolution.

These documented reconciliations should be retained either electronically or physically for a minimum of one year.

3.5 Agreed Management Action - Reconciliation between physical applications and APP

The reconciliation between manual applications received and those recorded on the APP system will be documented on the APP report used to complete the reconciliation and will include the details noted in the above reconciliation.

The reconciliations will be retained for a minimum period of one year.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Nicola Harvey, Head of Customer and Digital Services; Neil Jamieson, Customer Senior Manager; Lisa Hastie, Customer Contact Manager; Gary Jardine, Customer Service Manager; Karen Donaldson, Customer Hub Team Leader; Layla Smith, Business Manager; Julie Rosano, Executive Assistant.	**Implementation Date:** 31 October 2019

3.6 Recommendation - HMO Key Performance Indicators and Performance Reporting

- Performance reports currently provided to the Regulatory Committee should clearly highlight the exclusion of HMO licence application performance statistics and the supporting rationale in the overall Licensing division performance statistics;
- Management should develop a suite of SMARTER (Specific, Measurable, Attainable, Relevant, and Time-Bound; Easily understood and Relative) HMO licencing key performance indicators (KPIs);
- The KPIs and their reporting frequency should be agreed with the Regulatory Committee; and
- Performance against the revised KPIs should be reported to the Regulatory Committee on an ongoing basis at the agreed frequency.

3.6 Agreed Management Action - HMO Key Performance Indicators and Performance Reporting

The Regulatory Committee were previously advised that HMO performance data would be excluded whilst the Licencing introduced the significant change of moving towards a three-year licensing system. Performance reports therefore only included Civic and Taxi data in the period 2015-2018

Licencing will be reporting to Regulatory Committee on the first cycle of three-year licencing for HMO's prior to the setting of Licensing Fees for 2020/21 in early 2020. The Directorate will include within that report relevant performance data and make recommendations for approval for performance targets ongoing performance targets.

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Michael Thain, Head of Place Development; Andrew Mitchell Regulatory Services Manager; Alison Coburn, Operations Manager; Sandra Harrison, Executive Assistant.	**Implementation Date:** 31 Jan 2020

4. Training and guidance documentation — Low

Discussion with Team Leaders confirmed that there is currently no established HMO licencing team induction process for new team members, and no evidence was provided to confirm that new

employees had received induction training. Currently, new team members shadow more experienced team members.

HMO application processing guidance documentation was last updated in 2017. Some temporary changes have been made to the process since then to deal with application backlogs, however the guidance has not been updated to reflect these changes. Management has advised that this is due to the expected implementation of APP Cx system in August / September 2019 (refer Finding 1).

Risk

The potential risks associated with our findings are:

- New team members are not provided with sufficient training and guidance.
- Procedures are not adequate and applications may not be processed in accordance with current processes.

4.1 Recommendation - Induction process

The induction process should be established for new HMO licensing team members. This should include coverage of all relevant HMO application and payment processes associated with the role and completion of induction checklist.

4.1 Agreed Management Action - Induction process

Regulatory Services introduced a service specific induction program for all teams in 2018 in order to ensure that all new starts are appropriately supported.

Written Induction packs for the licensing service were created and will be used for all new staff. The pack includes a 6-week training programme which will be tailored for each new start depending on where they sit within the service

The member of staff identified by the audit had been assigned alternate duties was not therefore familiar with the process. This has been addressed with the individual concerned. Appropriate refresher briefings will be given for all managers within the service.

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Michael Thain, Head of Place Development; Andrew Mitchell Regulatory Services Manager; Alison Coburn, Operations Manager; Sandra Harrison, Executive Assistant.	**Implementation Date:** 30 Sept 2019

4.2 Recommendation - HMO application processing procedures

HMO application processing guidance should be reviewed and updated on a regular basis to ensure that it remains aligned with applicable legislative requirements and the Council's processes.

4.2 Agreed Management Action - HMO application processing procedures

The legislation in this area has not changed for some time nor are any changes anticipated.

For changes in operational processes revised guides have been created. For example, the HMO processing guide is currently being updated to reflect minor changes in HMO processing. These revised user guides will be rolled out across the whole service in November after the opportunity is taken for the licensing team self-assessment and Training Needs Analysis programme, due to start in October/November 19. This will reinforce the training

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Michael Thain, Head of Place Development; Andrew Mitchell Regulatory Services Manager; Alison Coburn, Operations Manager; Sandra Harrison, Executive Assistant.	**Implementation Date:** 31 Dec 2019

Appendix 1: Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on the operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or*** • ***Critical*** impact on the reputation of the Council which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or*** • ***Significant*** impact on the reputation of the Council.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation of the Council.
Low	A finding that could have a: • ***Minor*** impact on operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***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.

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:

Sub-process	Control Objectives
Application receipt and recording (Customer Team)	▪ Customer team has robust procedures and processing and review controls in place to ensure that correct fee is applied and charged for HMO licence applications. ▪ Daily cash and bank reconciliations are performed to ensure that all fee income is completely and accurately recorded (in the relevant general ledger code) and refunded (where applicable); ▪ BACS payments received are completely and accurately matched to licensing applications received via e mail; ▪ A daily reconciliation is performed between the ACR and APP systems ensure completeness of all applications registered and transferred to Licensing, with all exceptions investigated and resolved; ▪ Refund payment procedures are sufficiently robust to prevent applications being transferred to Licensing division prior to receipt of payment.
Application review and assessment (Licensing Team)	▪ Workflow is consistently monitored to ensure that the impact of increased volumes on available resources can be assessed and addressed; ▪ Workload is allocated to team members based on skills and experience; ▪ Team members are aware that any potential conflicts of interest and / or bribery in relation to licence applications should be communicated to management. Where conflicts of interest / bribery, have been highlighted, work is reallocated; ▪ Guidance; detailed procedures; and ongoing training have been developed and implemented to ensure that all team members understand the relevant legal requirements associated with assessment of HMO licence applications; ▪ Standard inspection templates have been developed and are consistently applied to support completion of property inspections and the decision to recommend grant of licence; ▪ The process for engaging with both statutory and non statutory consultees is consistently applied, with outcomes (including objections) consistently document and resolved, to ensure that the applicant and premises do not contravene applicable laws, regulations, or Council standing orders, and all opinions have been considered; ▪ There is appropriate segregation of duties between team members processing applications and recommending the grant of licence; ▪ A one year term is applied to all new licences, and cases submitted to committee, with three years for all other licences, in line with policy; ▪ The Council's Scheme of delegation is consistently applied in relation to the decision to grant or refuse HMO licences or to refer to licensing sub-committee for determination; and ▪ There are strong authorisation controls, compliant with delegation of authorities to authorise refund of fees where overpayments have been made, or discounts not applied.

Performance Framework and Reporting	▪ A performance framework has been established and consistently applied, and includes service standards; key performance indicators; and performance monitoring and reporting to relevant management governance forums and executive committees; ▪ Service standards have been agreed between Customer and Licensing teams. Performance is regularly monitored and reported against those service levels to identify any challenges that could impact upon performance and areas for further improvement.
ACR and APP System Controls	▪ Appropriate system security controls (for example unique passwords and regular password changes) have been established and are consistently applied to ensure protection of customer data; ▪ System access rights are appropriately allocated based on roles and responsibilities within the team, notably for new team members and any team members who have changed roles; ▪ Regular user access reviews are performed to confirm that user access rights remain appropriate; ▪ Appropriate disaster recovery and business continuity arrangements (including recovery time and recovery point objectives) have been established and tested for the ACR and APP systems. These objectives are aligned with CGI recovery time and point objectives and are sufficient to prevent loss of application data; ▪ Ongoing system issues and their impact on performance are recorded and escalated to ICT and relevant governance forums;

The City of Edinburgh Council

Internal Audit

The Council's Roads Service Improvement Plan

Final Report

8 August 2019

PL1808

Significant improvement required	Significant control weaknesses were identified, in the design and effectiveness of the control environment and 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.

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

Contents

This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2018/19 internal audit plan approved by the Governance, Risk, and Best Value Committee in March 2018. 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 performance of the Council's roads maintenance function continues to be a matter of ongoing concern to both elected members and the public.

An Internal Audit (IA) Contract Management audit presented to the Governance Risk and Best Value (GRBV) committee on 23 June 2016 focused on works commissioned by either the North West Locality or the Transport Design & Delivery (TDD) team, for which Edinburgh Roads Service (ERS) was the contractor.

An IA follow-up review to assess service progress towards addressing the outstanding findings raised in the Contract Management review, and confirm whether agreed actions previously implemented had been sustained, resulted in a number of previously closed findings being reopened.

These outcomes were presented to GRBV on 9 March 2017 and IA highlighted that the volume and significance of the outstanding and reopened findings were indicators of fundamental issues with delivery of Roads services across the Council that related to people; culture and relationship management; systems integration; financial and quality management; and concluded that the service was not operating effectively.

The follow up review established that whilst the Internal Audit recommendations and agreed management actions in the original Contract Management audit report were appropriate at that time, overall Roads service performance had continued to decline to the extent where a comprehensive service redesign was required. Management had recognised the need to improve service performance were developing a Roads Service Improvement Plan (the Plan)

GRBV therefore accepted an IA recommendation that the outstanding Contract Management Internal Audit findings should be closed, on the basis that the Plan would result in the design and implementation of a new service delivery model.

The Plan was presented to and approved by the Council's Transport & Environment Committee on 10 August 2017. The Plan comprised two interdependent workstreams: the Roads and Transport Organisational Review (the new service delivery model); and a range of roads service improvement initiatives. The scope of the plan included:

- Simplifying organisational structure to create a single combined roads service;
- Improving customer service and customer interaction;
- An improved system of road safety inspections and defect repairs;
- Enhancing the capability of the workforce through investment in training and equipment;
- Reviewing the fleet and depot arrangements within the service;
- Streamlining business processes through the removal of internal trading;
- Improved asset management; and
- Improved capital delivery and contract management

The Plan contained 32 actions. Of these, 31 actions had target implementation dates of April 2018 or earlier.

Regular updates on the Plan have been provided to the Council's Transport and Environment Committee (TEC), with the most recent (6 December 2018) subsequently referred to the Council's Governance, Risk and Best Value Committee on 15 January 2019. The report indicated that 50% of the

actions in the plan were complete, with the implementation of the new Roads Service organisational structure by 1 April 2019 a critical dependency for implementation of the remainder of the Plan.

Scope

This review assessed the design adequacy and operating effectiveness of the key project governance controls established to support effective implementation of the Improvement Plan (including establishing appropriate finance and budget arrangements); defect reporting; inspection and repairs; delivery of capital projects; and alignment of the Asset Management Plan with the Local Improvement Plans owned by the four Localities

We also provided assurance in relation to the following risks included in the Corporate Leadership Team and Place Directorate risk registers:

- CLT - 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

  Place - Asset Management - The deterioration of an asset through an insufficient/ineffective repairs and maintenance may cause health and safety risks to users, alongside service outages and resultant reparation/substitution expenditure

Testing was performed on a sample basis across the period from January 2018 to April 2019.

A copy of our agreed Terms of Reference is attached at Appendix 2

Limitations of Scope

The scope of our review is outlined above. There are no specific scope limitations.

Further details on the scope of our review are included at Appendix 2 – Areas of Audit Focus.

Reporting Date

Our audit work concluded on 12 April 2019, and 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. Roads improvement plan financial operating model and project governance
High	2. Roads services performance monitoring and quality assurance
Medium	3. Inspection, defect categorisation, and repairs
Low	4. Management of public liability claims
Advisory	5. Management or roads asset and capital data

Further detail on the basis of the classifications applied to our findings is included at Appendix 1.

Opinion

Significant Improvement Required

Our review identified significant control weaknesses in both the design adequacy and operating effectiveness of key project governance controls established to support implementation of the Roads Services Improvement Plan (the Plan); and operational controls established to monitor effective ongoing maintenance and repair of the Council's roads.

Our review of progress with implementation of the Plan highlighted the need to ensure that it is reviewed and rebased following completion of the Roads Services organisational review and implementation of the new service delivery model (expected to be completed by December 2019) to ensure that both completed and remaining plan actions remain relevant and are aligned to the revised organisational structure and service delivery objectives.

We also established the need to progress plans to replace the existing Roads internal trading mechanism with a new financial model, as this complex Plan action is only at the early stages of planning. In the interim, it is important to ensure that the new Roads organisational structure is appropriately reflected in the Council's general ledger and financial accounting systems.

Management has advised that success of the Plan will be measured by improvements in the annual Scottish Roads Maintenance Condition Survey and Road Condition Index that identifies the percentage of the Council's roads in need of maintenance; and improved responses from customer satisfaction surveys.

Whilst Plan progress reports to the Council's Transport and Environment Committee have included some performance information (for example in relation to roads defect repairs), more granular performance measures are required to confirm that implementation of both organisational changes and Plan actions have delivered the expected service delivery enhancements and performance outcomes.

It is also essential to ensure that appropriate first line risk based quality assurance checks are designed and implemented in relation to categorisation of defects; quality defect repairs; and quality of capital works to confirm the accuracy of performance reporting and support ongoing service delivery improvements.

We also identified the need to improve operational controls and training supporting the roads inspection; defect categorisation; and repairs processes, and established that security controls supporting remote

Confirm system access via an application on mobile devices require to be changed from single sign on to dual authentication to ensure that personal sensitive data in relation to public liability claims held in Confirm is appropriately secured in line with General Data Protection Regulation (GDPR) requirements. Consequently, two High; one Medium; and one Low rated findings have been raised. One Advisory finding has also been raised reflecting opportunities to improve ongoing management of roads asset and other capital data.

Areas of good practice

We also noted the following areas of good practice

- the design of the new Roads and Transport organisational structure and service delivery model has been effectively planned and has the potential to deliver significant roads service improvements if implemented and operated as designed;
- implemented Plan actions (for example, a mandatory requirement to capture and store before and after photographs of all defect repairs) are already generating service delivery improvements in some areas, such as defect classification and repair performance;
- the capital budget for carriageways; footways; street lighting; traffic signals; and structures was rebased and presented to the Transport and Environment Committee in February 2019 and includes capital projects carried forward from previous years in addition to projects scheduled for delivery in 2019/20;

  Appropriate governance frameworks and management oversight have been established to monitor progress with delivery of the plan, and identify (at an early stage), any emerging issues that could impact its delivery; and
- The revised approach to roads capital maintenance is delivering the expected service delivery improvements that should soon be reflected in the annual Scottish Roads Maintenance Condition Survey and Road Condition Index.

Management response

The Roads Service Improvement Plan was not established as a formal (Prince 2) project and was instead managed as an amalgam of improvement actions. Whilst it is acknowledged that there has been drift in timescales, this is mainly attributable to ongoing focus on organisational change and implementation of the new service restructure.

Considering this, the oversight, governance, and engagement (whilst informal) has been good during the past nine to twelve months, with approximately 50% of Plan actions now implemented and evidence of improved performance in some areas, in particular defect repairs within timescale; the reduction of the road defect backlog; the reduction in the street lighting defect backlog; an increase in the number of capital schemes; and an improvement in the Road Condition Index (RCI) score.

As of the 1st of August, a third tier manager has been appointed to the new role of Roads and Transport Infrastructure Manager and recruitment/assignment to subsequent posts is due to commence imminently. It is expected that the restructure will conclude by the end of December 2019, which is essential to support the refresh and successful implementation of the Roads Improvement Plan.

3. Detailed findings

1. Roads Improvement Plan financial operating model and project governance	High

Roads Services budget alignment and financial operating model

Implementation of the new roads organisational structure and service delivery model will also require review and realignment of existing budgets with the new model, to ensure that anticipated cost savings and benefits can be effectively monitored.

Another key financial Plan deliverable is removal of the established roads internal trading mechanism that recharges costed repairs to internal Council client cost centres. Successful implementation of this action will involve significant re-configuration of existing Roads procurement; costing; and recharge arrangements, and the systems that support these processes (the Axim procurement and costing system; the Confirm asset and workflow management system; the Telford system used to cost capital works; and establishing interfaces with the Oracle general ledger system).

Management has advised that the Telford system is now unsupported and that a replacement is currently being considered.

We confirmed that whilst discussions were ongoing between the Roads Services Commercial Team and Finance colleagues regarding budget structures and future costing arrangements, the financial operating model and supporting systems requirements have not yet been designed, and there were no established plans to support completion of their design and subsequent implementation.

We also note that the plan includes use of a schedule of rates for roads works, however, it is not clear whether this will be required until the design of the new financial operating model has been agreed.

Roads Improvement Plan implementation timeframes

Regular Roads Improvement Plan (Plan) updates have been provided to the Council's Transport and Environment Committee (TEC), with the most recent (6 December 2018) subsequently referred to the Council's Governance, Risk and Best Value Committee on 15 January 2019.

This report indicated that 50% of the actions in the plan were complete, and that the implementation of the new Roads Service organisational structure and service delivery model by 1 April 2019 is a critical dependency for implementation of the remainder of the Plan.

Implementation of the new organisational structure and service delivery model is currently in progress, and management has advised that it is now expected to complete by the end of the 2019 calendar year.

At the time of our review, there were no clear plans or revised timeframes for the delivery of the remaining Plan actions following implementation of the new structure and service delivery model, or for the development of new roads services processes designed to align with the new structure.

Management has advised that whilst slippage with plan deliverables is evident, service performance is improving, as is evidenced by a number of key performance indicators.

Risks

The potential risks associated with our findings are:

- Optimism bias reported to Committee may lead to a lack of Elected Member and Citizen trust in the Council's ability to deliver on commitments;
- If the development of systems, procedures and processes going forward is not managed as a

portfolio of interdependent projects, initiatives may stall or conflict, leading to failure to achieve the desired improvements in service delivery;

- If the transition to revised integrated financial systems is not effectively project managed, operational service delivery may be impacted, and effective cost management and control may not be achieved; and
- Without a formal post-implementation review of the revised structure, required adjustments to resourcing may not be captured and implemented;

1.1 Recommendation – Roads Service Improvement Plan review (including financial operating model)

Following implementation of the new Roads Service organisational structure and service delivery mode, the Roads Service Improvement Plan (the Plan) should be reviewed. The review should include:

- consideration as to whether previously implemented and remaining Plan actions remain appropriate and aligned with the new Roads organisational structure and service delivery model;
- whether any new plan actions are required;
- inclusion of a financial operating model workstream that will support design of a new financial model that includes appropriate procurement; costing; recharge; and budget processes that is supported by appropriate technology systems;
- consideration of any additional funding requirements;
- consideration of risks; issues; and dependencies associated with Plan delivery;
- allocation of responsibility for delivery of Plan actions across the Roads senior management and Finance teams; and Digital Services;
- revision of completion timeframes, with revised timeframes that are realistic and achievable.

Following completion of the review, a full business plan will be developed to support implementation of the remaining and any newly identified Plan actions.

1.1 Agreed Management Action - Roads Service Improvement Plan review (including financial operating model)

Accepted. The Roads Service Improvement Plan (the Plan) will be reviewed following completion of the organisational restructure, and will consider the points noted in the recommendation. A review of the financial operating model will also be undertaken with the aim of embedding a new budget structure for the service. Once completed the Plan business case will be refreshed to reflect any significant changes.

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Gareth Barwell, Head of Place Management; Cliff Hutt, Roads and Transport Infrastructure Manager; Alison Coburn, Operations Manager; Nicole Fraser, Executive Assistant	**Implementation Date:** 30 April 2020

1.2 Recommendation – Roads Service Improvement Plan approval

Following review and refresh of the Roads Service Improvement Plan, the revised business plan should be presented to both the Council's Change Board and the Transport and Environment Committee for review and approval, with regular ongoing updates provided to both forums in line with the reporting requirements detailed in the Council's Project Management Toolkit for Major Projects.

1.2 Agreed Management Action - Roads Service Improvement Plan approval

On appointment of the tier 3 and 4 management team, a re-base of the improvement plan will take place and the revised plan will be submitted to the Council's Change Board and the Transport and Environment Committee for approval, with ongoing progress updates provided to both forums.	
Owner: Paul Lawrence, Executive Director of Place **Contributors:** Gareth Barwell, Head of Place Management; Cliff Hutt, Roads and Transport Infrastructure Manager; Alison Coburn, Operations Manager; Nicole Fraser, Executive Assistant	**Implementation Date:** 31 July 2020

1.3 Recommendation – Roads Service Improvement Plan project governance

Delivery and implementation of the Roads Service Improvement Plan should be managed and governed in line with the requirements specified in the Council's Project Management Toolkit for Major Projects.

1.3 Agreed Management Action - Roads Service Improvement Plan project governance

Accepted. The re-based plan will be managed in line with the Project Management Toolkit for Major Projects. The plan will be managed by the Roads service Performance Coordinator once appointed in the revised structure.

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Gareth Barwell, Head of Place Management; Cliff Hutt, Roads and Transport Infrastructure Manager; Alison Coburn, Operations Manager; Nicole Fraser, Executive Assistant	**Implementation Date:** 20 December 2020

1.4 Recommendation - Post implementation reviews

- A post implementation review of the new Roads organisational structure and service delivery model should be performed at an appropriate point in time to assess whether the new model is operating as expected and consider whether any further adjustments to the structure is required; and
- A post implementation review should also be scheduled at an appropriate point in time following final implementation of all Roads Service Improvement Plan actions to consider whether anticipated service delivery benefits have been realised.

1.4 Agreed Management Action - Post implementation reviews

A post implementation review of both the new organisational structure (31 March 2020) and completed Roads Service Improvement Plan (the Plan) actions (March 2021) will take place to assess the effectiveness of the new service and any requirements for change, and the impact of the changes delivered through the Plan.

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Gareth Barwell, Head of Place Management; Cliff Hutt, Roads and Transport Infrastructure Manager; Alison Coburn, Operations Manager; Nicole Fraser, Executive Assistant	**Implementation Date:** 31 March 2021

2. Roads services performance monitoring and quality assurance — High

Service delivery performance monitoring

Management has advised that the key measures of successful implementation of the Roads Service Improvement Plan (the Plan) are improvements in both the Road Condition Index; improved delivery of inspection and defect repairs as measured by ley performance indicators; and feedback obtained from customer satisfaction surveys.

These broad measures of success are relevant but require to be supported by more granular performance measures to assess whether the expected benefits from the restructured Roads service delivery model (which involves significant service delivery operational changes, particularly in relation to inspections) and implemented Plan actions are being realised and service delivery improvements achieved on an ongoing basis.

Whilst Plan progress reports provided to the Transport and Environment Committee have included some performance information on (for example) Roads defect repairs, there is currently no established ongoing performance reporting that details performance outcomes in comparison to clearly defined key performance indicators, as has recently introduced in Waste and Cleansing.

Roads services quality assurance

To confirm the completeness and accuracy of ongoing service delivery performance monitoring and reporting, it is essential that appropriate (risk based) quality assurance processes are established and maintained.

Our review confirmed that there are currently no established quality assurance checks in relation to:

- the categorisation of road and footway defects by inspectors
- the quality of routine reactive repairs of carriageway and footway defects

Additionally, the quality assurance process applied by the Technical Design and Delivery Team has not been subject to recent review.

Risks

The potential risks associated with our findings are:

- Lack of detailed improvement measures may lead to a failure to take timely corrective action if desired service improvements are not being realised as and when anticipated;
- Without regular service performance reporting at Committee level, timely information on progress with delivery of anticipated service improvements will not be available to Elected Members and Citizens; and
- Lack of effective quality assurance processes could potentially result failure to remedy inaccurate categorisation of defects and poor quality repairs, and potential loss of external quality accreditation

2.1 Recommendation – Service Delivery Performance Monitoring

- a set of SMARTER (specific; measurable; achievable; relevant; timely; explainable; and readjusted when appropriate) Roads key performance measures should be defined and implemented to support ongoing monitoring of the effectiveness and quality of service delivery, and confirm whether expected financial and service delivery benefits are being realised;

- a roads dashboard should be developed (potentially (similar to that recently developed for Waste and Cleansing) and implemented that details actual service delivery performance in comparison to key performance measures;
- the Roads dashboard should be used by the Roads management team to determine the necessary actions required to improve service delivery where performance targets are not being achieved
- the Roads dashboard and supporting service delivery improvement actions should be provided to the Council's Corporate Leadership Team, and Transport and Environment Committee for review and scrutiny at an appropriate frequency;

2.1 Agreed Management Action - Service Delivery Performance Monitoring

One of the roles included in the new Roads structure is a Roads Service Performance Coordinator. The team member appointed to this role will be responsible for designing; implementing; and maintaining a performance and quality assurance framework that will incorporate the recommendations made to support ongoing monitoring and management of the Roads service.

This will involve ensuring that all Roads teams develop team plans that include key performance measures; outline their respective roles and responsibilities for delivery; and are aligned with overall Council's commitments that are relevant to Roads.

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Gareth Barwell, Head of Place Management; Cliff Hutt, Roads and Transport Infrastructure Manager; Alison Coburn, Operations Manager; Nicole Fraser, Executive Assistant	**Implementation Date:** 31 July 2020

2.2 Recommendation – Roads services quality assurance framework

1. An appropriate risk based Roads services quality assurance framework should be designed; implemented; and maintained to confirm that the quality of services delivered remains acceptable. This should include (but not be restricted to):

- ongoing review of a sample of defect categorisations across the population of inspectors to confirm that defects have been appropriately categorised. This could be performed as a desktop review, using photographic information recorded on the Confirm asset and workflow management system. Management should consider whether these checks should be performed before or after the defect has been repaired, based on the risks associated with incorrect categorisation;
- ongoing review of a sample of defect repairs. This review could include a combination of site inspections and / or review of photographic evidence recorded on Confirm; and
- The Transport Design & Delivery Team quality assurance process should be reviewed and refreshed to align with the new Roads organisational structure and service delivery model.

2. quality assurance key performance measures should be defined, and quality assurance outcomes reported in the Roads performance dashboard (refer recommendation 2.1);
3. quality assurance key performance measures should be included in the objectives set as part of annual looking forward conversations; and
4. themes emerging from quality assurance reviews should be shared with Roads team members and used to determine and address both individual and team training needs (refer recommendation 3.2 below).

2.2 Agreed Management Action - Roads services quality assurance framework

1. The existing Transport Design and Delivery quality framework will be revised to reflect the new Roads and Transport Infrastructure Service and rolled out across the service. As part of this review, the recommendations highlighted above will be considered and incorporated where appropriate. The Design, Structures and Flood Prevention Manager will be responsible for refreshing the quality framework once appointed.	
Owner: Paul Lawrence, Executive Director of Place **Contributors:** Gareth Barwell, Head of Place Management; Cliff Hutt, Roads and Transport Infrastructure Manager; Alison Coburn, Operations Manager; Nicole Fraser, Executive Assistant	**Implementation Date:** 30 June 2020
2. A sampling regime will be designed and embedded for safety inspections to ensure that defects are being categorised properly. This process will be designed and implemented by the Team Leader for Safety Inspections to be appointed as part of the ongoing restructure.	
Owner: Paul Lawrence, Executive Director of Place **Contributors:** Gareth Barwell, Head of Place Management; Cliff Hutt, Roads and Transport Infrastructure Manager; Sean Gilchrist, Asset and Performance Manager; Alison Coburn, Operations Manager; Nicole Fraser, Executive Assistant	**Implementation Date:** 30 June 2020
3. A sampling regime will be designed and embedded for road defect repairs to ensure that repairs are fit for purpose and effective.	
Owner: Paul Lawrence, Executive Director of Place **Contributors:** Gareth Barwell, Head of Place Management; Cliff Hutt, Roads and Transport Infrastructure Manager; Sean Gilchrist, Asset and Performance Manager; Alison Coburn, Operations Manager; Nicole Fraser, Executive Assistant	**Implementation Date:** 30 June 2020
4. Key performance indicators for each team will be included in the target setting for each 4th tier manager and their direct reports to ensure focus on these measures. Emerging themes from Team Plans and quality assurance reviews will also be shared with Roads teams, and individual and team training needs will be considered based on the themes identified. This process will be designed and implemented by the Service Performance Coordinator to be appointed as part of the ongoing restructure.	
Owner: Paul Lawrence, Executive Director of Place **Contributors:** Gareth Barwell, Head of Place Management; Cliff Hutt, Roads and Transport Infrastructure Manager; Sean Gilchrist, Asset and Performance Manager; Alison Coburn, Operations Manager; Nicole Fraser, Executive Assistant	**Implementation Date:** 30 June 2020

3. Inspection, defect categorisation, and repairs	**Medium**

Operational Guide - Roads Safety Inspection and Defect Categorisation

The “Operational Guide - Roads Safety Inspection and Defect Categorisation Procedure”, introduced 1 March 2016, sets out the Council’s service standards for planned and reactive roads defect inspections, defect categorisation and repair timescales.

We were unable to find a record of the guide being submitted either to full Council or the Transport and Environment Committee for approval, in line with standard practice across Scottish Local Authorities

The Council has recently altered its service standard to include separate timescales for defect inspection and defect repairs, and the Operational Guide has not been updated to reflect this.

Inspector training and qualifications

One of the Roads Service Improvement Plan actions involved delivery of training to Inspectors across the Localities on defect categorisation and use of the Confirm asset and workflow management System. This training has contributed to a significant reduction in the volume of 'category 1' emergency road repairs.

Additionally, four inspectors have attended training provided by an Institute of Highway Engineers approved trainer, which results in official registration.

Our review confirmed that there were no further internal or external training plans for inspectors following implementation of the new centralised organisational structure and service delivery model in addition to the training previously delivered and / or attended.

Confirm asset management and workflow system

The Confirm Connect application is used by inspectors and repair squads to access the Confirm system remotely on mobile devices. Whilst the application has a dual user authentication process (user name & password), there are some handsets currently in use where single sign on is required to access data held on the Confirm system, which does include personal sensitive data in relation to claims.

Management has advised that this is a known legacy issue affecting a limited number of handsets.

The Operational Guide includes an annual programme of planned Roads asset safety inspections that follow pre-defined routes. The routes have been created and the inspection results are recorded in the Confirm system. It is currently not possible to monitor progress of completed inspections in comparison to plan as Confirm cannot provide completed and accurate management information due to technical issues in relation to inspection dates generated by the system.

Risk

The potential risks associated with our findings are:

- If the Safety Inspection and Defect Categorisation Procedure is not aligned with current processes and has not been approved by either the relevant Council Executive Committee or full Council, it may lack robustness as a defence against potential liability claims;
- If inspectors do not have up to date qualifications and registration the robustness of compliance with inspection regimes as a defence when repudiating liability claims may be undermined;
- Without reliable management information management do not have assurance that adequate progress is being made with the programme of planned inspections; and
- Without two-stage authentication to access the Confirm Connect Application there is a risk of potential non compliance with General Data Protection Regulations (GDPR) Article 5(1)(f) and Article 32 in relation to information security and security of processing.

3.1 Recommendation – review and approval of the Operational Guide

The "Operational Guide - Roads Safety Inspection and Defect Categorisation Procedure" should be updated to reflect current Roads service standards for inspection and repair times and presented to either the Transport and Environment Committee or full Council for review and approval.

3.1 Agreed Management Action - review and approval of the Operational Guide

The Transport and Environment Committee will be asked to consider and approved the revised inspection defect categorisation procedure developed by Roads in September 2019. This is already included in the Committee forward plan.

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Gareth Barwell, Head of Place Management; Cliff Hutt, Roads and Transport Infrastructure Manager; Sean Gilchrist, Asset and Performance Manager; Alison Coburn, Operations Manager; Nicole Fraser, Executive Assistant	**Implementation Date:** 31 October 2019

3.2 Recommendation – Inspector training and qualifications

A formal training plan should be designed and established for all inspection team members. This should include (but not be restricted to):

- ongoing training in defect categorisation and use of the Confirm asset management and workflow system;
- delivery of training on an 'as needs' basis based on the outcomes of ongoing quality assurance reviews (refer finding 2); and
- ongoing training and certification with the Institute of Highway Engineers, or another relevant professional body.

3.2 Agreed Management Action - Inspector training and qualifications

1. Design and implement a training framework for all relevant Inspectors in line with the newly adopted 'Road Safety Inspection and Defect Categorisation Procedure'

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Gareth Barwell, Head of Place Management; Cliff Hutt, Roads and Transport Infrastructure Manager; Sean Gilchrist, Asset and Performance Manager; Alison Coburn, Operations Manager; Nicole Fraser, Executive Assistant	**Implementation Date:** 31 January 2020

2. Ensure all relevant Inspectors are accredited by an appropriately accredited professional body.

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Gareth Barwell, Head of Place Management; Cliff Hutt, Roads and Transport Infrastructure Manager; Sean Gilchrist, Asset and Performance Manager; Alison Coburn, Operations Manager; Nicole Fraser, Executive Assistant	**Implementation Date:** 31 August 2020

3.3 Recommendation– Management information for planned inspections

The supplier of the Confirm system should be contacted to determine whether a system change can be implemented to enable a more realistic system based inspection due date allocation to be provided by the system for allocation of future inspection dates.

Where this cannot be provided, management should design and implement an alternative process to monitor progress with planned inspections and include these outcomes in the Roads service performance dashboard (refer finding 2).

3.3 Agreed Management Action - Management information for planned inspections

On appointment, the new Service Performance Coordinator and Team Leader – Safety Inspections will work with Pitney Bowes (the supplier of the Confirm system) to develop a new process to plan and monitor safety inspection performance

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Gareth Barwell, Head of Place Management; Cliff Hutt, Roads and Transport Infrastructure Manager; Sean Gilchrist, Asset and Performance Manager; Alison Coburn, Operations Manager; Nicole Fraser, Executive Assistant	**Implementation Date:** 31 March 2020

3.4 Recommendation - authentication protocol for the Confirm Connect application

Roads should identify users with mobile devices where only single sign on is required to access the Confirm Connect application and data held on the Confirm system.

These devices should be replaced with devices that include dual factor authentication to access the application.

3.4 Agreed Management Action

An audit of all handsets will be undertaken, and any non-complaint handsets will be removed and replaced

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Gareth Barwell, Head of Place Management; Cliff Hutt, Roads and Transport Infrastructure Manager; Sean Gilchrist, Asset and Performance Manager; Jordan Walker, Senior Systems Development Officer; Alison Coburn, Operations Manager; Nicole Fraser, Executive Assistant	**Implementation Date:** 31 January 2020

4. Management of public liability claims — Low

Public liability claims are initially registered on the Confirm system, investigated by the Locality Roads and Environment teams, and then assigned to the Council's Insurance Services team for registration on the Local Authority Claims Handling System (LACHS) and onward transmission to the Council's claims handlers.

There is currently no reconciliation performed between the volume of claims recorded on LACHS and Confirm.

Additionally, Insurance Services can provide detailed management information which would be useful in helping Roads Services manage its claims experience by understanding the systemic themes and root causes of the claims received. At present there is no established agreement between Roads and Insurance Services in relation to provision of claims management information.

Risk

The potential risks associated with our findings are:

- Claims received but not reported to Insurance Services are not identified;
- Without appropriate claims management information reporting processes, the Council will be unable to review the nature of the claims and identify and address any systemic causes.

4.1 Recommendation – Management of public liability claims

A spreadsheet should be designed; implemented; and maintained; that records all claims received and monitors their progress from receipt through transfer to the Local Authority Claims Handling System (LACHS) system; and onward transmission to the claims handlers.

4.1 Agreed Management Action– Management of public liability claims

A new process will be developed within the Confirm system which requires reconciliation between accident claim enquiries and those logged on the Local Authority Claims Handling System (LACHS) system.

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Gareth Barwell, Head of Place Management; Cliff Hutt, Roads and Transport Infrastructure Manager; Sean Gilchrist, Asset and Performance Manager; Jordan Walker, Senior Systems Development Officer; Alison Coburn, Operations Manager; Nicole Fraser, Executive Assistant	**Implementation Date:** 28 May 2020

4.2 Recommendation– Management of public liability claims

Roads management should meet with the Insurance Services team to determine the availability of management information in relation to public liability claims.

Where reports are available that detail the root cause of public liability claims, these should be provided to Roads senior management at an appropriate frequency (for example, monthly or quarterly) for review, so that the main root causes can be determined, and (where possible) appropriate preventative action taken to reduce volumes of future claims.

4.2 Agreed Management Action – Management of public liability claims

Quarterly meetings will be arranged between the Safety Inspection team and the Insurance team to identify trends and areas of focus.

This process will be designed and implemented by the Team Leader, Safety Inspections to be appointed as part of the ongoing restructure.

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Gareth Barwell, Head of Place Management; Cliff Hutt, Roads and Transport Infrastructure Manager; Sean Gilchrist, Asset and Performance Manager; Alison Coburn, Operations Manager; Nicole Fraser, Executive Assistant	**Implementation Date:** 30 April 2020

5. Management of roads asset and capital data — Advisory

The Confirm asset and workflow management system is the core asset management system used for road assets. At present this does not include data on structures; capital works; gullies; and road signs

(though information may be held elsewhere), and does not contain the Road Condition Index information, which is entered separately on the Geographical Information System (GIS).

Opportunity

There is an opportunity to better optimise repair strategies if all the information relating to a particular road asset is consolidated and maintained in one central database

5.1 Recommendation – consolidated asset management data

An action should be included in the Roads Service Improvement Plan (refer finding 1) to assess the feasibility of consolidating all relevant Roads information including capital works; structures; gullies; road signs and Road Condition Index information on one centralised asset management system (potentially Confirm).

5.1 Agreed Management Action - consolidated asset management data

The Asset and Performance team will work with Pitney Bowes to scope the potential to consolidate these systems, and the financial costs involved. Once the costs and benefits have been considered, a management decision will be made as to whether to undertake this consolidation.

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on the operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or*** • ***Critical*** impact on the reputation of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or*** • ***Significant*** impact on the reputation of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation of the organisation.
Low	A finding that could have a: • ***Minor*** impact on operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***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.

Include link to audit charter for overall report ratings.

Appendix 2 – Areas of Audit Focus

The audit areas and related control objectives that were tested in detail were:

Audit Area	Control Objectives
Roads Service Improvement Plan	• An effective overall approach has been adopted to manage the development and implementation of The Roads Service Improvement Plan; • The revised structure and delivery model has been effectively designed to meet the objectives of the Improvement Plan; • Effective arrangements are in place (or planned) to manage the remaining actions required to fully realise the expected benefits of the Improvement Plan, once the revised organisational structure is in place; and • A clear benefits realisation monitoring plan is in place to track the effectiveness of the plan.
Defect Reporting Inspection & Repairs	• Effective and comprehensive arrangements are in place to enable citizens to report road defects; • The Council has adopted an appropriate and realistic categorisation system for road defects, and this is being applied in a reasonable and consistent manner, which enables the method of repairs to be optimised from an asset management perspective; • An effective and comprehensive process is in place to ensure that all roads are routinely surveyed for defects with a frequency appropriate to the category of road; • An effective and responsive process is in place to ensure that all reported roads defects are inspected and appropriate repairs are initiated promptly in accordance with stated policy; • Those responsible for carrying out and managing road surveys and inspections have received appropriate training; • Those responsible for road surveys and inspections are equipped with appropriate technology to enable the results of inspections to be recorded and evidenced as far as possible in real time; • An effective process is in place for the scheduling and performance of reactive defect repairs; • An effective quality control process operates over the completed repair work; • Realistic and accurate performance indicators are in place which measure and report road condition and defect repair performance in a way which is meaningful and consistent with industry practice;

Audit Area	Control Objectives
	• A Transport Asset Management Plan ensures that the Council is pro-actively reducing the level of reactive defect repairs needed through effective planned maintenance; and • The Council has an effective regime in place for dealing with liability claims arising from road defects.
Delivery of Capital Projects	• The proposed integrated roads service structure and processes have been designed to facilitate effective delivery of capital projects; • These arrangements ensure proper linkages between the defect reporting, inspection and repairs process and the capital planning process; • Contracting arrangements which will provide certainty in terms of the delivery of future capital projects have been secured; • Plans are in place to rebase the capital plan from 1 April 2019 in order that clear measurement of delivery against plan may be made; and • For 2019-20 and future years, arrangements are in place to ensure that the capital plan and budget is accurately phased throughout the year and accurate up to date costing/measurement information will be available to track delivery against plans.
Finance and budget arrangements	• Adequate finance and budgetary control arrangements have been developed and are ready to operate from the inception of the integrated service; • There is a clear plan going forward for the further development of finance and budgetary control arrangements after the inception of the new service; • Proposed arrangements for the integrated service clearly identify budgetary responsibility within the service and there are clear lines of delegation for budgetary responsibility, and related upward reporting; • Costing and reporting arrangements for the new service ensure that individual officers have adequate information and systems support to enable them to manage their budgets; and • Proposed costing arrangements for the integrated service ensure that costing information used to manage budgets is reconcilable to the finance reports generated from the Council's main accounting system.
Alignment with Local Improvement Plans	• Adequate arrangements are in place to ensure that the Transport Asset Management and Local Improvement Plans owned by the Council are consistent.

The City of Edinburgh Council

Internal Audit

Waste and Cleansing
Performance Management Framework

Final Report

1 August 2019

PL1807

Adequate	An adequate and appropriate control environment and governance and risk management framework is in place enabling the risks to achieving organisation objectives to be managed

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

Contents

This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2018/19 internal audit plan approved by the Governance, Risk and Best Value Committee in March 20. 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 Environmental Protection Act 1990 places obligations on the Council as a Waste Collection Authority and a Waste Disposal Authority. The Act also imposes duties on local authorities to keep clean public highways for which they are responsible. Practical guidance on how this can be achieved is included in the Scottish Government's Code of Practice on Litter and Refuse (COPLAR).

Waste and Cleansing Improvement Plan

The Council established an integrated Waste and Cleansing service in 2016 to support implementation of a more holistic and effective approach to managing waste and cleanliness across the city. The new service combined the existing waste and recycling service collections and disposal; street cleaning; environmental enforcement; and a number of ancillary services.

However, elected members remained concerned about the significant volume of public complaints about street cleanliness, and refuse collections.

Consequently, a Waste and Cleansing Improvement Plan was developed and approved by the Council's Transport and Environment Committee on 1 November 2016. The Plan highlighted the key systemic issues that were impacting on waste collection performance and street cleanliness, together with a total of 65 proposed actions to ensure that they were addressed.

Regular progress updates were provided to the Committee, with a final update presented on 9 March 2018, confirming that 63 of the 65 actions had been completed, and that the Plan would be closed.

The remaining two Plan actions (implementation of Routesmart technology, and a Special Uplifts Review) together with additional improvement opportunities were to be taken forward separately by the service, and it was minuted that the Committee would continue to receive further progress updates.

The Special Uplifts review involves the private sector performing special uplift collections, and has not yet been completed. A pilot is currently in progress, and (if successful) will be implemented.

The additional improvement opportunities identified included an ongoing review of performance indicators and the introduction of new dashboards to support performance reporting to the Transport and Environment Committee from August 2018.

Following completion of Improvement Plan actions, Waste and Cleansing Services has reported improved performance for waste collection and street cleansing. However, the level of recorded complaints is still high and continues to be of concern to Elected Members. In particular, the introduction of the new chargeable garden waste service and the four-day kerbside collection model in October 2018 had an impact on performance.

Implementation of Routesmart technology

Routesmart is now being used to determine the most optimal routes for kerbside collections, resulting in a significant decrease in volumes of missed bin reports (as reported to the Transport and Economy Committee in May 2019 (refer: Waste and Cleansing Performance Update May 2019). Following the successful implementation of Routesmart for Waste kerbside collections, implementation to support routing for street cleansing and communal bins is now being progressed.

The second phase of Routesmart implementation is scheduled for late 2020 and will support integration and provision of real time information between Routesmart and existing Council systems, and web forms submitted by customers, enabling real time collection information to be relayed from

frontline crews directly to customers. This will provide enhanced real time management information whilst waste is in the process of being collected and facilitate more detailed performance measurement, Successful phase two implementation is significantly dependent on the Customer Digital Enablement project being delivered by Customer and Digital Services.

Scope

This review assessed the design adequacy and operating effectiveness of the Waste & Cleansing performance management framework, including the key processes and controls established to enable demand forecasting and service planning; performance measurement and reporting; performance management; and customer feedback and complaint handling.

The review also provides assurance in relation to the following Corporate Leadership Team risk:

- Customer dissatisfaction around delivery of citizen facing services (e.g. waste management, roads, etc) may lead to an increase in complaints with consequential financial pressures and reputational damage.

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

Testing was performed across the period 1 April 2018 to 31 March 2019, with reports and documentation produced up to the conclusion of our fieldwork being considered.

Limitations of Scope

There are no specific scope limitations.

Reporting Date

Our audit work concluded on 14 June 2019, 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	
Low	1. Policy Framework

Opinion

Adequate

Our review confirmed that the current Waste and Cleansing performance management framework has been adequately designed to support ongoing demand forecasting and service planning; performance measurement and reporting; performance management; and customer feedback and complaint handling, and that the framework is operating effectively.

The new Waste and Cleansing performance framework has been designed in conjunction with the phased implementation of Routesmart technology and includes performance indicators that are aligned with currently available performance information. Additionally, quarterly performance reporting detailing performance outcomes in comparison to established performance indicators is now reported quarterly to the Transport and Environment Committee, with reports provided in August and December 2018 and May 2019.

It is acknowledged that development of the Waste and Cleansing performance management framework is an iterative process, and that key performance indicators and quarterly performance reporting provided to the Transport and Environment Committee will continue to be further refined as implementation of Routesmart technology progresses.

We identified some minor control weaknesses in the Waste and Cleansing performance management framework in relation to forecasting and budgeting; alignment with the Council's Business Plan; the content of the Waste and Cleansing policy handbook; and identification of continuous improvement opportunities.

Consequently, one Low rated finding has been raised. Further information is included at Section 3.

3. Detailed findings

1. Performance management framework	Low

Demand forecasting and budgeting

In 2017/18 Waste & Cleansing showing a large overspend of £8.5M.

In 2018/19 the Place budget was realigned to ensure alignment with actual performance and anticipated population growth, however, a further overspend of £1.4M was evident in 2018/19. Discussion with Finance confirmed that is this because the Waste and Cleansing uplift is based only on waste collection and disposal, and not the combined Waste and Cleansing service.

Waste and Cleansing performance indicators

Review of the indicators included in the Waste and Cleansing performance dashboards to confirm alignment with the Performance Management Framework established to support the Council's Business Plan highlighted that the indicator "percentage of wards showing an improvement in street cleanliness" is not included in the Waste and Cleansing performance dashboard.

Waste and Cleansing policy handbook

The Waste and Cleansing Policy Handbook does not include a Street Cleansing policy document although we note that the Council Policy in this area is essentially to comply with the national Code of Practice on Litter and Refuse guidance.

Additionally, whilst the Waste & Cleansing Policy Handbook includes detail of what materials may or may not be placed in the various recycling bins, there is no listing of materials that should not be placed in residual waste bins.

Continuous improvement

At present Waste and Cleansing employees at supervisor level and above attend regular management meetings which provide the opportunity to share continuous improvement ideas.

Currently, there is no means for employees below supervisor level to share their continuous improvement ideas. This can only be achieved through their line manager

Risks

- Ongoing overspends in comparison to budget;
- Waste and Cleansing service and Council performance measures are not fully aligned;
- Additional costs associated with removing inappropriate items from residual waste bins; and
- Improvement opportunities that could address pperational issues may not be identified.

1.1 Waste and Cleansing budget uplift

Waste and Cleansing management should engage with Finance to ensure that the calculation of the uplift in the 2020/21 budget accurately reflects consolidated waste collection; disposal; and street cleansing costs; and anticipated population and household growth.

1.1 Agreed Management Action – Waste and Cleansing budget uplift

Finance colleagues will be engaged to ensure that the Waste and Cleansing budget is rebased to reflect actual demographic changes and includes street cleansing.

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Gareth Barwell, Head of Place Management; Andy Williams, Waste and Cleansing Service Manager; Karen Reeves, Technical Manager; Alison Coburn, Operations Manager; Nicole Fraser, Executive Assistant	**Implementation Date:** 29 May 2020

1.2 Performance indicators

The indicator “percentage of wards showing an improvement in street cleanliness” should be included in the annual performance reports produced by Waste and Cleansing.

1.2 Agreed Management Action – Performance indicators

This indicator will be included as a question in quarterly survey and the results included in annual Waste and Cleansing performance reports. The next annual Waste and Cleansing performance report is dur to be presented to the Transport and Environment Committee in May 2020.

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Gareth Barwell, Head of Place Management; Andy Williams, Waste and Cleansing Service Manager; Karen Reeves, Technical Manager; Alison Coburn, Operations Manager; Nicole Fraser, Executive Assistant	**Implementation Date:** 29 May 2020

1.3 Recommendation - Waste and Cleansing policy

As part of the next scheduled Waste and Cleansing Policy Handbook refresh, the handbook should be updated to include:

- a list of items that are not suitable for inclusion in residual waste bins, together with an indication of the alternative arrangements for their disposal; and
- reference to the Scottish Government’s Code of Practice on Litter and Refuse (COPLAR) guidance with confirmation that the Council’s Street Cleansing policy is to follow the guidance.

Links to the COPLAR guidance should also be included in the Waste and Cleansing pages of the Council’s external website.

1.3 Agreed Management Action – Waste and Cleansing policy

The Policy Handbook will not be updated to reflect items suitable for inclusion in residual waste bins as it is not updated frequently enough to ensure that this information would be up to date and accurate.

A clearer link to the Scottish Government’s Code of Practice on Litter and Refuse guidance will be included in all customer communications and on the website.

Owner: Paul Lawrence, Executive Director of Place **Contributors:** Gareth Barwell, Head of Place Management; Andy Williams, Waste and Cleansing Service Manager; Karen Reeves, Technical Manager; Alison Coburn, Operations Manager; Nicole Fraser, Executive Assistant	**Implementation Date:** 27 December 2019

1.4 Recommendation - Employee forums

A mechanism should be established to provides Waste & Cleansing employees with the opportunity to participate directly in the continuous improvement of the service

1.4 Agreed Management Action – Employee forums	
A quarterly employee forum will be introduced, and a cross section of waste and cleansing employees invited to discuss any operational issues and suggestions for improvement. A generic e mail account will also be established for employee feedback and promoted in internal communications. The employee forum and e mail account will also be used to gather employee feedback on planned service changes. There are also plans at a Directorate level to host sessions with a cross section of staff from Place Management to discuss the Council's financial pressures and discuss opportunities for improvement in services. This is planned to take place by the end of October.	
Owner: Paul Lawrence, Executive Director of Place **Contributors:** Gareth Barwell, Head of Place Management; Andy Williams, Waste and Cleansing Service Manager; Karen Reeves, Technical Manager; Alison Coburn, Operations Manager; Nicole Fraser, Executive Assistant	**Implementation Date:** 27 December 2019

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on the operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***;*** *or* • ***Critical*** impact on the reputation of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***;*** *or* • ***Significant*** impact on the reputation of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation of the organisation.
Low	A finding that could have a: • ***Minor*** impact on operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***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.

Appendix 2 – Audit Focus Areas

Audit Area	Control Objectives
Performance Measurement & Reporting	• Performance measures have been defined and implemented that are aligned to COPLAR guidance; Council performance objectives; Waste & Cleansing Improvement Plan objectives; and industry best practice, particularly in relation to customer service; • Performance reporting has been developed and implemented and is aligned with performance measures; • Performance reports are based on accurate data which reconciles to underlying systems and records and also to externally reported waste data; and • Supporting rationale for performance outcomes is included in performance reports and communicated to management, elected members and the public.
Performance Management	• Performance outcomes are regularly monitored by management, with areas for improvement identified and used to support ongoing performance management; • There is a clear interaction between the Waste and Cleansing Improvement Plan, reported performance measures, and the way in which the operational performance of the service is managed; • Performance measures are clearly communicated to teams and employees when setting objectives as part of 'looking forward' conversations; • A process has been established to enable employees to contribute their continuous improvement ideas to improve service delivery. These are regularly reviewed; considered and included within plans to further improve performance; performance monitoring; and reporting.
Customer Feedback & Complaints	• Effective links are in place between Waste & Cleansing Service's and the Council's corporate customer contact processes and systems, and this supports timely and effective responsive action and provides good data flow for performance reporting; • Waste & Cleansing Service and corporate complaints definitions, policies and procedures are aligned, enabling accurate and consistent classification of both service requests and complaints; • Arrangements for gathering customer feedback on the Waste & Cleansing Service are robust and comprehensive; and • Customer feedback is fully reflected in service planning and reporting.
Demand Forecasting & Service Planning	• An appropriate model has been established to model demographics, and forecast future demand for Waste & Cleansing Services;

Audit Area	Control Objectives
	• Output from the model has been incorporated into service plans; budgets; resourcing; and capital plans (for example purchase of new waste and recycling lorries).

The City of Edinburgh Council

Internal Audit

Major Project Governance – Schools and Customer Transformation

Final Report

6 August 2019

MP1802

Overall report rating:

Generally adequate but with enhancements required	Areas of weakness and non-compliance in the control environment and governance and risk management framework that that may put the achievement of organisational objectives at risk

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

Contents

This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2018/19 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2018. 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.

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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

Delivery of effective change and capital projects 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 fewer resources.

An Internal Audit review of Project and Programme Management and Benefits Realisation (completed January 2018) established that inconsistent project management methodologies were being applied across Council projects, and that a standard project and programme management framework was required.

Consequently, a second line Strategic Change and Delivery (SC&D) team was established within Strategy and Communications with responsibility for oversight of the Council's Portfolio of Change. and providing portfolio progress updates to the Council's Change Board (essentially the Corporate Leadership Team) and elected members at the Governance, Risk and Best Value Committee (GRBV).

SC&D also developed and implemented a standard project management toolkit designed to support consistent delivery of all Council projects, that should be applied by all project managers across the full population of the Council's projects.

The Senior Responsible Officer (SRO) for each project is responsible for ensuring that projects are managed and delivered in line with the project management toolkit and providing monthly project updates to Strategic Change and Delivery team for inclusion in Change Board and GRBV reporting.

During 2018, SC&D performed a "deep dive" across all projects included in the Council's Portfolio of Change to establish whether the projects were supported by appropriate business cases. Where no business cases had been prepared, the review considered whether there the information that should form the basis of the business case was included in other project documents or reports provided to Executive Committees. Where insufficient information was available, projects were requested to prepare retrospective business cases for approval by the Change Board.

Scope

The scope of this audit assessed the adequacy and effectiveness the project governance frameworks established to support the new St John's RC Primary and Queensferry High Schools capital projects, and the Customer Transformation programme, and whether the frameworks applied are aligned with the Strategic Change and Delivery team's project management toolkit.

As both capital projects and the Customer Transformation Programme had commenced prior to implementation of the project management toolkit, our review assessed whether project governance frameworks applied were adequately designed; consistently applied; and broadly aligned with framework requirement to support ongoing reporting to the Change Board across the Council's portfolio of change.

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

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

Reporting Date

Our audit work concluded on 31 May 2019 and our findings and option are based on the conclusion of our work as at that date.

2. Executive summary

Total number of findings: 2

Summary of findings raised	
Medium	1. Project Business Cases
Medium	2. Third party project management and delivery dependencies

The basis for classification of IA findings raised is included at Appendix 1.

Opinion

Generally adequate but with enhancements required

Our review confirmed that the governance frameworks established to support delivery of the new St John's RC Primary and Queensferry High Schools, and the Customer Transformation Programme are generally adequate with enhancements required.

Whilst both schools capital projects and the Customer Transformation Programme had commenced prior to implementation of the Council's project management toolkit, we confirmed that the established project governance frameworks applied were adequately designed; consistently applied; and broadly aligned with toolkit requirements, with ongoing progress reporting provided to the Council's Change Board.

We did identify some moderate project governance control weaknesses that highlighted the need to ensure that business cases are updated to reflect any significant project scope changes, and re-presented to the Council's Change Board for approval; whole of life costing estimates are included in business cases to ensure that the costs of properties and / or services provided post implementation are appropriately reflected in future capital and revenue budgets; that the risk; issues; assumptions; and dependencies (RAIDs) log for schools reflect the full population of risks that could potentially impact the Council; and that key third party project management (schools only) and delivery dependencies, associated risks and mitigating controls are reflected in RAIDs logs and included in monthly progress reports provided to the Council's Change Board.

Consequently, two medium rated findings have been raised. Further information is included in Section 3.

3. Detailed findings

1. Project business Cases	Medium

At the time that the Customer Transformation project and both school projects commenced, the project management toolkit had not been implemented, and there was no requirement for projects to submit standard format business cases to the Council's Change Board or relevant Executive committee for review and approval.

However, Strategic Change and Delivery performed a subsequent deep dive review across all projects included in the Council's Portfolio of Change, and where no business cases had been prepared, or where there was insufficient documentation supporting the rationale for and approval of the project, projects were requested to prepare retrospective business cases for approval by the Change Board.

Customer Transformation

The Customer Transformation Programme presented a consolidated business case to the Change Board for approval in January 2017 that detailed the scope of all individual projects included within the Programme. However, this consolidated business case has not been refreshed and re-presented following significant changes to the scope of the projects included within the Programme (for example the Intelligent Automation and Paperless Strategy project workstreams).

Instead, mini business cases and proposal summaries have been created on an ad hoc basis as individual projects have evolved.

Following completion of our audit review, an initial Customer Transformation Programme Business Case was prepared and provided to the Strategic Change and Delivery team.

Schools

Business cases were not prepared for either the Queensferry High School or St John's RC Primary School projects. Instead, approval was obtained from full Council as part of the Wave 3 and Wave 4 school programmes.

In August 2018, the Change Board requested that individual retrospective business cases were created for both schools and all other schools in the portfolio.

Management has advised that a retrospective business case was prepared for St John's and was provided to the Change Board for discussion, and that it was decided at the Change Board that no additional retrospective cases were required for schools projects.

Whole of Life Costing - for both school projects, there has been no consideration of the whole of life costing that quantifies the ongoing capital and revenue costs associated with maintaining the property and delivering educational services from the building (for example ongoing property repairs and maintenance; school teacher salaries; technology costs and janitorial and cleaning costs).

The Property and Facilities Management team has recently calculated an annual lifecycle cost for maintenance of new school buildings that captures the costs of utilities; rates; cleaning; and repairs and maintenance per square metre for a high school that can be applied to all new school buildings. This lifecycle cost is essentially a subset of a "whole life" costs for a new school.

Whilst our finding relates specifically to new schools, it can equally be applied to all major projects (including the Customer Transformation Programme) that will significantly change how services are currently delivered.

This finding was raised in the Portfolio Governance Framework Internal Audit review completed in May 2019, and Finance has accepted a recommendation to work with project managers to support the

calculation of whole of life costs for inclusion in major project business cases, based on currently available information on the costs associated with building new properties and the delivery of relevant services. It is expected that this will be implemented by March 2020.

Risks

The potential risks associated with our findings are:

- significant changes to the scope of projects are not reviewed and approved by senior management and the Council's Change Board;
- decisions are made to proceed with major projects without a full understanding of ongoing post implementation capital and revenue costs; and
- future capital and revenue budgets are set based on no or inaccurate ongoing whole of life cost information.

1.1 Recommendation – Customer Transformation Programme business case

1. the refreshed Customer Transformation business case should be presented to the Council's Change Board for review and approval;
2. reflecting the unique structure of the Customer Transformation Programme (essentially a collation of a number of individual projects), a significant scope change threshold should be agreed with the Change Board to determine which changes will require a presentation of a refreshed Programme business case to the Change Board for their approval, and which changes can be approved by the Programme Board; and
3. any subsequent business case refreshes should consider inclusion of whole of life costing estimates (where appropriate).

1.1 Agreed management action – Customer Transformation Programme business case

1. A comparison will be performed between originally approved and current Customer Transformation Programme business cases and details of any significant changes presented to the Change Board.
2. A significant scope change threshold will be considered and agreed with the Strategic Change and Delivery Team and the Change Board to determine which changes can be approved by the Customer Transformation Board, and which should be presented to the Change Board for approval.
3. Accepted – inclusion of whole of life costing will be considered in any future business case refreshes and Finance will be engaged to determine the most appropriate whole of life costing models for the proposed changes.

Owner: Stephen Moir, Executive Director of Resources **Contributors:** Nicola Harvey, Head of Customer and Digital Services; Layla Smith, Layla Smith Business Manager; Julie Rosano, Executive Assistant;	**Implementation Date:** 27 December 2019

1.2 Recommendation – schools project business cases

1. the refreshed business cases for the schools projects should be updated to include (where possible) details (or an estimate) of whole of life costs for the new schools buildings and services; and
2. the refreshed business cases for the schools projects should be presented to the Council's Change Board for review and approval.

1.2 Agreed Management Action – schools project business cases

Business cases are now being produced that include whole of life costs for all new schools. It is anticipated that the sophistication of whole of life costing calculations will improve over time with support from Finance and other relevant Directorates / Divisions.

New business cases will be prepared in early 2020 to support the annual budgeting process. These will be provided to Internal Audit to confirm that whole of life costs are now included.

Owner: Alistair Gaw, Executive Director of Communities and Families **Contributors:** Crawford McGhie, Senior Manager, Estates and Operational Support; Stephen Moir, Executive Director of Resources; Peter Watton, Head of Properties and Facilities Management; Lindsay Glasgow Strategic Asset Management Senior Manager; Hugh Dunn, Head of Finance; Rebecca Andrew, Principal Accountant; Nickey Boyle, Senior Executive Administrator; Layla Smith Business Manager; Annette Smith, Executive Assistant	**Implementation Date:** 29 May 2020

2. Third party project management and delivery dependencies — Medium

Schools projects – risks; assumptions; issues and dependencies (RAIDs) management

For both schools projects, project management responsibilities are outsourced to an external third party.

Review of the risks; assumptions; issues and dependencies log for each school project confirmed that whilst project specific RAIDs had been identified, recorded, and were being appropriately addressed and monitored, the risks associated with outsourcing ongoing project management responsibilities to external third parties and wider Council risks had not been considered and recorded.

Management also advised that RAIDs are discussed and updated at every Investment Steering Group (ISG) governance meeting, however, this could not be verified as there is no standing agenda item for discussion of RAIDS and review of the RAIDs log, and only an actions log is produced. Additionally, the action log does not include timelines for completion of the agreed actions.

Customer Transformation and Schools – third party dependencies

Both the Customer Transformation Programme and schools projects are significantly dependent on external third parties for key project deliverables.

Whilst third party contractual obligations and roles and responsibilities have been established and agreed, and effective oversight of third party delivery progress is evident through established programme and project governance forums, the extent of external third party dependencies; the associated third party delivery risk; and the controls established to manage this risk are not highlighted in the monthly project updates provided to the Council's Change Board.

Risks

The potential risks associated with our findings are:

- The Council's Change Board has no assurance that key third party project management and delivery risks and dependencies are being effectively managed;
- Incomplete action logs result in issues and tasks arising from ISG meetings not being recorded or tracked to completion; and

2.1 Recommendation – Schools risks; assumptions; issues; and dependencies (RAIDs) logs

1. the schools projects risks; assumptions; issues; and dependencies (RAIDs) log should be reviewed and updated to ensure that it includes all relevant Council risks (for example, financial; legal and compliance; environmental; and reputational risks) that apply to the project, and also the risks associated with external third party project management in addition to the specific operational project risks already recorded.
2. discussion on new and emerging risks and review of the RAIDs log should be included as a standing agenda item for all Investment Steering Group (ISG) governance meetings.
3. ISG meeting action logs should be updated to include decision/action details; action owners; date opened; target close date; actual close date; and status, with any emerging actions from the RAIDs discussion recorded.

2.1 Agreed Management Action - Schools risks; assumptions; issues; and dependencies (RAIDs) logs

1. Council wide risks associated with projects (for example (for example, financial; legal and compliance; environmental; and reputational risks) will be recorded in the Communities and Families risk register together with details of ownership and actions taken to address / mitigate these risks;

   Third party risks and dependencies are recorded in individual project RAIDS logs. Significant third party risks will also now be escalated for inclusion in the Communities and Families risk register
2. No separate standing item for RAIDS log is required on the Investment Steering Group (ISG) agenda as the highlight report that is already included as a standing agenda item covers the risks; assumptions; issues; and dependencies (RAIDS) logs for the specific risks associated with schools projects. At the ISG meeting, the project manager highlights any significant RAIDS items at ISG discussion. Additionally, risk registers are regularly reviewed by the project manager and the design team during each project;
3. Communities and Families will ensure that the template used for ISG meeting minutes is updated to incorporate details around RAID actions, using a standard meeting template. Management will request Business Support to include further details as recommended above. Where this support cannot be provided, service management will record their own notes and actions from the RAID discussions and retain these together with minutes provided by Business Support.

Owner: Alastair Gaw, Executive Director of Resources **Contributors:** Crawford McGhie, Senior Manager, Estates and Operational Support	**Implementation Date:** 27 December 2019

2.2 Recommendation – Schools and Customer Transformation - dependency on third parties

1. external third party project delivery dependencies should be recorded in the risks. Issues; assumptions and dependencies (RAIDs) logs for both the Customer Transformation and schools projects; and
2. the extent of dependencies on external third parties should also be included in monthly change board updates, together with details of the actions taken to mitigate the associated risks.

2.2 Agreed Management Action - Schools - dependency on third parties

Management accepts this risk as there are no material external third party dependencies for schools projects that the Change Board would need to be aware of on a monthly basis. Any significant issues would be raised with Executive Director of Communities and Families and the Change Board immediately via established escalation processes.

Risk accepted by: Executive Director, Communities and Families, and Crawford McGhie, Senior Manager, Estates and Operational Support	**Implementation Date:** N/A
2.2 Agreed Management Action – Customer Transformation Programme- dependency on third parties	
Recommendations accepted. External third party project delivery dependencies will be recorded in the Customer Transformation risks; assumptions; issues and dependencies log and reported in the monthly Change Board pack.	
Owner: Stephen Moir, Executive Director of Resources **Contributors:** Nicola Harvey, Head of Customer and Digital Services; Layla Smith, Business Manager; Julie Rosano, Executive Assistant	**Implementation Date:** 27 December 2019

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or*** • ***Critical*** impact on the reputation of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or*** • ***Significant*** impact on the reputation of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation of the organisation.
Low	A finding that could have a: • ***Minor*** impact on operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***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.

Appendix 2 – Areas of Audit Focus

The audit areas and related control objectives that will be tested in detail are as follows:

Audit Area	Control Objectives
Project governance	• the programmes/projects concerned have been assessed for inclusion in the Council's Portfolio of Change using the project prioritisation matrix; • appropriate project governance forums (for example, a project board and workstream governance meetings) have been established with a clearly defined remit which details key members, their roles and responsibilities; • a full project business case has been prepared for the programmes/projects; approved by the project board; the Change Board; and relevant Council executive committees (where required); • the business case is updated to reflect any significant project changes (for example creation of additional workstreams; changes in approach; changes in building structure; or changes to system specifications) and is re circulated to all relevant governance forums for approval; • key deliverables have been identified and allocated to appropriate individuals who have a clear understanding of their delivery requirements and timeframes; • there is a clear project plan that details the timeframes; ownership; and progress of all key project deliverables; • project costs (including ongoing building lifecycle maintenance costs for the schools projects) and benefits (based on appropriate baseline measurements) have been quantified (where possible) and are reflected in the project business case; • monitoring processes have been established to ensure that project costs and benefits are monitored throughout the life of the project through to post implementation (normally the end of the payback period specified in the project cost / benefits analysis included in the business case); • there is an up-to-date risks, issues and dependencies (RAIDS) log, with evidence that all existing and new and emerging risks, issues, and dependencies are appropriately owned and effectively managed; • project progress updates (including an appropriate RAG status; including benefits tracking; and RAIDS reporting) are provided to the project board and the Strategic Change and Delivery team (if required) in the prescribed reporting format and within required timeframes for inclusion in the major projects portfolio reporting provided to the Change Board; • actions from governance meetings are documented; appropriately delegated; and tracked through to completion; and • post implementation reviews (including the project team and end users) are scheduled / have been held to reflect on 'lessons learned' and confirm that all anticipated benefits have been realised.
Project skills and experience	• the Senior Responsible Officer is able to demonstrate that project managers are appropriately skilled with proven project delivery experience; and • appropriate project management methodology and tools were employed by the project manager to ensure effective delivery of the project.
Oversight of third parties	• a governance process has been established to ensure that the Council has effective oversight of any third parties involved in the project. This should include (as a minimum); ➢ formal clarification of third party roles, responsibilities, and project deliverables;

	➢ visibility of RAID logs and progress reports; ➢ regular meetings to discuss performance and progress; ➢ an established escalation process to escalate performance issues; and • a secure process has been established for sharing private or commercially sensitive information with third parties; and • appropriate oversight of development of technology solutions and testing performed by third parties (specifically CGI development and testing of intelligent automation prior to implementation) has been applied.
Building handover process (Schools)	• the Council has specified and agreed with the contractor the relevant tests to be performed on the completed building prior to handover; • appropriate building completion checks including mechanical and electrical and health and safety have been performed, with supporting evidence of the outcomes provided; • all significant building and health and safety defects identified have been remedied and retested prior to handover; • a health and safety file has been prepared by the contractor and provided to the Council detailing all of the relevant health and safety aspects of the building; • the handover process should also ensure that the Council is familiarised with all relevant safety factors; and • building handover is accepted by a Council officer and local building users (for example Head Teacher at an appropriately senior level.
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 • appropriate stakeholder engagement and communication plans have been established, with key stakeholder engagement milestones reflected in the project plan.