Education, Children and Families Committee

10.00am, Tuesday 11 June 2024

Internal Audit Update Report: June 2024 – referral from the Governance, Risk and Best Value Committee

Executive/routine	**Executive**
Wards	

1. For Decision/Action

The Governance, Risk and Best Value Committee has referred the Internal Audit Update Report: June 2024 report to the Education, Children and Families Committee to consider the significant concerns that the Governance, Risk and Best Value Committee has for service delivery implications within its area of responsibility were a cyber-attack or other incident which affects business continuity to take place, and to note that there will be a follow up report which will also be referred to it.

Dr Deborah Smart
Executive Director of Corporate Services

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Referral Report

Internal Audit Update Report: June 2024 – referral from the Governance, Risk and Best Value Committee

2. Terms of Referral

2.1 On 04 June 2024 the Governance, Risk and Best Value Committee considered the Internal Audit Update Report: June 2024 which provided an update to Committee on delivery of the 2023/24 Internal Audit Plan approved by Committee in March 2023 and the outcomes of internal audits completed since May 2024.

2.2 The Governance, Risk and Best Value Committee agreed:

Motion

2.2.1 To note progress with the 2023/24 Internal Audit (IA) plan approved by Committee in March 2023;

2.2.2 To note the outcomes of 2023/24 internal audits completed during April and May 2024;

2.2.3 To note the final audit report which will support the 2023/24 Internal Audit annual report and opinion will be presented to Committee in September 2024;

2.2.4 To note the outcomes of the recently completed GRBV Self-assessment and skills evaluation.

2.2.5 To note the information on audit arrangements for Council Arm's Length Organisations (ALEOs) as requested by Committee in March 2024, and advises of any further action required from Internal Audit;

2.2.6 To note that the executive summary of the B Agenda audit: Appendix 3 CD2304 Directorates Cyber Incident Response IA Report Phased Implementation 130524, states: "Progress with implementing actions will be monitored by the Cyber Resilience Board and an update on the agreed actions, timescales, and progress to date will be provided to the Governance, Risk and Best Value Committee in September 2024"

2.2.7 To agree that this 'update' will be a full report setting out a detailed plan, separated out for areas each executive committee is responsible for, with a view that this report will be referred on to all executive committees.

2.2.8 To agree this report will cover:

2.2.8.1 Identified areas of highest risk to operational delivery and the potential mitigation.

2.2.8.2 Timescales on the development of the plan for mitigations

2.2.9 To agree to refer this audit report to all executive committees asking them to consider the significant concerns GRBV committee has for service delivery implications within their areas of responsibility were a cyber-attack to take place, and noting that there will be a follow up report which will also be referred to them.

(Moved: Councillor Campbell, Seconded: Councillor Kumar)

Amendment 1

2.2.10 To note progress with the 2023/24 Internal Audit (IA) plan approved by Committee in March 2023;

2.2.11 To note the outcomes of 2023/24 internal audits completed during April and May 2024;

2.2.12 To note the final audit report which will support the 2023/24 Internal Audit annual report and opinion will be presented to Committee in September 2024;

2.2.13 To note the outcomes of the recently completed GRBV Self-assessment and skills evaluation.

2.2.14 To note the information on audit arrangements for Council Arm's Length Organisations (ALEOs) as requested by Committee in March 2024, and advises of any further action required from Internal Audit; and

2.2.15 To agree that Internal Audit will give consideration to proportionate internal control assurance arrangements for ALEOs and to make recommendations alongside the future ALEO framework due to be considered by GRBV in October
(Moved Councillor Miller, Seconded Councillor Staniforth)

In accordance with Standing Order 22.13, Amendment 2 was accepted as an addendum to the motion.

Decision

To approve the following adjusted motion by Councillor Campbell:

2.2.16 To note progress with the 2023/24 Internal Audit (IA) plan approved by Committee in March 2023;

2.2.17 To note the outcomes of 2023/24 internal audits completed during April and May 2024;

2.2.18 To note the final audit report which will support the 2023/24 Internal Audit annual report and opinion will be presented to Committee in September 2024;

2.2.19 To note the outcomes of the recently completed GRBV Self-assessment and skills evaluation.

2.2.20 To note the information on audit arrangements for Council Arm's Length Organisations (ALEOs) as requested by Committee in March 2024, and advises of any further action required from Internal Audit;

2.2.21 To note that the executive summary of the B Agenda audit: Appendix 3 CD2304 Directorates Cyber Incident Response IA Report Phased Implementation 130524, states: “Progress with implementing actions will be monitored by the Cyber Resilience Board and an update on the agreed actions, timescales, and progress to date will be provided to the Governance, Risk and Best Value Committee in September 2024”

2.2.22 To agree that this ‘update’ will be a full report setting out a detailed plan, separated out for areas each executive committee is responsible for, with a view that this report will be referred on to all executive committees.

2.2.23 To agree this report will cover:

2.2.23.1 Identified areas of highest risk to operational delivery and the potential mitigation.

2.2.23.2 Timescales on the development of the plan for mitigations

2.2.24 To agree to refer this audit report to all executive committees asking them to consider the significant concerns GRBV committee has for service delivery implications within their areas of responsibility were a cyber-attack or other incident which affects business continuity to take place, and noting that there will be a follow up report which will also be referred to them; and

2.2.25 To agree that Internal Audit will give consideration to proportionate internal control assurance arrangements for ALEOs and to make recommendations alongside the future ALEO framework due to be considered by GRBV in October.

3. Background Reading/ External References

3.1 Governance, Risk and Best Value Committee – 04 June 2024 – Webcast

4. Appendices

Appendix 1 – Internal Audit Update Report: June 2024

Appendix 2 – B Agenda - Appendix 3 CD2304 Directorates Cyber Incident Response IA Report Phased Implementation 130524

Governance, Risk and Best Value Committee

10.00am, Tuesday, 4 June 2024

Internal Audit Update Report: June 2024

Executive/routine
Wards

1. Recommendations

1.1 It is recommended that the Committee:

1.1.1. notes progress with the 2023/24 Internal Audit (IA) plan approved by Committee in March 2023.

1.1.2. reviews the outcomes of 2023/24 internal audits completed during April and May 2024.

1.1.3. notes the final audit report which will support the 2023/24 Internal Audit annual report and opinion will be presented to Committee in September 2024.

1.1.4. notes the outcomes of the recently completed GRBV Self-assessment and skills evaluation.

1.1.5. notes information on audit arrangements for Council Arm's Length Organisations (ALEOs) as requested by Committee in March 2024, and advises of any further action required from Internal Audit.

Laura Calder
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Report

Internal Audit Update Report: June 2024

2. Executive Summary

2.1 This report provides an update to Committee on delivery of the 2023/24 Internal Audit (IA) plan approved by Committee in March 2023 and the outcomes of internal audits completed since May 2024.

2.2 The final audit which will support the 2023/24 IA annual report and opinion will be presented to Committee in September 2024. The 2023/24 IA annual report and opinion will also be presented to the September 2024 meeting.

2.3 A report detailing outcomes from the recent self-assessment and skills evaluation for GRBV members and further actions is presented for approval.

2.4 This report also provides details of internal control assurance arrangements for the 7 Council Arm's Length External Audit Arrangements (ALEOs) included in the Council's Governance Hub as requested by GRBV members in March 2024.

3. Background

3.1 The 2023/24 IA plan was approved by the Governance, Risk and Best Value Committee on 14 March 2023.

3.2 A self-assessment and skills evaluation for GRBV members in line with CIPFA guidance for Audit Committees was facilitated by IA as part of the approved 2023/24 IA plan.

3.3 At the March 2024 GRBV meeting, members requested further information on the internal control assurance arrangements for the Council's ALEOs.

4. Main report

4.1 As reported to Committee in February 2024, the 2023/24 IA plan consists of 43 engagements (31 for the Council and 12 for other organisations). This included IA facilitation of a self-assessment and skills evaluation for the Governance, Risk and Best Value Committee.

4.2 As at 10 May 2024, a total of 42 of 43 audits are complete with the final audit at reporting stage. A total of 12 audits were completed during April - May 2024 (8 for the Council and 4 for other organisations).

4.3 The audit report for Project Beech – historical complaints and disciplinaries, which will be the final report to support the 2023/24 IA annual report and opinion will be presented to committee in September 2024.

4.4 Details of all 2023/24 audits and overall engagement opinions is provided in Appendix 1.

Outcomes of audits completed in April - May 2024

4.5 The following 7 audits were completed for the Council during April - May 2024:

Rating	Audit
Limited Assurance	• Directorates Cyber Incident Response
Reasonable Assurance with high rated findings	• Enterprise Resource Planning – project assurance
Reasonable Assurance with no high rated findings	• Trams to Newhaven – project assurance • Void Management • Mental Health Services (Thrive) • Overtime and Expense Payments
Substantial Assurance	• CGI Complex Change Management

4.6 Due to the nature of the findings in the Directorates Cyber Incident Response audit and the potential exposure to risks, this report is presented as a B Agenda paper.

4.7 In addition, the GRBV Self-assessment and skills evaluation exercise in line with CIPFA guidance for Audit Committees is complete, with a workshop held with elected members to discuss outcomes in April 2024. A copy of the report is presented at Appendix 4.

4.8 Audits with a limited assurance outcome or high rated findings are automatically presented to Committee for review and scrutiny. Members have also requested that the following two reports be presented for scrutiny:

- Mental Health Services (Thrive)
- Housing Void Management

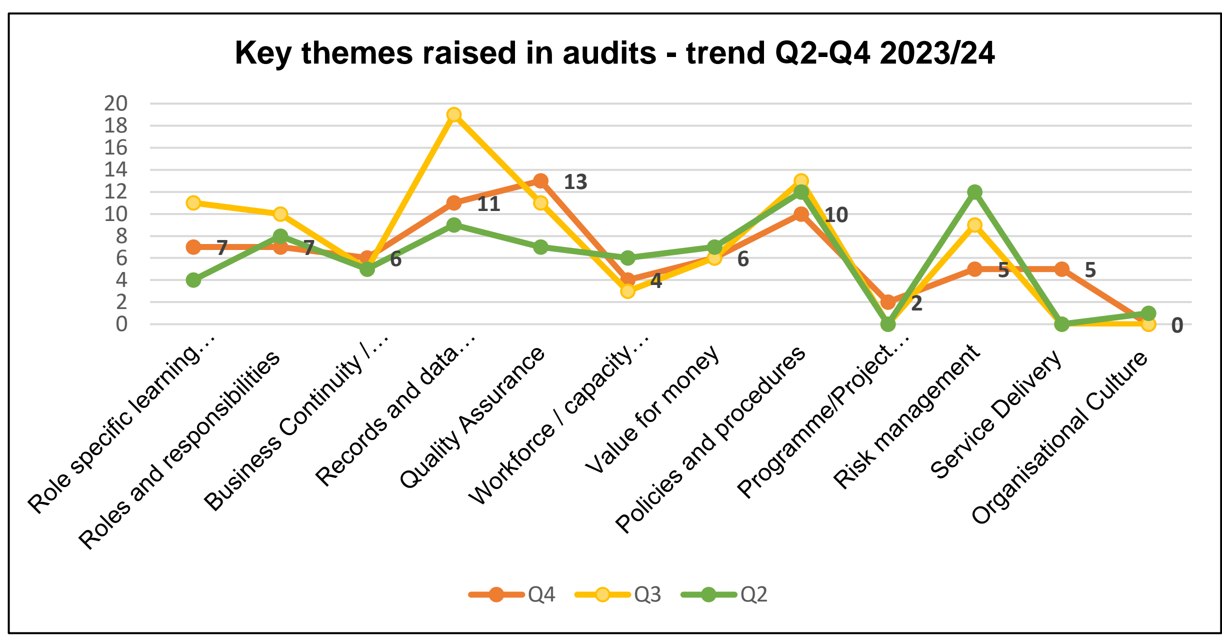
4.9 The final project assurance reports for the Enterprise Resource Planning Project and the Trams to Newhaven Project are also presented to Committee for review.

4.10 All Council audit reports are published on the Council's website following Committee.

Key thematic issues raised in completed Council audits

4.11 Since Q2 2023/24, key thematic issues raised across the recommendations from audits completed have been tracked and reported to committee. The chart below sets out the trend in key themes raised Q2-Q4 and demonstrates that quality

assurance, records and data management, and policies and procedures are a continued area requiring improvement. A summary of the issues raised across each of the May audits for each theme is provided in Appendix 2.



4.12 One audit for Lothian Pension Fund (LPF) was completed in April 2024:

Rating	Audit	Further detail
Limited Assurance	Business Continuity Management	Outcomes will be reported to the LPF Pensions Audit Sub-Committee on 24 June 2024.

4.13 A further audit for the Edinburgh Integration Joint Board (EIJB) was completed in May 2024:

Rating	Audit	Further detail
Reasonable Assurance	Workforce Optimisation	Outcomes will be presented to the EIJB Audit and Assurance Committee on 4 June 2024 and will be referred to GRBV information.

4.14 Two audits were also completed for SEStran and the Lothian Valuation Joint Board as part of an established audit service arrangement, with outcomes due to be reported to each organisation's relevant scrutiny committees in June 2024.

Audit arrangements for Council Arm's Length External Audit Arrangements (ALEOs)

4.15 At the March 2024 GRBV Committee meeting, Committee requested information on internal control assurance arrangements for Council ALEOs.

4.16 The Head of Internal Audit requested this information from the seven ALEOs included in the Council's ALEO Governance Hub which was established in 2016 to

scrutinise delivery of services by ALEOs. Details of internal control assurance arrangements, as advised by each ALEO, is provided in Appendix 5.

4.17 The responses from ALEOs set out in appendix 5, confirm that formal internal audit arrangements completed by an independent provider is in place for only 1 of 7 of the ALEOs included within the Council's ALEO Governance Hub – Lothian Buses. In-house control reviews are completed in line with an annual programme for a further 3 (Edinburgh Trams, Edinburgh Leisure, and Capital City Partnership) and the remaining 3 ALEOs (Transport for Edinburgh, Capital Theatres and the EICC) have no formal arrangements for regular review of internal controls, although they have advised there is reporting on the overall system of internal controls either to an audit committee equivalent or through an annual assurance statement.

4.18 Some assurance on governance, risk and control is also provided by external audit, however this will be limited to controls in place to support the financial statements.

4.19 It is also noted that a review of ALEOs is currently underway by the Council's Governance team which is considering the future ALEO framework. Outcomes of that review are due to be presented to GRBV in October 2024.

5. Next Steps

5.1 The final audit which will support the 2023/24 IA annual report and opinion will be presented to Committee in September 2024. The 2023/24 IA annual report and opinion will also be presented to the September 2024 meeting.

6. Financial impacts

6.1 Costs for delivery of agreed co-source audits are within the agreed budget with use of co-source resource limited to specialist areas only.

6.2 There are no associated budget implications for completion of audits completed for other organisations as direct recharge is applied for costs incurred.

7. Equality and Poverty Impact

7.1 None. An assessment is not required because the reason for this report is to report Internal Audit activity to Committee. Consequently, there will be no differential equality or poverty impacts as a result of the proposals in this report.

8. Climate and Nature Emergency Implications

8.1 None. The reason for this report is to report Internal Audit activity to Committee. Consequently, there will be no differential climate or nature emergency implications as a result of the proposals in this report.

9. Risk, policy, compliance, governance, and community impact

9.1 This report identifies several specific impacts on, and areas of improvement for the Council's risk, policy, compliance, and governance frameworks. Management should seek to take adequate steps to reduce the impacts across the key risk areas set out.

9.2 Council officers and elected members are consulted on the findings of Internal Audit throughout the year. No specific consultations have taken place in relation to this report.

10. Background reading/external references

10.1 Public Sector Internal Audit Standards

10.2 Global Internal Audit Standards

10.3 Approved 2023/24 IA Plan GRBV March 2023 – item 8.1

10.4 Internal Audit 2023/24 Q4 Update Paper GRBV May 2024 – item 8.3

10.5 Minute of Governance, Risk and Best Value Committee of 19 March 2024 – item 1.2

11. Appendices

11.1 Appendix 1 – 2023/24 audit plan delivery as at 10 May 2024

11.2 Appendix 2 – Key themes raised across April – May 2024 audits

11.3 Appendix 3 – Internal Audit Reports for scrutiny:

- Enterprise Resource Planning project assurance
- Trams to Newhaven project assurance
- Mental Health Services (Thrive)
- Housing Void Management
- Directorates Cyber Incident Response – B Agenda

11.4 Appendix 4 – GRBV Self-evaluation and skills assessment report

11.5 Appendix 5 – ALEOs: Internal control assurance arrangements

Appendix 1 - 2023/24 audit plan delivery as at 10 May 2024

Audits complete			Outcome
1.	Cross Directorate	**Council Budget Setting Process – Lessons Learned:** review of Corporate Leadership Team lessons learned for the 2023/24 Council budget setting process, as requested by GRBV March 2023.	n/a advisory review
2.		**Procurement – Contract Standing Orders:** assessment of compliance with the Council's Contract Standing Orders – specifically tender documentation, evaluation of tenders and quotes and award for a sample of contracts cross directorate.	Reasonable Assurance
3.		**Health and Safety – Findings only:** thematic control gaps and findings related to general health and safety risks were raised this report, in line with the authority granted under the Internal Audit Charter.	Limited Assurance
4.		**Supplier and Contract Management:** assessment of application of the Contract Handover, and Contract Review Meeting guidance as set out in the Council's Contract Management Manual and toolkit.	Limited Assurance
5.		**Recruitment and Selection:** review of compliance with the Council's Recruitment and Selection Policy including pre-advertisement requirements such as approval, supporting documentation, recruitment panels, training, advertisement, screening, and pre-employment checks.	Reasonable Assurance
6.		**Validation of Implementation of Previously Closed Management Actions:** review of a sample of previously implemented and closed IA agreed management actions for the Council to confirm that they have been effectively sustained.	Reasonable Assurance
7.		**Cyber - Directorates Incident Response:** review of directorates and service level approach to cyber incident management in line with the readiness, response, and recovery model. This included a review of a sample of departmental business impact analysis, business continuity plans and training/awareness.	Limited Assurance
8.		**Overtime and expense payments:** review of compliance with controls established to ensure that overtime and expense payments are made in line with the council's Pay Policy and Overtime guidance. Focussed on a high-level review of a sample of areas with high overtime and expenses volumes /values.	Reasonable Assurance
9.	Corporate Services	**Key Financial Systems – Debtors:** review of the design and operation of key controls established to ensure timely creation of debtor invoices, prompt processing of payments and effective control of write-offs, cancellations, credit notes and recovery.	Reasonable Assurance
10.		**Key Financial Systems – VAT recovery:** review of design and operation of controls established to ensure adequate arrangements are in place to maximise the recovery of VAT and ensure recovery is in line with requirements.	Reasonable Assurance

11.		**CGI - IT Currency Management, Obsolescence, and Innovation Review:** review of CGI's established approach to currency management and obsolescence of hardware and software including reviewing, consolidating, and replacing applications including implementation of new, and maintenance of existing solutions.	Reasonable Assurance
12.	Corporate Services	**CGI – Complex Change Management:** agile review of the end-to-end change journey for a sample of complex change requests to identify areas for improvement and highlight good practice.	Reasonable Assurance
13.	Children, Education and Justice Services	**After School ASN Care Provision - Review of Lessons Learned:** initial feedback on lessons learned completed by officers in CEJS for reporting to the Education, Children and Families Committee and GRBV in November 2023.	n/a advisory review
14.	Place	**Edinburgh Employer Recruitment Incentive (EERI):** review of the design and effectiveness of processes established for managing EERI fund applications from employers including eligibility, assessment, payments, and verification.	Limited Assurance
15.		**Health and Safety - Outdoor Infrastructure:** review of processes established to ensure the health and safety of outdoor infrastructure – specifically: cemeteries, public art and play areas.	Limited Assurance
16.		**Port Facility Security Plan:** annual review of the Port Facility Security Plan and emerging risks as per Department for Transport requirements.	Reasonable Assurance
17.		**Management of ad hoc mixed tenure works:** review of processes for scheduling and funding/payment for ad hoc common repairs across mixed tenure blocks.	Limited Assurance
18.		**Housing - Repairs Right First Time:** review of the Council's approach and performance for completing repairs 'right first time' in line with the Scottish Social Housing Charter, including completion of all aspects of the repair within the Council's target timescale and no recall to resolve subsequent defects within 12 months.	Limited Assurance
19.		**Housing stock condition – tenant safety, damp, and mould:** review of the Council's initial approach to the Scottish Housing Regulator's January 2023 request that landlords ensure that they have appropriate, proactive systems to identify and deal with any reported cases of damp and mould timeously and effectively.	Substantial Assurance
20.		**Management of scaffolding for housing property repairs:** review of the design and operating effectiveness of the Council's approach to managing scaffolding during repairs to housing properties including relevant consents and permits, advance notification to and ongoing communications with occupants, contractor and budget management and health and safety risk assessments.	Limited Assurance

21.	Place	**Corporate Property Helpdesk:** review of processes established to log, allocate and monitor completion of repairs tickets logged with the Corporate Property Helpdesk. Included oversight and reporting of performance information.	n/a advisory review
22.		**Community Centres:** review of oversight arrangements to confirm that community centres are safely and effectively managed in line with established community centre management arrangements agreed with the Council.	Limited Assurance
23.		**Fleet – Mission Zero for Transport:** review the Council's readiness to ensure all its fleet is renewed to a standard that meets the targets laid out by the Scottish Government's Mission Zero for Transport (legally binding target of net-zero by 2045) and the Council's target to be net zero by 2030.	Reasonable Assurance
24.		**Housing - Void Management:** review of the design and operation of controls established to ensure that empty council housing properties (voids) are managed effectively including review of programmed voids.	Reasonable Assurance
25.	Health and Social Care Partnership	**Financial Sustainability:** review of the processes applied to confirm the ongoing financial sustainability of the partnership, and the design and appropriateness of actions to address any significant gaps identified.	Limited Assurance
26.		**Budget Monitoring and Reporting:** review of HSCP in year budget monitoring and reporting systems and processes.	
27.		**Mental Health Services (Thrive):** review of strategic approach to support delivery of outcomes for provision of mental health and wellbeing services across Edinburgh.	Reasonable Assurance
28.	Major Projects	**Trams to Newhaven:** project assurance review during the final stage of construction. Review included ongoing governance and financial management, stakeholder management and readiness for operations.	Reasonable Assurance
29.		**Enterprise Resource Planning (ERP):** project assurance review of project management and governance supporting the R12 upgrade of the Oracle financial systems and implementation of the new sundry debt management solution (Apex).	Reasonable Assurance
30.	Lothian Pension Fund (LPF)	**LPF People Processes:** review of the adequacy and operating effectiveness of established people processes to ensure robust controls are in place, complied with and support achievement of LPF objectives.	Substantial Assurance
31.		**LPF Senior Managers and Certification Regime (SM&CR):** review of the adequacy and operating effectiveness of governance processes established to provide assurance of compliance with the key elements and prescribed responsibilities of the SM&CR.	Reasonable Assurance
32.		**LPF Information Security:** review of the design of the suite of IT policies, standards and procedures that have been developed during 2022 to prevent, respond and manage information security across LPF, as well as ensuring they are aligned to the IT strategy due to be formalised during 2023.	Substantial Assurance

33.		**LPF Business continuity and incident response:** review of the adequacy and operating effectiveness of key controls and processes established to provide assurance that LPF maintains business continuity plans to ensure they maintain services during an emergency or extended incident.	Limited Assurance
34.		**LPF Validation of Implementation of Previously Closed Management Actions:** review of a sample of previously implemented and closed IA agreed management actions for LPF to confirm that they have been effectively sustained.	Substantial Assurance
35.	Edinburgh Integrated Joint Board	**Workforce Optimisation:** review of the governance and oversight processes to monitor delivery of the initial short-term actions set out in the 'Working Together' the EIJB Workforce Strategy 2022-25.	Reasonable Assurance
36.		**Hosted Services:** review of budget, oversight and assurance arrangements established for hosted services (services which are operationally managed on a pan Lothian basis).	Reasonable Assurance
37.		**Change programme - Older People's Pathways Plus programme:** review of oversight and assurance for funding, progress, and delivery of the change programme (with specific focus on the Older People's Pathways Plus programme).	Substantial Assurance
38.		**EIJB Validation of Implementation of Previously Closed Management Actions:** review of a sample of previously implemented and closed IA agreed management actions for the EIJB to confirm that they have been effectively sustained.	Substantial Assurance
39.	Other audit activities	**GRBV self-assessment and skills evaluation:** facilitation of GRBV Committee self-assessment and skills evaluation in line with relevant CIPFA guidance.	N/A
40.	Other organisations	**SEStran - Financial Sustainability:** one audit delivered for South-East of Scotland Transport Network (SEStran) as part of an established audit service arrangement.	Reasonable Assurance
41.		**Lothian Valuation Joint Board – Customer Support:** one audit delivered for Lothian Valuation Joint Board (LVJB) as part of an established audit service arrangement.	Reasonable Assurance
42.		**Royal Edinburgh Military Tattoo – Revenue Recognition:** one audit delivered for Royal Edinburgh Military Tattoo as part of an established audit service arrangement.	Reasonable Assurance
Audits in reporting			**Reporting Date**
43.	Children, Education and Justice Services	**Review of Historic Complaints and disciplinaries:** review of historic complaints and disciplinaries to confirm whether any handled by for employees noted in Project Apple outcomes had been appropriately investigated and reported. This review is being completed by Internal Audit and the Council's Legal Team.	September 2024

Appendix 2 – Key themes raised across April - May 2024 audits

The table below provides a summary of the key themes raised across the audits completed in April - May 2024; it should be noted that more than one key theme may be raised from an audit recommendation.

Key theme	Summary
Roles and responsibilities	Key theme in 4 of 5 audits. Issues raised include ensuring managers are aware of their responsibilities for reviewing overtime and expense claims and retention requirements for supporting evidence. Procedures should also be documented to ensure clarity on roles and responsibilities including where there is cross directorate/cross team working. Business continuity roles and responsibilities should be clearly documented, communicated, and regularly reviewed. Governance and oversight roles and responsibilities should also be clearly documented.
Policies and procedures	Key theme in 4 of 5 audits. A policy specific issue was raised relating to ensuring manager responsibilities for reviewing overtime and expenses claims was clearly stated with the Pay Policy. The remaining issues were related to operational procedures and processes and include documenting and communicating end to end processes to ensure clear direction and to support training/induction, and should include key controls, timescales, linkage to other teams and remits of relevant oversight/governance forums. Procedures should include clear processes for collating, validating, and reporting performance information. Lessons learned processes should be documented together with a supporting communications process to ensure learning is cascaded.
Records and data management	Key theme in 4 of 5 audits. Issues include ensuring key systems can record essential data, and where there are known issues ensuring that data quality is a priority for system development/replacement. Data requirements for performance reporting and monitoring should be documented including where there is cross directorate/cross team or third party involvement. Training records should be reviewed and updated regularly to ensure accurate records are maintained. Records and data requirements to support delivery of services should be clearly understood and adequate contingency arrangements in place to support business continuity in the event of a prolonged incident.
Risk Management	Key theme in 3 of 5 audits. A targeted approach to identifying, recording, and managing cyber incident related risks is required at a CLT, directorate and operational level. Risks to delivery of key strategies such as Thrive Edinburgh should be reviewed and clearly documented, ensuring linkage to locality, operational, and partnership level risk registers, where relevant. Quality assurance actions should be prioritised by risk to provide focus on which actions should take priority.
Programme/Project Management	Key theme in 1 of 5 audits. Issues raised in audits/quality assurance reviews should be regularly reviewed as part of improvement programmes to ensure lessons are learned and to identify thematic issues and opportunities for efficiencies.

Key theme	Summary
Value for Money	Key theme in 4 of 5 audits. Areas of high of overtime and expenses spend should be reviewed regularly by directorates and divisions. Commercial aspects of complex change requests should be scrutinised to ensure value for money is achieved on costs of proposals, as well as ensuring changes are implemented efficiently. KPIs should include clear baselines to enable monitoring of costs/savings achieved. Key improvement projects such as the voids improvement project should include close monitoring of costs/savings and consideration of where efficiencies can be made.
Quality Assurance	Key theme in all 5 audits. Data validation processes should be in place to verify the accuracy of key operational and financial data, particularly where there are known data quality issues. Processes should be in place to review levels of service delivery provided inline with requirements, for both internal and third party provided services. Key strategies/policies should be reviewed in line with statutory guidance / requirements to ensure alignment. Clear arrangements should also be in place for oversight of quality and implementation of lessons learned processes.
Workforce / Capacity Planning	Key theme in 4 of 5 audits. Overtime usage data should be reviewed regularly to inform operation workforce/capacity planning including areas of frequent/high use. Workforce planning requirements for delivery of key strategies and services such as mental health and void management should be clearly documented and should align with organisational structures. Resilience arrangements for responding to an extended major incident should be documented, reviewed, and tested regularly to ensure adequate capacity to respond.
Role specific learning and training	Key theme in 4 of 5 audits. Issues raised include providing clear guidance for managers reviewing overtime and expense claims, guidance on retention requirements for supporting evidence, and instruction for new managers of casual workers. Providing training on operational risk management was also raised, as well as ensuring role specific learning matrices are kept up to date. Providing training for completion of business impact analysis and resilience protocols should be a priority.
Business continuity/resilience	Key theme raised in 3 of 5 audits. Specifically in the Directorate Cyber Incident Response audit with linkage to other key themes such as roles and responsibilities, role specific learning and records/data management. Adequate workforce and capacity planning arrangements are also required to ensure continuity of service for key operational services during change and organisational restructuring.

The City of Edinburgh Council
Internal Audit

Enterprise Resource Planning (ERP) – project assurance report
April 2024

MP2302

Reasonable Assurance

Enterprise Resource Planning - Project Assurance Report

Contents

1. Executive Summary and Opinion
2. Background
3. Scope and approach
4. Control assessment summary
5. Summary of findings

Appendix 1: Control assessment and assurance definitions

ERP - project assurance report

1. Executive Summary and Opinion

Reasonable Assurance

Between August 2018 and March 2024, Internal Audit (IA) completed an agile system development lifecycle review which considered the design and effectiveness of the controls in place to manage the ERP programme and ensuring delivery of objectives. IA was involved throughout the project providing real-time assurance and advice as the system was developed. This included attendance at key meetings and meetings with key stakeholders through-out the project. In addition, IA provided support for several ad-hoc areas of work that arose during the project lifecycle including a review of the procurement cut-over process, review of controls for shared bank data maintenance, and review of key board papers to ensure accurate and timely information to enable informed decision making.

Several IA findings were raised in the initial stages of the project, mainly relating to project governance, these were actioned by the project team and Internal Audit continued to monitor the effectiveness of governance throughout the project. As this was a systems development lifecycle review, in which Internal Audit reviewed systems design, configuration, testing and refinement in real-time as the development of the systems progressed, there were limited reportable findings beyond project governance. Issues were raised with the Project Team and confirmed as complete prior to progressing to the next stage of the system development.

It is noted that the original timescale to deliver the project in Quarter 2 of 2022 was not achieved which was due to several factors including: delays in the IT change process, ensuring implementation did not impact year-end accounting activities and an initial lack of compatible sundry debt management solutions.

The initial budget for the project was £14.023m, this was adjusted during the project and was supplemented by £961k from a Corporate Services directorate underspend in 2022/23. The total spend of the project was £14.390m, excluding the projected cost of £593k Debt Management (Apex) Phase 2 which is planned for May 2024.

A lessons learned exercise was completed by the project which considered the issues and challenges faced throughout the project as well as the key factors of success. IA feedback included ensuring detailed project plans and project governance structures including clear roles and responsibilities is established early on for similar projects. Additionally, project teams should engage the support of the Corporate Risk Team to understand management of project risks. Ensuring the right individuals are identified at the project planning stage may also maintain project stability.

Future projects should also ensure that decisions consider the impact on all business areas affected and that clear project resourcing plans are in place to ensure adequate resources to support timely delivery, especially if project leads have a key role in business-as-usual activities such as year-end. Future projects should also ensure access to relevant project management tools and training at project outset.

It is important that the lessons learned from this major project are reviewed to aid the success of future projects of the same scale, such as the new HR system and replacement social care operating system. The lessons learned report was presented to the Strategic Programme Board for review in March 2024. It is recommended that key learning and factors of success are communicated wider across Council projects and programmes.

2. Background

Internal Audit provided agile assurance on a systems development lifecycle basis for the Enterprise Resource Planning (ERP) Project throughout the project from August 2018 to March 2024. This report provides a summary of assurance work undertaken and findings raised between August 2018 and March 2024.

The initial internal audit scope was agreed in August 2018, with a rebased scope aligned to the final phase of the project agreed in April 2022. Details of the scope are provided at section 3.

Project Overview:

The overall project aim was to optimise, streamline and improve processes for Finance, Procurement, Human Resources, Payroll, and Debt Management, as well as upgrading and integrating systems. This included:

- an upgrade of Oracle e-Business Suite (EBS) systems and implementing new modules for Finance and Procurement
- developing iTrent for HR and Payroll and upgrading the reporting tool, Business Objects, to expand the functionality of these systems.
- implementing a new debt management system.

Business Case and budget

The ERP Programme was a significant commitment to a major upgrade and replacement of key Council financial and procurement systems. It was therefore important that adequate rigour and scrutiny was applied to all costs associated with delivery to ensure that the solution was delivered within budget and provided value for money.

The initial budget for the project was £14.023m, this was adjusted during the project and was supplemented by £961k from a Corporate services directorate underspend in 2022/23. The total spend of the project was £14.390m, excluding the projected cost of £593k Debt Management (Apex) Phase 2 which is planned for May 2024.

Project timeline

- June 2018 - Finance and Resources Committee approved a Reset Agreement for the previous Business World project, initiating the rebranded ERP project
- 2018/21 – Systems design, system selection and initial programming and configuration
- March 2021 - HR closure report produced following successful delivery against ERP objectives
- 2021/22 – Programming and systems configuration of Oracle R12 and Apex continues following by systems testing, systems refinement and training
- July 2023 - Debt Management solution (Apex) Phase one delivered
- October 2023 – Oracle version R11 upgraded to R12
- May 2024 – Debt Management solution (Apex) Phase two planned for delivery

2. Background (Continued)

Project Governance

A Project Management Office (PMO) was established to monitor and support the delivery of the key strands of the programme. This included a Project Manager role that was responsible for the operational delivery of the project throughout. In addition, there was a Senior Responsible Officer (SRO) in place with responsibility for overall oversight and key decision-making. In addition, the following governance forums were established:

- a dedicated ERP board met fortnightly throughout the programme, with a set agenda and a comprehensive supporting board pack produced for each meeting with actions tracked. Membership included a wide variety of specialists and key stakeholders, including representatives from the key delivery partners CGI and Claremont
- weekly team meetings and monthly meetings with the wider workstream teams
- weekly project meeting to review and monitor progress with key external delivery partners
- weekly Change Request meetings to review and tracking outstanding requests with the CGI Project Manager

Key stakeholders

Due to the length of the project, there were changes at SRO, project manager, Change Manager and PMO Analyst level. A handover was provided to support project continuity.

The programme was divided into several workstreams, each with a workstream lead supported by a senior stakeholder. The workstreams were:

- Finance
- Human Resources
- Procurement
- Banking and Payments System
- Debt Management System

The key third party stakeholders involved with project delivery were Claremont, Oracle, Midland and CGI.

Risk Management

A RAID (Risks, Issues, Assumptions, Dependencies) log was maintained by the Change Manager/PMO Analyst with regular risk meetings held with the project team to review the risks, identify any emerging issues and update the log as appropriate.

Key risks were reported to the ERP board through presentation within every board pack and clear discussion of key risks was evident by observation from Internal Audit at board meetings and review of action notes.

3. Scope and approach

The scope of this review was to assess the design adequacy and ongoing operating effectiveness of the key controls supporting delivery of the ERP project.

The initial key areas included within scope agreed in August 2018 were:

- Project Governance
- Procurement and support arrangements
- System Design
- Data Migration and Security
- System Testing
- System Implementation
- Communication and Training
- Post Implementation

The scope of assurance work was extended as the project progressed to include:

- Contract Management
- System Design – Sundry Debt Management
- System Implementation – Go/no go and contingency
- In addition, several ad-hoc areas of work and support were provided, including:
    - a review of the Procurement cut-over process
    - shared bank details data maintenance
    - sundry debt management options appraisal review
    - project Lessons Learned exercise.

The following audit approach was applied:

- An 'agile' audit approach with Internal Audit work completed on an ongoing basis throughout the systems development lifecycle and aligned with the relevant stages of the project plan.
- All control gaps identified were discussed with the SRO and project team when they arose to support real-time system development. Where relevant findings were raised formally and reported to the Project Board.
- Bi-monthly updates were provided to the ERP Project Board on progress with audit work and implementation of findings raised.
- Internal Audit had ongoing engagement throughout the project with regular meetings with the project team and attendance at meetings including with workstream leads, finance, project risk reviews and attendance at ERP Project Board meetings throughout the project.

4. Control assessment summary

A summary of findings raised is set out below, it is important to note that as this was a systems development lifecycle review, in which Internal Audit reviewed systems design, configuration, testing and refinement in real-time as the development of the systems progressed, there were limited reportable findings beyond project governance. Issues were raised with the Project Team and confirmed as complete prior to progressing to the next stage of the system development.

Audit area	Overall assessment	Findings / recommendations raised	Finding status
Project Governance	Limited Assurance	1 finding (High Priority) 3 recommendations 1 finding (Medium Priority) 3 recommendations 1 finding (Advisory) 1 recommendation	All Actions Complete ✓
Procurement and support arrangements	Substantial Assurance	n/a	n/a
System Design	Substantial Assurance	n/a	n/a
Data Migration and Security	Substantial Assurance	n/a	n/a
System Testing	Substantial Assurance	n/a	n/a
System Implementation	Substantial Assurance	n/a	n/a
Communication and Training	Substantial Assurance	n/a	n/a
Post Implementation	Substantial Assurance	n/a	n/a
Contract Management	Substantial Assurance	n/a	n/a
System Design – Sundry Debt Management	Substantial Assurance	n/a	n/a
System Implementation – Go/no go and contingency	Substantial Assurance	n/a	n/a

5. Summary of findings and Lessons Learned

Project Governance and ERP Detailed Project Plans

- The project commenced in July 2018 and by November 2018, a detailed project plan had not yet been developed for both the programme and the key delivery and enabling workstreams. It was noted, that lack of detailed plans was recorded as a project risk.
- In November 2018, it was highlighted that the Project Team did not have access to project management tools (for example Microsoft Project and Microsoft Project Viewer) which were required to support effective and timely management of the project. The Programme Team had raised a change request CGI in May 2018 which had not yet been actioned. This was escalated to Digital Services and resolved, with access provided.
- Initially, whilst clear roles and responsibilities were documented for the Senior responsible officer (SRO), and the Programme Manager, clearly defined roles and responsibilities were not documented for the wider programme team including project team members and workstream leads.
- An approved Terms of Reference, structure and schedule of meetings (including standing agenda items, forward planning and minutes) and reporting process was documented for the Project Board, however similar governance arrangements had not yet been agreed for other key meetings such as the Project Working Group, Change Request tracking meetings; and Risk Management meetings. These were subsequently established and communicated.

ERP Management of Risk

Internal Audit reviewed the ERP risk management processes to ensure that all project risks were appropriately recorded, reviewed, and managed effectively. Project risks were held within a project 'RAID Log'. It was noted that the RAID log was in the early stages of development and there was a lack of understanding among some project team members and workstream leads on project risk management. It was recommended that the Project Team engaged the support of the Corporate Risk Team, and an initial risk workshop was held in January 2019 and a further workshop held in February 2019. Further reviews of the RAID log found this to be comprehensive with regular review at a project and board level, including escalation of risks impacting the critical path, as required.

Lessons Learned Exercise

The project team completed a lessons learned exercise at project close, which was included in the project closure report. Internal Audit feedback for lessons learned included ensuring detailed project plans and an effective project governance structure including clear roles and responsibilities is established early on for similar projects. Additionally, project teams should engage the support of the Corporate Risk Team to understand management of project risks.

Due to the turnover of key project roles, and complexity / duration of the project, it was sometimes difficult for new project staff to get up to speed quickly. The turnover also meant that earlier decisions were sometimes difficult to confirm, and due to timescales, decisions were sometimes made by senior officers via email. Ensuring the right individuals are identified at the project planning stage may help maintain project stability.

Future projects should also ensure that board decisions consider the impact on all business areas affected and clear project resourcing plans are in place, especially if project leads are key to business-as-usual activities. Future projects should also ensure access to relevant project management tools and training at project set up.

Appendix 1: Control assessment and assurance definitions

Overall Assurance Ratings	
Substantial Assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.
Reasonable Assurance	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.
Limited Assurance	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.
No Assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.

Finding Priority Ratings	
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.
Low Priority	An issue that results in a small impact to the achievement of objectives in the area audited.
Medium Priority	An issue that results in a moderate impact to the achievement of objectives in the area audited.
High Priority	An issue that results in a severe impact to the achievement of objectives in the area audited.
Critical Priority	An issue that results in a critical impact to the achievement of objectives in the area audited. The issue needs to be resolved as a matter of urgency.

The City of Edinburgh Council
Internal Audit

Trams to Newhaven – project assurance report
May 2024

MP2301

Overall report rating	Reasonable Assurance

Trams to Newhaven Agile –project assurance report

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1. Executive Summary and Opinion
2. Background
3. Scope and approach
4. Control assessment summary
5. Summary of audit findings

Appendix 1: Control assessment and assurance definitions

Trams to Newhaven – project assurance report

Reasonable Assurance

1. Executive Summary and Opinion

Between August 2018 and March 2024, Internal Audit (IA) completed provided agile internal audit assurance on the Trams to Newhaven project which considered the design and operating effectiveness of controls established to manage delivery of the project and ensure delivery of key project objectives. IA was involved throughout the project providing real-time assurance and advice as the project progressed through its various phases. IA involvement was in line with an agreed terms of reference and included review of key processes and supporting documentation/governance processes and attendance/observation at key meetings and meetings with key stakeholders throughout the project.

Several IA findings were raised throughout the project, with control gaps identified discussed with the SRO and the project team when they arose to support real-time improvements. Some findings were advisory in nature to support project efficiencies rather than address specific risks. All high and medium rated findings were raised formally and reported to the Trams Project Finance and Risk sub-group, and the Trams Project Board.

Our initial assessment in late 2018 considered development of the business case, and financial model, with joint work undertaken with external audit. During the initial stages of the project IA identified some high and moderate weaknesses in the design and effectiveness of the governance, risk and control frameworks established to support delivery of the project. These actions were dealt with promptly by the project team to ensure governance was strengthened.

A summary of these control assessments in line with the audit scope is set out at section 4, with a summary of findings at section 5. Findings were raised with officers and evidence was provided to IA to demonstrate adequate actions were taken to address the risks identified by IA.

While several findings were raised throughout the project timeline. No control weaknesses persisted, and therefore reasonable assurance was provided to demonstrate that the design and operating effectiveness of project controls was adequate and supported the Council's objectives of delivering the Trams to Newhaven project. One Medium finding related to community benefits is outstanding as at April 2024. This is due for completion by 30 June 2024.

It is also noted there is an ongoing risk throughout the defects and handover process and while the new asset is established for ongoing management. Officers expect this to be mitigated by the establishment of a Major Projects and Commissioning team to provide ongoing oversight of the process.

It is also important to note that project construction was paused between March and June 2020 in line with national Covid-19 guidance, an issue which was outside the Council's influence. IA confirmed that adequate consideration was given to Covid-19 associated risks and prompt action taken to minimise these, where possible.

A number of lessons learned exercises were completed throughout the project for key phases and processes, and a final lessons learned considered the issues and challenges faced throughout the project as well as the key factors of success. IA feedback reflected on the robust governance structure, experienced project team and the specialist advisory input throughout the project. Stakeholder management by the Council's project team was a key strength with an effective balance struck between ensuring robust challenge while working collaboratively with the Managed Delivery Unit, Edinburgh Trams and contractors to deliver the project.

Lord Hardie's Inquiry into delivery of the initial trams project started in July 2014 with the final Inquiry Report published in September 2024, and the Council presented a response to Full Council on 14 December 2023. As this was after the completed line to Newhaven opened for revenue service in June 2023, and therefore had no direct impact on the management of the Trams to Newhaven project, IA did not consider this to be in scope.

2. Background

Internal Audit provided agile assurance on the Trams to Newhaven project throughout the project stages from August 2018 to March 2024. This report provides a summary of assurance work and findings raised between August 2018 and March 2024. The initial internal audit scope was agreed in August 2018, with a rebased scope aligned to the final phase of the project agreed in April 2022. Details of the scope are provided at section 3.

Business Case and budget

In December 2015, the Council approved in principle, the option to extend the Edinburgh Tram lines from York Place to Newhaven. In September 2017, the Council considered the updated Outline Business Case and approved commencement of a range of procurement activities to assess affordability and prepare a Final Business Case (FBC).

The approved budget for the project was £207.3M and a financial model was developed by the Council's Finance team to monitor project costs including borrowing and repayment. Detailed cost management procedures and responsibilities are also set out within the Project Execution Plan (PEP). Arrangements included budget monitoring split by phase and production of cost reports and monthly cost forecasting. The financial model was reviewed throughout the project including a review of assumptions and cost impacts as a result of Covid-19.

As at 1 May 2024 no final settlement had been reached with the contractor and the contractual risk had not been settled.

Project timeline

The FBC was approved in March 2019 and following procurement contracts were awarded to the preferred bidders in April 2019. Following stage 1 of the project which included an Early Contractor Involvement (ECI) phase from May – October 2019, a Notice to Proceed was approved by the Council in October 2019, with the stage 2 construction phase commencing November 2019.

Completion of works was delayed slightly due to Covid-19, with construction sites closed between March and June 2020 in line with national Covid-19 guidance. Following a testing and commissioning phase, the Newhaven line opened for revenue service on 7 June 2023.

Project Governance

A comprehensive PEP was in place throughout the project and regularly updated to ensure ongoing oversight, direction and effective decision making, and a clearly defined governance structure was established which included a Project Board and Finance and Risk sub-group (FRG) and working groups as needed.

The role of Senior Responsible Officer (SRO) for the project was undertaken by an appropriately experienced Council officer. The SRO had day to day responsibility for the project. Management of all aspects of the construction of the project undertaken by a contracted Managed Delivery Unit (MDU). A range of external advisors were also engaged by the Council to provide professional services and specialist advice.

2. Background continued

Risk Management

The project adopted a life cycle approach to risk management which included identification, evaluation, treatment and review of risks throughout the project. A Programme level risk register was in place which contained strategic risks associated with overall delivery of the project, as well as an Infrastructure and Systems risk register and a Swept Path risk register which considered specific risks to those project deliverables. The risk management process was supported by a suite of risk management related review meetings including a monthly risk review with all key stakeholders and a quarterly Quantitative Risk Analysis (QRA) which provided an assessment of risk impacts at both a cost and time level. This approach was used to consider risks associated with cost uncertainty, schedule delays and unknown unknowns.

Supplier and Contract Management

Supplier and contract management was considered throughout the project, this included contract management of the MDU. Community benefits associated with the contracts were also considered and relevant audit recommendations raised to strengthen processes.

Support for Business

A Support for Business package totalling £2.44M was in place to support a range of measures developed following consultation. This included a voucher scheme to increase footfall for businesses in the local area and a business continuity fund that provided grants (up to £6,000) to help eligible small independent retailers with short term cashflow issues. A robust process was established to review and assess applications with appropriate evidence requirements. An independent process was also in place to consider application appeals.

Ready for operations

Ready for Operations governance arrangements were approved by the Board in January 2022 to ensure adequate preparation for operations and handover of the asset to the Council / Edinburgh Trams. This included a Ready for Operations sub-group chaired by an independent advisor which provided oversight and reviewed progress of the operational readiness and handover elements of the project, progressed through each of the six Systems and Operations Workstreams.

Lessons Learned / Lord Hardie Inquiry

Processes were in place to ensure that lessons learned were captured throughout the project and reported at key stages. In addition, an independent inquiry chaired by Lord Hardie was commissioned following the 2014 Tram Project. Submissions were heard in May 2018, and the inquiry findings were published in September 2023. Reports considering the recommendations from the Lord Hardie inquiry were presented to the Council's Transport and Environment Committee and the Governance, Risk and Best Value Committee in November 2023 and Full Council in December 2023. A report detailing project lessons learned was also reported to the Council's Transport and Environment Committee in April 2024.

3. Scope and approach

The scope of this review was to assess the design adequacy and ongoing operating effectiveness of the key controls supporting delivery of the Trams to Newhaven project.

The initial key areas included within scope agreed in August 2018 were:

- Options appraisal process
- Project business case
- Project governance
- Financial model and budget management
- Procurement process and supplier management
- Initial Lessons learned from Phase 1
- Stakeholder engagement

The scope of assurance work was extended as the project progressed to include:

- Review of optimum bias and contingency approach
- Support for Business application controls
- Benefits realisation
- Risk management and change management
- Contractor Insolvency mitigation
- Covid-19
- Readiness for Operations including defects and testing and transfer of assets/responsibilities
- Health and safety including incident reporting
- Lessons learned including Hardie Inquiry

The following audit approach was applied:

- An 'agile' audit approach with Internal Audit work completed on an ongoing basis and aligned with the relevant stages of the project plan.
- Initial assessments were completed in conjunction with Azets (External Audit) who reported any findings in their annual audit report to the Council, and the Controller of Audit.
- All control gaps identified were discussed with the SRO and project team, and where relevant raised as findings and reported to the Project Board.
- Bi-monthly updates were provided to the Project Board and Finance and Risk Group and a phase end report summarising findings to date was presented in August 2022.
- Internal Audit had ongoing engagement throughout the project with regular meetings with the SRO and project team and attendance at Project Senior Management Team meetings, Change Management meetings, Programme Risk Reviews; Quantitative Risk Assessments (QRA), the Finance and Risk Sub-group and the the Project Board to support their ongoing assessment of project governance.

4. Control assessment summary

Audit area	Overall assessment	Findings / recommendations raised	Finding status
Options appraisal process	Reasonable Assurance	1 finding (High) 1 recommendation	Complete ✓
Project Governance including risk & change management	Reasonable Assurance	1 finding (Medium) 2 recommendations	Complete ✓
Financial Model including contingency	Substantial Assurance	n/a	n/a
Procurement	Reasonable Assurance	1 finding (Medium) 1 recommendations	Complete ✓
Initial Lessons Learned	Substantial Assurance	n/a	n/a
Stakeholder engagement	Substantial Assurance	1 advisory finding	n/a
Support for Business application controls	Substantial Assurance	n/a	n/a

Audit area	Overall assessment	Findings / recommendation s raised	Finding status
Benefits Realisation	Reasonable Assurance	1 finding (Medium) 1 recommendation	Open
Risk Management and Change Management	Substantial Assurance	n/a	n/a
Supplier management/ contractor insolvency	Substantial Assurance	n/a	n/a
Covid-19	Substantial Assurance	n/a	n/a
Readiness for Operations including defects	Substantial Assurance	1 advisory finding	n/a
Health and Safety – incident reporting	Substantial Assurance	1 advisory finding	n/a
Final Lessons Learned	Substantial Assurance	n/a	n/a

5. Summary of audit findings

Options appraisal – initially reliance was placed on the original options appraisal for transport modes which took place in support of the Parliamentary bill. Following a recommendation from external audit, an updated options assessment was completed and formed part of the Final Business Case.

Project governance – review of Project Board meetings from 2017 to March 2019 highlighted a number of reporting and record keeping weaknesses including missing minutes and lack of a record of follow-up on agreed actions / information to follow. An action tracker and decision log was introduced with a requirement for an agreed target date for completion of actions which was reviewed at all Board meetings. This included recording completion of actions pending further information. A review process was introduced to ensure all Board papers including previous meeting minutes were reviewed by the SRO prior to issue.

Change/risk management – robust change management controls were in place including review and approval of all changes by the Finance and Risk Sub-group. In addition, strong risk management processes were established and maintained throughout which included a full review of risks with key delivery partners and quarterly risk reviews aligned with associated cost impacts.

Procurement – improvement areas for the procurement process for the Tram Infrastructure & Systems Contract and Swept Path Contract were identified including ensuring full consideration of procurement associated risks for contract with non-standard or specialist requirements. A lessons learned review was undertaken which resulted in communications being issued to procurement colleagues to alert them to associated risks with complex specialist projects and a prompt within the procurement plan/strategy for record additional actions and checks.

Stakeholder engagement – the audit concluded that clear stakeholder and citizen engagement and communication plans were developed with progress/outcomes monitored and reported as required.

Support for business – the audit concluded that a clear framework was in place to support the Support for Business workstream, with adequate governance and oversight of budgets and decision making.

Benefits realisation / community benefits – improvements in ensuring adequate evidence with progress of community benefits was highlighted, including ensuring the contract design for major projects includes community benefits clauses to ensure that contractors are aware of the requirement to update Council systems with details of progress towards meeting delivery of community benefits as agreed in the terms of the contract. It was also recommended that the Contract Handover Report should detail agreed Community Benefits to ensure that these are recorded, managed and reported as required. Finally, any changes to agreed Community Benefits targets should be approved by the Senior Responsible Officer and reported to an appropriate governance forum. As part of project close and lesson learned, a report should be prepared which details the community benefits set out to be delivered in the full business case and contract, the changes that occurred to delivery targets during the project, the reasons for the changes, and the final position of community benefits delivered a project close.

Supplier management / insolvency checks – adequate arrangements were established to confirm the ongoing financial viability and workforce capacity for key contractors and suppliers in the current operating environment.

Covid-19 – robust arrangements were implemented to respond to and manage the impacts of Covid-19 including a robust review of the project timeline and key milestones, review of project costs and associated impacts, and adherence to social distancing/infection control guidance on site and within project offices.

Readiness for operations - appropriate governance arrangements, delivery plans and reporting arrangements were established to prepare the project transition from construction to readiness for operations.

Lessons learned – lessons learned were undertaken throughout the project with outcomes reported to the Project Board and shared with other major project teams where relevant. A final lessons learned was completed and reported to relevant committees. The Council response to the Lord Hardie Inquiry was also reported to Full Council in December 2023.

Appendix 1: Control assessment and assurance definitions

Overall Assurance Ratings	
Substantial Assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.
Reasonable Assurance	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.
Limited Assurance	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.
No Assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.

Finding Priority Ratings	
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.
Low Priority	An issue that results in a small impact to the achievement of objectives in the area audited.
Medium Priority	An issue that results in a moderate impact to the achievement of objectives in the area audited.
High Priority	An issue that results in a severe impact to the achievement of objectives in the area audited.
Critical Priority	An issue that results in a critical impact to the achievement of objectives in the area audited. The issue needs to be resolved as a matter of urgency.

Internal Audit Report

Mental Health Services (Thrive)

8 May 2024

HSC2302

Overall Assessment	Reasonable Assurance

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This Internal Audit review is conducted for the City of Edinburgh Council under the auspices of the 2023/24 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2023. 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 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.

Executive Summary

Overall Assessment	Reasonable Assurance

Overall opinion and summary of findings

Improvements are required in the design and operating effectiveness of the processes, procedures and controls established to support delivery of Mental Health Services strategy outcomes.

The following improvements have been identified to support effective management of Mental Health Strategy objectives and associated governance, strategic, financial, and service delivery risks:

- the Thrive Edinburgh strategy and Commissioning Plan should be formally mapped to the Scottish Government strategy
- governance and performance monitoring arrangements to evidence delivery of the strategy should be improved, including the use of SMART objectives
- an overall workforce plan for Thrive Edinburgh aligned to revised structures should be developed
- a quality assurance framework and plan should be introduced, including lessons learned
- risk management arrangements should be improved.

Areas of good practice identified

- newsletters are distributed to service users, carers, third sector, staff and on the Thrive website to update on the latest news and events
- Thrive on Thursdays are 1-hour sessions which provide insight into various topics
- annual conferences where presenters and participants find out what initiatives are happening as part of Thrive Edinburgh
- there is a significant amount of activity taking place over the city
- short learning films have been created based on real life experience
- iThrive provides an online space for Mental health and wellbeing information for staff and citizens.

Audit Assessment

Audit Area	Control Design	Control Operation	Findings	Priority Rating
1. Strategy for Mental Health	Green	Orange	Finding 1 – Strategy and Commissioning Plan	Medium Priority
2. Performance	Orange	Orange	Finding 2 – Performance Reporting and Monitoring	Medium Priority
3. Resource and Capacity Planning	Orange	Orange	Finding 3 – Workforce Planning	Medium Priority
4. Quality Assurance	Orange	Orange	Finding 4 – Quality Assurance and Lessons Learned	Medium Priority
5. Governance and Oversight	Orange	Orange	See Finding 2	N/A
6. Risk Management	Orange	Orange	Finding 5 – Risk Management	Low Priority

See Appendix 1 for Control Assessment and Assurance Definitions

Background and scope

In line with the Scottish Government's Mental Health and Wellbeing Strategy mental health is a cross-government priority, building on the partnership between the Scottish and Local Governments. The strategy sets out the shared vision of the Scottish Government and COSLA vision to improve mental health and wellbeing.

'Thrive Edinburgh' brings together the City of Edinburgh Council (the Council), NHS Lothian, third sector and academia to build upon the work of current providers of emotional and mental health services. Thrive's 'A Mental Health and Wellbeing Road Map for All 2019-2029' is the strategy for Edinburgh for addressing health inequalities at a structural, community and individual level. The strategy includes elements to address prevention of illness, promotion of mental health, early detection of problems and treatment. This includes delivery of a Edinburgh Adult Health and Social Care Commissioning Plan 2023-2026. A progress update on Thrive Pillars and Workstreams was published in February 2024. The Thrive strategy aims to develop new methods and measures to understand mental health needs and priorities.

Audit Scotland undertook a review of Mental Health Services in 2023, which included recommendations for Councils, HSCPs, and IJBs. In addition, the Mental Welfare Commission (MWC) carry out local and national visits to gather views from citizens on the care they have received and check on the care. Investigations are carried out where the MWC believe care or treatment has gone wrong.

Statistics on data on mental health is collated by various bodies including Public Health Scotland, the Scottish Social Services Council and the Scottish Government. In addition, the EHSCP has a Performance Monitoring Framework (PMF) which collects, reports and scrutinises performance of services delivered.

The EHSCP is due to carry out a management structure review which is going out to consultation in May 2024, which includes the aim of having a Head of Service for Mental Health in post by July 2024.

On 18 March 2024, the Edinburgh Integrated Joint Board approved a Medium-Term Savings Plan of £60m which will have a significant impact on service delivery and likely to impact core statutory duties and areas requiring improvement.

Scope

The objective of this review was to assess the adequacy of design and operating effectiveness of the key controls established to ensure the delivery of outcomes for provision of mental health and wellbeing services across Edinburgh.

Risks and Business Plan Outcomes

The review also provided assurance in relation to the following Corporate Leadership Team (CLT) risks:

- Governance and Decision Making
- Regulatory and Legislative Compliance
- Workforce
- Financial and Budget Management
- Service Delivery.

Business Plan Outcomes:

- Core services for people in need of care and support are improved.

Reporting Date

Testing was undertaken between 12 March 2024 and 3 April 2024.

Our audit work concluded on 3 April 2024 and our findings and opinion are based on the conclusion of our work as at that date.

Findings and Management Action Plan

Finding 1 – Strategy and Commissioning Plan

Finding Rating	Medium Priority

Thrive Edinburgh produced the City of Edinburgh's mental health strategy 'A Mental Health and Wellbeing Roadmap for all 2019-2029', which outlines how Edinburgh will address mental health inequalities. In line with Scottish Government (SG)requirements, this roadmap should have been aligned to the Scottish Government Mental Health Strategy 2017-2027 (which was revised in 2023).

Comparison of the roadmap with the SG strategy found that outcomes were aligned. Management advised that a mapping exercise based on the previous SG strategy was performed by the EHSCP to ensure that all Government objectives had been included in Thrive Edinburgh's roadmap, however a mapping exercise on the revised SG strategy has not yet been done.

To support implementation of the roadmap, the Thrive Adult Health and Social Care Commissioning Plan 2019-2022 has been created. The Commissioning Plan outlines priorities and outcomes and has 6 workstreams. However, this only covers the period up to 2022 so a revised plan aligned to the life of the roadmap is required.

Management have advised that development of a revised Commissioning Plan has been on hold, awaiting the creation of the new EIJB Strategic Plan, which has been delayed since 2023.

Risks

- **Service Delivery** – without an up-to-date commissioning plan, the EHSCP may not deliver services which meet the needs of citizens
- **Regulatory and Legislative Compliance** – the EHSCP may not meet regulatory and legislative requirements.

Recommendations and Management Action Plan: Strategy and Commissioning Plan

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
1.1	A mapping exercise should be undertaken and documented to confirm that the Thrive Edinburgh 2019-29 Strategy 'Roadmap' continues to align to the current Scottish Government Mental Health and Wellbeing Strategy.	Undertake a mapping exercise to ensure that the current thrive roadmap aligns with the SG mental health and wellbeing strategy.	Chief Officer, EHSCP	Strategic Programme Manager (Thrive Edinburgh)	30/12/2024
1.2	Following publication of the EIJB Strategic Plan, the Commissioning Plan should be updated, and mapped to ensure it aligns with the current Scottish Government Mental Health and Wellbeing Strategy.	Produce updated Thrive Commissioning Plan which reflects the priorities of new EIJB Strategic Plan and the Scottish Government Mental Health and Wellbeing Strategy.	Chief Officer, EHSCP	Strategic Programme Manager (Thrive Edinburgh)	30/06/2025

Finding 2 – Performance Reporting and Monitoring

Finding Rating	Medium Priority

A performance monitoring framework sets out what information is reported, to which officers and groups, and at what frequency. It helps to provide assurance that there is effective oversight of activities and performance, and that outcomes will be achieved on time. In addition, the use of SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) objectives helps to ensure the achievement of measurable objectives within agreed timeframes.

There is extensive reporting on the 35 Change Programmes contained within Thrive Edinburgh's Commissioning Plan to relevant officers. This includes quarterly and 6-monthly activity reports, annual reports on individual change programmes, and a Living Well summary report (which included statistics for the period 2019-2022, including personal goals attainment scoring, quality of life measures, and user feedback).

In addition, annual summary reports on the change programme work have been provided to EIJB's Performance and Delivery Committee. However, there is no regular and detailed reporting on individual change programmes to committee.

Although there is a Performance Monitoring Framework in place for the EHSCP, a formal framework for monitoring delivery of overall outcomes has not yet been established for the Thrive Edinburgh roadmap.

In addition, review of the Commissioning Plan notes that while it states key activities to perform, it did not include measurable targets or timeframes and, as such, objectives are not SMART.

Management advised that, in the initial stages of the roadmap and commissioning plan, performance baselines and targets were unclear but as delivery has progressed, they will be able to set baselines and targets to support monitoring of key indicators.

A governance structure for Thrive Edinburgh was stated in the Thrive Progress Update in February 2024. This includes committees such as the Clinical and Care Governance (CCG) Committee which last received a report on Thrive in 2020. It is noted the CCG Committee has not met since December 2023.

Risks

- **Strategic Delivery –** senior officers and members may not be aware of key performance issues and decisions required resulting in delays to service delivery
- **Financial and Budget Management** - the Council / EHSCP may not achieve best value from contracted services
- **Regulatory and Legislative compliance** - limited assurance that service providers meet regulatory and legislative requirements
- **Service Delivery** - service providers may not provide contracted and required levels of service.

Recommendations and Management Action Plan: Performance Reporting and Monitoring

Ref.	Recommendation	Agreed Management Action	Acton Owner	Lead Officers	Timeframe
2.1	A performance monitoring framework should be developed for the Thrive Roadmap and Commissioning Plan, which sets out what measures will be reported, to where and what	Finalise the Performance Monitoring Framework reflecting the refreshed Thrive Commissioning Plan and associated roadmap and sign off from the Strategic	Chief Officer, EHSCP	Strategic Programme Manager (Thrive Edinburgh), and	01/10/2025

	frequency. This should include SMART (specific, measurable, achievable, relevant and timebound) performance measures and outcomes to demonstrate progress with baselines and targets to enable comparison against actual and planned performance. The framework should be approved by a relevant governance forum who will be responsible for oversight of performance.	Planning Group and Performance and Delivery Committee.		Head of Service (Mental Health)	
2.2	The governance structure for Thrive should be reviewed and updated. Specifically, the committees which should have oversight of the work should be documented as well as lead officers.	Review and update the governance arrangements for the current commissioning plan for thrive. Review the governance arrangements once the refreshed commission plan for thrive is agreed.	Chief Officer, EHSCP	Head of Service (Mental Health) and Strategic Programme Manager (Thrive Edinburgh)	31/12/2024 01/10/2025

Finding 3 – Workforce Planning

Finding Rating	Medium Priority

Workforce planning is essential to ensure the EHSCP has a skilled and capable workforce to deliver strategic priorities and to meet changing needs. The EIJB has a 2022-2025 Workforce Strategy which outlines the 'vision, intent and strategic objectives for health and social care in Edinburgh'.

There are the 35 change programmes contained within Thrive Edinburgh's Commissioning Plan, and at the time of audit fieldwork a workforce plan for mental health services had not been developed. Management advised that a review of the structure of services is currently underway which is inclusive of the EIJB Medium Term Financial Savings Plan and following this workforce planning aligned to the 35 change programmes will be developed. More recently EHSCP have been advised by the Scottish Government that additional money available to support the recruitment of Mental Health Officers will cease at the end of March 2024 placing further pressure on our capacity to improve and develop services.

Risks

- **Strategic Delivery –** strategic outcomes may not be achieved if there are insufficient resources to deliver services
- **Regulatory and Legislative compliance** – lack of resources could result in breaching regulatory and legislative compliance
- **Workforce** – given the projected growth and demand within Edinburgh, existing financial challenges will not allow for an increase in resource and will place additional pressures on the workforce.

Recommendations and Management Action Plan: Workforce Planning

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
3.1	Following completion of the structure review, a workforce plan for Thrive Edinburgh should be developed which reflects the roadmap and change programmes. The workforce plan should be approved by senior management and a relevant governance forum with progress towards delivery of the plan monitored periodically.	Develop workforce plan reflecting the priorities of the refreshed Commissioning Plan / roadmap and present to the relevant governance forum.	Chief Officer, EHSCP	Head of Service (Mental Health)	01/10/2025

Finding Rating	Medium Priority

Finding 4 – Quality Assurance and Lessons Learned

A Quality Assurance (QA) Framework reflects a strong commitment to evidence-based decision making and continuous improvement. The EHSCP currently uses the Clinical and Care Governance Framework for QA reviews of mental health. Management have advised that this is currently under review to develop a consistent approach to QA and practice audits across localities.

Management have also advised that targeted audits have been performed to determine whether the change programmes have been effective. However, a QA plan to ensure that the effectiveness of all relevant change programmes has not yet been developed.

There are groups within the EHSCP that meet to discuss progress on improvement activities, including within Mental Health Services. However, there is currently no process to communicate lessons learned more widely or to provide details of complaint resolution consistently across localities. Management acknowledges improvements are needed on how information is cascaded to staff to ensure improve practice and provide consistent and clear messaging.

Management advised that they contribute to briefings provided to COSLA, but they do not receive feedback in response to this and so are unaware if the feedback influences recommendations or decisions made.

Risks

- **Financial and Budget Management** – lack of financial oversight may result in overspend
- **Regulatory and Legislative compliance** – the Council / EHSCP may not meet the statutory requirements
- **Governance and Decision Making** – senior management and members may not have oversight of the delivery of the service
- **Reputational Risk** – reputational damage if services do not provide the required service to citizens.

Recommendations and Management Action Plan: Quality Assurance and Lessons Learned

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
4.1	The revised EHSCP Quality Assurance Framework should be utilised to review the effectiveness of Thrive Edinburgh services. A quality assurance plan should be developed which sets out what areas will be reviewed, when they will be reviewed, and which governance forum will receive reporting on results of QA activity and at what frequency.	A quarterly professional governance and operational performance/assurance plan for Thrive will be developed.	Chief Officer, EHSCP	Head of Service (Mental Health)	31/06/2025

	Actions from QA activity should be recorded and progress in addressing any required actions monitored.				
4.2	A lessons learned process and a supporting communications approach should be developed, for example, through use of template emails with bullet points or through provision of briefings so the information cascaded is consistent.	A lesson learned process and communications plan will be developed and implemented to ensure consistent information is cascaded.	Chief Officer, EHSCP	Strategic Programme Manager (Thrive Edinburgh)	31/12/2024
4.3	The EHSCP should request feedback on information briefings provided by Thrive Edinburgh to COSLA to understand key decisions made and to support service delivery and improvement.	The Chief Officer / Operations Manager will engage with Strategy and Insight and Vice Chair of the EIJB to seek feedback on the discussion held at COSLA.	Chief Officer, EHSCP	Strategic Programme Manager (Thrive Edinburgh)	31/10/2024

Finding 5 – Risk Management Arrangements

Finding Rating	Low Priority

Risk management enables risks to EHSCP or service objectives to be identified, recorded, and managed. This provides greater assurance that objectives are achieved on an ongoing basis.

Although the EHSCP and the four localities have risk registers in place, none of them include risks relating to Thrive Edinburgh as a whole or its change programmes.

Management have advised that they are aware risk registers need to be developed further and that further guidance for staff inputting to the risk registers would be beneficial.

An operational risk was identified in relation to key-person dependency, as all 6 workstreams are chaired by one officer, the Strategic Programme Manager (Thrive Edinburgh).

Risks

- **Governance and Decision Making -** risks are not effectively identified, recorded, and managed which could affect the achievement of objectives and ineffective oversight
- **Service Delivery -** colleagues are unaware of risks impacting service delivery, reducing the likelihood that service objectives are achieved.

Recommendations and Management Action Plan: Risk Management Arrangements

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
5.1	A review of risks related to Thrive Edinburgh should be undertaken, and risks identified should be recorded within the EHSCP and locality risk registers. This should include statements on the risks, the impact and likelihood, mitigating actions, timescales, and responsible officers. Specifically, the responsibility for chairing each of the 6 workstreams should be reviewed to reduce key-person dependency. The risk register should be regularly provided to relevant committees and groups for review.	Risk register for the current Thrive commissioning plan will be implemented and reported to the appropriate governance groups.	Chief Officer, EHSCP	Head of Service (Mental Health) and Strategic Programme Manager (Thrive Edinburgh)	31/12/2024
5.2	The EHSCP should engage with the Council's Corporate risk management team to arrange training for officers who complete and update risk registers.	There will be engagement with appropriate teams to ensure that officers have received risk management training.		Head of Service (Mental Health) and Strategic Programme Manager (Thrive Edinburgh)	31/12/2024

Appendix 1 – Control Assessment and Assurance Definitions

Control Assessment Rating		Control Design Adequacy	Control Operation Effectiveness
Well managed		Well-structured design efficiently achieves fit-for purpose control objectives	Controls consistently applied and operating at optimum level of effectiveness.
Generally Satisfactory		Sound design achieves control objectives	Controls consistently applied
Some Improvement Opportunity		Design is generally sound, with some opportunity to introduce control improvements	Conformance generally sound, with some opportunity to enhance level of conformance
Major Improvement Opportunity		Design is not optimum and may put control objectives at risk	Non-conformance may put control objectives at risk
Control Not Tested	**N/A**	Not applicable for control design assessments	Control not tested, either due to ineffective design or due to design only audit

Overall Assurance Ratings	
Substantial Assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.
Reasonable Assurance	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.
Limited Assurance	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.
No Assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.

Finding Priority Ratings	
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.
Low Priority	An issue that results in a small impact to the achievement of objectives in the area audited.
Medium Priority	An issue that results in a moderate impact to the achievement of objectives in the area audited.
High Priority	An issue that results in a severe impact to the achievement of objectives in the area audited.
Critical Priority	An issue that results in a critical impact to the achievement of objectives in the area audited. The issue needs to be resolved as a matter of urgency.

Appendix 2 – Audit Areas and Control Objectives

Audit Area	Control Objectives
Strategy for Mental Health	The EHSCP has a clearly established strategy for delivery of mental health services which is aligned with the priorities set out in the Scottish Government Mental Health and Wellbeing Strategy.
Performance	There are clearly established mechanisms for monitoring and reporting on mental health performance data and outcomes to support service delivery and development, and for accurate and timely reporting to national bodies as required.
Resource and Capacity Planning	Resourcing requirements to deliver effective mental health services are regularly evaluated and action taken to ensure adequate capacity to meet needs.
Quality Assurance	A clearly established quality assurance framework is in place to assess quality of mental health services delivered, which includes an embedded approach to lessons learned from both practice reviews and inspection reports from the Mental Welfare Commission and other relevant national bodies such as Audit Scotland.
Governance and Oversight	There are clearly established and robust governance and oversight arrangements in place for mental health services, including a governance forum responsible for review and scrutiny of delivery of overall strategy aims and service delivery, with regular reporting on performance, resources, quality assurance and external body reviews.
Risk Management	Risks related to Mental Health Services are identified, recorded, and managed within a service risk register, and regularly reviewed to ensure appropriate mitigating actions are in place and remain effective, with escalation to divisional and directorate level risk committees where required.

Final Internal Audit Report

Housing Void Management

07 May 2024

PL2307

Overall Assessment	Reasonable Assurance

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This Internal Audit review is conducted for the City of Edinburgh Council under the auspices of the 2023/24 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2023. 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 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.

Overall Assessment	Reasonable Assurance

Executive Summary

Overall opinion and summary of findings

The housing pressures on the Council as declared in the Housing Emergency are recognised. Officers have taken steps to improve performance with a number of key actions identified to reduce the number of void properties, re-let times, and increase the number of re-lets.

Current performance is not in line with the projected target of reducing the void rate to 3% by 31 October 2024, as reported to the Housing Homelessness and Fair Works Committee in October 23. The target was developed based on the projected 80 new monthly voids per month, however voids during this period have been circa 100 per month. Management have revised the target timeline to 31 March 2025. The following opportunities to strengthen operational controls and increase efficiencies in the void management process have been identified:

- Documenting procedures for the Empty Homes process and for performance reporting and regulatory reporting including reviewing information provided by other teams such as finance.
- Reviewing the key controls within the Empty Homes void end to end process to ensure they enable efficient operations and minimise delays while retaining a full audit trail of progress, including mandatory pre and post inspection checks, additional works authorisation and electronic evidence to support key stages of the process (where feasible).
- Manual documentation should clearly evidence that a mandatory check has been completed and all relevant documents/emails should be stored in an accessible location.
- Categories used for performance reporting should be reviewed to clearly reflect the current position of the property, including which team the keys are currently sitting with.
- Quality Assurance checks of the key controls within the Empty Homes Void process should be embedded into the Housing Operations Quality Assurance process. Actions raised as part of the quality assurance process should be prioritised in terms of risk.

Areas of good practice identified

- Relevant void management process information is provided via the Council's website and by officers as required
- Empty Homes Improvement plans are tracked, have clear key actions, and include responsible owners, and expected completion dates
- Void properties are regularly discussed at various levels of management, including:
    - Homelessness Incident Management Team
    - Void Weekly Decision Logs
    - Weekly Void Summary Reports which are reported to the Chief Executive, Council Leader, and Executive Director.
    - discussion at relevant Leaders Meetings - though it is understood that this is now completed via email.

It is also acknowledged that there was a change in management of the Empty Homes process in March 2023 and the structure of the team is currently part of the ongoing Housing Review. In addition, it is recognised that the Empty Homes process is currently undergoing a number of ongoing improvements as part of the Empty Homes Improvement Plan and the proposed introduction of a new IT module called ‘Connect’ which is proposed to go ‘Live’ in June 2024.

Audit Assessment

See Appendix 1 for Control Assessment and Assurance Definitions

Audit Area	Control Design	Control Operation	Findings	Priority Rating
1. Policies and Procedures	●	●	Finding 1 – Policies and Procedures	Medium Priority
			Finding 2 – Training Assessment of Needs/Matrix	Low Priority
2. Quality and Health and Safety Checks	●	●	Finding 3 – Void Process Key Controls	Medium Priority
			Finding 4 – Quality Assurance	Medium Priority
3. Improvement and Governance	●	●	Finding 5 – Management Information	Medium Priority
			Finding 6 – Performance and Improvement	Medium Priority

Management Response to Executive Summary

We welcome the findings of the audit. Reducing the number of void Council homes to the stretching target of 3% by 31 March 2025 is an absolute priority for the service and management is committed to strengthening processes to help achieve this target. Lack of quality data and systems functionality to support the end-to-end process of voids management has been a significant factor in the difficulties the service has experienced in managing voids and these issues are recognised through a number of findings in the audit. Work is underway, along with colleagues in ICT, to identify and implement improvements that can be made in this area. A further workshop is being held in May 2024 drawing together managers and team leaders from across the service who are involved in the management of voids to walk through the end-to-end process, identify barriers and opportunities for improvement. Establishing quality controls for voids will be a key priority in the development of a new Quality Management System. This will be progressed by a new Quality Assurance team to be established as part of the Housing and Homelessness Service Review.

Background and scope

As at 31 March 2023, the City of Edinburgh Council (the Council) owned 20,658 social housing properties across the city that are let to tenants in line with the Council's letting policy.

Before a tenant moves into their new home, the Council must carry out all repairs according to the Edinburgh Standard of Let (the Council's Lettable Standard) and ensure all services such as electricity and gas where provided are safe to be turned on. The Council's Lettable standard was reviewed and updated in November 2023.

The Scottish Housing Regulator (SHR) is an independent regulator of social Landlords and the Scottish Social Housing Charter provides the basis for the SHR to assess and report on how well the Council is performing and enables the Council and its stakeholders to identify areas of strong performance and areas for improvement. The Council must report to the SHR through the Annual Return on the Charter (ARC). The table below sets out the three performance measures which are relevant to empty properties and the Council's performance compared to the Scottish average for 2022/23.

ARC Indicator		CEC	Scottish average
17	Percentage of lettable houses that became vacant in the last year	5.87%	N/A
18	Percentage of rent due lost through properties being empty during the last year	2.3%	1.4%
30	Average length of time taken to re-let properties in the last year (days)	107.7	55.6

As at 8 April 2024, there were 1,241 empty properties. This includes 212 properties categorised as 'not for let' due being used as a decant, earmarked for temporary accommodation, disposal, or demolition.

It is recognised that COVID-19 caused significant disruption for the management and relet of empty properties and caused a backlog of empty properties. The Void Project Plan as at September 2023 includes the key actions underway to deliver the void plan and a performance target to reduce voids to a 3% void rate by 31 October 2024 which has been subsequently revised to 31 March 2025.

The Empty Homes repairs service has been subject to annual internal quality management audits carried out by the Housing Compliance team based. The report and findings from the most recent Empty Homes team audit was issued on 5 September 2023.

Housing Operations currently use the NEC Housing, Total Mobile systems, and Empty Homes Database to record and manage Void Housing properties. As part of the Housing Service Improvement Plan the 'Connect' module of Total Mobile module of Total Mobile will be used from June 2024.The Empty Homes process map versions 6 and 7 (updated 14 February 2024) were used to identify and test key controls within this review.

Scope

The objective of this review was to assess the adequacy of design and operating effectiveness of the key controls established to ensure that the Void Housing process (from tenancy termination to return of keys for re-let), is managed effectively and in compliance with relevant housing regulations, standards, and legislation.

Alignment to CLT Risks

- Regulatory and Legislative Compliance
- Health and Safety
- Service Delivery
- Fraud and Serious Organised Crime

Reporting Date

Testing was undertaken between 01 February 24 and 22 March 2024

Our audit work concluded on 11 April 2024 and our findings and opinion are based on the conclusion of our work as at that date.

Findings and Management Action Plan

Finding 1 – Policies and Procedures

Finding Rating	Medium Priority

Testing of the Empty Homes process map highlighted a number of issues in following the process including a lack of evidence of appropriate checks being completed and lack of adequate record keeping. Appendix 3 of this report provides a summary of our testing results. In addition, our review highlighted the following:

a) The first step of the process map notes that keys are obtained from the Team Leader within each Locality, but the walkthrough highlighted that this is not always the case as sometimes, the keys are picked up from Multi-storey Buildings, Housing Officers etc., so the process needs to be updated to reflect this.

b) Inconsistencies in the practice to manage keys were noted across Locality Offices with three offices using logbooks to sign keys in and out to reduce the risk of keys going missing, but the fourth manages this via email.

c) Each of the four Locality Offices use spreadsheets to track the empty property through the Empty Property team process. However, each of the Team Leaders use different colours for different reasons, which carries a key dependency risk, if the Team Leader was absent for a significant period or left the Council. As part of the audit weekly progress meetings IA noted to the Project Manager that it would be beneficial if each of the spreadsheets had a 'key' to explain what each of the colours meant.

d) There is evidence to demonstrate that the Empty Homes process map has been cascaded to Team Leaders who were requested to share the new process map with relevant staff at team meetings. However, no evidence was provided to support that this was done.

While there is a high level process map, there is no documented procedure detailing the tasks to be completed to ensure all relevant officers have a clear understanding of their roles and responsibilities.

The Council's Lettable standard was reviewed and updated in November 2023. Updated Quality Control Officer (QCO) Void Inspection Sheets which included a check between the Standard of Let and the final inspection check were issued to relevant officers in March 2024. The Empty Homes procedures also require updating to ensure that the Empty Homes process is aligned to the lettable standard.

In addition, the last review date for the 'Tenancy Management - Programme Voids - Tenant and Resident Services, Guidance note' is November 2019 and it is noted on the Policy register with a review January 2022 timescale.

Performance information is gathered on a regular basis for a number of forums, however there is no documented process to support performance reporting of the Empty Homes process, and there is no documented process/procedure setting out how the figures reported in the annual SHR return are obtained, including the different roles that are involved, and the different reports/systems used.

Risks

- **Service Delivery –** policies and procedures may not be up to date and may not reflect the current process, and standards. Relevant officers may not understand the required tasks and what is expected of them.

Recommendations and Management Action Plan: Policies and Procedures

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
1.1	A documented procedure which adequately records the end to end Empty Homes process should be developed to provide clear management direction and to support new start induction where required. This procedure document should be aligned to the Council's Lettable standard and this procedure should be communicated to all relevant officers.	A procedure will be documented that records the end to end empty homes process, aligned to the Council's lettable standard. This will be communicated to all relevant officers.	Executive Director of Place	Service Director, Housing and Homelessness Head of Housing Operations	31/10/2024
1.2	The 'Tenancy Management - Programme Voids - Tenant and Resident Services Guidance note should be reviewed.	The guidance note will be reviewed. If required, the note will be revised. A date for its next review will also be set.			31/10/2024
1.3	A documented process to support performance reporting of the Empty Homes process should be implemented to provide clear management direction and to support new start induction where required.	The process that is currently in place to provide performance reporting on voids will be documented. This process will be updated as systems are improved and developed in the future.			31/10/2024
1.4	A documented process/procedure to support how the figures reported in the annual Scottish Housing Regulator (SHR) return are obtained, should be developed to provide clear management direction and to support new start induction where required. The procedure should include the different roles and teams that are involved in the reporting process, and the different reports/systems used. The procedure should also detail checks undertaken to validate the accuracy of the data prior to reporting.	A procedure will be documented ensuring that team roles, responsibilities, systems, and reports entailed in the process are included. The procedure will also include details of the checks that are performed on the data reported. This will be communicated through training of all relevant officers.			31/10/2024

Finding 2 – Training Assessment of Needs/Matrix

Finding Rating	Low Priority

The service area uses Training Needs Assessment (TNA) spreadsheets for the training of Craft Operatives, Quality Control Officers (QCOs) and the Team Leaders. These records should be completed and dated by Officers and should be signed off by the relevant Line Managers. However, there was no evidence of to support that a TNA had been signed off by a manager within the Empty Homes Team.

An overarching Training Matrix is held by the Housing Health and Safety Officer to monitor all Health and Safety Training completed. It was established that this may not be up to date as there is currently a vacant Health and Safety post (since summer 2023) and this post has not been replaced due to the ongoing Housing Review. It was noted that this post is to be embedded under the new structure.

A check of the TNAs showed that Asbestos Awareness Training should be completed annually, and Risk Assessment training should be covered every 3 years. However, a check of the training matrix was completed for the Team Leaders and QCOs whom IA had met with as part of the audit walkthrough process, there was no record for these officers within the spreadsheet for Asbestos Awareness training in 2023 and there was no relevant tab/sheet which covered Risk Assessment Training.

Risks

- **Service Delivery –** officers may not have completed the required mandatory training, within the required timescales and a lack of effective monitoring by the line managers.

Recommendations and Management Action Plan: Training Assessment of Needs/Matrix

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
2.1	Training Needs Assessment spreadsheets should be updated, and completion monitored by relevant officers and line managers on a regular basis. All relevant officers required to complete the required Asbestos Awareness Training and Risk Assessment Training should be requested to complete the training as soon as feasible.	The Training Needs Assessment will be reviewed and updated if required with regular reviews date set. Any out of date Asbestos Awareness and Risk Assessment Training will be completed.	Executive Director of Place	Service Director, Housing and Homelessness Head of Housing Operations	31/10/2024
2.2	The Health and Safety Training Matrix should be updated and maintained on a regular basis	The Health and Safety training matrix spreadsheet will be updated and monitored.			31/10/2024

Finding 3 – Empty Homes Void Process Key Controls

Finding Rating	Medium Priority

A sample of 20 void properties was selected from the 'Locality Voids Report 12 February 2024'. The sample was split to select 10 properties each from the comments field using the sub-headings of 'Voids Team' and 'Ready to Let'.

A sample of properties where the comments were marked as 'ready to let' were chosen, to confirm whether there was evidence of final inspections / final checks being completed for the identified properties.

During the sample testing, it was highlighted that three of the void 'ready to let' homes had been marked as ready to let by entering the 'Actual Key Returned Date' on the Empty Homes Database when the properties had only been transferred to another team and the property was not ready to be re-let. The Project Manager advised that guidance would be issued to address this to the relevant Team Leaders within the Empty Homes Team.

Management advised that the 'ready to let' term was used internally to indicate that keys are passed from the Repairs team to the Locality team and did not mean the property was necessarily ready to be re-let and that these properties are still shown as being a 'Void property' on the Housing NEC system. However, there is no documented guidance which sets this out. Therefore, substantiating the full position of the properties included in the sampling testing proved difficult. A summary of the main testing outcomes can be found within Appendix 3 of this report.

During the audit review, evidence to support why the property had been recorded as a void for a significant period (i.e.> 6 months), had to be obtained from several sources, i.e. Void Inspection sheets, Empty Homes Spreadsheets, and the Empty Homes Database and copy emails. Whilst there was evidence to support the works in the majority of properties sampled, there were significant gaps in the information held and it was not possible to follow a full audit trail of the journey of works / teams to a property for the some of the cases tested, i.e. from the tenancy end date/void date noted within the Locality Voids Report to the tenancy re-let date.

The evidence provided to support the audit sample mainly related to the voids team, but IA were advised that the keys are often passed to a number of different teams prior to and after the keys have been passed to the Empty Homes teams.

In addition, there was no evidence to support that the completed Quality Control Officer (QCO) Void Inspection Sheets inspection checks were aligned to the lettable standard.

Risks

- **Service Delivery –** mandatory checks within the Empty Homes process are not completed or are missed.

Recommendations and Management Action Plan: Empty Homes Void Process Key Controls

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
3.1	Key controls within the Empty Homes void end to end process should be determined and documented. This should include but not be limited to consideration of: • mandatory pre and post inspection checks	As per recommendation 1.1, the Empty Homes procedure will be formally documented. The procedure will include: • mandatory checks with evidence of completion	Executive Director of Place	Service Director, Housing and Homelessness	31/10/2024

	• additional works authorisation • electronic evidence to support key stages of the process (where feasible) • requirement for all manual documentation to clearly evidence that a mandatory check has been completed and • storage of all relevant documents and emails to support the evidence of checks completed/decisions made in an accessible location. The Empty Homes procedure document referred to in finding 1 should clearly document each of the above points.	• how additional works are authorised • where relevant documentation should be stored.		Head of Housing Operations	

Finding 4 – Quality Assurance

Finding Rating	Medium Priority

Prior to October 2023, the Empty Homes repairs service had been subject to annual internal quality management audits conducted by the Housing Compliance team, which were based on the ISO 9001 standard and subject to external assessment.

The service is currently part of a structural review, and it is not known whether a new quality management process will be in place or whether future annual reviews of the Empty Home's repairs process will be undertaken. The date for a future Empty Homes review has not been completed within the Compliance Audit Schedule as the future audit schedule will be developed by the Compliance team once the team is in place.

Management have however advised that Quality Assurance has been included within the proposed new Housing and Homelessness structure.

The following quality assurance issues were also noted:

- testing highlighted a lack of regular quality control checks to ensure that the key controls within the Empty Homes Void Process have been completed and completed accurately, for example, relevant mandatory pre and post inspection checks, appropriate authorisation for completion of works, final inspections/checks vs the Lettable standard.
- findings raised in Compliance Team audit reports were recorded within the ISO Response Tracker but were not prioritised in terms of risk, so therefore there may be a lack of clarity for managers which actions are of higher priority for completion.
- review of Audit Action Meeting Minutes highlighted that the relevant action reference number is not crossed referenced between the ISO action tracker and the relevant meeting minutes, as a result it was challenging to conclude on whether the discussion was considering the risks raised.

Risks

- **Legislative and Regulatory Compliance –** without a robust quality assurance process, non-compliance issues and errors may go undetected
- **Service Delivery –** failure to complete required tasks in line with the Empty Homes process which could lead to misinformation and / or inaccuracies in the property status recorded
- **Service Delivery –** lack of clarity on which improvement actions should take priority.

Recommendations and Management Action Plan: Quality Assurance

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
4.1	Quality Assurance checks of the key controls within the Empty Homes Void process should be embedded into the Housing Operations Quality Assurance process. Assurance checks should include mandatory Health and Safety Checks, appropriate	Quality Assurance checks will be included as part of the Quality Management System that will be developed.	Executive Director of Place	Service Director, Housing and Homelessness	31/01/2025

	authorisation for completion of works, final inspections/checks vs Lettable standard.			Head of Housing Operations	
4.2	Actions raised as part of the quality assurance process should be prioritised in terms of risk to provide clear prioritisation for managers on which actions should be completed first.	Prioritisation of actions will be considered as part of the development of the Quality Management System.			31/01/2025
4.3	Actions raised as part of the quality assurance process should be cross-referenced between the action tracker and the minutes of meetings held ensure progress made is discussed and accurately recorded.	Tracking of actions will be considered as part of the development of the Quality Management System.			31/01/2025

Finding 5 – Management information

Finding Rating	Medium Priority

Housing Operations currently use the NEC Housing, Total Mobile systems, and Empty Homes Database to record and manage Void Housing properties, however, management have advised that the systems "cannot talk to each other" and do not adequately support the tracking of voids, and as a result, obtaining effective management information is difficult. Management have advised that the new Total Mobile Connect model (due to be implemented in June 2024), will address some of the issues identified.

Management also advised that Performance reporting is largely based on a manual process to update relevant fields, i.e. the ready to let status within the comments field within NEC which is used as a 'blunt tool' used to obtain an understanding of the current status of void properties. Performance information is collated by using the 'Weekly Locality Void Report' and is used to provide summary information to relevant Housing Managers, Service Director, Executive Director, the Chief Executive, and the Council Leader.

As noted at Finding 3, discrepancies in the property status was noted with management stating that the 'ready to let' is a term used internally to indicate that keys are passed from the Repairs team to the Locality team and is not meant to show that the property is actually ready to be re-let and that these properties are still shown as being a Void property on the Housing NEC system. However, where properties are recorded within the NEC system as 'ready to let', these are included within the 'Locality Void Report' and therefore included within the weekly performance report figures as 'Repairs complete/to be let' when they are not actually 'ready to let'. Internal Audit requested Housing team about the details of rent loss data, indicator 18 of the annual data return, provided annually to the SHR. Management could not provide those details during the fieldwork stage of the audit as the key staff member was on leave. The key staff member, after their return, have informed that the rent loss data is received from the Council's Finance team, however no independent oversight by Housing Operations could be substantiated to ensure completeness and accuracy of the reported rent loss data.

The Empty Homes Improvement Plan is on the agenda of the Housing Operations Improvement Plan monthly update meetings; however, no minutes are taken for these meetings to support evidence of discussions on progress.

Risks

- **Service Delivery –** management information does not accurately reflect the Void property status.
- **Service Delivery –** Reporting to the Scottish Housing Regulator is inaccurate which could also impact on the Housing Services reputation.
- **Financial and Budget Management** – the Void rent loss figure is inaccurate.

Recommendations and Management Action Plan: Management Information

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
5.1	The sub heading reporting categories used for performance reporting should be reviewed to clearly reflect the current position of the property,	The current manual process of using comments to track the status of voids is an interim process in the absence of adequate tracking and reporting in systems.	Executive Director of Place	Service Director, Housing and Homelessness	31/08/2024

	including which team the keys are currently sitting with.	The use of 'Repairs complete / Ready to Let' as one of those statuses will be reviewed, and if decision is made to change it will be implemented.		Head of Housing Operations	
5.2	Assurance should be obtained from relevant managers involved in the Empty Homes process to support that data used for performance and annual reporting has been accurately recorded, including the correct allocation to relevant codes within relevant housing systems.	Weekly reports are currently in place to support managers to carry out this data validation. In addition, as per recommendation 4.1, Quality Assurance checks will be included as part of the Quality Management System that will be developed to ensure data used for performance and annual reporting has been accurately recorded.			31/01/2025
5.3	Housing Operations management should document the procedure to ensure accurate and complete data reporting to the SHR, to ensure there is no key person dependency. Data reported to the SHR should also be supported with an audit trail.	As per recommendation 1.4, a procedure will be documented ensuring that team roles, responsibilities, systems, and reports entailed in the process are included. The procedure will also include details of the checks that are performed on the data reported. This will be communicated through training of all relevant officers.			31/10/2024
5.4	Minutes and/or action notes should be maintained for the Housing Operations Improvement Plan monthly update meetings.	Action notes will be maintained for the Housing Operations Improvement Plan monthly update meetings			31/08/2024

Finding 6 – Performance and improvement

Finding Rating	Medium Priority

Performance indicators are reported through the Housing Service Improvement Plan (HSIP) which is reported on a six monthly basis to the Housing, Homeless and Fair Work Committee. A weekly void summary is also provided to management detailing numbers by void category.

It is recognised that COVID-19 caused significant disruption for the management and relet of empty properties and caused a backlog of empty properties. The Void Project Plan as at September 2023 set a target of 3% void rate to be achieved by October 2024 (circa 566 properties including those in the 'unable to let' category) with the aim of reducing the number of voids to 986 by March 2024.

In November 2023, the Council declared a Housing Emergency which highlighted Edinburgh had the highest number of households in temporary accommodation in Scotland and a severe shortage of social rented homes with circa 200 bids per property advertised.

As at 8 April 2024, the number of void properties was 1,241, which is 25% higher than the voids plan projected target for this period. The average void length is 555 days, with 543 (44%) properties void for over 1 year. The table below provides a breakdown of the position as at 8 April 2024:

	Total Voids	Average Duration	% of Voids
Under 3 Months	280	43 days	22.6%
3 to 6 Months	196	135 days	15.8%
6 to 12 Months	222	275 days	17.9%
12 to 18 Months	139	448 days	11.2%
18 Months +	404	1303 days	32.6%
Total	**1241**	**555 days**	**100.0%**

The void rent loss of from April to December 2023 was £1,685,233.

Management advised that due to the Housing Emergency the focus since November 2023 has been on turning around shorter-term voids for re-let resulting in a backlog of longer-term voids.

Management have also advised that further work has been done on the voids plan since the report in October 2023. Following further refinement of data, assumptions (increase in new monthly voids from 80 to 100), capacity and actual performance, an update will be provided to the Housing Homelessness and Fair Work Committee on 14 May 2024. Management propose to set a target of voids reduced to 650 by 31 March 2025, an extension of 5 months in reaching the target 3% void rate.

During times of crisis, key controls such as updating policies and procedures, maintaining training and data quality issues can seem less of a priority and can fall by the wayside, however it is important to retain a focus on maintenance of key controls, as getting to the root cause of these issues and ensuring there are effective controls can help increase overall efficiency and effectiveness. Management has advised that this focus will continue to be provided through the Homelessness Incident Management Team.

Risks

- **Strategic Delivery –** Projected Housing void targets are not met resulting in less Empty Homes being available for re-let and an increase in potential loss of income through void rent loss.

Recommendations and Management Action Plan: Performance and improvement

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
6.1	Management should review the findings raised in this report and consider as part of the Voids Plan where there are opportunities for improving efficiencies and cross-team working/handovers. Progress towards meeting the 3% void target should be tracked closely with a focus on improving management information and data accuracy so pressure points are identified promptly, and remedial action taken.	Progress towards meeting the target of 3% is closely monitored through weekly meetings and reports, with opportunities for improvements being identified and implemented.	Executive Director of Place	Service Director, Housing and Homelessness Head of Housing Operations	31/08/2024

Appendix 1 – Control Assessment and Assurance Definitions

Control Assessment Rating		Control Design Adequacy	Control Operation Effectiveness
Well managed	(green)	Well-structured design efficiently achieves fit-for purpose control objectives	Controls consistently applied and operating at optimum level of effectiveness.
Generally Satisfactory	(light green)	Sound design achieves control objectives	Controls consistently applied
Some Improvement Opportunity	(amber)	Design is generally sound, with some opportunity to introduce control improvements	Conformance generally sound, with some opportunity to enhance level of conformance
Major Improvement Opportunity	(red)	Design is not optimum and may put control objectives at risk	Non-conformance may put control objectives at risk
Control Not Tested	**N/A**	Not applicable for control design assessments	Control not tested, either due to ineffective design or due to design only audit

Overall Assurance Ratings	
Substantial Assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.
Reasonable Assurance	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.
Limited Assurance	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.
No Assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.

Finding Priority Ratings	
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.
Low Priority	An issue that results in a small impact to the achievement of objectives in the area audited.
Medium Priority	An issue that results in a moderate impact to the achievement of objectives in the area audited.
High Priority	An issue that results in a severe impact to the achievement of objectives in the area audited.
Critical Priority	An issue that results in a critical impact to the achievement of objectives in the area audited. The issue needs to be resolved as a matter of urgency.

Appendix 2 – Areas of Audit Focus and Control Objectives

Area of Audit Focus	Control Objectives
Policies and Procedures	• Clear and up to date policies and procedures which are aligned to the relevant void management legislation and standards are in place with consistency of approach across each of the localities. • Policies and procedures have been communicated to all relevant staff and appropriate training on the void management process has been provided. • Relevant detailed information on lettable standards (i.e. what property conditions to expect when a property is let out to tenants and when the keys are returned) is provided to tenants via the Council's website and by officers, as required.
Quality and Health and Safety Checks	• Appropriate quality checks and relevant health and safety checks are completed to ensure that the empty property meets relevant legislation, regulations, and standards. • Quality issues and remedial actions identified are tracked, have appropriate timescales for completion and are reported to an appropriate level of management.
Improvement and Governance	• There is effective oversight of the reporting of void management operational performance, including the frequency of reporting, and an escalation process to management which clearly identifies the action taken when expected performance improvements are not being made. • Improvement plans are tracked, have clear key actions, and include responsible owners, expected completion dates, and have appropriate management oversight. • Performance data reported to the SHR on void management is accurate and supported by evidence including the correct allocation to codes within relevant housing systems.
Risk Management	• Risks related to void management are identified, recorded, and managed within a service risk register, and regularly reviewed to ensure appropriate mitigating actions are in place and remain effective, with escalation to divisional and directorate level risk committees where required.

Appendix 3 – Summary of Audit Test Results

In line with the IA terms of reference, the following control objectives were tested through a sample of 20 void properties which were selected from the Locality Voids Report 12Feb 2024 v0.1:

- **Quality and Health and Safety Checks:** - Appropriate quality checks and relevant health and safety checks are completed to ensure that the empty property meets relevant legislation, regulations, and standards.

The selected sample was split to select 10 properties from each of the sub-headings of 'Voids Team' and 'Ready to Let'. The outcomes of sample testing are as follows:

Voids Team Sample Testing:

- 3 out of 10 cases did not have evidence of asbestos checks. IA observed during the process walkthrough that the Quality Control Officers and Team Leaders can complete a check to see if a recent Asbestos check has been completed by checking the AMS (Asbestos Management System) Register to see if an asbestos survey has been done recently. This is completed via their phone. However, testing highlighted that there is nothing recorded to demonstrate that this check has been completed either within the Void Inspection Sheets, the Empty Homes database, or the Team Leaders Empty Homes Spreadsheets.
- 5 out of 10 cases did not have a record of the Needle Stick risk check being completed.
- IA were advised that the current status of the property should be updated within the 'notes column' of the Empty Homes Database, however testing highlighted that 8 out of 10 cases did not have the 'notes' column completed on the database. However, it is acknowledged that there was other evidence such as photos to support the ongoing works was available for 4 of these cases.
- IA were advised that if the keys had been passed to another team for example the dampness team, that this would be recorded within the "Keys Passed to Internal Team" fields within the Empty Homes database. However, testing highlighted that no data had been recorded within the relevant fields within this section of the record for 4 out of the 10 cases and one case had the code "C19" entered, and it was not possible to determine the definition of this code.

Ready to Let Sample:

- 3 of the void 'ready to let' homes had been marked as ready to let by entering the 'Actual Key Returned Date' on the Empty Homes Database when the properties had only been transferred to another team and the property was not actually ready to be re-let.
- 5 out of 10 properties were either not recorded on the Empty Homes Locality spreadsheets or the records were incomplete.
- There is a lack of consistency for definitions of different colours used within the individual Team Leaders Empty Homes spreadsheets, therefore, a consistent approach should be taken, or a key included to explain what each of the colours mean on their individual spreadsheets.

- There were no inspection sheets for 2 of the properties and for a further 2 properties it was not clear whether it was an initial inspection or post work inspection which had been completed.
- It was not possible to establish whether the asbestos check had been completed on three of the properties as the check had not been recorded as having taken place and for a further 3 properties, there was evidence to support that 'asbestos aware' but again it was unclear whether the asbestos check had been completed as this not been recorded as such.
- Within 4 of the properties there was nothing recorded to demonstrate that a final inspection check of the property had been completed.
- The Empty Homes process map includes a step to note that the final inspection sheet should be issued via email to issued Empty Homes Team Leaders, Business Support, and Locality Housing Team Leaders but there were no copy emails available to support that this task had been done in 7 of the cases tested.
- There was no evidence for the approval of additional works in one of the cases tested.

Internal Audit Report

Governance, Risk and Best Value Committee Self-assessment and skills evaluation

13 May 2024

MIS2301

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This Internal Audit review is conducted for the City of Edinburgh Council under the auspices of the 2023/24 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2023. 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 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.

Summary of assessment

This was the first self-assessment of the Council's current Governance, Risk and Best Value Committee (GRBV) in line with the 2022 CIPFA Audit Committee guidance. Therefore, a number of improvement actions were identified across each of the three areas included in the review: good practice self-assessment, skills evaluation and committee terms of reference.

1) Good practice self-assessment

GRBV member scoring suggests potential for improvement and consideration is required across the following areas:

- enabling report recommendations and committee referrals to achieve greater traction with Executive Committees and senior officers to ensure increased scrutiny and improved performance, including a review of current referral procedures, a clear approach to making amendments on the day of committee, and effective monitoring of outstanding actions
- strengthening the agenda planning meeting process, including reviewing timings to ensure that a member from each political group can attend, and using this forum as an opportunity for members to request further information to support their scrutiny role
- agreeing how the committee can evaluate how it adds value to the Council, including considering frequency of further self-evaluation exercises, periodic performance reporting, and ways to seek external feedback on committee performance
- ensuring a specific skills assessment for the GRBV Convenor is programmed to be completed on a periodic basis
- developing an action plan to collate areas of weakness identified by members and to track improvement actions agreed.

2) Knowledge and skills self-evaluation

GRBV member scoring indicates a good level of understanding across the range of expected topics. The following core area was identified as a priority training area - improving core knowledge of specialist topics including:

- options appraisals, essentials of procurement, whole life costing, transformation, and NHS Finance.

Members identified a range of further areas where training and information would be beneficial, and it was noted that reviewing the requirements for newer members should be considered as a priority to bring them up to the level of more experienced members.

Feedback from members will be used by Committee Services and lead officers of core areas to develop a forward training programme which will support the requirements identified by members, including the appropriate delivery models together with timescales for provision of this learning.

Members also recognise it is important to consider the skills mix across the Committee and to identify any gaps in core knowledge which may help inform appointment of future members, where appropriate.

3) Review of the current GRBV terms of reference (TOR)

Internal Audit's review in line with CIPFA guidance and member feedback identified a number of suggested improvements to provide greater clarity as to the role and functions of the committee. Members agreed a future workshop to review and agree these suggestions with Committee Services would be beneficial.

Areas of strength

Although a review of GRBV Effectiveness was undertaken in 2021, this was the first time the Council's current GRBV Committee had completed a self-assessment and skills evaluation in line with the 2022 CIPFA Audit Committee guidance. The current committee term commenced in August 2022, with the appointment of two new members to the Committee in August 2023.

While no area demonstrated full compliance with the CIPFA good practice self-assessment (see Appendix 1 for summary of scoring), the exercise demonstrates a high level of understanding of the role of the Committee and determination from all members to strengthen the value the GRBV Committee provides to the Council.

The following areas of strength were highlighted:

- **purpose and governance**: members have a good understanding of the role and purpose of the Committee and acknowledge that, while the current terms of reference covers core areas, there is opportunity to strengthen this
- **functions of the committee:** committee considered the core areas of their remit to largely be covered over the past year, and welcome the opportunity for regular engagement with external and internal audit, risk management and other functions of the Council such as finance, performance, and procurement
- **membership and support:** there is a broad range of in-depth specialist knowledge, experience and soft skills held by Committee members across the board
- **effectiveness of the committee:** meetings are effective, with a good balance between scrutiny and challenge and active discussion and engagement
- **knowledge and skills**: high average scores were noted for a wide range of areas including:
    - governance structures of the Council
    - committee purpose and role
    - role in monitoring internal audit arrangements
    - the role and functions of the external auditor
    - risk management
    - values of good governance (principles of public life, members and staff code of conduct and whistleblowing arrangements)
    - all soft skills assessed (strategic thinking, effective scrutiny, focus on improvement, practicality, and objectivity).

Background and approach

The 2023/24 Internal Audit work programme included facilitation of a self-evaluation and skills assessment for the Council's Governance, Risk and Best Value Committee (GRBV) in line with relevant Chartered Institute of Public Finance and Accountancy (CIPFA) guidance.

In October 2022, CIPFA published 'Audit Committees: Practical Guidance for Local Authorities and Police', which includes information on 'Self-Assessment of Good Practice' and 'Evaluating the impact and effectiveness of the Audit Committee'. The guidance also includes a Position Statement which sets out roles and responsibilities and good practice principles for Audit Committees. Relevant resources from this guidance have been provided to all GRBV members.

CIPFA expects that all local government bodies make their best efforts to adopt the principles, aiming for effective Audit Committee arrangements.

Where an Audit Committee has a high degree of performance against the good practice principles outlined, it is an indicator that the Committee is soundly based and has in place a knowledgeable membership. These are the essential factors in developing an effective Audit Committee.

Approach

The following approach was applied to the review:

- completion of a two-part survey by all GRBV members including a self-assessment aligned to good practice and a self-evaluation aligned to the key areas of the CIPFA knowledge and skills framework:
    - the self-assessment included 25 questions aligned to the purpose, function, membership, support and effectiveness of the committee.
    - the self-evaluation considered 18 knowledge areas which members scored themselves on a scale of 1 to 5. Members were asked to provide examples to support their self-evaluation and they were also asked to comment on any current and future learning requirements identified for these areas.
- review of the current GRBV Committee remit and Terms of Reference in line with CIPFA guidance
- review of a summary of responses with the GRBV Committee at a workshop to discuss and agree improvement actions
- preparation of a summary report of outcomes, highlighting key areas of strength and skills gaps identified together with a forward action plan of recommendations which aim to support development of the GRBV Committee work programme and training plans.

Alignment to CLT Risks

- Governance and Decision Making - inability of management and elected members to effectively manage and scrutinise performance and take appropriate strategic and operational decisions.

Reporting Date

The surveys were completed by members between July to November 2023. Outcomes were reviewed by Internal Audit during December 2023, and a workshop was held with GRBV members on 30 April 2024 to discuss outcomes and agree priorities.

The final outcomes and improvement actions were reported to Committee in June 2024.

Section 1: GRBV Good Practice Self-assessment

The good practice self-assessment exercise provided a high-level review that incorporated the key CIPFA principles for Audit Committees. Where a scrutiny committee has a high degree of conformance against the good practice principles, it is an indicator that the committee is soundly based and has in place a knowledgeable membership. It is recommended that a regular self-assessment is used to inform the Committee's work programme and training plans.

The self-assessment included 25 questions aligned to the purpose, function, membership, support, and effectiveness of the Committee. Members were asked to score each question as Yes, No or Partial, and then asked to provide reasons or suggestions for improvement for any area they considered to be not fully compliant.

Answers provided by 9 members were weighted and assigned a score according to the extent of compliance and improvement needed in each area. Scores ranged from 5 for any areas identified as fully compliant to a score of 0 for any area demonstrating significant non-compliance. The total score was 59 out of a maximum possible score of 125. Two newer members were not required to complete the self-assessment.

Outcomes of Assessment

A total of 25 improvements were identified (3 significant, 10 moderate and 12 minor), however many are linked to either other self-assessment areas, to the skills evaluation or to the review of the terms of reference. A summary of self-assessment scoring is provided in Appendix 1.

A workshop was held with GRBV members on 30 April 2024 to discuss outcomes and to agree priority areas for development. Discussion with members highlighted recognition that a regular self-assessment in line with good practice such as CIPFA's guidance for Audit Committees is beneficial however, it is important to consider this in the context of the role and structure of the scrutiny committee for a large council.

Through member discussion at the workshop there was agreement that not all areas in the self-assessment will be given focus and priority. The following priority areas were agreed:

1. The referral process both from GRBV to Executive Committees and vice versa needs strengthened. Members agreed there is a need to be clear on what GRBV expects a receiving committee to do when a referral is made to ensure the purpose does not get lost. Similarly, clear instruction is required for papers referred to GRBV. Referral reports need to be specific and reference point being referred and supporting discussion in webcast and be clear on what the ask of the Committee is.
2. Standing orders should be strengthened to support effective scrutiny through structured use of amendments on the day of Committee. Members agreed that, where required, time should be taken during the meeting to agree amendment or referral wording to ensure clarity on the request.
3. The GRBV Agenda Planning Meeting (APM) could be more effective to enable members to request further information to support their scrutiny role in advance of the final papers being issued for the Committee meeting. Members also requested that the timing of APM be reviewed to enable more members to attend, as there was a clash with other meetings for some members.
4. Members considered annual performance reporting on the work of GRBV Committee. Members were clear this should add value and not be a tick box exercise. A mid-term report detailing work in line with remit, training and ongoing issues/concerns was considered to be of value.
5. Members agreed that annually would not be appropriate frequency for future self-assessment exercises with a preference for every 2.5 years to align with the beginning and middle of the Council term.
6. Although ad-hoc meetings had taken place, it was agreed an annual meeting between external and internal audit and the Committee would be added to the work programme. This could be part of an existing meeting.

Section 2: Knowledge and Skills Self-evaluation

The knowledge and skills self-evaluation aims to guide members on their training needs and support the evaluation of the overall knowledge and skills of the Committee. The assessment was based on the CIPFA knowledge and skills framework for Audit Committee members, with some additional topics added based on local partnership arrangements and on any other core topics included in the current GRBV Terms of Reference.

CIPFA acknowledges that there is a range of knowledge and experience that members can bring to a committee that will enable it to perform effectively. No one committee member is expected to be a specialist in all areas, but there are some core areas of knowledge that committee members should acquire which have been identified by this process.

The knowledge and skills self-evaluation included 18 knowledge areas to establish competency in topics including knowledge of the Council, committee, governance, audit functions, risk and controls, financial and treasury management and counter fraud. Specialist knowledge through qualifications and experience, and self-evaluation of proficiency in skills such as strategic thinking, scrutiny and objectivity were also established.

Outcomes of the self-evaluation

The knowledge and skills self-evaluation was completed by all 11 GRBV members. A RAG status was applied to 50 responses for the 18 knowledge areas assessed (average scores of 4 or 5 = **green**, 3 = **amber** and 1 or 2 = **red**). This scoring was used to highlight priority and moderate areas of improvement, as well as areas of strength.

GRBV member scoring indicates a good level of understanding across the range of expected topics with 5 priority training areas, 28 moderate areas of improvement and 17 areas of strength identified. A summary of the knowledge and skills self-evaluation and forward training programme is included in Appendix 2.

The following priority training areas, which relate to improving core knowledge of specialist topics include:

- options appraisals
- essentials of procurement
- whole life costing
- transformation
- NHS Finance

It was also noted that the newer members would benefit from further learning in some of the moderate areas and areas of strength and therefore a review of their requirements should be undertaken to align them with other members.

Feedback from members on training requirements and preferences for delivery modes/frequency will be used by Committee Services and lead officers of core areas to develop a forward training programme which will support the requirements identified by members over the next 12 months.

Members also considered the mix of skills across the Committee and noted areas where there may be reliance on the expertise of one member, for example technology. Members agreed to be aware of the skills mix across the Committee and to ensure any gaps in core knowledge are identified and used to inform future training programmes and appointment of future members, where appropriate.

Section 3: Committee Remit and Terms of Reference

CIPFA's guidance for audit committees includes a suggested Terms of Reference (TOR) for local authority Audit Committees. As part of this exercise Internal Audit review the current GRBV TOR in line with this guidance to establish if any improvements could be made to the TOR or to the wider governance guidance available to Council members.

In addition, Internal Audit reviewed coverage of the current GRBV TOR in line with member self-assessment feedback specific to this document.

Outcomes of Review

A number of suggested improvement actions for the TOR or provision of information to GRBV members were identified through this exercise. The results of this review and suggested improvement actions were discussed with the Head of Democracy, Governance & Resilience to ensure that proposals were practical and in line with wider governance arrangements in place.

Suggested improvements were also shared with GRBV members, and it was agreed at the workshop on 30 April 2024 that a further workshop would be arranged to specifically consider the suggested improvements ahead of the next review of the GRBV TOR.

Suggested improvements in line with CIPFA guidance include:

- **governance and statement of purpose**: setting out the Committee's position in the Council's governance structure within the Council website committee pages and adding a detailed statement of purpose to the TOR
- **governance, risk, and control**:
  - linking the TOR to relevant codes, frameworks and supporting guidance, such as the CIPFA good governance framework and financial management code, and the local code of governance
  - including more detail on the type or limitations of scrutiny activity for topics outlined, and naming and outlining any reviews done for significant partnerships
- **governance reporting**: referencing and including a requirement for annual review of the Council's annual governance statement within the TOR and Committee work programme
- **financial reporting**: including reference to financial reporting, and considering the categories which should be subject to scrutiny
- **assurance, internal and external audit arrangements**:
  - specifically set out consideration of the Council's assurance framework within the TOR
  - consider adding further detail of external audit arrangements or linking to their engagement letter if included here.
  - reference and link to the detail of internal audit arrangements set out in the internal audit charter.
- **accountability arrangements**: as set out in section 1, consider publishing an annual report for GRBV Committee covering CIFPA recommended practice.

Appendix 1: GRBV Good Practice Self-Assessment Summary

This self-assessment provides a high-level review that incorporates the key CIPFA principles for Audit Committees.

Where an audit committee has a high degree of performance against the good practice principles, it is an indicator that the committee is soundly based and has in place a knowledgeable membership. CIPFA consider these to be the essential factors in developing an effective scrutiny committee.

Through completion of a regular self-assessments, committees should aim to increase their total score and number of fully compliant areas.

Key	Does not comply	Partially complies and extent of improvement needed			Fully complies	Total Score
Improvement Rating	Major	Significant	Moderate	Minor	N/A	Maximum possible score: 125
Weighting of answers	0	1	2	3	5	
GRBV Scoring	Nil / **Total: 0**	Three/ **Total: 3**	Ten/ **Total: 20**	12/ **Total: 36**	Nil / **Total: 0**	**Total Score:** 59

	CIPFA Good Practice Questions	Member ratings	Score
Audit committee purpose and governance			
1	Committee members have a good understanding of the role and purpose of the GRBV committee.	Yes: 7 of 9 Partial: 2 of 9 No: n/a	**Minor: 3**
2	GRBV committee escalates issues and concerns promptly to Full Council and executive committees when necessary.	Yes: 6 of 9 Partial: 2 of 9 No: 1 of 9	**Minor: 3**
3	GRBV committee reports its performance at least annually to the main committee – benefits of this	Yes: 6 of 9 Partial: n/a No: 2 of 9 Unsure: 1	**Minor: 3**
4	Members understand the GRBV committee Terms of Reference, and it covers the following core areas: • Governance arrangements • Risk management arrangement • Internal control arrangements (including financial management, value for money, ethics & standards, counter fraud & corruption) • Annual governance statement • Financial reporting • Assurance framework • Internal audit • External audit	Yes: 8 of 9 Partial: 1 of 9 No: n/a	**Minor: 3**

CIPFA Good Practice Questions		Member ratings	Score
Functions of the Committee			
5	GRBV committee adequately considered the areas above over the last year	Yes: 7 of 9 Partial: 2 of 9 No: n/a	**Minor: 3**
6	GRBV committee has only considered agenda items that align with its core functions or selected wider functions over the last year	Yes: 4 of 9 Partial: 2 of 9 No: 2 of 9 [1 nil response]	**Moderate: 2**
7	Any areas that the GRBV committee does not cover that are expected by members	**Minor: 3** Yes: 1 of 9 Partial: n/a No: 7 of 9 [1 nil response]	**Minor: 3**
8	GRBV committee should meet privately with the external auditors and Head of Internal Audit at least once a year.	**Minor: 3** Yes: 7 of 9 Partial: n/a No: n/a Unsure: 1 [1 nil response]	**Minor: 3**
Membership and Support			
9	The size of GRBV committee is appropriate, and has an appropriate use of substitutes	Yes: 7 of 9 Partial: n/a No: 1 of 9 [1 nil response]	**Minor: 3**
10	There is an appropriate balance of appointed members to ensure that the committee is knowledgeable and skilled	Yes: 6 of 9 Partial: n/a No: 3 of 9	**Moderate: 2**
11	An evaluation of member knowledge, skills and training needs has been undertaken in the last two years ** Scoring reflects this review*	Yes: 4 of 9 Partial: n/a No: 5 of 9	**Moderate: 2**
12	The Convener had a specific skills assessment for their role in the last two years – **convener only**	No: 1 of 1	**Moderate: 2 now complete**
13	Regular training and support arrangements are in place covering the areas set out in the 2022 guidance	Yes: 7 of 9 Partial: n/a No: 2 of 9	**Minor: 3**
14	There is a satisfactory level of knowledge across the GRBV committee membership as set out in the 2022 guidance	Yes: 7 of 9 Partial: n/a No: 2 of 9	**Minor: 3**
15	There is adequate secretariat and administrative support provided to the GRBV committee	Yes: 8 of 9 Partial: 1 of 9 No: n/a	**Minor: 3**
16	GRBV committee has good working relations with key people and organisations, including external audit,	Yes: 6 of 9	**Moderate: 2**

	CIPFA Good Practice Questions	Member ratings	Score
	internal audit and the relevant Chief Officers such as the Chief Executive, Chief Finance Officer and Executive Directors	Partial: 3 of 9 No: n/a	
Effectiveness of the committee			
17	GRBV committee has sought feedback on its performance from those interacting with the committee or relying on its work	Yes: n/a Partial: n/a No: 9 of 9	**Moderate: 2**
	Seeking feedback would be beneficial in assessing the overall effectiveness of the committee	Yes: 5 of 9 Partial: n/a No: 3 of 9 Unsure: 1	
18	Meetings are well chaired, ensuring key agenda items are addressed with a focus on improvement	Yes: 6 of 9 Partial: 3 of 9 No: n/a	**Moderate: 2**
19	Meetings are effective with a good level of discussion and engagement from all the members	Yes: 7 of 9 Partial: 2 of 9 No: n/a	**Minor: 3**
20	GRBV committee maintains a non-political approach to discussions throughout	Yes: 1 of 9 Partial: 5 of 9 No: 3 of 9	**Moderate: 2**
21	GRBV committee adequately engages with a sufficiently wide range of leaders and managers, including discussion of audit findings, risks and action plans with the responsible officers	Yes: 4 of 9 Partial: 4 of 9 No: 1 of 9	**Moderate: 2**
22	GRBV committee fulfils its role to make recommendations for the improvement of governance, risk and control arrangements	Yes: 5 of 9 Partial: 3 of 9 No: 1 of 9	**Moderate: 2**
23	GRBV committee recommendations and referrals achieve sufficient traction with senior officers and executive committees	Yes: 3 of 9 Partial: 4 of 9 No: 2 of 9	**Major: 1**
24	Would it be beneficial for GRBV committee to evaluate whether it has added value to the organisation	Yes: 8 of 9 Partial: n/a No: 1 of 9	**Major: 1**
25	Do GRBV members feel the committee has areas of weakness	Yes: 7 of 9 Partial: n/a No: 1 of 9 [1 nil response]	**Major: 1**

Appendix 2: GRBV skills assessment and training action plan

The skills assessment covered the CIPFA 18 core areas and considered the current GRBV Terms of Reference and was issued to all 11 GRBV members. A RAG status was applied to responses (average scores of 4 or 5 green, 3 amber and 1 or 2 red).

Priority and moderate areas of improvement as well as areas of strength are detailed below together with an action plan for suggested training. A programme of training to develop these areas over the next 12 months will be developed with Committee Services and lead officers for each of the areas.

Priority areas for improvement			
Section	**Core knowledge areas requiring focus**	**Training and delivery preference**	**Timescale**
Section 12. Other Key areas:	• options appraisals • essentials of procurement • whole life costing • transformation • NHS Finance	Committee services and lead areas will arrange learning for these areas. ***Members preference is learning supplemented by written guidance.***	**31 December 2024**
Moderate areas for improvement			
Section	**Core knowledge areas requiring focus**	**Training and delivery preference**	**Timescale**
Section 1. Organisational Knowledge - Corporate Governance, Roles and Relationships	• Service and subsidiaries performance, council values, business plan and objectives for councillors	Performance workshop has been arranged and will include update on Council values; how this is being progressed, measured, and monitored. Annual operational objectives session to be arranged for GRBV members. ***Hybrid workshop supplemented by reference documents***	**30 May 2024**
Section 3. Governance	• knowledge of CIPFA/SOLACE principles • annual governance statements • local code of governance	Awareness session with links to key guidance ***Online module / self-directed learning, supplemented by reference documents***	**30 June 2025**
Section 4. Internal Audit	• Public Sector IA Standards • IA Plan, Charter and annual opinions • Head of Internal Audit role	IA specific workshops to be delivered to cover this, linking to the publication of the new IA Global Standards which take effect from January 2025 ***Hybrid workshop supplemented by reference documents***	**30 November 2024**
Section 5. The Control Environment	• essential elements of the Council's control environment • GRBV's role in monitoring the control environment	Workshop with IA, risk, finance, governance, and other key areas to be arranged – linkage to assurance mapping currently in development. ***Hybrid workshop supplemented by reference documents***	**31 December 2024**

Section 6: Financial Management and Accounting	• preparation of financial statements • principles of the *CIPFA Financial Management Code* and level of compliance • Chief Finance Officer (Section 95) role • GRBV's role in financial monitoring of the Council and its subsidiaries	Review training provided at start of term to ensure it covers the development areas, re-run training as refresher. Cover the boundary and responsibilities between the role of F&R and GRBV / the difference between scrutiny at F&R and scrutiny at GRBV. Develop an annual accounts training package supported by an online module covering the basics. Consider as mandatory for GRBV (and F&R members). ***Online module / self-directed learning, supplemented by reference documents***	**30 June 2025**
Section 7: External Audit	• key external audit reports and assurances provided • most recent audit plan and opinion reports • appointment of auditors and quality assurance arrangements • GRBV's role in monitoring external audit and other inspections	Arrange session with Audit Scotland to cover key points. ***Hybrid workshop supplemented by reference documents***	**31 December 2024**
Section 8. Risk Management	• Risk management policy and strategy • Council's risk maturity and areas for improvement • GRBV's role in monitoring the effectiveness of the Council's risk management arrangements	Risk management workshop was held on 22 April 2024. A further workshop to be arranged as required. ***Hybrid workshop supplemented by reference documents***	**31 March 2025**
Section 9. Counter Fraud	• main areas of fraud and corruption risk the Council is exposed to • knowledge of the *CIPFA Code of Practice on Managing the Risk of Fraud and Corruption* • the Council's arrangements for tackling fraud	Develop session covering this with linkages to counter fraud team and annual reporting etc. Provide details on the Council wide Fraud and SOC group and systems used ***Online session supplemented by reference documents***	**30 June 2025**
Section 11. Treasury Management	• regulatory requirements • treasury risks • the Council's treasury management strategy • the Council's policies and procedures in relation to treasury management	Arrange session covering the key points and include context on changing markets and world financial outlook ***Online session supplemented by reference documents***	**30 June 2025**
Section 12. Other key areas	• understanding of local government finance • overview of business planning • understanding of EIJB governance • understanding of good governance in partnerships	Re-run session for newer members and as refresher for current members. Include specific coverage of EIJB including governance and interaction between CEC NHSL and NHS Finance. ***Online session supplemented by reference documents***	**30 June 2025**

Areas of strength			
Section	**Core knowledge and skill area**	**Training and delivery preference**	**Timescale**
Section 1. Organisational Knowledge - Corporate Governance, Roles, and Relationships	• knowledge of Council structure and decision-making processes	Re-run session for newer members and as refresher for current members. Link to EIJB points at Section 12 (amber).	**30 June 2025**
Section 2. GRBV Committee Role and Functions	• knowledge of the purpose and role of the GRBV committee	Re-run session for newer members and as refresher for current members. Include guidance on what actions can be taken by a scrutiny committee where a report needs changed – parameters, best practice and guidance.	**30 June 2025**
Section 4. Internal Audit	• GRBV's role in monitoring the effectiveness of the Council's internal audit and inspection arrangements	Will be covered in IA session to be arranged.	**30 November 2024**
Section 6: Financial Management and Accounting	• understanding of the principal financial risks the Council faces	Re-run session for newer members and as refresher for current members.	**30 June 2025**
Section 7: External Audit	• the role and functions of the external auditor and current auditors	Will be covered in external audit session to be arranged.	**31 December 2024**
Section 8. Risk Management	• principles of risk management, including linkage to good governance and decision-making	To be covered in future risk management workshop.	**31 March 2025**
Section 10. Values of Good Governance	• the Seven Principles of Public Life • Council's key arrangements to uphold ethical standards (e.g. Code of Conduct) • the Council's whistleblowing arrangements • GRBV's role in scrutiny of whistleblowing monitoring and investigation outcome reports	Re-circulate guidance document from the Governance team which is provided at the start of the Council term, which includes links to the SG / standards commission code of conduct – this sets out the key principles.	**30 June 2024**
Section 14. Strategic Thinking and Understanding of Materiality	• focusing on material issues and overall position, rather than being side-tracked by detail	Sections 14 – 18: Future session on these topics to be considered.	**30 June 2025**

Section 15. Effective Scrutiny: Questioning and Constructive Challenge	• understanding of the principles and approaches to effective scrutiny • frame questions that draw out relevant facts and explanations • challenge performance and seek explanations while avoiding hostility or grandstanding		
Section 16. Focus on Improvement	• clear plan of action and allocation of responsibility		
Section 17. Able to Balance Practicality against Theory	• ability to understand the practical implications of recommendations, to understand how they might work in practice		
Section 18. Objectivity	• ability to evaluate information on the basis of evidence presented and avoiding bias or subjectivity		
Section 19. Meeting Management Skills (Convener Only)	• ability to chair GRBV meetings effectively, including summarising issues raised, ensuring all participants are able to contribute and focusing on the outcome and actions from meetings	Area of strength for current Convener – provide further support as needed.	**n/a**

Appendix 5 – ALEOs - Internal control assurance arrangements

ALEO	Internal Audit Provider	Frequency of Audits	Audit Programme	No of Audits	Governance Forum	Tracking actions	Independent IA Yes/No	Summary
EICC	None	N/A	N/A	N/A	N/A	N/A	**No**	No formal and independent internal audit arrangements in place. An Audit & Risk Committee is in place with their remit to review, on behalf of the board, the effectiveness of the system of internal control on an annual basis. Other sub-committees to the board are also established (Remuneration Committee as an example). The Executive advised they continuously review internal controls within the organisation and they have created a culture where everyone has the ability to challenge and make continuous improvement.
Capital City Partnership	In-house reviews	Quarterly	No - quarterly checks and balances on KPIs and outcomes	All major funded programmes	Council (performance measures only)	No	**No**	No formal and independent internal audit arrangements in place. Work includes quarterly checks and balances on KPIs on programmes. No auditing of governance, risk and controls.
Capital Theatres	None	N/A	N/A	N/A	N/A	N/A	**No**	The Audit & Risk committee meets twice a year and an internal control report is reviewed at this meeting. This is then reported to the Board at the next relevant meeting. No audits performed.
Transport for Edinburgh	None	N/A	N/A	N/A	N/A	N/A	**No**	No formal and independent internal audit arrangements in place. Controls testing of equipment and assets in place. Annual assurance statement completed and submitted to Place Directorate.
Edinburgh Trams	Internal reviews	Year Round	Yes - Inter Department Audit Plan	Not specified	Light Rail Peer Review Group Audit & Risk Committee Board	Yes	**No**	Internal audit process that includes: - Light Rail Peer Review Group - Inter Department Audit Plan - Directors' system walkouts All of which are agreed annually by the Board, with progress checked periodically by ETL Audit & Risk Committee. The review covers equipment, policies, and procedures. Annual assurance statement completed and submitted to Place Directorate.
Lothian Buses	BDO LLP	Year Round	Yes	5	Lothian Buses Audit and Risk Committee	Yes	**Yes**	Formal audit plan in place with external provider. Five audits per year plus a follow-up audit. Reports to the Audit and Risk Committee 4 times per year.
Edinburgh Leisure	In-house reviews	Year Round	Timetable based on risk score	30	Audit & Risk Board Sub-Committee	Partially - issues picked up via reporting lines	**No**	Annual in-house audit timetable of venues/departments based on risk score. However, no formal and independent internal audit arrangements in place, reviews are completed in house. Reported to Audit and Risk Board Sub-Committee three times per year.