Transport and Environment Committee

10.00am, Monday 18th November 2024

Internal Audit: Audit outcomes June to October 2024 – referral from the Governance, Risk and Best Value Committee

Executive/routine

Wards

1. For Decision/Action

The Governance, Risk and Best Value Committee has referred the Internal Audit: Audit outcomes June to October 2024 to consider future monitoring of the implementation of management actions.

Dr Deborah Smart
Executive Director of Corporate Services

Contact: Taylor Ward, Committee Officer
Legal and Assurance Division, Corporate Services Directorate

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Referral Report

Internal Audit: Audit outcomes June to October 2024 – referral from the Governance, Risk and Best Value Committee

2. Terms of Referral

2.1 On 31 October 2024, the Governance, Risk and Best Value Committee considered a report which provided an update on the outcomes of the 2024/25 Internal Audits completed between 5 June to 2 October 2024.

2.2 The Governance, Risk and Best Value Committee agreed:

1) To review the outcomes of the 2024/25 internal audits completed between 5 June to 2 October 2024 and management action plans to address the recommendations made.

2) To note the key thematic issues raised across the findings from audits completed during this period.

3) To note that management actions for the Directorate Cyber Incident Response audit completed in May 2024 had now been agreed.

Security Arrangements for Council Premises

4) To note that management response had not yet been provided and the deadline for this was the 31 March 2025.

5) To note with concern the lack of training and support for duty holders, and the lack of central reporting and recording when incidents occurred.

6) To note with further concern that there was no formal process allocating spend when security assets reached end of life.

7) To agree that the management actions must provide a detailed and robust plan for budgetary responsibility and prioritising spend to ensure security of buildings, using improved incident data to inform the decision-making process.

Safety of Council Operated Heavy Goods Vehicles

8) To note that limited assurance could be provided to confirm that HGV drivers and operational services consistently met the compliance requirements as required in line with the Council's driving policy.

9) To agree to refer the report by the Head of Internal Audit to the Transport and Environment Committee and recommends that they consider future

monitoring of the implementation of management actions, specifically including:

9.1) The Driving for Council Policy was updated and presented to Committee in 2025/26.

9.2) Monitoring the establishment of the performance monitoring framework.

9.3) Monitoring the reintroduction of Driver Assessor Training and the restoration of ongoing completion of Certificate of Professional Competence (CPC) Training spaced over a five year period.

9.4) Monitoring the improved use of the functionality of the fleet systems to reduce risk and increase compliance.

9.5) Monitoring the introduction of safety standards for new vehicles.

9.6) Monitoring the introduction of the in-cab system with improved safety standards.

9.7) Monitoring the process for improved incident and complaint monitoring, and ensuring that the data collected was used effectively to improve safety outcomes.

9.8) Monitoring improved risk management processes.

10) To agree to refer this audit to Policy and Sustainability Committee for consideration of Management Action 5.4 on the recommendation regarding drug and alcohol consumption while driving.

11) To recommend that the Policy and Sustainability Committee hold an engagement session with HR, Internal Audit, the department and the Trade Unions to discuss the findings from the audit and to consider other options.

4. Background Reading/ External References

4.1 Governance, Risk and Best Value Committee – 31 October 2024 – Webcast

4.2 Governance, Risk and Best Value Committee of 31 October 2024

5. Appendices

Appendix 1 – Internal Audit: Audit outcomes June to October 2024

Governance, Risk and Best Value Committee

10.00am, Tuesday, 31 October 2024

Internal Audit: Audit outcomes June to October 2024

Executive/routine
Wards

1. Recommendations

1.1 It is recommended that the Committee:

1.1.1. reviews the outcomes of 2024/25 internal audits completed during between 5 June to 2 October 2024 and management action plans to address the recommendations made

1.1.2. note the key thematic issues raised across the findings from audits completed during the period

1.1.3. notes that management actions for the Directorates Cyber Incident Response audit completed in May 2024 have now been agreed and a copy of the report is presented for review.

Laura Calder
Head of Internal Audit
Legal and Assurance, Corporate Services Directorate
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Report

Internal Audit: Audit outcomes June to October 2024

2. Executive Summary

2.1 This report provides an update to Committee on the outcomes of the 2024/25 Internal Audits completed between 5 June to 2 October 2024.

2.2 A total of 11 audits have been completed for the Council with the following overall engagement opinions: Limited Assurance - 3 audits, Reasonable Assurance - 5 audits, Substantial Assurance - 2 audits, and 1 Advisory review.

2.3 A total of 45 findings were raised across the 11 audits completed (14 High, 19 Medium, 10 Low and 2 Advisory). Details of management action plans, and timescales for addressing the risks associated with audit findings are provided within each audit report.

2.4 In line with current scrutiny arrangements, 6 audits with a limited assurance overall outcome or high rated findings are automatically presented to Committee for review and scrutiny,

2.5 As the audit of Early Years Cross Boundary Places was completed at the specific request of the Committee, this audit report is also presented for scrutiny.

2.6 Members have also requested that a further two reports which have an overall outcome of Reasonable Assurance or Substantial Assurance with no high rated findings raised be presented for scrutiny.

2.7 Audits completed during the period highlight a number of key thematic issues which should be considered by management and the Committee, to ensure the root cause of the issues raised is addressed.

2.8 A copy of the audit report for the Directorates Cyber Incident Response audit completed in May 2024 with management actions agreed with management on 3 October 2024, is presented to Committee at Appendix 3 for review.

3. Background

3.1 The 2024/25 Internal Audit (IA) plan was approved by the Governance, Risk and Best Value Committee (GRBV) in March 2024, and updated in May 2024 to include two further audits as requested by Full Council in March 2024.

3.2 Following the June 2024 Committee, the Convenor of GRBV requested that a report which specifically covers audit outcomes only, be provided to future meetings to enable sufficient focus on scrutiny of completed audits.

3.3 Separate reports on IA activity and directorate performance in implementing agreed management actions from previous audits are provided as further agenda items for this Committee.

3.4 Key issues raised across the recommendations from audits completed are tracked and reported to management and Committee for consideration of thematic or systemic improvements required.

3.5 An audit of Directorates Cyber Incident Response was completed in May 2024 as part of the 2023/24 IA Plan. A phased implementation approach where actions would be developed with oversight of the Cyber Resilience Board was agreed to enable development of consistent and appropriate management actions.

4. Main report

4.1 A total of 11 Council audits from the 2024/25 IA plan have been completed between 5 June to 2 October 2024. The outcomes of these audits with the overall engagement opinions is provided in the table below:

Rating	Audit
Limited Assurance	• Security for Council Premises • Safety of Council HGVs • Partnership Working
Reasonable Assurance with high rated findings	• Transfer of the Management Development Funding • Social Care Direct • Educational Support Provision
Reasonable Assurance with no high rated findings	• Port Facility Security Plan • Non-contracted Spend and Waivers
Substantial Assurance	• Early Years Cross Boundary Places • Voters Photo ID
Advisory	• City Deal Managing Cost Inflation

4.2 A total of 45 findings were raised across the 11 audits completed (14 High, 19 Medium, 10 Low and 2 Advisory). Details of management action plans, and timescales for addressing the risks associated with audit findings are provided within each audit report

4.3 Audits with a limited assurance outcome or high rated findings are automatically presented to Committee for review and scrutiny.

4.4 As the audit of Early Years Cross Boundary Places was completed at the specific request of the Committee, this report is also presented for scrutiny.

4.5 Members have also requested that the following reports be presented for scrutiny:

- City Deal Cost Inflation
- Non-contracted spend and waivers

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

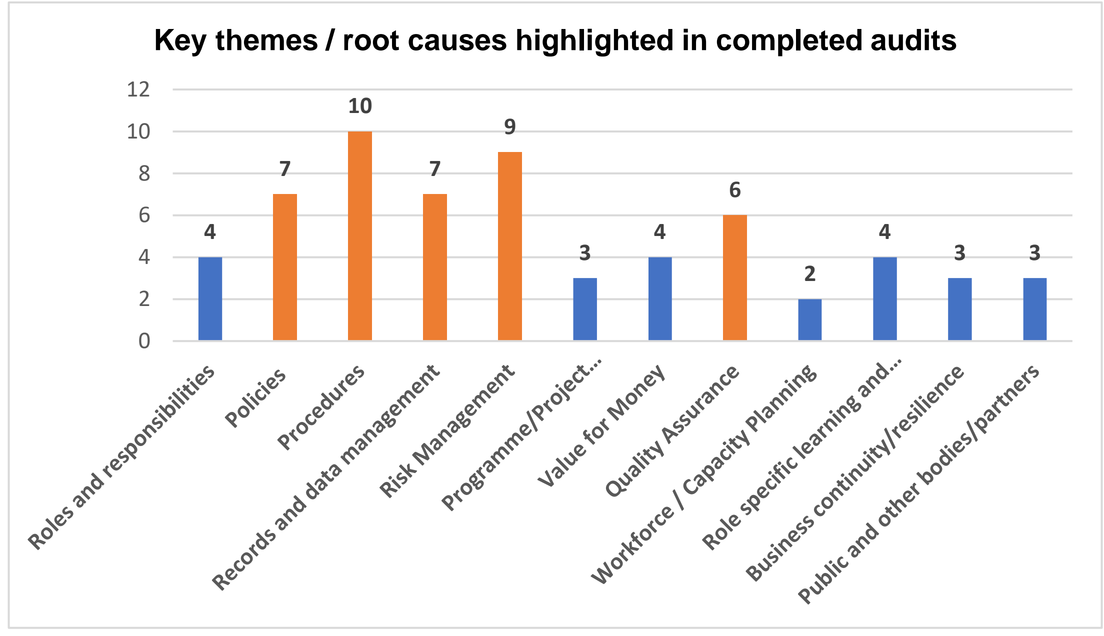
Root cause and thematic areas for improvement

4.7 Key thematic areas for improvement were highlighted in the 11 audits completed between 5 June to 2 October 2024. It is important that management reviews these to treat the root cause and prevent issues reoccurring rather than merely the fixing the individual instances identified.

4.8 The top 5 key thematic areas where issues were raised relate to:

- Procedures
- Risk Management
- Policies
- Records and data management
- Quality Assurance

4.9 The number of instances a key theme was raised is provided in the chart below and summary of all key themes raised across each of the completed audits is provided in Appendix 1.



Directorates Cyber Incident Response audit

4.10 An audit of Directorates Cyber Incident Response was completed in May 2024 as part of the 2023/24 IA Plan. A phased implementation approach with oversight from

the Cyber Resilience Board was agreed to enable development of consistent and appropriate management actions. A copy of the updated audit report with management actions and timescales agreed with management on 3 October is presented to Committee for review at Appendix 3.

4.11 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.

5. Next Steps

5.1 Progress of delivery 2024/25 IA plan and audit outcomes will be reported quarterly to the Committee with the next report scheduled for January 2025.

5.2 Implementation of agreed management actions from completed audits by services are tracked by IA, and all overdue actions reported to the Committee quarterly with the next report scheduled for January 2025.

6. Financial impacts

6.1 Costs for delivery of audits are within the agreed budget.

6.2 Services should consider the potential cost impacts associated with audit recommendations and key thematic issues, including potential savings from inefficiencies identified.

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 Internal Audit 2024/25 Annual Plan – approved by GRBV March 2024, and updated May 2024

11. Appendices

11.1 Appendix 1 – Key themes raised across Internal Audits

11.2 Appendix 2 – Internal Audit Reports for scrutiny:

- Security for Council Premises
- Safety of Council HGVs
- Partnership Working
- Transfer of the Management Development Funding
- Social Care Direct (Adult Services)
- Educational Support Provision
- Early Years Cross Boundary Places
- City Deal Cost Inflation
- Non-contracted spend and waivers

11.3 Appendix 3 – B-Agenda: Directorates Cyber Incident Response Audit Report with agreed management actions

Appendix 1 – Key themes raised across Internal Audits

The table below provides a summary of the key themes raised across the audits completed between 5 June to 2 October 2024; it should be noted that more than one key theme may be raised from an audit recommendation.

Key theme	Summary
Roles and responsibilities **Raised across 4 audits**	Roles and responsibilities for **building security** including duty holders are not clearly documented and understood. No service level agreement or monitoring arrangements are in place for the two teams responsible for providing **Social Care Direct** adult services. A lack of clarity or understanding by security provider operatives of some aspects outlined in the **Port Facility Security Plan** was noted and responsibility for operational risk management is not clearly understood. Specific roles and responsibilities for **partnership working** are not defined and there is no documentation to confirm partner organisations' compliance / agreement with aspects of duties including Edinburgh Partnership Local Outcome Improvement Plan and Locality Improvement Plans.
Policies **Raised across 7 audits**	There is no overall Council strategy for managing **non-contracted spend and waivers**. The approach to **building security** is not documented in a policy document (or included within another policy). The **Driving for the Council** policy was approved 5 years ago and is outdated with a review required to confirm aligned to current practice. There is no strategy clearly outlining approach and roles and responsibilities for managing **City Deal Cost Inflation**. The Eligibility Criteria Policy which directs the **Social Care Direct service** has not been updated since 2015 and is not applied consistently. An Integrated Impact Assessment was not performed to identify any equality, environmental, or economic impacts of the decision on **Education Support Provision.** The **Early Years Delivery Plan** 2024-27 should be reviewed every two years and include clear version control.
Procedures **Raised across 10 audits**	Directorate approaches to managing **non-contracted spend and waivers** is required including a process to investigate retrospective waivers and ensuring management oversight of feeder systems. The **Procurement Handbook** should be reviewed to ensure all sections remain valid and helpful to those involved in the procurement process.

Key theme	Summary
	Some procedures for the **Transfer of the Management Development Funding** were incomplete and there are no standard operating procedures documented for Duty Holders or central support teams to ensure **building security.** In addition, no standard operating procedures are documented for **HGV/ Fleet** relating to compliance with the Driving for the Council policy. Current procedures for **Social Care Direct** adult services are not being followed and require updating, and guidance for data input is out of date. There is no formal process in place for the **City Deal** team to consider fraud risks or risk of serious organised crime associated with the delivery of projects. There was no documented programme and supporting templates for the **Port Facility Security** team to record the number security drills, exercises and learning outcomes in accordance with the security plan, as well as a need to ensure the plan is developed and approved in time and operational arrangements such as meetings and training/certifications are clearly understood. The **Partnership Working** governance framework to support Edinburgh Partnership was last discussed at the April 2019 board meeting and requires review. In addition, no tracker is used to ensure that all required actions from the Edinburgh Partnership Board are recorded and tracked to completion and a number of other requirements are not being regularly confirmed/documented. There are no Key Performance Indicators (KPIs) or operational performance reporting in place for **Social Care Direct** adult services**.** The Terms of Reference for the **Strategic Programme Board** should be finalised, and version controls added to document reviews/updated.
Records and data management **Raised across 7 audits**	Incomplete and missing data from Registered Social Landlords was noted for **Transfer of the Management Development Funding.** Three separate systems are used for **HGV safety** related data, but there is no management oversight of reconciliations and minor data quality issues were noted on the systems. Similarly, **Social Care Direct** systems are not linked leading to incomplete and inaccurate data with input errors found. Formal records were not maintained for **Port Facility Security** drills and exercises and document retention processes did not align to those stated in the security plan. Information held on the **Edinburgh Partnership** website was out of date. Staff training records for **UK Parliamentary Elections – Voter Photo ID** were incomplete and did not match the list of staff who worked on polling day. There is no central procedure or system to centrally record and manage **Building Security** incidents.

Key theme	Summary
Risk Management **Raised across 9 audits**	The risks associated with feeder systems, specifically related to **non-contracted spend and waivers** should be noted in directorate risk registers. A **Partnership Working** risk register is required to capture Edinburgh Partnership risks which may impact on its ability to deliver its objectives, with alignment to the Councils risk management strategy and the Community Strategies team to ensure community planning risks are appropriately captured. **Building security** risks are not identified, recorded or managed at a local or central level, similarly there is no fleet risk register to ensure that **HGV Safety** and driving risks are identified, recorded or managed at local or central level. **Social Care Direct** risk registers are incomplete and require updating, and training on risk management is required for officers. There is no documented approach for managing risks associated with **City Deal Cost Inflation** including wider cost increases, and alignment to the Council's risk management strategy including risk assessments, risk tolerance and risk appetite. There should be a dynamic review of **Port Facility Security** risks with new and emerging risks added at the time that they are identified and progressed until resolved. Additionally, a full review of the health and safety risk assessments for security operations should be undertaken. An assessment of **Education Support Provision** risks should be performed to identify and appropriately manage any risks associated with the transition to the new model of education support provision. The **UK Parliamentary Elections – Voter Photo ID** service risk register should be updated to include all relevant controls and actions to mitigate identified risks, and risk scoring should be reviewed to accurately record current likelihood and impact.
Programme/Project Management **Raised across 3 audits**	**Social Care Direct** operational teams should ensure system requirements related to Social Care Direct services are captured in specification of SWIFT replacement project There was no formal action plan in place for **UK Parliamentary Elections – Voter Photo ID** to address the Electoral Commission's recommendations following May 2023 local elections when photo ID requirements were introduced. The **Strategic Programme Board (SPB)** should ensure evidence of formal approval by the Senior Responsible Office for project proposals is recorded and guidance and templates to support / govern projects are provided on the Orb.
Value for Money **Raised across 4 audits**	Due to a lack of system-based segregation of duties supporting the **Transfer of the Management Development Funding,** system users were able to process payments, note authorisations on behalf of authorisers and then pass requests for payments to Finance colleagues without intervention. While funding can only be provided to Registered Social Landlords, funding budgeted for affordable housing projects could be diluted.

Key theme	Summary
	An approach to **managing cost inflation** and ensuring value for money is required for the City Region Deal. **Non-contracted spend and waivers** for all Council contracts require ongoing monitoring and review to ensure the Council achieves value for money. The eligibility criteria policy for **Social Care Direct** adult services should be consistently applied to ensure consistent decision making and value for money is achieved across all Council localities.
Quality Assurance **Raised across 6 audits**	There is a lack of regular reporting on **non-contracted spend and waivers** to both CLT and the F&R Committee and no monitoring of non-contracted spend/waivers on feeder systems. There are no central quality processes to confirm responsible officer duties for **building security** are being performed. Similarly, there are no central processes to confirm **HGV safety** service compliance with the Driving for the Council policy. Quality Assurance recommendations and actions for **Social Care Direct** are not tracked, and there is no continuous internal QA programme and thematic issues & lessons learned are not communicated. There is no requirement for **City Region Deal** partner organisations to confirm that they have quality monitoring processes in place to alert management where work is not being completed to the agreed standards, or to confirm that all information is complete and accurate. A review of the decision-making process for **Education Support Provision** should be performed to identify lessons learned.
Workforce / Capacity Planning **Raised across 2 audits**	There is no workforce plan to support delivery of **Social Care Direct** services. There are no resource planning procedures in place to ensure that the Edinburgh Partnership has sufficient resources available to support timely and effective **partnership working** and delivery of community planning outcomes and objectives.
Role specific learning and training **Raised across 4 audits**	No training has been provided to duty holders responsible for **building security,** similarly no training has been provided to services or line managers responsible for managing **HGV drivers** specifically. Role specific learning for **Social Care Direct** is not centrally monitored and security provider operative refresher training for some aspects of the **Port Facility Security Plan** is required as well as ensuring training and certification logs are monitored and kept up to date.

Key theme	Summary
Business continuity/resilience **Raised across 3 audits**	The **Building Security** audit raised issues related to ability to respond to emergency security situations. A lack of clarity or understanding by some security provider operatives of some aspects of the **Port Facilities Security Plan** contingency and evacuation protocols and security exercises were highlighted. Limited business continuity/workforce planning arrangements with a reliance on the goodwill of officers to deal with a backlog of **Social Care Direct** referrals was highlighted which may impact service delivery.
Public and other bodies/partners **Raised across 4 audits**	Lack of robust monitoring arrangements for **managing cost inflation** across City Region Deal Partner Organisations was noted. A need to ensure third party security providers are aware of all requirements to support the **Port Facility Security Plan** and that there is timely engagement with the Department of Transport was raised. Instances of incomplete data returns from Registered Social Landlords in receipt of **management development funding** were identified. Due to inadequate record keeping, it is not clear whether Edinburgh Partnership Local Outcome Improvement Plan 2022-2028 was presented to and approved by the governance forums of individual partners supporting **partnership working**.

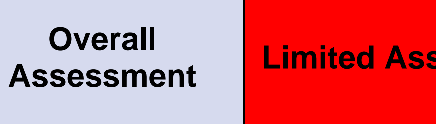
Internal Audit Report

Security Arrangements for Council Premises

Phased Implementation

26 September 2024

CD2406



Contents

Executive Summary 3
Background and scope 4
Findings and Management Action Plan 5
Appendix 1 – Control Assessment and Assurance Definitions 13
Appendix 2 – Areas of Audit Focus and Control Objectives 14

This Internal Audit review was conducted for the City of Edinburgh Council under the auspices of the 2024/25 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2024. 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 have been raised with senior management and elected members as appropriate.

Executive Summary

Overall Assessment	Limited Assurance

Overall opinion and summary of findings

Review of security arrangements for Council premises has highlighted that while there are arrangements in place to manage physical premises security, there are significant design and operating effectiveness gaps in the policies, procedures and controls.

The following improvements are required to effectively manage the security risks faced at individual properties and across the estate:

- policy and procedures should be agreed and documented, and training provided to Duty Holders to ensure they are equipped with the necessary skills and knowledge to perform their duties
- a process to centrally record and monitor security incidents is required to ensure the risk profile across the estate is understood
- actions from reviews performed by the Security Manager should be tracked to ensure issues are addressed
- budgetary responsibility and authorisation for security related works should be agreed
- risks associated with premises security should be identified, recorded, assessed, and managed in line with the Council's Risk Management Framework.

Areas of good practice

- Duty Holders visited during the audit were knowledgeable on the security issues they faced based on historical incidents, outstanding requests/ repairs, and funding barriers
- the list of premises Duty Holders was up to date, with all named responsible officers sampled still in post, and all properties visited had a Duty Holder assigned.

Phased Implementation

Management recognises the need to establish a coordinated and consistent approach to managing security of premises across the Council. A phased implementation approach will be adopted to ensure that detailed management actions which address the findings and recommendations are developed.

Management actions and implementation dates will be provided to Internal Audit by 31 March 2025. Following this, these will be reported to Committee.

Audit Assessment

Audit Area	Control Design	Control Operation	Findings	Priority Rating
1. Policies and procedures for Council premises	Red	N/A	Finding 1 – Security policy, procedures, and training	High Priority
2. Central Security Arrangements for Council premises	Red	Amber	Finding 3 – Security reviews and recommendations	Medium Priority
			Finding 4 – Security budgets	High Priority
3. Local Security Arrangements for Council premises	Red	Amber	Finding 2 – Recording and management of incidents and works	High Priority
4. Risk management	Red	N/A	Finding 5 – Security risk management	High Priority

See Appendix 1 for Control Assessment and Assurance Definitions

Background and scope

The City of Edinburgh Council (the Council) has a duty of care to ensure the security and protection of their communities, employees, public buildings, and assets. Ensuring Council premises are secure is essential to safeguarding the Council from data breaches, emergency incidents, criminal activity, and anti-social behaviours. Security is also essential for the health and safety of both employees and visitors to Council premises.

The Council is responsible for a diverse range of premises with varying ages, conditions, and uses. This requires the security of individual properties to be considered on a case-by-case basis. There are currently no overarching policies and procedures covering security arrangements at Council premises. Additionally, external facilities management contractors are responsible for some security aspects of PPP contracted schools.

The Terrorism (Protection of Premises) draft bill (known as Martyn's Law) which aims to ensure public premises and events are better prepared for, and protected from, terrorist attacks is currently in draft and consultation by the UK Government. This legislation will likely require Council to mitigate the impact of a terrorist attack and reduce harm, by taking steps according to building or event capacity. Following the conclusion of the consultation process, the Government will introduce the Bill to Parliament as soon as parliamentary time allows and it is expected to require a detailed understanding of the current state of security across the Council's estate, as well as new controls to be designed and implemented to ensure the Council meets its statutory obligations once known.

Scope

The objective of this review was to assess the adequacy of design and operating effectiveness of the key controls established to ensure the Council effectively manages physical and building security.

Alignment to Risks and Business Plan Outcomes

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

- Health and Safety (including public safety)
- Regulatory and Legislative Compliance
- Financial and Budget Management
- Property
- Resilience
- People
- Reputational Risk.

Business Plan Outcomes:

- Edinburgh is a cleaner, better maintained city that we can all be proud of.

Limitations of Scope

The following areas were excluded from scope:

- a detailed review of CCTV arrangements
- resilience arrangements
- fire and flood threats.

Reporting Date

Testing was undertaken between 24 June 2024 and 15 August 2024.

Audit work concluded on 15 August 2024, and audit findings and opinion are based on the conclusion of work as at that date.

Findings and Management Action Plan

Finding 1 – Security policy, procedures, and training

Finding Rating	High Priority

The Council's Corporate Property Strategy, approved in August 2023, aims to create a property estate which: is future proofed, leads to operational and resource efficiencies, maximises the use of assets to deliver Council policies, complies with health and safety and other regulatory requirements, and takes a balanced view of costs and benefits in each business case for change, amongst other aims. This presents an opportunity to embed premises security into policies, procedures, and decision making.

The following gaps which may impact the effectiveness of security related policies, procedures, and training have been identified:

Overarching Security Policy

There is no overarching Council security policy setting out the wider roles, responsibilities, budgetary authorities, governance, inter-dependencies, escalation processes, and relevant legislation for colleagues across the Council who are responsible for the physical security of buildings. As a result, the approach to security is siloed, with limited collaborative working between the various teams who are stakeholders in building security.

FM Security Team Policy and Operating Procedures

A draft Security Policy was created by the FM Security Team in line with the requirements of the SLA in October 2021, aimed at defining the roles and responsibilities of the FM Security Team. However, this document was not finalised and approved, and supporting standard operating procedures were not documented.

Duty Holder Procedures

Health and Safety Duty Holders are responsible for undertaking statutory health and safety duties in addition to their normal managerial roles, as well as identifying, assessing, and controlling health, safety and welfare risks under their management. They are also responsible for the security of each premises and designing controls to manage security as it relates to their building.

There are no standard operating procedures or guidance documents available to assist Duty Holders in undertaking their security duties. There is a Health and Safety Duty Holder Guidance document, but this does not refer to security. Missing processes include routine review of the state of physical security at each premises, performing security risk assessments, reporting security incidents, and escalating security concerns.

Duty Holder Training

There is no training provision to inform Duty Holders undertaking their security responsibilities. Basic security training (including free resources where available) should be included in Duty Holder essential learning requirements.

Property and Facilities Management Service Level Agreement (SLA)

The Property and Facilities Management SLA sets out the objectives, services provided, key deliverables and approach to the provision of physical security services by the FM Security Team. However, the current version of the SLA is dated 2018 and therefore may require review to ensure it remains appropriate.

Risks

- **Regulatory and Legislative Compliance –** legal action or fines for failing to protect premises adequately, including breaches in data protection or health and safety legislation
- **Reputational Risk -** adverse publicity resulting from security breaches and incidents
- **Health and Safety (including public safety) -** lack of policy and guidance relating to the security of premises and ensuring adequate consideration of health and safety including public safety
- **People –** insufficient policy and guidance to ensure effective security provision which may result in a negative people impact
- **Property –** lack of clarity of policy and guidance leading to potential impacts to Council colleagues and citizens accessing Council premises.

Recommendations and Management Action Plan: Security policy, procedures, and training

<table>
<tr><th>Ref.</th><th>Recommendation</th><th>Management Response</th></tr>
<tr><td>1.1</td><td>Key stakeholders for building security should be identified, and a Council-wide security policy should be developed, consulted on and approved, outlining:
• the role of building security as it relates to our estate and the stakeholders of Council-owned property
• the responsibilities and requirements of Duty Holders and other stakeholders in ensuring that of our buildings including third party supplier provision and resources
• processes and procedures designed to manage and monitor the security of the operational estate
• links to other relevant policies, procedures, and legislation where appropriate, such as fire and building regulations with relevant internal contacts
• reliance on other key processes such as contract management for school PPP contracts.
The policy should be subject to approval and regular review and held centrally on the Orb for colleague access. Stakeholders should be engaged to ensure they are aware of their role and responsibilities.</td><td rowspan="2">A phased implementation approach will be adopted to ensure that detailed management actions which address the findings and recommendations are developed.
Management actions and implementation dates will be provided to Internal Audit by 31 March 2025.</td></tr>
<tr><td>1.2</td><td>Security procedures for Duty Holders should be documented, approved, and communicated to relevant officers. This should include requirements for designing local controls and where to seek advice, including:
• access controls and key/code management
• CCTV processes and procedures
• staff and visitor management
• boundary and perimeter management
• systems testing e.g. alarms and doors
• fire and theft prevention controls
• fire and emergency plans and protocols that should be in place and be practiced periodically, e.g. evacuation
• deterrent controls such as signage and lighting
• incident reporting
• the procurement of security assets
• security risk assessments and management.
Procedures should be subject to approval and regular review and held centrally on the Orb for colleague access. Stakeholders should be engaged to ensure they are aware of their role and responsibilities.
The Council should also consider combining security roles, responsibilities, and procedures for Duty Holders into the Duty Holder Guidance Document.</td></tr>
</table>

<table>
<tr><td>1.3</td><td>Standard operating procedures for second line functions whose decisions have an impact on premises security should be reviewed/documented to confirm they are aligned with the security policy and supporting procedures. This should include (but not be limited to):
• security procedures for property lets (e.g. hiring of school and other community spaces to public groups for meetings and activities)
• assurance from other partners and groups over the security procedures in place at Council owned properties and events where the Council is a stakeholder (e.g. Community Centres, Facilities Management contractors in schools).
Duty Holders should be made aware of relevant processes and procedures to allow them to develop local controls based on their needs, as well as those of the users of the building, other stakeholders, and any limitations of the building itself.</td><td rowspan="4">A phased implementation approach will be adopted to ensure that detailed management actions which address the findings and recommendations are developed.
Management actions and implementation dates will be provided to Internal Audit by 31 March 2025.</td></tr>
<tr><td>1.4</td><td>Training should be provided to ensure that Duty Holders and relevant support teams have the appropriate skills, knowledge and understanding of processes to help keep our buildings secure.</td></tr>
<tr><td>1.5</td><td>A Council-wide quality assurance process should be designed to review and confirm all relevant teams comply with relevant security policy and procedures, and that required documentation is held to evidence compliance, demonstrate effective governance and decision making, and is available for inspection and audit purposes, where required.</td></tr>
<tr><td>1.6</td><td>The Facilities Management SLA should be reviewed to ensure it remains appropriate for both Facilities Management and the wider Council approach to premises security.</td></tr>
</table>

Finding 2 – Recording and management of incidents and works

Finding Rating	High Priority

Due to the availability of resources and the volume of security incidents across the estate, the FM Security Team is limited in their ability to provide pro-active, and preventative security advice to the highest risk properties. The Council's Security Manager therefore responds on a reactive basis to large volumes of security incidents and requests after being informed an incident has occurred. The effectiveness of this approach relies on sound processes of incident reporting and risk management.

Recording and Managing Incidents

There is no central recording place for security incidents or requests. Various channels are used by duty holders to report incidents; therefore, the FM Security Team rely on other services alerting them of issues. Reporting of incidents currently happens via:

- **The SHE portal** is the Council's current system for reporting health and safety incidents. Depending on the type of incident, it could be recorded on the SHE portal. The portal does not have any categories or sub-categories relating to security incidents and so reporting on a per property basis was not available. The SHE portal is due for replacement in October 2024
- **Significant Occurrence Notification** forms are used within Children, Education and Justice Services as well as the Health and Social Care Partnership, to inform senior management of significant incidents in front-line services. These are not used across other Directorates

Security Incident Reporting

There is no reporting of security incidents or performance data to an oversight group or committee of the Council. As a result, the wider strategy and decision-making process around security obligations, investment and resource allocation may not be fully informed.

Unresolved works potentially impacting security

The Corporate Property Helpdesk is used for general facilities management support requests such as repairs or requests for assistance/advice.

Various control weaknesses were identified in a February 2024 Internal Audit report which affect the helpdesk's ability to track and see requests through to an appropriate resolution in a timely manner.

Site visits identified examples of previously raised security requests which had not been addressed, including:

- faulty access controls on the main entrance of a high-risk premises, reported in June 2024. Works were still outstanding at the time of the audit visit in August 2024
- one boundary wall with a neighbouring residential property which is derelict and has temporary fencing erected. Correspondence showed this was first reported before 2021.
- trees marked for felling for a number of years, but the works not completed, allowing easy access to grounds and damaging outbuildings
- multiple properties with CCTV cameras which were out of order or inadequate for the building's needs.

Risks

- **Financial and Budget Management –** inadequate financial planning and unexpected costs
- **Health and Safety (including public safety) –** risk of theft (including data theft), vandalism, and the compromised safety of employees and visitors.
- **Resilience –** inability to respond appropriately to incidents
- **Service Delivery –** security incidents may disrupt the day-to-day operations of the Council
- **Regulatory and Legislative Compliance –** legal action or fines for failing to protect premises adequately, including breaches in data protection or health and safety legislation
- **Reputational Risk -** adverse publicity resulting from security breaches and incidents.

Recommendations and Management Action Plan: Recording and management of incidents and works

Ref.	Recommendation	Management Response
2.1	A process to centrally capture, record, monitor, and report security incidents and requests should be agreed, including consideration of building into the SHE replacement portal. If this is not feasible, then a consistent Council wide process and supporting controls should be implemented.	A phased implementation approach will be adopted to ensure that detailed management actions which address the findings and recommendations are developed. Management actions and implementation dates will be provided to Internal Audit by 31 March 2025.
2.2	A process to escalate any unresolved security issues should be agreed and implemented. This could link to the new controls arising from the Corporate Property Helpdesk audit report completed in February 2024.	

Finding 3 – Security reviews and recommendations

Finding Rating	Medium Priority

When responding to security incidents or engaging in other projects and programmes, the Council's Security Manager may determine that a security review of the premises is required. A report of outcomes and controls is prepared with recommendations to address any gaps, as well as documenting any risks posed by the building itself which cannot be addressed with additional controls. These are provided to the relevant Duty Holder or Business Manager (e.g. Headteacher, Care Home Manager) to take actions forward.

The reports are informal and lack sufficient detail to understand when and why the review was undertaken and who needs to be involved to resolve any highlighted issues. Management have advised that recommendations are often not progressed due to barriers, including unclear budget responsibility and a lack of available funds for adaptations to the existing estate (see Finding 4).

There is also no process to record, track, and monitor the recommendations made by the Security Manager through to resolution. Residual risks faced by the Council because of the security findings are also not recorded on a relevant risk register for monitoring and tracking (see Finding 5).

Risks

- **Health and Safety (including public safety)** – risk of theft (including data theft), vandalism, and the compromised safety of colleagues and visitors
- **Resilience** – inability to respond appropriately to incidents
- **Service Delivery** – security incidents may disrupt the day-to-day operations of the Council
- **Regulatory and Legislative Compliance** – legal action or fines for failing to protect premises adequately, including breaches in data protection or health and safety legislation
- **Reputational Risk** - adverse publicity resulting from security breaches and incidents.

Recommendations and Management Action Plan: Security reviews and recommendations

Ref.	Recommendation	Management Response
3.1	A report template should be developed to formalise the Premises security reports and ensure consistent and relevant details are reported such as when and why the review was undertaken, and who is the intended recipient and owner of actions raised. Management should also consider circulating reports to all relevant stakeholders.	A phased implementation approach will be adopted to ensure that detailed management actions which address the findings and recommendations are developed. Management actions and implementation dates will be provided to Internal Audit by 31 March 2025.
3.2	A process for monitoring progress towards implementing security recommendations raised in security reviews should be implemented. Any residual risks should be recorded within service and directorate risk registers and managed in line with the Council's Risk Management Framework (see Finding 5).	
3.3	An escalation route for recurring or unmitigated building security risks should be designed and implemented to ensure that relevant senior managers are aware of ongoing security issues.	

Finding 4 – Security budgets

Finding Rating	High Priority

Repairs and Maintenance

Budget responsibility for the maintenance and repair of existing security infrastructure at Council premises lies with Facilities Management's Repairs and Maintenance team, with exception of specific departments such as Housing and Concierge who hold their own repairs and maintenance budget, as well as PPP-contracted schools where the FM contractor is responsible for maintenance and repairs of existing infrastructure.

New security assets and replacement of end-of-life assets

There is no allocated budget for the replacement of end-of-life security assets, or the additional capital expenditure required to enhance security measures in existing buildings.

Additionally, when security works are required, it is currently the Duty Holder who is responsible for obtaining quotes and securing funding to pay for upgrades. As Operational Services do not have a security budget, these works are often unfunded and therefore do not progress.

There is no process to centrally authorise and prioritise security works, or to provide support to implement alternative controls to manage risks where costs are not achievable.

Risks

- **Financial and Budget Management** – inadequate financial planning and unexpected costs
- **Health and Safety (including public safety)** – risk of theft (including data theft), vandalism, and the compromised safety of colleagues and visitors
- **Service Delivery** – security incidents may disrupt the day-to-day operations of the Council
- **Regulatory and Legislative Compliance** – legal action or fines for failing to protect premises adequately, including breaches in data protection or health and safety legislation
- **Reputational Risk** - adverse publicity resulting from security breaches and incidents.

Recommendations and Management Action Plan: Security budgets

Ref.	Recommendation	Management Response
4.1	Budget responsibility for the maintenance, repair, and replacement of existing security infrastructure, as well as responsibility for funding the procurement of security adaptations, should be confirmed and agreed by all stakeholders.	A phased implementation approach will be adopted to ensure that detailed management actions which address the findings and recommendations are developed. Management actions and implementation dates will be provided to Internal Audit by 31 March 2025.
4.2	A process should be implemented to capture all outstanding security works and report these to an appropriate oversight group for prioritisation and authorisation. Prioritisation should be risk-based and in line with an agreed criterion.	

Finding 5 – Security risk management

Finding Rating	High Priority

Physical premises security controls are key to mitigating health and safety, resilience, data security, and business continuity risks. The observations outlined in Findings 1 – 4 present challenges for colleagues across the Council to assess and manage the current level of risk faced across the estate in relation to physical premises security, as well as the effectiveness of security controls as they relate to their individual roles and associated risks. In addition, there is no risk register which captures physical premises security risks for individual premises and the wider estate.

Conflicting legislation can also give rise to conflicting security risks, such as fire legislation requiring exits with pushbuttons at child-friendly heights, which increases the risk of children letting themselves out the building. This places a reliance on manual supervision rather than secondary, physical security controls should a child circumvent supervision. While compliance with other legislation is viewed as equally important, education colleagues faced with this dilemma find it difficult to balance this with the security risks associated with a child potentially letting themselves out the building.

Statutory obligations in relation to premises security are expected to change with the introduction of 'Martyn's Law' which is currently being consulted by the UK Government. The proposed bill will impose requirements on certain premises and events to increase their preparedness for, and protection from terrorist attacks. The Council may be required to take proportionate steps, depending on the size and nature of the activities that take place at each premises. Discussions on the implications of the new bill to the Council are in the early stages including provision of a briefing note to the Chief Executive on the scope of the Bill and proposed recommendations. It is understood that once the legislation is enacted it will be carefully scrutinised, following which a full Council Protect Strategy, with clear actions, will be produced by the Council's Protect Single Point of Contact for consultation and approval.

Risks

- **Financial and Budget Management** – inadequate financial planning and unexpected costs
- **Health and Safety (including public safety) –** risk of theft (including data theft), vandalism, and the compromised safety of employees and visitors
- **Governance and Decision Making** – uninformed decision making around the use of buildings
- **Regulatory and Legislative Compliance –** legal action or fines for failing to protect premises adequately, including breaches in data protection or health and safety legislation.

Recommendations and Management Action Plan: Security risk management

Ref.	Recommendation	Management Response
5.1	Risks associated with individual premises and the estate should be identified, recorded, assessed, and managed in line with the Council's Risk Management Framework. Once known, the risk profile and landscape should be monitored to inform decision-making.	A phased implementation approach will be adopted to ensure that detailed management actions which address the findings and recommendations are developed. Management actions and implementation dates will be provided to Internal Audit by 31 March 2025.
5.2	A process should be implemented to ensure collaboration between teams to find solutions where conflicting risks are identified, and to limit reliance on manual or backup controls.	
5.3	Development of the Council's Protect Strategy should include consideration of risks to security of Council premises with engagement and communication across all key stakeholders.	

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 – Areas of Audit Focus and Control Objectives

Audit Areas	Control Objectives
Policies and procedures for Council premises	• policies and procedures for the security of Council premises are in place and up-to-date and reflect all control objectives stated below, including any relevant legislation.
Central Security Arrangements for Council premises	• the decision-making and governance approach for security of Council premises is robust, with security matters considered in a timely manner, costs are known, and responsibility for implementing actions clearly defined and monitored • regular reviews of Council premises are undertaken to confirm that security arrangements are adequate and aligned with the needs of users of the buildings and relevant legislation • when the security needs of building users change, the required changes, including costs, are determined and approved early in the decision-making process • recommendations on security of Council premises are logged and reviewed by an appropriate senior officer and / or governance forum for oversight, with cost details, associated risks, and alternative measures outlined where appropriate • a methodology has been designed to prioritise security of Council premises works, covering both repairs to existing infrastructure, and the installation of new security measures • the budgets for premises security maintenance and upgrades are clearly stated and assigned to appropriate departments.
Local Security Arrangements for Council premises	• there is a named responsible officer for building security for all individual Council premises, responsible for overseeing and reviewing the adequacy and effectiveness of security arrangements • officers responsible for security of premises have received adequate training and guidance to assist them in undertaking their duties • responsible officers undertake the necessary inspections, assessments, and other duties on a regular basis to ensure the security of their buildings and maintain adequate records of outcomes and actions • checks are performed to confirm that responsible officers have completed all relevant tasks and assessments in relation to building security in line with procedures • a reporting line has been established for all responsible officers to escalate security of premises issues.
Risk management	• risks related to security arrangements for Council premises 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.

Internal Audit Report

Safety of Council Operated Heavy Goods Vehicles (HGVs)

01 October 2024

PL2403

Overall Assessment	Limited Assurance

Contents

Executive Summary 3
Findings and Management Action Plan 6
Appendix 1 – Control Assessment and Assurance Definitions 22
Appendix 2 – Areas of Audit Focus and Control Objectives 23
Appendix 3 – Legislation and Statutes relevant to Driving for the Council 24

This Internal Audit review was conducted for the City of Edinburgh Council under the auspices of an addition to the 2024/25 internal audit plan approved by the Governance, Risk and Best Value Committee in May 2024. 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 have been raised with senior management and elected members as appropriate.

Executive Summary

Overall Assessment	Limited Assurance

Overall opinion and summary of findings

Review of the design and operating effectiveness of the Council's Heavy Goods Vehicles (HGVs) key safety processes and procedures provide limited assurance on the maturity of control environment to manage the driving risks associated with its HGV fleet. Limited assurance can be provided to confirm that HGV drivers and operational services consistently meet the compliance requirements as required in line with the Council's driving policy.

The following key areas for improvement have been identified to enhance HGV safety and compliance with the Council policy and driving legislations:

- Driving for the Council Policy, last reviewed six years ago, requires review and updating to align with the current driving practices; supporting procedures should be designed to comply with policy provisions, with key performance indicators established to monitor driving performance and trends
- minimum safety standards and technological features should be established for Council's HGV fleet, and these should be clearly defined in the Council's HGV procurement/lease programme
- pre-employment health and licence checks for all new and agency drivers must be completed before issuing employment offer letters to ensure optimum use of available resources and minimise service delivery impacts
- a defined process with clear roles and responsibilities should be introduced to ensure consistent management of HGV drivers Certificate of Professional Competence (CPC) and Driver Assessor training
- the functionalities of existing Fleet systems should be fully explored to address compliance risks and gain best value from system investments
- specific procedures and guidance on routes for busy areas and use of telematics should be developed for operational services to ensure policy directives are translated into action
- key themes and root causes from incident investigations and complaints should be systematically analysed and reported to improve management of recurring driving risks
- driving risks should be identified and recorded in the Fleet Services and Operational services risk registers and managed and monitored through the Council's risk management framework.

The Council's insurance providers conducted an external review in August 2021 to assess the Council's policy and arrangements for fleet and driver risk management. The findings of that external review were aligned to the findings noted in this audit report. The external review provided 31 recommendations on Health and Safety policy, responsibilities, culture; driver management; vehicle management; journey planning and risk assessment; and monitoring, incident and claims management.

Discussions with the Council's Insurance Services highlighted that there has been limited engagement with insurers who await a written update to communicate the progress in implementation of these recommendations. As a result, the insurers have scheduled an Operator Licence review due to take place in November 2024 to assess the current compliance levels. The outcome of this review may impact on the Council's fleet insurance premiums and potentially on the continuation/extension of the Council's Fleet Operator's Licence.

Given the safety risks highlighted in this report, Internal Audit has recommended that management reconsider the introduction of alcohol and drug testing. Management is seeking guidance from the Governance, Risk and Best Value Committee on this recommendation, as a previous proposal for testing was declined by the Policy & Sustainability Committee in November 2023, noting that 'drug and alcohol testing would not ever be reviewed unless a motion requesting such a review was passed at full council or there was a legal requirement to do so'.

Audit Assessment

See Appendix 1 for Control Assessment and Assurance Definitions

Audit Area	Control Design	Control Operation	Findings	Priority Rating
1. Policy and Governance			Finding 1 – Driving policy, procedures, and performance monitoring	High Priority
2. Vehicle Safety			Finding 5 – Operational HGV Safety Controls	High Priority
3. Driver Safety		N/A	Finding 2 – Pre-employment driver health and licence checks	High Priority
			Finding 3 – HGV drivers training	Medium Priority
			Finding 4 – Fleet system functionality	Medium Priority
4. Operational Safety		N/A	Finding 5 – Operational HGV Safety Controls	High Priority
5. Risk Management			Finding 6 – Incident and complaint management and monitoring	Medium Priority
			Finding 7 – Risk management	High Priority

N/A - controls not tested due to inadequacy of design

Background and scope

At the Governance, Risk and Best Value (GRBV) meeting held in May 2024, members approved a motion requesting an addition to the 2024/25 audit plan, to include a review of the safety precautions adopted by the Council to ensure safety of the heavy goods vehicle (HGV) fleet, and whether Council employed HGV drivers meet the requirements for driving such vehicles. The motion was in response to a tragic incident within Edinburgh involving a commercial HGV which resulted in the death of a child, and a number of high-profile cases across the country. This audit will be conducted in line with the motion and subsequent discussions held at Full Council, GRBV Committee, and Transport and Environment Committee meetings.

The Council operates around 1,300 fleet assets, of which approximately 210 weigh above 3,500 kg, which are considered HGVs for the purposes of its operator license.

Despite a general downwards trend in the number of reported collisions by Transport Scotland, which publishes annual Scottish Transport Statistics, a number of high-profile HGV collisions have been recorded in Scotland which resulted in serious injury or fatality. These have involved both commercially and publicly owned HGVs. Several safety technologies are available which enhance the operation of HGVs in built-up urban areas, however due to the varying age of the Council's current fleet, not all vehicles have these installed.

The Finance and Resources Committee approved a fleet replacement programme in November 2023 which captured the intended replacement of all truck mounted vehicles operating within the fleet, including refuse collection vehicles.

Scope

The objective of this review was to assess the adequacy of design and operating effectiveness of the key controls established to ensure the Council's HGV fleet is safe for other road users, and that drivers meet all requirements for driving such vehicles.

Alignment to Risks and Business Plan Outcomes

This review provides assurance in relation to the following Corporate Leadership Team (CLT) risks:

- Health and Safety (including public safety)
- People
- Regulatory and Legislative Compliance
- Reputational
- Financial and Budget Management.

Business Plan Outcomes:

- Outcome 13 Improved safety and wellbeing for vulnerable citizens
- Outcome 14 Core services are maintained or improved

Limitations of Scope

The following areas were excluded from scope:

- safety of Council operated vehicles weighing under 3,500 kg
- controls/requirements for drivers of vehicles weighing under 3,500 kg.

Reporting Date

Audit work concluded on 17 September 2024, and the audit findings and opinion are based on the conclusion of our work as at that date.

Findings and Management Action Plan

Finding 1 – Driving policy, procedures and performance monitoring

Finding Rating	High Priority

Policy

The Driving for the Council policy (the policy) was approved by the Finance and Resources Committee in December 2018. It includes a standard statement on review stating that the policy should be reviewed as an when a change is deemed necessary, there are organisational changes, or changes to legislation/government policy.

The policy has not been reviewed since its initial approval in 2018 and Internal Audit's review noted gaps in the policy, as it does not:

- include references to the Driving for the Council - Telematics Policy
- include the Council practice to not allow the drivers to drive under Section 88 of the Road Traffic Act 1988, which allows drivers meeting certain criteria to drive while their renewal application is pending
- reference the Council's priorities and environmental commitments such as the Council Emissions Reduction Plan.

Additionally, audit discussions highlighted that the following provision of the policy is no longer applied as the vehicle suppliers have advised against it:

- Employees who are HGV passengers, will receive basic training on the operation of HGV vehicles, relating to the steering and braking mechanisms of the vehicles.

The audit also highlights an inconsistent approach across services in complying with the provisions of the policy, such as

- responsibility for supervision of the HGV safety checks required to confirm vehicles are safe before they are driven each day
- responsibility for administering HGV driver CPC training (finding 3)
- responsibility for performing HGV driving risk assessments and identifying, recording and managing driving risk (finding 7)
- monitoring of tachograph downloads every 28 days (finding 4).

Procedures

There are no documented Standard Operating Procedures in relation to driving or compliance with the policy for the Fleet Compliance team or operational services.

Performance Monitoring

The policy requires Heads of Services to ensure that there is a system for monitoring driver performance through performance indicators and identify any trends; and Executive Directors and the Chief Executive are required to monitor driver and fleet related incident rates and performance indicators.

Management have confirmed that no performance monitoring procedures and controls have been designed to monitor and report the performance of drivers or fleet services, identify trends and compliance to the policy, and inform decision making.

Risks

- **Financial and Budget Management** – lack of policies and procedures with poor controls leading to increased costs of insurance premiums, decrease in claims defensibility and potentially invalidated insurance policy
- **Health and Safety (including public safety)** – increased risk of incidents for drivers, passengers and other road users
- **People** – unclear roles and inconsistent processes impacting efficiency, accountability, training, and succession planning
- **Regulatory and Legislative Compliance** – potential non-compliance with legislative requirements and the requirements of the Council's HGV Operators Licence.
- **Reputational** – damage to the Council's reputation due to increasing complaints and incidents

- **Strategic Delivery** – driving risk may not be managed within the Councill's risk appetite.

Recommendations and Management Action Plan: Driving policy, procedures and performance monitoring

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
1.1	The Driving for the Council policy should be reviewed and updated to align with current practices to ensure it provides up to date and appropriate direction. The updated policy should be approved by Fleet Services, Human Resources and the relevant executive committee. The draft version of the policy should also be consulted with the fleet insurers. The policy should be scheduled for regular review and update at a predefined frequency to ensure it remains updated and accurately reflects roles, responsibilities and requirements to drive for the Council.	Driving for the Council policy will be reviewed and updated to align with current practices. The updated policy will be approved by relevant Service Areas and Policy and Sustainability Committee. The Policy will be reviewed annually and reported to the Policy and Sustainability Committee for their approval.	Interim Executive Director of Place	Head of Operational Support, Performance and Improvement Fleet and Workshops Manager	30/11/2025
		Agreed, An HR assurance statement is presented to the Policy and Sustainability Committee annually. The assurance statement confirms which HR policies will be reviewed in the next financial year and HR will confirm to Committee that the Driving for the Council will be reviewed during 2025/26.	Executive Director of Corporate Services	Service Director, Human Resources Head of Human Resources	20 April 2025 (for assurance statement) 31 March 2026 (for policy review and update)
1.2	Standard Operating Procedures for key driving roles and responsibilities should be established and documented for second-line functions such as the Compliance team, and consistently implemented across first-line operational services. These should be regularly reviewed and updated to reflect changes to the process and confirm alignment to the driving policy and legislation.	The roles and responsibilities of drivers within the current policy will be reviewed and updated to include the responsibilities of the fleet compliance team and Service Managers.	Interim Executive Director of Place	Head of Operational Support, Performance and Improvement	28/06/2025

1.3	A performance monitoring framework should be established with key performance indicators (KPI) for drivers, first line operational teams and second line functions within Fleet Services team. The framework should include monitoring of performance against KPIs and reporting of performance to senior management and relevant governance forum/committee.	In addition to the 6-monthly accident report a framework of KPI's will be setup and established for the following areas: - Gate check and spot checks of vehicles - Driving assessments completed. - Vehicle inspection audit - Driving infringements.		Fleet and Workshops Manager	31/03/2025

Finding 2 – Pre-employment driver health and licence checks

Finding Rating	High Priority

The Driving for the Council policy requires managers to ensure completion of pre-employment health and licence checks before employment is offered to any candidate for the driving role.

Fitness to Drive: Recruiting managers must ensure that appropriate fitness to drive checks have been completed with the Council's Occupational Health provider prior to issuing offer of employment to any candidate for driving role. They must also ensure that all new HGV drivers have provided a GP letter confirming their fitness to drive, before any candidate is appointed to a driving role. HGV drivers over 45 years of age are required to go through a medical check every five years, increasing to annual medical checks for HGV drivers over the age of 65.

Management have confirmed in audit discussions that the relevant services do not have consistently applied processes and procedures to arrange and conduct these health/fitness to drive checks for new driving candidates or existing drivers. There is a reliance on candidates/colleagues to disclose any medical conditions impacting their ability to drive.

Licence Checks: Management have confirmed that formal licence and permit checks for candidates appointed to driving roles are not performed until the candidate has joined. The newly appointed candidates are often placed on other non-driving roles, until these licence checks are completed.

Agency Staff: The policy also requires line managers to ensure completion of health and licence checks for agency drivers, but the Council does not have any established procedure and control to verify the completion and accuracy of licence/health checks processed by third-party agencies for their drivers.

Issues related to driver health and licence checks have been previously raised in the 2018 Council wide Drivers Health and Safety Audit, 2019 Findings only audit on the completion of driver licence checks, and the annual follow up validation audit reported in April 2024.

Risks

- **Health and Safety (including public safety)** – undisclosed and unmonitored medical conditions increasing the risk of potential incidents
- **People** – recruitment inefficiencies leading to scheduling and resourcing challenges
- **Service Delivery** – services impacted due to drivers working in non-driving roles whilst waiting for completion of licence checks
- **Regulatory and Legislative Compliance** – potential non-compliance with legislative requirements and the requirements of the Council's HGV Operators Licence
- **Reputational** – damage to the Council's reputation due to increasing complaints and incidents
- **Strategic Delivery** – driving risk may not be managed within the Councill's risk appetite
- **Financial and Budget Management** – lack of controls around pre-employment health and fitness checks leading to increased costs of insurance premiums, decrease in claims defensibility and potentially invalidated insurance policy.

Recommendations and Management Action Plan: Pre-employment driver health and licence checks

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe

2.1	The Recruitment and Onboarding team within Human Resources should mandate provision of evidence to demonstrate satisfactory completion of fitness to drive health checks and licence checks before an unconditional offer of employment letter is issued to any candidate being appointed to a driving role.	Agreed - A reminder will be issued to the HR Onboarding team confirming that where a driver is being onboarded the recruiting manager must confirm that the appropriate checks with Fleet have been completed. For HGV drivers this should also include confirmation from the candidate their GP about their fitness to drive.	Executive Director of Corporate Services	Service Director, Human Resources Head of Human Resources Lead Consultant, Employee Life Cycle and Reward	31/01/2025
2.2	Recruitment resources for managers should be updated with guidance to support completion of the required pre-employment driver health and licence checks.	Risk Accepted – To ensure there is only ever 'one version of the truth' for managers to follow, the recruiting manager guidance includes several links to other guidance on the Orb. This approach ensures that managers are following the latest guidance and reduces the risk of errors. The onboarding requirements are clearly outlined in both the Driving for the Council Policy and a guidance.			Not applicable
2.3	Fleet Services should receive confirmation and evidence of pre-agreed health and licence checks from the third-party agencies before agency drivers are permitted to drive Council vehicles. Fleet Services should also explore the option to link the approval of agency PO and/or invoice with the health and licence checks evidence.	Fleet Services will work with HR colleagues to explore the option to link the approval of agency PO and/or invoice with the health and licence checks evidence.	Interim Executive Director of Place	Head of Operational Support, Performance and Improvement Fleet and Workshops Manager	28/02/2025
2.4	Fleet Services should introduce a quality assurance process to periodically review and report compliance of health and licence checks for a sample of new, existing and agency drivers.	A system will be devised either through E consent or supported on the reissue of a D906 to confirm that a driver has no known medical changes preventing them from driving.			28/02/2025

Finding 3 – HGV drivers training

Finding Rating	Medium Priority

Driver Certificate of Professional Competence (CPC) training

Professional drivers are required to have a Driver Certificate of Professional Competence (CPC) to drive an HGV in the UK and can be fined up to £1,000 for driving professionally without a Driver CPC. Drivers must complete 35 hours of periodic training every five years to receive and maintain their CPC.

The Council administers and bears the cost of CPC training, but Internal Audit review noted that there is no established framework and supporting procedures to accurately record, regularly monitor and periodically confirm the completion of HGV drivers CPC training. There are inconsistent manual approaches with the Learning and Development (L&D) team maintaining the CPC training records and administering on behalf of HGV drivers for one service, while other services monitor and administer completion of CPC training themselves for their drivers.

There was a backlog of CPC training as the Council's training supplier had paused provision of training due to Covid restrictions in April 2020 until April 2022. Additionally, the Place L&D team stepped in to address gaps in CPC training monitoring, however manual excel records for drivers CPC training were noted to be incomplete. Consequently, CPC for many HGV drivers were scheduled to expire in September 2024. Fleet Services and Place L&D developed a plan in January 2024 to update the CPC training records for HGV drivers. Following completion of audit fieldwork, it was confirmed that all HGV drivers with CPC expiring in September 2024 have now completed their 35 hours training. It is difficult to provide assurance on the currency of driver CPC during April 2020 to August 2024, as the monitoring controls were inadequate.

Analysis of the available CPC training records highlight that the Council's 105 out of 194 drivers (including agency drivers) in a sample of two depots had their CPC expiring in September 2024. While the 35 hours CPC training requirement is spread over a five-year period, these 105 drivers spent 349 man-days in the first six months of 2024 to complete their training. Management has advised that there was no impact to service delivery, as more than 75% of the drivers have not been contracted to work on Mondays and most of these trainings were completed on a Monday.

Driver Assessor training

Driver assessor training is a standard industry practice and is required by the Council's policy for all new drivers. Assessment and coaching are provided in-house by the certified drivers. It aims to suggest improvements to enhance driving techniques and lower risk exposure.

The Council's driver assessor training was not delivered due to Covid restrictions between April 2020 until June 2024, as the certifications of in-house trainers (certified to provide assessor training) had expired. The training was reintroduced in June 2024, however audit discussions noted that all the relevant stakeholders are not yet aware of the training reintroduction. There is therefore lack of a joint process between Fleet and operational services to arrange and monitor driver assessor training for HGV drivers.

Risks

- **Financial and Budget Management** — poor driver training regime leading to increased costs of insurance premiums, decrease in claims defensibility and potentially invalidated insurance policy
- **Health and Safety (including public safety)** – increased risk of incidents for drivers, passengers and other road users
- **People** – training inefficiencies leading to resourcing/scheduling challenges
- **Service Delivery** – service delivery impacted due to lack of adequately trained drivers
- **Regulatory and Legislative Compliance** – potential non-compliance with legislative requirements and the requirements of the Council's HGV Operators Licence
- **Reputational** – damage to the Council's reputation due to increasing complaints and incidents

- **Strategic Delivery** – driving risk may not be managed within the Councill's risk appetite

Recommendations and Management Action Plan: HGV drivers training

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
3.1	A consistent procedure with clear roles and responsibilities should be documented and agreed with operational services and the Place L&D team to record, monitor and confirm the completion of CPC training for existing and newly appointed HGV drivers. The procedure should also include circulation of regular and timely reports to line managers with details of drivers with expiring CPC and completed training details.	A procedure will be put in place and the roles and responsibilities will be documented and agreed with operational services and the L&D (Place) team to record, monitor and confirm the completion of CPC training for existing and newly appointed HGV drivers.	Interim Executive Director of Place	Head of Operational Support, Performance and Improvement Fleet and Workshops Manager	28/02/2025
3.2	Evidence of accurate completed training records should be maintained, and management should explore the use of existing Council systems such as Vision to record and evidence the training and eliminate the data quality risk with manual excel spreadsheets.	The Vision/ Davis system will be updated and utilised going forward to maintain and monitor CPC training.			28/02/2025
3.3	The reintroduction of driver assessor training should be communicated to all services that operate HGV vehicles.	Fleet Compliance manager to communicate with service areas to identify any gaps in driver assessors and provide training as required. Fleet Compliance Manager will define when driver assessor training is required.		Head of Operational Support, Performance and Improvement Fleet and Workshops Manager Fleet Compliance Manager	31/03/2025

Finding 4 – Fleet system functionality

Finding Rating	Medium Priority

Fleet Services operate following three systems for managing driving permits:

- **Tranman** is used to record driver data and manage driving permits
- **Vision** is a compliance system used to monitor driver working hours and breaks
- **Davis** is integrated with the Driver and Vehicle Licensing Agency (DVLA) and automates routine license checks.

Internal Audit noted that these systems are not used to their full functionality. These systems can be used to assist the Council's fleet services and operational services with driving risk management, pro-active management of upcoming driver actions such as HGV licence renewals, monitoring training, and managing compliance with aspects of the driving policies and legislation.

Davis licence checking system

The Davis licence checking system is configured to automate HGV driver license checks every 3 months but includes following system limitations:

- the system assesses the risk associated with each driver, but this functionality is not currently used
- automated system emails are sent to the Fleet Compliance team and they review individual reports, but risk is not monitored across teams/services and the Council
- the system has the functionality to flag upcoming actions for drivers and managers to proactively manage compliances such as licence renewals, training completion or expiring permits. However, these system notifications are currently not configured for operational service managers.

Vision fleet management system

The Vision fleet management system is used to record and track vehicle and driver compliance with the Road Transport (Working Time) Regulations 2005 and the Drivers' Hours and Tachographs (Amended etc.) (EU Exit) Regulations 2019. A 'Driver Upload - Compliance Status by Driver' report is issued to the services on a weekly basis and it lists drivers who have not downloaded tachograph data within the 28-day legislative requirement. As at 26 August 2024, 32 non-compliant tachograph cards were reported with 8 non-compliant for more than 56 days, and a maximum for over 138 days.

The Vision system has the functionality to provide alerts and reports to operational services to help them assess driver compliance with driving hours, breaks, and other compliance metrics. However, the system is not fully configured with the tools available to assist operational services drivers and managers complete their driving responsibilities.

Data Quality

There are no processing and monitoring controls such as reconciliation among the systems to obtain assurance over the completeness and accuracy of data across all the systems. The audit also noted minor data quality issues such as permit reference numbers being missing or reference to long-term sickness not being removed when driver permits are reactivated after a return to work. There are also concerns around the compliance of Tranman system with the Council's data protection and UK GDPR requirements as the access to Tranman system provides all users with unrestricted access to all the information including sensitive and personal information in incident reports.

Risks

- **Health and Safety (including public safety)** – increased risk of incidents for drivers, passengers and other road users
- **Service Delivery** – reliance on manual controls which increases the risk of error or omission
- **Regulatory and Legislative Compliance** – potential non-compliance with legislative requirements and the requirements of the Council's HGV Operators Licence
- **Financial and Budget Management** – under-utilisation of fleet systems and noncompliance with legislative requirements leading to increased

insurance premiums, decrease in claims defensibility and potentially invalidated insurance policy

Recommendations and Management Action Plan: Fleet system functionality

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
4.1	The risk assessment and upcoming driver flag functionality of the Davis system should be explored to confirm if the issues related to exemptions and complex licences are due to functionality or configuration. Where configuration allows, system controls should be used to manage risks and inform decision making.	The risk system is switched on within the Davis System but there are limitations relating to the exemptions. Solutions will be explored with the supplier and actions supplied. Follow up dates will be provided for IA.	Interim Executive Director of Place	Head of Operational Support, Performance and Improvement Fleet and Workshops Manager	28/02/2025
4.2	Where appropriate: • training should be provided to users of the systems to ensure the reporting functionality fully utilised and is used to monitor compliance and manage driver risk within services. • where services do not have access to systems (e.g. Davis), processes to report upcoming actions and monitor compliance from services should be designed and implemented.	The Compliance Manager will engage with Information Governance colleagues to understand any issues with granting managers access to the driving licencing system. Dependant on the above training to be provided to managers in order for them to monitor compliance on driving licencing within the system.			31/03/2025
4.3	System data validation controls should be reviewed and incorporated into processes to ensure the quality of data within Fleet systems.	Validation control is currently reconciled on a bi-monthly basis. Reconciliation to be reduced to monthly.			31/12/2024
4.4	A review of the systems used by Fleet should be carried out to confirm compliance with UK GDPR requirements. Alternative options to store sensitive and personal information should be explored if there are limitations in the system to comply with the data protection legislations.	Fleet will work with colleagues in Information Governance Team to understand the GDPR requirements and review Tranman to ensure compliance. Alternatives will be explored if required.			28/02/2025

Finding 5 – Operational HGV Safety Controls

Finding Rating	High Priority

HGV Safety Standards

The Council's driving policy requires Council's purchased/leased HGVs to be 'fitted with Advanced Emergency Breaking System (AEBS), whenever it is reasonably practicable to do so'. However, Internal Audit noted that the Council does not have an established minimum safety standard, including features and technology requirements, for its existing fleet and new HGVs.

Additionally, the Fleet Asset Management Plan 2023-2029 also did not include any safety standards for the future fleet of HGVs to be sourced for next five years.

Routing

HGV drivers are expected to avoid driving in high-risk areas at peak times, however Internal Audit noted that there are no specific procedures or guidance to support drivers to achieve this requirement e.g. listing of high-risk areas, intimation of peak times for different areas and the alternative route options.

Management have confirmed that digital solutions are available, and they are currently being explored to improve route planning for HGVs, with features such as digital ringfencing within maps of high-risk areas at peak times to alert drivers to change route.

Telematics

The Driving for the Council - Telematics Policy was agreed by the Policy and Sustainability Committee in May 2023. The policy aims to reduce driving incidents, improve driving behaviour, reduce exposure to high risk driving situations, and optimise routes.

While data access controls have been introduced to restrict access to telematics data, but there is no routine processing or analysis of thematic level telematics data to monitor driving standards and exposure to risk, or to inform training requirements for specific teams and HGV drivers.

Finding 1 also highlighted the lack of driving related performance measures in services, and as a result it has not been possible to confirm if the objectives of Telematics policy are achieved.

Drug or alcohol consumption while driving

Driving for the Council policy, Alcohol and drugs policy and Alcohol and drugs policy user guide prohibits the use of alcohol and drugs while driving Council vehicle or private vehicle driven on Council business. The policy requires the managers to observe and record suspected behaviours, have a discussion with the concerned colleague, and take actions to send colleagues home or involve Police/HR services, when the managers 'reasonably believe' that the colleague is under the alcohol or drug influence.

Audit discussions with the Council's Fleet and Operational services have highlighted strong concerns around the potential use of alcohol or drugs while driving for the Council, but there are no evidence-based procedures e.g. random or 'with cause' drug/alcohol testing to deal with suspected instances. Managers expressed reservations to allege colleagues for alcohol/drugs consumption at work, based only on suspected behaviours, and they are unable to take concrete actions where the concerned colleagues deny the consumption.

The 2021 external review by insurers recommended to introduce testing for drugs and alcohol abuse and it has also been adopted in a few other Scottish local authorities.

The Council's Policy and Sustainability Committee approved the new drugs and alcohol policy on 23 May 2023 and noted that 'drug and alcohol testing at work was invasive and unnecessary.' The Committee also resolved that 'drug and alcohol testing would not ever be reviewed unless a motion requesting such a review was passed at full council or there was a legal requirement to do so'.

Risks

- **Health and Safety (including public safety)** – increased risk of incidents for drivers, passengers and other road users
- **People** – challenges with scheduling, resourcing, and staff morale
- **Service Delivery** – potential service delivery disruptions due to inefficient routing of the vehicles and operational service delivery impacted due to routing inefficiencies and incidents due to consumption of alcohol or drugs

Risks (continued)

- **Regulatory and Legislative Compliance** – potential non-compliance with legislative requirements and the requirements of the Council's HGV Operators Licence
- **Reputational** – damage to the Council's reputation due to increasing complaints and incidents
- **Financial and Budget Management** – lack of operational safety controls leading to increased costs of insurance premiums, decrease in claims defensibility and potentially invalidated insurance policy.

Recommendations and Management Action Plan: Operational HGV Safety Controls

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
5.1	Fleet Services, in consultation with other relevant Council departments, should establish safety standards, including technology features, for its HGV fleet. These standards should also be integrated into the procurement/lease programme of Council's future fleet.	Specifications for all new vehicles contain reference to safety features. A stand-alone document detailing this will be produced and approved by the Fleet Renewal Programme Board. This will also be documented in the updated Driving for the Council Policy.	Interim Executive Director of Place	Head of Operational Support, Performance and Improvement Fleet and Workshops Manager	31/01/2025
5.2	The Council should consider if a digital solution is available to assist with the routing of HGVs which will allow high-risk areas to be defined and vehicles to be re-routed at peak times to avoid such areas. Alternatively, manual procedures with clear instructions to avoid busy routes, along with alternate routes, should be provided to HGV drivers.	Specification for in-cab replacement system will include the ability for the driver to be alerted to any route specific hazards and the ability to create prohibited areas at certain peak times. Technical specifications of the in-cab solution would be consulted with the Council's digital services and/or external provider to assess its suitability with the Council's hardware and software infrastructure, particularly the iOS server.		Service Director, Operational Services Head of Neighbourhood Environmental Services	31/07/2025

5.3	Operational services should design controls which utilise telematics data to monitor driving performance for their area, identify themes and target training requirements for teams or vehicle drivers.	Operational services will design controls which utilise telematics data to monitor driving performance for their area, identify themes and target training requirements for teams or vehicle drivers.			28/02/2025
5.4	Interim Executive Director of Place and Service Director, Human Resources should present a joint report to elected members to reconsider alcohol and drug testing for HGV drivers, referencing the findings of this audit and findings of the insurers' review of the Council's Operator Licence compliance, scheduled for November 2024.	At its meeting on 23 May 2023, the Policy and Sustainability Committee approved the following motion: 1) To approve the new Alcohol and Drugs Policy. 2) To note that this policy had been reviewed and revised to address the recommendations agreed following the Independent Inquiry and Whistleblowing Culture Review by Susan Tanner QC, with Pinsent Mason in 2021. 3) To note that drug and alcohol testing at work was invasive and unnecessary. 4) To therefore resolve that, in contrast to paragraph 4.7 of the report by the Executive Director of Corporate Services, drug and alcohol testing would not ever be reviewed unless a motion requesting such a review was passed at full council or there was a legal requirement to do so. Guidance to be sought from GRBV on next steps as a result of audit recommendations and previous Committee decision.	Interim Executive Director of Place Executive Director, Corporate Services	Interim Executive Director of Place Service Director, Human Resources	31/10/2025

Finding 6 – Incident and complaint management and monitoring

Finding Rating	Medium Priority

Incidents investigations and monitoring

Incidents are investigated by the individual operational services. Fleet Services are not involved in the incident investigation process but are provided with the incident report following investigation for oversight and recording to the Tranman system.

Internal Audit noted that a six-monthly Fleet Incident Analysis report providing a high-level summary of incidents across the fleet categorised by type of incident, directorate involved, age of driver involved in the incident, third party or Council fault, is presented to the Council's Health and Safety Group.

However, the report is not adequately detailed to monitor and analyse the Council wide incidental investigation data by:

- classification of incidental vehicles between HGVs and non-HGVs
- categorisation of the impact of incidents i.e. fatal, serious and minor
- breakdown of incidents by service area (as 93% of incidents related to one directorate)
- root cause/theme of the incidents and comparison with previous six-monthly periods to note trends and review the results of corrective actions taken during previous periods
- impact of the incidents including financial impact due to claims etc. and service delivery impact due to disruptions
- lessons learned from incident investigations to incorporate into new procedures or training to prevent repeated occurrences.

Thematic analysis of driving incidents can contribute to the ongoing improvement of driving standards, as well as compliance with the driving policy and legislation.

HGV Complaints

Complaints relating to Council vehicles and driving are referred directly to the relevant service area, provided this is identified by the original complaint.

Where a complaint is not specific, e.g. provides a registration number only, this is referred to Fleet Services to identify the vehicle, service area, and driver, before referring to the service for investigation.

However, there are no procedures and controls for the central oversight of complaints and analyse key themes of driving complaints for effective management of driving complaints and risks.

Risks

- **Financial and Budget Management** – absence of post incident analysis indicating lack of continuous monitoring leading to increased costs of insurance premiums, decrease in claims defensibility and potentially invalidated insurance policy
- **Health and Safety (including public safety)** – limited learning from incidents leading to repeat incidents
- **People** – lack of learning culture towards driving and safety
- **Service Delivery** – operational service delivery impacted by vehicles and drivers involved in incidents
- **Regulatory and Legislative Compliance** – potential non-compliance with legislative requirements and the requirements of the Council's HGV Operators Licence
- **Reputational** – damage to the Council's reputation due to increasing complaints and incidents
- **Strategic Delivery** – driving risk may not be managed within the Councill's risk appetite.

Recommendations and Management Action Plan: Incident and complaint management and monitoring

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
6.1	The process for investigating incidents and complaints related to driving should be reviewed to ensure that all key stakeholders and services are adequately involved in the resolutions and lessons learned process.	The process for investigating incidents and complaints related to driving will be reviewed to ensure that all key stakeholders (including the Insurance team) and services are adequately involved in the resolutions and lessons learned process.	Interim Executive Director of Place	Head of Operational Support, Performance and Improvement Fleet and Workshops Manager Service Director, Operational Services	28/02/2024
		Business Support administrator will have access and training to LACHS system, used by insurance team to record all incidents, to improve captured information and GDPR compliance			30/09/2025
6.2	The information presented in six-monthly incident reporting should be reviewed to confirm that there is sufficient detail to allow service areas to make informed decisions around driving standards. The report should be updated to include but not restricted to data points suggested in the finding and any further details or metrics as required by service areas or oversight groups to inform decision making and ongoing driving improvement.	The six-month incident reporting document will be reviewed. The report will be updated to report and analyse the following: - Classification of accident whether HGV or non-HGV - Categorisation of impact: serious, fatal, minor - Root cause of accidents.		Head of Operational Support, Performance and Improvement Fleet and Workshops Manager	30/04/2025
6.3	Fleet Services should consider including analysis and comparison of complaints data in the six-monthly incident reporting, to compile and analyse complaints, identify themes, share information amongst services, and inform training needs.	Fleet Services and Service areas will consider including analysis and comparison of complaints data in the six-monthly accident reporting, to compile and analyse complaints, identify themes, share information amongst services, and inform training needs.			30/04/2025

Finding 7 – Risk management

Internal Audit noted that there are no established and embedded risk management procedures to manage driving risks such as driver behaviour, legal and regulatory compliance, health and safety, vehicle safety, insurance cover and costs. None of the Council, directorate or service risk registers captures driver and vehicle risks to manage them in line with the Council's Risk Management Framework.

Risk assessments to confirm that driving risks are routinely being considered were not completed for one of the key operational services, which uses the highest number of HGV drivers.

Risks

- **Financial and Budget Management** — inadequate risk management procedures leading to increased costs of insurance premiums, decrease in claims defensibility and potentially invalidated insurance policy
- **Health and Safety (including public safety)** – increased possibility of incidents impacting safety of drivers, passengers and other road users
- **People** – poor culture towards vehicle and drivers safety procedures
- **Service Delivery** – operational service delivery impacted due to limited identification, consideration and management of driver related risks
- **Regulatory and Legislative Compliance** – ability to comply with legislative requirements and apply the rules of the Councils HGV Operators Licence
- **Reputational** – damage to the Council's reputation due to increasing complaints and incidents
- **Strategic Delivery** – driver risk may not be sufficiently identified, assessed and managed.

Recommendations and Management Action Plan: Risk management

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
7.1	Fleet Services should engage with the Council's Risk Management team to implement the Council's Risk Management Framework arrangements to identify, record, manage and monitor driving risks for the Council and its citizens.	Fleet Services will engage with the Council's Risk Management team to implement the Council's Risk Management Framework arrangements to identify, record, manage and monitor driving risks for the Council and its citizens.	Interim Executive Director of Place	Head of Operational Support, Performance and Improvement Fleet and Workshop Manager	31/01/2025

7.2	Operational services should complete regular risk assessments to confirm that driving risks are continually and adequately managed.	A list of standardised risk assessments will be developed and shared with service areas to adept and adopt to included driver risks.		Service Director, Operational services	30/04/2025

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

Audit Areas	Control Objectives
Policy and Governance	• policies and procedures for the Council's fleet (including HGVs and drivers) are in place, up-to-date, and accurately reflect the risk and control environment.
Vehicle Safety	• the fleet replacement programme has considered the use of technology (such as speed monitoring and limitation), to ensure the safety of all Council operated HGVs, ensuring all HGVs meet agreed upon safety standards • data from vehicle telematics is used to continually monitor and improve the safety of Council vehicles.
Driver Safety	• checks are performed both initially and ongoing to confirm that all HGV drivers have the necessary qualifications, licenses, medicals or other documentation required by their roles. Evidence of the checks performed is documented • HGV drivers are required to undergo appropriate training, which is maintained on an ongoing basis, and covers the safety requirements expected of HGV drivers, as well as any changes to legislation or operations as they are implemented. All training is recorded, and completion monitored regularly • HGV drivers working conditions are monitored to ensure they promote the safe operation of HGVs, such as use of tachographs, telematics, and feedback.
Operational Safety	• additional operational safety measures have been considered and implemented where appropriate, including but not limited to: ○ routing HGVs away from high-risk areas, such as schools and nurseries, at peak times ○ use of telematics and complaints data to monitor or flag poor driving standards ○ regular informal vehicle safety checks being carried out ○ regular formal servicing and maintenance of the HGV fleet.
Risk Management	• incident data is recorded and reviewed in a timely basis to identify and resolve issues with working conditions, the health and wellbeing of drivers, training requirements, or the maintenance of the fleet. Lessons learned are identified and shared as appropriate • risks related to Council operated HGVs are identified, recorded, and managed within a service risk register, and are 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 – Legislation and Statutes relevant to Driving for the Council

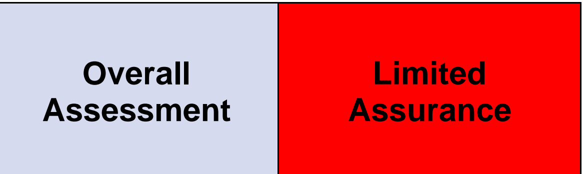
- Road Traffic Act 1998 - covers road safety, licencing, and vehicle standards
- Operator Licensing (Goods Vehicles) Regulations - require fleet operators to hold an operators licence to run vehicles over 3.5 tonnes
- Drivers' Hours and Tachographs Regulations - set limits on driving hours, breaks, rest periods, and mandatory use of tachographs
- Corporate Manslaughter and Corporate Homicide Act 2007 - holds organisations accountable if gross management failures result in death which could include vehicle maintenance or driver negligence
- Highway Code - guidance on safe use of roads
- Road Vehicles (Construction and Use) Regulations 1986 - set out construction, weight limits, and use of vehicles on public roads
- Vehicle Excise & Registration Act 1974 - vehicle tax and registration
- Health and Safety at Work etc Act 1974 - health and safety obligations relevant to safety of/from HGV vehicles.

Internal Audit Report

Partnership Working (Edinburgh Partnership Board)

02 October 2024

CD2401



Contents

Executive Summary 3
Background and scope..... 4
Findings and Management Action Plan..... 5
Appendix 1 – Control Assessment and Assurance Definitions.....13
Appendix 2 – Areas of Audit Focus and Control Objectives.....14

This Internal Audit review is conducted for the City of Edinburgh Council under the auspices of the 2024/25 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2024. 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 have been raised with senior management and elected members as appropriate.

Executive Summary

Overall Assessment	Limited Assurance

Overall opinion and summary of findings

Initial discussions with management highlighted that the control environment supporting the Edinburgh Partnership and community planning processes, is not yet fully established, and a performance improvement programme is underway. As a result, Internal Audit agreed to perform a 'findings only' review which included an assessment of the design of processes via walkthrough discussions with officers and review of key documentation to identify areas for improvement.

The following areas of improvement to ensure Council objectives are achieved and associated risks are managed were identified:

- The governance framework should be reviewed, updated and approved with defined roles and responsibilities for constituent partner organisations, a clear decision making and accountability structure and procedures to monitor and manage the timely delivery of governance related actions.
- Priorities and outcomes within Community Planning and the Local Outcome Improvement Plan should be aligned and the Locality Improvement Plans should be updated.
- Outstanding elements of performance management framework should be implemented, and the framework should be updated to include expected targets and/or milestones.
- Resources required to ensure effective delivery of community planning outcomes and objectives should be identified and recorded.
- Risk management arrangements should be introduced to effectively manage Partnership and community planning risks, in line with the Council's Risk Management Framework.

Areas of good practice

- The three common priorities are reflected in the Council's Business Plan 2023-2027 are aligned to the outcomes within the Edinburgh Partnership Community Plan 2022-2028.
- A Local Outcome Improvement Plan (LOIP) annual report is reported to the Edinburgh Partnership Board on an annual basis which provides progress made with the identified three priorities.
- Quarterly reports which highlight the progress made for each priority are presented to the LOIP Delivery Group.

Audit Assessment

Audit Area	Control Design	Control Operation	Findings	Priority Rating
Edinburgh Partnership Board Governance	● (orange)	N/A Design only	Finding 1 – Edinburgh Partnership Governance Arrangements	High Priority
			Finding 2 – Edinburgh Partnership Priorities and Outcomes	Medium Priority
Performance and Risk Management	● (orange)	N/A Design only	Finding 3 – Performance Monitoring and Resource Planning	Medium Priority
			Finding 4 – Risk Management	Medium Priority

See Appendix 1 for Control Assessment and Assurance Definitions

Background and scope

The City of Edinburgh Council's (the Council) Business Plan 2023-27 recognises the needs to work closely with citizens and other partner organisations to achieve its strategic objectives and business plan priorities. Effective partnership working allows the partners to collaborate and jointly work towards long-term shared goals and commitments for Edinburgh to be a fair, welcoming, pioneering, and thriving city, as expressed by the 2050 Edinburgh City Vision.

The Edinburgh Partnership is the community planning partnership for the city of Edinburgh, which brings together public agencies, the third sector, and the private sector with communities, to improve the city, its services and the lives of people who live and work in Edinburgh. The Edinburgh Partnership Community Plan 2022-2028 sets the strategic direction for community planning in Edinburgh over 6 years, describes the shared priorities of the partners involved, describes what will be done to achieve those priorities, and describes how progress against those priorities will be measured. As part of the Transformation and Improvement programme an implementation Plan will be developed, which has a proposed deadline of March 2025.

Increased demands with the pandemic and cost of living crisis, and the consequent negative impacts on the economic, physical, and social wellbeing of citizens, against a backdrop of reducing public sector resources, presents real challenge in achieving the Edinburgh Partnerships objectives.

The Edinburgh Partnership recognises the need to strengthen community planning and increase cross-sector collaborative working. In September 2023 the Partnership Board agreed to undertake a Transformation and Improvement Programme to develop a renewed approach to community planning. The latest Transformation and Improvement Programme update was presented to the Edinburgh Partnership on 11 June 2024 and outlined a proposed programme of engagement to ensure that all partners and partnerships can contribute to the way forward.

Scope

The objective of this review was to assess the adequacy of the design of the key controls established to ensure that the Council realises proposed partnership working benefits, efficiencies and improved outcomes as set out in the 2023-27 Business Plan.

Initial discussions with management highlighted that the control environment, supporting the Edinburgh Partnership and community planning processes, is not yet fully established, and a performance improvement programme is underway. As a result, Internal Audit has agreed to undertake a findings only review to identify areas for improvement.

Alignment to Risks and Business Plan Outcomes

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

- Strategic Delivery
- Financial and Budget Management
- Supplier Contracts and Partnership Management
- Governance and Decision Making
- Regulatory and Legislative Compliance
- Reputational Risk

Business Plan Outcomes:

Partnership working underpins all the outcomes set out in the Business Plan.

Limitations of Scope

The following areas were excluded from scope:

- All informal partnership working outside the scope of the Edinburgh Partnership or its Community Plan 2022 – 2028.

Reporting Date

Testing was undertaken between 23 July 2024 and 23 August 2024.

Our audit work concluded on 28 August 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 – Edinburgh Partnership Governance Arrangements

Finding Rating	High Priority

Review of the Edinburgh Partnership governance processes highlighted the following areas of improvement:

Governance framework review and update - The governance framework to support Edinburgh Partnership was last discussed at the April 2019 board meeting and has not been reviewed since. The Board agreed in April 2019 to include several adjustments to the governance framework document and review the updated governance arrangements after twelve months. Management have advised that the updated governance framework was scheduled to be presented to the Board on 17 April 2020, but the meeting was cancelled due to the Covid-19 pandemic. The governance framework document, with the requested adjustments, has not been reviewed since. Management have advised that the framework will now be updated in March 2025 as part of the Transformation and Improvement Programme.

Partner roles and responsibilities - While the Governance framework states the remit and membership of Partnership sub-groups, specific roles and responsibilities of constituent partner organisations are not defined. There is no documentation to confirm partner organisations' compliance with 'Community planning partners duties' included in section 14 of the Community Empowerment Scotland Act 2015. Discussions with management highlighted awareness of the need to encourage consistent understanding of the legislative requirements and compliance across all partners.

Decision making - There is no established procedure to support clear decision making and accountability structure within the Partnership governance framework document and arrangements.

Governance skills and experience - The Good Governance Standards for Public Services, included within the Governance Framework document, refers to 'making sure that appointed and elected governors have the skills, knowledge and experience they need to perform well'. However, there is no supporting process in the Edinburgh Partnership governance framework to review and confirm if the members of the Partnership board and its sub-groups meet this requirement.

Local Outcome Improvement Plan (LOIP) 2022-2028 - The Partnership Board reviewed the Edinburgh Partnership Local Outcome Improvement Plan (LOIP) 2022-2028 on 15 February 2022 and agreed 'to note that the approval of the Edinburgh Partnership LOIP required the formal agreement of individual partners through their governance arrangements'. Management has however not been able to confirm and evidence if the LOIP has been subsequently approved by the individual partners governance forums.

Monitoring of tasks and actions - There are limited controls in the Partnership governance processes to monitor and manage governance tasks and actions. Internal Audit review noted examples of reports to be submitted and issues to be escalated to the Partnership Board, but submissions were missed. Discussions with management highlighted that there is no comprehensive tracker to support the scheduling and monitoring of submission of the relevant reports/papers to the Partnership Board and other relevant governance forums. The Partnership Board papers are also not dated, making it difficult to associate the individual papers to specific Board meetings.

Risks

Strategic Delivery/Governance and Decision Making:

- Absence of a formally approved governance framework leading to potential ambiguity in decision making, unclear roles and responsibilities, augmented risk of legislative non-compliance, reduced accountability and transparency, and limited management oversight
- Partnership Organisations are unclear about their roles, responsibilities and accountabilities causing inefficiencies and misalignment of efforts.

Strategic Delivery/Governance and Decision Making Risks continued:

- Ambiguous decision making and accountability structure leading to inconsistent, slow and ineffective decisions ensuing into poorer outcomes for Edinburgh Partnership
- Limited skills, experience and authority of board members to effectively discharge their designated roles and responsibilities.
- Governance tasks/actions are not effectively managed and may be missed/omitted from implementation
- Ineffective escalation process leading to Board members unaware of key issues impacting delivery of Partnership objectives
- Limited buy-in from individual partners to the LOIP plan impacting the delivery of the plan.

Regulatory and Legislative compliance: Non-compliance to the provisions of community planning legislation.

Recommendations and Management Action Plan: Edinburgh Partnership Governance Arrangements

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
1.1	The governance framework document should be reviewed to ensure it meets the Edinburgh Partnership Board approval requirements and should include each of the relevant finding points included in finding 1 as part of the review process. The revised document should be presented to the Partnership Board for approval and agreement sought on an appropriate timescale for further review. The review should be included as a standing agenda item on the Board work programme.	Accepted as recommended. This will be delivered through the transformation and improvement programme.	Executive Director of Corporate Services	Head of Strategic Change and Delivery Strategy Manager (Communities)	31/03/2025
1.2	Formal agreement of the Edinburgh Partnership LOIP should be obtained from individual constituent partners through their governance arrangements.	Management accepts the risk. It is the responsibility of partners to ensure commitments made on behalf of their organisation are appropriately approved.			Not applicable

1.3	A process should be established to ensure that required actions from the Edinburgh Partnership Board are recorded and tracked to completion. The tracker should include a target date and owner, with a progress update to provide ongoing assurance ensure that all actions have been completed. Any delays or changes should be noted within the tracker document and if appropriate the Edinburgh Partnership Board should be advised of delays/changes.	Accepted as recommended.	Executive Director of Corporate Services	Head of Strategic Change and Delivery Strategy Manager (Communities)	30/05/2025
1.4	An escalation tracker should be introduced to ensure that all issues raised by Lead Officers within the Local Outcome Improvement Plan quarterly reports are captured within relevant reports to the Edinburgh Partnership Board, as expected.	Accepted as recommended.	Executive Director of Corporate Services	Head of Strategic Change and Delivery Strategy Manager (Communities)	30/05/2025
1.5	All individual reports presented to the Edinburgh Partnership Board should include the date of the committee it is being presented to, to ensure that all reports are specifically identifiable and attributable to specific Board meetings.	Accepted as recommended.	Executive Director of Corporate Services	Head of Strategic Change and Delivery Strategy Manager (Communities)	30/05/2025
1.6	Documented evidence, such as an assurance statement, should be obtained from partnership organisations to confirm their legislative compliance with section 14 of the “Community Empowerment Scotland Act 2015”.	Risk accepted. It is the responsibility of partners to ensure they meet their legislative duties in accordance with their own assurance processes. A biennial assessment will support an evaluation of how the CPP is operating.	Executive Director of Corporate Services	Head of Strategic Change and Delivery Strategy Manager (Communities)	Not applicable

Finding 2 – Edinburgh Partnership Priorities and Outcomes

Finding Rating	Medium Priority

Locality Improvement Plans 2017-2022 - The Locality Improvement Plans (LIP) 2017-2022 are published on the Edinburgh Partnership website, however, these plans are out of date and require review. Management have advised that these will be updated after the completion of community planning workstream as part of the Transformation and Improvement Programme.

Community Planning 2022-2028 - There is a clear link between the outcome measures noted under each theme of the Community Planning 2022-2028, and the Local Outcome Improvement Plan (LOIP) annual report. However, the 'action specific measures section' of the LOIP annual report notes 'Indicators focused on the actions are still to be defined as service standards setting work to be undertaken'. There are key achievements and challenges noted within the LOIP annual report, however the source of this information and their alignment to the Community Plan document, Delivery Plan and the Partnership objectives is not clear.

Local Outcome Improvement Plan - Delivery Plan - The Partnership Board approved the Edinburgh Partnership Local Outcome Improvement Plan (LOIP) 2022-2028 in March 2022 and noted 'to agree that that the delivery plan would be updated to include timelines. Review of the LOIP Delivery Plan highlighted that some of the actions and measures are incomplete, do not have named lead officers and timescales noted, and there was no indicator for one of the measures.

In addition, the LOIP delivery plan is not dated, and version controlled, therefore, it was difficult to ascertain whether the listed actions and measures are still current. Some of the timescales and dates were also noted to have passed but it was not possible to determine if those actions/measures have been completed.

Risks

Strategic Delivery:

- Locality improvement plans are not aligned with the current Edinburgh Partnership priorities leading to potential misalignment of locality teams objectives and outcomes.
- Out of date and inaccurate information on the Partnership website leading to key stakeholders being misinformed and potential reputational risk
- Misalignment of the actions, measures and outcomes within the Partnership plans impacting achievement of Partnership objectives
- Lack of an updated LOIP delivery plan impacting timely and effective delivery of actions and limited visibility of the delivery group to monitor the delivery and performance of actions.

Recommendations and Management Action Plan: Edinburgh Partnership Priorities and Outcomes

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
2.1	The Locality Improvement Plans (LIPs) should be updated to ensure that they are aligned with the current Edinburgh Partnership priorities and to ensure that teams and partners at a local level are working to the required objectives/outcomes.	Work to develop refreshed LIPs will be carried out as part of the transformation and improvement programme and subject to a revised place based approach.	Executive Director of Corporate Services	Head of Strategic Change and Delivery	31/12/2025

2.2	The Edinburgh Partnership website should be reviewed and updated, and a process to ensure a regular review is performed should be established to ensure that the information held remains up to date and accurate.	Accepted as recommended.		Strategy Manager (Communities)	31/12/2025
2.3	A process should be established to ensure there is clear linkage of actions, measures and outcomes, between the different plans to provide assurance that the relevant actions measures and outcomes within the Edinburgh Partnership plans are aligned.	Accepted as recommended.			30/05/2025
2.4	The 'Action specific measures section' within the Local Outcome Improvement Plan (LOIP) should be reviewed and updated to ensure that all relevant performance indicators are identified and established.	Accepted as recommended.			30/05/2025
2.5	The LOIP Delivery Group delivery plan should be updated to include a document date and version control. In addition, the plan should include detail of all complete/outstanding actions and measures, with named lead officers and defined timescales for completion of actions. Where there are revised timescales, a supporting rationale should be recorded.	Accepted as recommended.			30/05/2025

Finding 3 – Performance Monitoring and Resources Planning

Finding Rating	Medium Priority

Partnership Performance Monitoring - The Edinburgh Performance Framework was developed in 2018, however, as noted in the update report presented to the Edinburgh Partnership Board on 5 March 2024, the following elements of the framework have not yet been fully implemented:

- Medium-term performance indicators
- Exception Reporting
- SMART target setting
- Monitoring Framework.

While the Local Outcome Improvement Plan (LOIP) 2022-2028 annual report includes annual comparisons for the key performance indicators (KPIs) within the report, the KPIs do not include any targets and/or milestones to measure performance against.

Resource Planning – Management have advised that the resourcing is organised by requesting funds or capacity for each project/workstream from partner organisations. IA review however noted that there are no established controls and procedures to ensure that sufficient resources are planned and available for Edinburgh Partnership to deliver its priorities, outcomes and objectives. Management have also advised that Resourcing is part of the Support and Facilitation workstream of Transformation and Improvement Programme.

Risks

- **Strategic Delivery:** Limited oversight and monitoring of Partnership performance against planned targets and milestones impacting effective and efficient achievement of Partnership objectives
- **Financial and Budget Management**: Potentially inadequate resources for the Partnership to achieve timely delivery of community planning outcomes and objectives.

Recommendations and Management Action Plan: Performance Monitoring and Resources Planning

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
3.1	The outstanding elements of the performance framework should be implemented with clear timescales and supporting procedures.	Management is currently reviewing the approach to performance and will be implementing a new integrated performance management approach as part of the transformation and improvement programme.	Executive Director of Corporate Services	Head of Strategic Change and Delivery Strategy Manager (Communities)	31/12/2025
3.2	The performance framework should be updated to include expected targets and/or milestones against each KPI to provide Edinburgh Partnership board with effective oversight on targeted and achieved performance.	The recommended actions will be included within the new Performance management framework.			31/12/2025

3.3	Resource planning procedures should be introduced to ensure that the Edinburgh Partnership has sufficient resources available to support timely and effective delivery of community planning outcomes and objectives.	The recommended procedures will be established as part of the Transformation and improvement programme.			31/12/2025

Finding 4 – Risk Management

Finding Rating	Medium Priority

Edinburgh Partnership Risks - A formal risk management framework has not yet been established within the Edinburgh Partnership with no risk register in place to record the identification, assessment and management of risks.

Community Strategies Team Risks- Risk management is also not fully integrated within the Community Strategies team. Management have advised that they are currently liaising with the Council's Corporate Risk Management team to develop a risk register.

Risks

Strategic Delivery:

- Risks, impacting Partnership's ability to deliver its objectives might not be identified and managed.
- The Community Strategies team risks may not be effectively identified and managed which may impact ability to manage community planning objectives on behalf of the Council.

Recommendations and Management Action Plan: Risk Management

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
4.1	Risk management should be embedded within the Edinburgh Partnership and a risk register should be produced to capture Partnership risks which may impact on its ability to deliver its objectives.	Accepted as recommended.	Executive Director of Corporate Services	Head of Strategic Change and Delivery	31/12/2025
4.2	Risk management procedures, in accordance with the Council's Risk Management Framework, requires to be integrated within the Community Strategies team, and the risk register should be used to effectively identify, manage and escalate community planning risks.	Accepted as recommended.		Strategy Manager (Communities)	31/03/2025

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 – Areas of Audit Focus and Control Objectives

Audit Areas	Control Objectives
Edinburgh Partnership Board Governance	• Clear decision-making and accountability structures and processes for the Edinburgh Partnership have been defined and agreed by all partners. • The drivers for the requirement of the Edinburgh Partnership are clear, and a clear vision and joint strategy has been set and formally committed to by all partners. • Roles and responsibilities of the Edinburgh Partnership's constituent organisations are clear with individual members of required skills been identified and involved. • Outcomes for Edinburgh Partnership activity have been agreed and indicators for measuring progress clearly defined, with regular reporting on progress and any challenges faced to the Board, and to Council committees where there is an impact on delivery of Council services.
Performance and Risk Management	• The Edinburgh Partnership has agreed and implemented a system for managing and reporting on the collective performance. • The Edinburgh Partnership working budget monitoring process is established, including measuring, and capturing efficiencies achieved through sharing resources (finance, staff, premises, equipment etc.) • Risks associated with the Edinburgh Partnership have been identified, recorded, and are managed appropriately.

Final Internal Audit Report

Transfer of the Management of Development Funding (TMDF)

10 July 2024

PL2401

Overall Assessment	Reasonable Assurance

Contents

Executive Summary ... 3
Management Response to Executive Summary ... 4
Background and scope ... 5
Findings and Management Action Plan ... 6
Appendix 1 – Control Assessment and Assurance Definitions ... 10
Appendix 2 – Areas of Audit Focus and Control Objectives ... 11

This Internal Audit review is conducted for the City of Edinburgh Council under the auspices of the 2024/25 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2024. 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

There is a generally sound system of governance, risk management and control in place for managing the transfer of management development funding (TMDF) process. Some scope for improvement was identified, which if not addressed, may put at risk the achievement of objectives in the area audited. The following improvement actions are recommended:

- the payment authorisation process should be reviewed to ensure there is clear evidence of payment authorisation on the HARP system and the authorisation is checked prior to processing the payment
- reasonable timescales should be established for ensuring Scottish Government (SG) signage is mounted at development sites in a timely manner and evidence of signage erection is retained
- guidance should be established for completing Registered Social Landlord (RSL) profile sheets.

Areas of good practice identified

- an effective process has been established to reconcile payments data between four sources prior to financial drawdown from SG
- there is consistent reporting to the SG and evidence to demonstrate scrutiny of profile sheets in progress meetings
- robust user access controls have been established to ensure movers and leavers access to the HARP system is deactivated.

Audit Assessment

See Appendix 1 for Control Assessment and Assurance Definitions

Audit Area	Control Design	Control Operation	Findings	Priority Rating
1. Grant Payment	Red	Green	Finding 1 – Recording authorisations of payments to RSLs	High Priority
2. Application of Grant	Green	Light green	N/A – No issues noted	N/A
3. Programme Management	Orange	Light green	Finding 2 – Mounting of Development Site Signage	Low Priority
4. Monitoring & Reporting	Orange	Light green	Finding 3 – Completeness and accuracy of TMDF reporting	Low Priority
5. Records Management	Green	Light green	See findings 1 and 3	Low Priority

Management Response to Executive Summary

We welcome the findings of the audit and are committed to addressing the risks highlighted. We're grateful for Internal Audit raising the potential payment authorisation risk and in utilising the HARP system to address this. The Council's approach to payment authorisations and grant offers is in line with the agreed Scheme of Delegation and any grant offer exceeding £7m requires Scottish Government sign-off, payments in HARP system cannot exceed the amount of the grant offer to the RSL. In line with the recommendations of this audit, the Council will implement the agreed management actions below and will discuss with Scottish Government whether any further amendments to the HARP system are required. In addition to the controls that the Council and Scottish Government have, RSLs have their own controls in place. Therefore, officers in the Housing service consider the overall risk of fraudulent activity in this area to be low.

Background and scope

The City of Edinburgh Council (the Council) receives an annual development funding grant from the Scottish Government (SG) for the Affordable Housing Supply Programme (AHSP). The purpose of the funding is to provide assistance for housing under section 92 of the Housing (Scotland) Act 2001.

Development funding received from the SG in 2023/24 totalled £52.713 million and is paid in instalments following receipt of draw down notices from the Council by specified dates. The terms of the grant offer specify that the Council must manage the AHSP, and disbursement of the grant to Registered Social Landlords, in accordance with the grant procedures issued by the Scottish Ministers, and the procedures set out in the Council's Local Housing Strategy.

The SG's grant offer requires the Council to include the management of development funding in its Internal Audit plan once every two years, and to submit the audit report to the Scottish Ministers.

Scope

The objective of this review was to assess the adequacy of key controls established to support management of transfer of development funding from the Council to registered social landlords, in line with the Scottish Government requirements.

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

Risks

- Regulatory and Legislative Compliance
- Financial and Budget Management
- Fraud and Serious Organised Crime

Business Plan Outcomes

- People have decent, energy efficient, climate proofed homes they can afford to live in.

Limitations of Scope

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

- Processes established to identify and escalate breaches of the application of the Transfer of Management Development Funding (TMDF) grant, as they have been reviewed as part of the 2023-24 Annual Validation audit.

Reporting Date

Testing was undertaken between 2 April and 4 June 2024.

Our audit work concluded on 4 June 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 – Recording authorisations of payments to RSLs

Finding Rating	High Priority

Payment requests from Registered Social Landlords (RSLs) must be authorised in line with agreed authorisation thresholds.

Consolidated authorisations for multiple RSLs are provided via email and these emails are saved to the Council shared drive by Housing colleagues. Discussion with management highlighted that since consolidated authorisations contain commercially sensitive information about other RSLs, authorisation emails are not saved to the HARP system, which is also accessible to RSLs. Instead, Housing Officers note authorisations in a comment box on the authoriser's behalf and update a manual payment spreadsheet to note the authorisation.

Further discussion with management also highlighted that Finance colleagues do not have access to the authorisation emails and do not perform any additional checks to confirm the authorisation.

As there is a lack of system based segregation of duties, it is possible for a HARP user to check a RSL payment request (which averaged £371,182 in 2023/24), note the authorisation, update the payment spreadsheet, and then pass the request to Finance colleagues to process the payment without intervention.

Risks

- **Financial and Budget Management** – there is a risk that erroneous and unauthorised payments are made to the Registered Social Landlords.
- **Fraud and Serious Organised Crime –** there is a risk that fraudulent payments can be made to the Registered Social Landlords.

Recommendations and Management Action Plan: Recording authorisations of payments to RSLs

Ref.	Recommendation	Agreed Management Action	Action Owner / Lead Officers	Timeframe
1.1	The Council should enquire with the Scottish Government, owners of the HARP system, to explore the possibility of whether the system has functionality that allows authorisation to be processed on the system or functionality for authorisation emails to be saved on the system in a secure, private area.	The Council will explore both suggested options with Scottish Government. However, the implementation of the procedure in management action 1.2 will be prioritised to resolve the risks identified.	**Owner:** Service Director, Housing and Homelessness **Leads:** Senior Housing Development Officers	30/10/2024
1.2	In the interim, and should a system based solution not be possible, finance colleagues should be provided with access to authorisation emails and pre-payment authorisation review checks should be introduced to ensure adequate segregation of duties.	The Council will develop a procedure that will require responsible officers and authorising managers within Housing & Homelessness to include relevant colleagues from the Finance & Payments teams in all future AHSP grant payment authorisation emails. This procedure will be implemented upon receipt of the 2024/25 TMDF grant offer from Scottish Government.	**Owner:** Service Director, Housing and Homelessness **Leads:** Senior Housing Development Officers	30/10/2024

Finding 2 – Mounting of Development Site Signage

Finding Rating	Low Priority

The conditions of the Scottish Government's (SG) grant offer state that the Council must ensure that SG funding of housing provision is acknowledged by including its logo on all signage at development sites.

The Council has a documented procedure to ensure a lead officer makes Registered Social Landlords aware of site signage requirements and for ensuring that evidence of site signage being mounted is provided to the Council. However, the procedure does not provide timescales for completing checks to ensure site signage has been mounted.

A review of a sample of two sites found that signage had been requested for both sites but only after being prompted by the audit. For one site selected, site signage had not been mounted on site by the contractor approximately 3 months after site signage had been provided to the RSL.

Risks

- **Programme and Project Delivery –** there is a risk that the Council does not meet the conditions of the Scottish Government's grant offer, if checks are not completed and within in a timely manner, to ensure site signage has been mounted at development sites.

Recommendations and Management Action Plan: Mounting of Development Site Signage

Ref.	Recommendation	Agreed Management Action	Action Owner and Lead Officers	Timeframe
2.1	The Council's procedure for ensuring site signage includes the Scottish Government's logo should be reviewed with clear timescales established for requesting and obtaining evidence of signage being mounted, including timescales for follow-up and escalation when the signage has not been erected as required.	Updates will be made to site signage procedure to include timescale of 8 weeks from delivery of signage to the site for the service to contact the RSL/Council Housebuilding Team to request that evidence be provided that signage has been erected on site. The senior officer will review outstanding signage on a monthly basis with the responsible officer. In the event this evidence has not been provided within 8 weeks of signage delivery this will be escalated; there will be written notification to the responsible RSL Development Director to provide the evidence within 10 working days. Repeated failures to provide evidence will be raised with the RSL as a breach of grant conditions which would also be reported to Scottish Government.	**Owner:** Service Director, Housing and Homelessness **Leads:** Senior Housing Development Officers	30/10/2024

Finding 3 – Completeness and Accuracy of TMDF Reporting

Finding Rating	Low Priority

The Council is required to monitor and report to Scottish Government (SG) on the number of housing units started and completed, in alignment with the forecasted number indicated in the SG's grant offer.

Registered Social Landlords (RSLs) are expected to provide the Council with complete and accurate information on units started and completed via the HARP system. Management advised that RSLs are effective at providing timely information through HARP about spend data, but information provided on units starts and completions is often incomplete on HARP and must be requested via meetings, calls and emails. This leads to inaccurate monthly reporting to the SG, however any variations noted are adjusted in the following month's reports.

Discussion with management highlighted that while there are contractual requirements (via grant offer letter) for the Council to provide accurate monthly information to the SG, there are no similar agreements requiring RSLs to provide this information to the Council.

In addition, there is no documented guidance for updating the RSL Profile Sheets - spreadsheets used to monitor programme delivery that are provided to SG as part of monthly reporting and are used as part of the reconciliation process prior to drawdown from SG.

Currently, data within RSL Profile Sheets can be changed by any Housing Officer with access to the shared drive.

Risks

- **Programme and Project Delivery** – inaccurate information on the number of units started and completed is provided to the Scottish Government
- **Service Delivery** – lack of guidance and absence of key officers, may result in RSL Profile Sheets being updated inconsistently or inaccurately.

Recommendations and Management Action Plan: Completeness and accuracy of TMDF reporting

Ref.	Recommendation	Agreed Management Action	Action Owner/ Lead Officers	Timeframe
3.1	The Council should engage with the Scottish Government and raise the data quality issues arising from RSLs not currently completing the processes established to ensure complete and accurate data on units started and completed is provided through HARP. Discussions with the SG should also consider whether agreements should be established with RSLs to require them to provide the Council with timely and accurate information as part of grant funding conditions.	The Council will seek confirmation from Scottish Government if additional grant offer letter clauses could be added to any new grant offer letters, as well as including timescales for major milestone reporting on both HARP and to the Council to ensure full and accurate data is available on projects. If it is confirmed that it is not possible to amend the clauses, the council will seek guidance from Scottish Government on what best practice steps they can advise to ensure timely return of project data.	**Owner:** Service Director, Housing and Homelessness **Leads:** Senior Housing Development Officers	30/10/2024

3.2	Guidance for updating RSL Profile Sheets should be developed and reviewed upon substantive changes to the process.	Guidance will be developed on completion of the main programme Profile Sheets, including how to highlight any key changes made and noting the date this was carried out. Officers working on the programme will continue to archive the Profile Sheets each month to ensure both a clear audit trail that provides evidence of changes from the start of the financial year and to guard against data being lost.		30/10/2024
3.3	RSL Profile Sheets should be password protected and reviewed to consider where data can be secured, and automation applied to ensure the integrity of data is protected.	The Programme lead will create password protection on main RSL Profile Sheet with access restricted to staff working directly on TMDF and authorising senior managers as required.		30/10/2024

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	(orange)	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

Audit Areas	Control Objectives
Grant Payment	• Draw down notices and supporting evidence are reviewed and approved prior to submission to the Scottish Government (SG). • Where funding has not been fully utilised, the underspend is less than 10% of the amount drawn and is agreed between all parties.
Application of Grant	• The Council has established processes to ensure that the units completed during financial year 22/23 and 23/24 is as specified in table 4 of the SG's grant offer letter and any required changes are notified to the SG. • The Council has established processes to ensure that the number of units started during financial year 22/23 and 23/24 is as specified in table 5 of the SG's grant offer letter, and any required changes are notified to the SG.
Programme Management	• The Council works in partnership with registered social landlords to develop and implement effective strategies for local areas, consistent with the Council's Local Housing strategy. • There are procedures to ensure that the SG's funding is acknowledged by including its logo on signage at development sites.
Monitoring and Reporting	• Expenditure for 2023/24 does not exceed the allocation provided to the Council by the SG, and any carry forward into 2024/25 does not exceed 80% of the 2024/25 Resource Planning Assumption (RPA). *(RPA is the indicative amount of future grant to be provided to the Council by Scottish Ministers).* • There are established procedures to provide complete and accurate monthly reporting data to the SG, including but not limiting to grant funding spend, unit approvals, unit completions, or any other ad-hoc data requested by the SG.
General Data Protection Regulation (GDPR)	• The Council has established processes to ensure that access to commercially sensitive data and personal data (if any) is restricted in accordance with the General Data Protection Regulation (GDPR), and the Council's records management requirements.

Internal Audit Report

Social Care Direct (Adult Services)

06 September 2024

HSC2401

Overall Assessment	Reasonable Assurance

Contents

Executive Summary 3
Background and scope 4
Findings and Management Action Plan 6
Appendix 1 – Control Assessment and Assurance Definitions 16
Appendix 2 – Areas of Audit Focus and Control Objectives 17

This Internal Audit review is conducted for the City of Edinburgh Council under the auspices of the 2024/25 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2024. 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

Review of the design and operating effectiveness of the key processes, procedures and controls established to support delivery of Social Care Direct (Adult Services) has identified a number of issues, areas of non-compliance and scope for improvement.

The review recognises that the Social Care Direct Response Team (SCDRT) was established in April 2023 but expanded to all localities in January 2024. It is also noted, however, that several teams are involved in the delivery of Social Care Direct (Adult Services) and as a result some areas of service delivery and reporting are fragmented.

The following improvements have been raised to support development of key controls and to support mitigation of key risks to service and strategic objectives.

- policy & procedures should be updated to reflect current practice and ensure consistency in operations
- completion of officer training and continued professional learning should be monitored to ensure compliance with requirements
- a workforce plan should be developed for the SCDRT to ensure resources meet service needs and demands
- quality assurance processes should be strengthened to ensure actions are implemented following practice audits, to focus on operational QA including data quality and to share lessons learned
- an operational performance framework should be developed to monitor SCDRT performance
- risk registers should be reviewed regularly to ensure new, emerging and escalating risks are captured and mitigating actions taken

Areas of good practice identified

- the SCDRT welcomed audit findings to enhance their current practice and had begun addressing improvements prior to the report being issued
- communicating changes in both teams was effective
- an EHSCP Improvement plan is in place and monitored regularly
- the SCD (Corporate) training plan for new starts is comprehensive.

Audit Area	Control Design	Control Operation	Findings	Priority Rating
1. Policy and Procedures			Finding 1 – Policy, Procedures and Training	High Priority
2. Service Referrals and Screening Process				
3. Resource Management and Quality Assurance			Finding 2 – Workforce Planning and Quality Assurance	Medium Priority
4. Performance oversight and Governance			Finding 3 – Performance Monitoring and Data Quality	Medium Priority
5. Risk Management			Finding 4 – Risk Management	Low Priority

See Appendix 1 for Control Assessment and Assurance Definitions

Background and scope

The Adult Support and Protection (Scotland) Act 2007 is the legal framework for Adult Support and Protection (ASP) in Scotland. The Revised ASP Code of Practice provides guidance about the performance by Councils, public bodies, and other professionals under the Act. The Act defines an adult at risk, as a person aged 16 or over. Section 3(1) defines an 'adult at risk' as someone who meets all of the 3-point criteria (also known as the '3-point test).' Section 12A of the Social Work (Scotland) Act 1968 places a duty on the local authorities to assess need and then decide whether the assessed needs 'call for the provision' of services. The Eligibility Criteria Policy outlines the criteria to assess people's eligibility to receive care services and support.

In Edinburgh, ASP referrals come via the Customer Services Social Care Direct Corporate Team who take all calls for social care advice and then signpost or workflow referrals to the appropriate service required, including ASP concerns, which workflow to Social Care Direct Response Team (SCDRT) if there is no allocated worker. The SCDRT team focusses on prevention and early intervention. SCDRT Senior Social workers screen all incoming work and allocate work to a Social worker, Occupational Therapist or Community Care Assistant who have Conversation One (from the Three Conversations approach) with the service user with a view to maximising the existing assets the person has, sign posting or 'one and done' tasks such as urgent equipment or emergency (section 12) payments. Automated forms (those forms sent online) go to SCDRT, if not allocated, for screening and assessment. The teams are in different directorates and therefore have separate management, guidelines, training documents, policies and procedures.

Referrals, notes, and workflows are recorded on the Case Management Systems SWIFT/AIS. Where further assessment is required, the case is screened and work flowed to the relevant locality, and if appropriate, placed on their waiting list.

In February 2023, the Care Inspectorate published the Joint Inspection of Adult Support and Protection practice which identified areas of improvement for the Partnership including the management and oversight of screening and initial inquiries through Social Care Direct. The March 2023 inspection report Adult Social Work and Social Care in Edinburgh also identified significant weaknesses in the design, structure, implementation and oversight of key processes, including the assessment of people's needs and in their case management; approaches to early intervention and prevention were uncoordinated and inconsistent.

In June 2023, the Edinburgh Integration Joint Board approved a 3 year-Improvement plan in response to both Inspections. An update was provided to Policy and Sustainability Committee in March 2024. Monthly progress is also monitored through several governance forums and oversight groups.

Edinburgh Health and Social Care Partnership (EHSCP) are currently going through a restructure resulting in potential changes to services.

Scope

The objective of this review was to assess the adequacy of design and operating effectiveness of the key controls within the Social Care Direct Team with a specific focus on processes for screening referrals received, initial triage for adult concern and the response service for people to meet immediate needs.

Alignment to Risks and Business Plan Outcomes

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

- Health and Safety
- Technology and Information
- Service Delivery
- People
- Regulatory and Legislative Compliance
- Reputational

Business Plan Outcomes:

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

Limitations of Scope

The following areas were excluded from scope:

- Children's Services and Criminal Justice (only Adult Services were reviewed)
- Out of Hours service – this service deals with emergencies and has separate processes
- Duty to Inquire – as there has recently been an audit carried out in this area by the Council's Quality Assurance and Compliance Team.

Reporting Date

- Testing was undertaken between 13 June 2024 and 1 July 2024.
- Audit work concluded on 1 July 2024 and audit findings and opinions are based on the conclusion of audit work as at that date.

Findings and Management Action Plan

Finding 1 – Policy, Procedures and Training

Finding Rating	High Priority

Policy and procedure documents require updating - the Eligibility Criteria Policy has not been updated since 2015. This a key policy which aims to ensure decisions about care and support are fair. Testing noted the policy is not used consistently, with decisions often based on the capacity of localities, rather than policy criteria resulting in potentially inconsistent decisions, which could put people at risk and have an impact on financial budgets.

There is no Service Level Agreement (SLA) between the Social Care Direct Response Team (SCDRT) and the Social Care Direct (SCD) Corporate team which sets out roles and responsibilities for each team. An SLA would set out a clear understanding of service expectations for both teams, promote accountability and provide a clear mechanism for measuring performance.

The roll out of the SCDRT has been phased by one locality at a time between January and May 2024. While it is recognised that the procedures are continually developing, they are not in line with how the team records information, resulting in inconsistent notes and recording. The procedures do not include timescales for responding to customers and there is no written process for managing priority cases. Management have advised that the job role is based around managing risk therefore Social Workers are aware of how to manage priority, however, SCD (corporate) are not trained on risk and do not having a clear process of managing and recording priority.

There is no written process for managing backlogs for assessments. Management advised they have daily oversight and can run a report, however, this was not provided to Internal Audit to verify. Management also advised there is no backlog in the workflow mailboxes as officers work until the mailbox is empty each day which could be over normal working hours, which relies on the good will of officers, and does not demonstrate robust resilience and business continuity controls.

Some customer records are 'locked' for confidential reasons; SCD (corporate) can identify these when searching but these cases would not be shown in the work flowed cases to SCDRT and could be missed by officers who cannot access locked records.

When a customer requires emergency assistance, they can request support from the local authority via a Section 12 payment. Whilst individual teams have their own process for recording information and processing payments, management advised the request goes through four teams (SCD, SCDRT, locality, then business support). It is unclear how long it takes for a customer to receive a payment.

Learning and development - role specific learning for Social Workers and Community Care Assistants is outlined in the Orb, however, as some officers are 'on loan' from localities, management do not have oversight of completed training.

An excel based training matrix has been introduced for officers to complete. Officers are required to complete continuous professional learning for SSSC registration, however, there was no record of officers confirming completion.

SCD (Corporate) do not receive training on adult protection as they are only required to record information and workflow, however, the Adult Social Work and Social Care in Edinburgh Inspection report 2023 identified that the opportunity for early intervention and prevention is missed as SCD are at the 'front door.'

Risks

- **Regulatory and Legislative compliance** – if policies and procedures are not reviewed regularly, they may no longer align with statutory requirements

Risks continued

- **Workforce -** officers may not complete all the required role specific learning for their role
- **Health and Safety –** failure to have clear processes for managing demand of assessments in line with current resources could impact the wellbeing of officers
- **Reputational Risk –** lack of consistent and up to date policy and procedures may result in customers receiving inconsistent services
- **Service Delivery –** if policy and procedures are not up to date, officers will not work consistently, and practice will vary which may put service users at risk
- **Financial and Budget Management –** budgets may be impacted if services are provided to service users who do not meet the appropriate eligibility criteria. Section 12 payments may not be paid in a timely manner.

Recommendations and Management Action Plan: Policy, Procedures and Training

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
1.1	The Eligibility Criteria Policy should be reviewed and updated in line with current requirements. The policy should be approved by senior management and Committee where required. The policy should be communicated to all relevant colleagues and used consistently across relevant teams including SCDRT and localities.	The eligibility criteria will be reviewed, agreed through the appropriate governance route and communicated to staff and stakeholders.	Chief Officer, Health and Social Care Partnership	Head of Service, Assessment and Care Management	30/06/2025
1.2	A Service Level Agreement (SLA) between SCD Corporate and SCDRT should be developed outlining clear expectations on service standards, roles and responsibilities including updating procedures, undertaking quality assurance, performance monitoring and monitoring completion of training.	An SLA will be produced to ensure any immediate risks are mitigated. A review of SCDRT is due to be initiated and integral to that will be a requirement to ensure that there are clear expectations in relation to service standards, roles and responsibilities and joint procedures.			31/08/2025
1.3.1	SCDRT should update operational procedures to include: • timescales for responding to customers	The standard operating procedures and associated guidance will be reviewed and cover customer contact including urgent cases, KPI's, referrals section 12		Service Manager, SCDRT	31/12/2024

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
	• a process for priority or urgent cases • whether contact and referral forms are used as outlined in Rec 3.3 • a process for access and sharing required information on 'locked' records • a process for processing and monitoring section 12 requests • guidance on consistent case note headlines and case notes as outlined in Finding 3 • a process for managing backlogs within required timescales and resources available with consideration of colleague wellbeing • guidance on daily monitoring of workflow boxes • a quality assurance process (including data quality issues) as outlined in Rec 2.4.	requests, backlogs, case notes, workflow, quality assurance. Due to limitations with the current system, there is no other alternative process for the accessing and sharing of locked records. This will be included in future iterations of the standing operating procedures once the new system is implemented.			
1.3.2	SCD Corporate should update procedures to include: • a process for priority or urgent cases • a process for access and sharing required information on 'locked' records • guidance on consistent case note headlines and case notes as outlined in Finding 3 • a quality assurance as outlined in Rec 2.4.	SCD (Customer Services) procedures to be reviewed and updated by SCD Team Leader. Existing call flow to be validated, including priority case and locked record processes and case note guidance. NB QA action addressed at 2.4.2 Contact Team Manager to sign off procedures by 31/12/2024	Executive Director, Corporate services	Customer Contact Team Manager	31/12/2024
1.4.1	Role specific learning and training for SCDRT should be monitored and held centrally to allow for management oversight of completed learning and compliance with SSSC requirements.	Role specific learning and training will be monitored centrally to ensure compliance with mandatory training which is integral to our responsibility as an employer in terms of the SSSC.	Chief Officer, Health and Social Care Partnership	Head of Service, Assessment and Care Management	28/02/2025

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
		Meeting SSSC registration requirements is the professional responsibility of each individual registered social worker. Communications will be drafted to ensure that staff are aware of their responsibility in terms of registration requirements.			
1.4.2	SCD Corporate should consider whether Adult Protection Training for those answering calls, or closer working relations with SCDRT is required to ensure appropriate signposting and work flowing is completed.	Training to be requested from SCDRT and rolled out to all SCD Customer Services staff and added to new start induction process. Rollout to be completed by March 2025.	Executive Director, Corporate services	Customer Contact Team Manager	30/03/2025

Finding 2 – Workforce Planning and Quality Assurance

Finding Rating	Medium Priority

Workforce planning is essential to ensure there is a skilled and capable workforce to deliver strategic priorities and to meet changing needs. There is currently no workforce plan for SCDRT resources. Management have advised this will be developed following the Partnership restructure.

It was noted during fieldwork that when resources are low, continued service to customers is dependent on officers good will and senior management carrying out operational work. The SCDRT has been developed over the last 7 months with officers 'on loan' from localities. This means officers are balancing other priorities, such as a case load which could impact on the quality of services, they are able to provide within the SCDRT and, the service provided to customers. Loaned officers are also managed by localities, not the SCDRT which can present difficulties for competing priorities.

Quality Assurance (QA) provides a framework and guidance for continuous improvement. In May 2024, the Partnership approved the Clinical and Care Governance (CCG) QA framework. This high-level framework aims to provide a consistent approach to QA and practice audits across the Partnership. The SCDRT are included within the QA practice workplan, with two audits planned for 2024. The corporate SCD is however, not included in the workplan.

There are no action plans from practice audits and recommendations are not tracked, therefore it is unknown if recommendations have been taken on board. There is also no process to identify and address thematic issues or communicate lessons learned, to prevent repeat issues reoccurring.

Internal QA processes provide assurance that work is being carried out consistently and is good quality, errors can be rectified, and associated risks reduced. SCD (corporate) have an internal QA programme for new staff. Testing highlighted that there were incomplete notes on SWIFT and officers do not always complete the required fields. Incomplete SWIFT notes impact on the service provided to customers as they may have to duplicate the conversation with another colleague and may take longer to access a service required. There are also issues with work flowing to the wrong mailbox (team).

SCDRT do not carry out routine QA however, there is oversight by senior officers and management. Testing found that some required fields within the AIS system were not completed, and eligibility was being wrongly assigned.

Issues with data quality are captured in weekly reports issued to management, however, this does not include eligibility criteria, so management have no oversight of eligibility criteria being assigned or when it is not completed.

Management advised they check the data quality issues raised in reports and discuss these with officers, however, there is no written process to address issues raised and to prevent these from reoccurring.

There is also no mechanism for monitoring the time taken to issue a Section 12 payment, and there is a risk a customer may not receive urgent funds within a required timescale.

Risks

- **Governance and Decision Making – if** management are unaware of Quality Assurance and data quality issues, they could make uninformed decisions about resources, which could increase the risk on service delivery
- **Financial and Budget Management** – if eligibility criteria is not correctly assigned, management may not be able to effectively plan for resources to manage assessments, and more support may be provided to customers than required
- **Reputational Risk** – if errors are not identified and corrected, customers may not receive a quality or timely service
- **Strategic and Service Delivery** – if there are inadequate resources to meet demand strategic and service delivery objectives will not be achieved
- **Workforce** – inadequate resources will impact delivery of quality delivery services which meet customer needs.

Recommendations and Management Action Plan: Workforce Planning and Quality Assurance

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
2.1	A workforce plan for Social Care Direct Response Team (SCDRT) should be developed. The workforce plan should be approved by senior management and a relevant governance forum with progress towards delivery of services within the resources set out in the plan monitored periodically and revised as required.	A workforce plan will be developed once the redesign of the front door is completed which is anticipated to extend over a 12-month period	Chief Officer, Health and Social Care Partnership	Head of Service, Assessment and Care Management	31/08/2025
2.2	Findings and recommendations from Quality Assurance (QA) practice audits should be tracked to confirm when they have been completed and where necessary progress reviewed. A relevant governance forum should also receive reporting on results of QA practice audit activity at an agreed, and regular frequency.	A quality assurance framework will be developed which will include practice audit activity.			28/02/2025
2.3	Thematic issues and lessons to be learned following practice audits should be shared with practice teams to enable changes to be actioned as required. This should include development of an email template or bulletin to ensure information and key messages are cascaded consistently.	A quality assurance framework will be developed which will incorporate thematic issues and lessons learnt from practice audits and clear communication approach to share learning.			28/02/2025
2.4.1	SCDRT should develop an internal Quality Assurance (QA) process which focuses on data quality issues to ensure work is streamlined and complete. The process should include the frequency of QA checks and an overview of what the checks will include and how this will be reported to management for oversight and assurance.	A quality assurance framework will be developed and will incorporate data quality issues and set out frequency of QA checks.			28/02/2025
2.4.2	Social Care Direct (corporate) should develop an ongoing internal Quality Assurance process to ensure work is streamlined and complete and data quality issues are identified. The process should include the frequency of QA checks and an	Existing Quality Assurance model (including frequency) to be assessed to ensure fit for purposes. Signed off by SCD Team Leader	Executive Director, Corporate Services	Customer Contact Team Manager	31/12/2024

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
	overview of what the checks will include and how this will be reported to management for oversight and assurance.	Monthly updates, including any remedial actions/recommendations to be reported to SCD Team Manager Audit evidence will detail sample monthly updates			

Finding 3 – Performance Monitoring and Data Quality

Finding Rating	Medium Priority

A performance monitoring framework sets out the key measures to indicate whether a service is meeting required standards and outcomes and includes what information is reported where and at what frequency. An overarching performance framework is in place for the Partnership. This will be re-evaluated when the new strategic plan is confirmed, due later in 2024.

Review of the current framework presented to the Performance and Delivery committee of Edinburgh Integration Joint Board for approval in June 2024 notes that it is high level and does not detail operational level performance.

Weekly reporting is issued such as the Community Waits Summary, SCDRT Reporting and a 3 Conversations dashboard which include SCDRT data on how many cases have been work flowed to and from the team and how many conversations have been carried out and a monthly Departmental Management Team (DMT) report. However, there is no operational performance guidance to clearly set out performance reporting, including relevant officers responsible for reporting, who reports should be distributed to and what reports are priority.

Weekly reports issued outline the number of contacts within both SCD (Corporate) and SCDRT to other teams and the number of conversations completed. However, it was identified, that data in the reports may not be accurate due to the way information is recorded in SWIFT/AIS systems.

Data performance reports use manually input codes within case note headlines (e.g. NFA, (No further action), which leave room for error as if the code is not input correctly by the system user, the SWIFT reporting system will not pick it up. Also, parts of the system are not linked therefore performance data may be over or underinflated for some reporting. The system also does not track cases from logging, to screening, to assessment so dates input by SCD (corporate) are on a different system area (contact form) than dates input by SCDRT (assessment form). As parts of the system are not linked, dates may be recorded differently and the number of days between contacts reported will not be accurate, for example, if SCD (corporate) record contact on 02/02/24, the SCDRT target date on the assessment page should be the same date but testing highlighted that different dates had been used and this would not be picked up by data quality. As a result, when reporting, a customer may appear to have been contacted within 3 days when they have not, as reporting is based on the assessment dates, not the contact dates. It is acknowledged that a project to replace the SWIFT system is currently underway and due to go live in 2026. Workarounds to ensure data quality should be implemented in the interim to ensure timely and accurate reporting.

There is currently no formal governance structure for reporting on performance for the SCDRT, however, management have advised that when the re-structure is complete, it is expected performance will be reported to P&D committee.

Key Performance Indicators (KPIs) are measures used to evaluate performance. There are a number of Social Work governance KPIs which SCDRT base some of their performance on (KPI 1-conversation within 3 days, KPI 3-conversation about risk & KPI 6-AP referrals actioned within 48hrs), however, SCDRT are currently not reporting on all these KPIs and have not established their own KPIs for measuring team performance.

Risks

- **Strategic Delivery –** senior officers may not be aware of key performance issues and decisions required resulting in delays to service delivery
- **Regulatory and Legislative compliance** – senior officers may not get assurance that the service provided meets regulatory and legislative requirements
- **Service Delivery** – customers may not receive services within the required timescales

Recommendations and Management Action Plan: Performance Monitoring and Data Quality

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
3.1	An operational performance reporting framework for SCDRT, should be developed which sets out what measures will be reported, to where and what frequency. The framework should be approved by a relevant governance forum who will be responsible for oversight of performance.	A performance reporting framework for SCDRT will be developed utilising existing data and reported through service oversight arrangements and the HSCP Quality and Assurance frameworks.	Chief Officer, Health and Social Care Partnership	Head of Service, Assessment and Care Management	28/02/2025
3.2	SCDRT should develop SMART (specific, measurable, achievable, relevant and timebound) Key Performance Indicators (KPIs) and outcomes to demonstrate progress achieving regulatory requirements, service standards and required timescales and to enable comparison against actual and target performance.	KPI's will be developed as part of the redesign of the front door / Social Care Direct.			31/08/2025
3.3	Recognising that the SWIFT replacement system project is underway, in the interim until the new system goes live in 2026, reporting to support collation of performance data should be reviewed to ensure systems queries include information from contact and assessment data. Guidance should be issued to colleagues to set out clear requirements for data input in required fields to limit data errors and improve data quality.	Guidance will be produced setting out expectations and requirements for data entry at key points.		Service Manager, SCDRT	31/12/2024
3.4	Management should also ensure that accurate data input, collation, extraction and reporting for this area is raised as a key requirement for the new social care operating system that will replace the SWIFT system.	The HSCP lead of the SWIFT replacement project will be provided with key requirements from the social care direct team in terms of data input, collation, extraction and reporting.		Head of Service, Assessment and Care Management	28/02/2025

Finding 4 – Risk Management

Finding Rating	Low Priority

Risk Management enables risks to the Edinburgh Health and Social Care Partnership's (EHSCP) or service objectives to be identified, recorded and managed. This provides greater assurance that objectives are achieved on an ongoing basis.

A risk register is in place for the EHSCP, the Southeast (SE) Locality (which SCDRT risks are escalated to and the SCDRT, it was noted that the SE locality and the SCDRT risk registers are incomplete and require updating.

Management have advised that further guidance for staff inputting to the risk registers would be beneficial.

Risks

- **Governance and Decision Making –** risks are not effectively identified, recorded, and managed which could affect 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

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
4.1	Risk registers should be agreed and reviewed at an agreed frequency to identify increasing, new or emerging risks. The review of the risk register should be clearly recorded with clear leads and timescales for mitigating actions documented and monitored. Risks out with the Council's or EHSCP risk appetite or risk tolerance should be escalated to the SE locality risk registers for support to initiate mitigating actions.	A risk register will be developed for this service which will include risk owners and mitigation controls	Chief Officer, EHSCP	Head of Service, Assessment and Care Management	31/12/2024
		Specific SCD risk register to be developed and reviewed by SCD Team Leader monthly. Appropriate escalations will be included in wider Customer and Digital Services risk activities. Audit evidence will detail sample risk registers.	Executive Director, Corporate Services	Customer Contact Team Manager	31/12/2024

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	(orange)	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

Audit Area	Control Objectives
Policy and Procedures	• Up to date policies and procedures are in place which clearly set out the end-to-end Social Care Direct processes for adults including the effective management of screening referrals, to ensure that referrals are completed in a timely manner and to the required standard. • Role specific learning and training needs have been established for adult social care direct staff supported by regular training to ensure compliance with regulatory requirements and new or updated processes. • An up-to-date Service Level Agreement is in place between the Social Care Direct Corporate Team (Contact Centre) and the Social Care Direct Response Team which adequately reflects the roles and responsibilities between the two services.
Service Referrals & Screening Process	• There are adequate controls over the screening process to ensure that all referral requests for adult social care including those which are 'locked records' are completed within appropriate timeframes, accurately recorded, and appropriately prioritised. • In addition, appropriate processes are in place to ensure that an effective 'Conversation One' has been completed with the service user and to support the transfer of referrals across to localities. • All adult social care screening assessments are performed in line with the Partnerships eligibility criteria policy. • Urgent adult social care screening assessments are completed and reviewed at an appropriate level and within appropriate timeframes. An effective escalation process exists for all complex or urgent cases identified. • Emergency (section 12) payments are appropriately approved and issued in a timely manner.

Resource Management and Quality Assurance	• Workforce planning processes for the adult social care direct team have been developed and provide assurance that:
	  ○ workforce requirements are assessed, regularly reviewed and action taken to ensure there is adequate capacity to meet demand across the short; medium; and long term to deliver an effective service
	  ○ appropriate solutions are developed to manage any gaps identified (for example staff sickness and annual leave)
	• Improvement plans for the Adult Social Care Direct service are in place with objectives regularly managed and monitored.
	• A quality assurance framework is in place to assess the screening and management of ASP referrals, which includes an embedded approach to lessons learned from both internal practice reviews and external inspections.
	• A complaints procedure is in place which is supported by a process to ensure learning from complaints and process improvements where necessary.

Performance Oversight and Governance	• A performance framework for adult social care direct is in place which includes key performance indicators, outcomes and agreed targets/timescales to measure success. • There is regular and accurate performance monitoring reporting of key processes to identify areas of good performance, and where improvement is required including ensuring backlogs are regularly reviewed and managed. • Governance and oversight arrangements are in place to ensure regular review and scrutiny of delivery adult social care direct services by an appropriate governance forum.
Risk Management	• Risks related to Adult Social Care Direct 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.

Internal Audit Report

Education Support Provision

20 September 2024

CEJ2401

Overall Assessment	Reasonable Assurance

Contents

Executive Summary 3
Background and scope 4
Findings and Management Action Plan 5
Appendix 1 – Control Assessment and Assurance Definitions 8
Appendix 2 – Areas of Audit Focus and Control Objectives 9

This Internal Audit review was conducted for the City of Edinburgh Council under the auspices of an addition to the 2024/25 internal audit plan approved by the Governance, Risk and Best Value Committee in May 2024. 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

The transition from the Enhanced Support Base model to the Education Support Provision model was generally well managed, with effective gathering and review of data, decision making aligned with GIRFEC (Getting it Right for Every Child), and effective communications and consultations.

The following improvement actions were identified:

- an Integrated Impact Assessment should be performed to identify any equality, environmental, or economic impacts of the decision
- an assessment of risks should be performed to identify and appropriately manage any risks associated with the transition to the new model of education support provision
- a review of the decision-making process should be performed to identify any lessons learned.

Areas of good practice identified

- sufficient and appropriate data was gathered and considered prior to a decision being made on the model for education support provision in schools
- decision making was in line with the objectives of GIRFEC (Getting It Right For Every Child)
- extensive consultations were held with Head Teachers regarding rising demand for enhanced support and the resources required to meet this
- consultations were held with parents and all key stakeholders regarding the Council's wider vision of inclusive education for children and young people
- communications to parents on the outcome of their child's placement request were sent on a timely basis and included all relevant information.

Audit Assessment

Audit Area	Control Design	Control Operation	Findings	Priority Rating
1. Decision Making and Planning Processes	Orange	Orange	Finding 1 – Integrated Impact Assessments and Assessment of Risks	High Priority
2. Communications with Key Stakeholders	Green	Green	No findings identified	N/A
3. Lessons Learned	Red	*N/A	Finding 2 – Identification of Lessons Learned	Medium Priority
4. Risk Management	Green	Orange	See Finding 1	Medium Priority

(*N/A - Control operation not tested due to adequacy of design)

See Appendix 1 for Control Assessment and Assurance Definitions

Background and scope

Enhanced Support Bases (ESBs) were established as a pilot programme in academic session 2020/21. ESBs were classrooms set up within mainstream secondary schools to provide support for children and young people with complex additional support needs in relation to learning and communication.

Over the next three academic years a total of 9 ESBs were established in mainstream secondary schools across the city. Under the Education (Additional Support for Learning) (ASL) Act (2004) (the Act) ESBs were classified as special schools and parents were able to submit placement requests for their child through the Council's Education Resource Group (ERG). As parental requests increased, capacity of ESBs became an issue. Each ESB was designed to support a maximum of ten learners from S1 to S3, but in session 2023/24 it was identified that a number of ESBs were supporting 15 learners across S1 to S5.

There is also a requirement under the Act, and the accompanying Additional Support for Learning Code of Practice (2017), to provide transport for children from their homes to ESBs when requested by parents. This meant that children were often being transported across the city outwith their own learning community with transport costs and emissions increasing.

In September 2023 work was performed with the Headteachers of ESBs to identify available capacity. This work concluded that capacity would not be sufficient to cover the placement requests being made. Between September and December 2023, the existing provision was reviewed, and an options appraisal performed to determine the way forward. This included visits to ESBs, questionnaires, and discussions with ESB leaders and teaching staff.

The following three options were developed:

1. status quo – keep ESBs in the 9 current schools and increase the capacity of these to 15 learners in each for S1 to S5
2. extend the ESB pilot – rollout of ESBs to a further 4 schools
3. Education Support Provision (ESP) model – provide enhanced support in all mainstream secondary schools. A decision was taken by officers to proceed with option 3.

An amendment was submitted to the Governance, Risk and Best Value Committee meeting on 19 March 2024 requesting an audit be carried out on the decision not to offer ESB placements for the next school year, and instead to replace them with ESP provision.

Scope

The objective of this review was to assess the adequacy of design and operating effectiveness of the key controls in place for the decision making and communication of the transition from the Enhanced Support Base model to the Education Support Provision model.

Alignment to Risks and Business Plan Outcomes

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

- Governance and Decision Making
- Service Delivery
- People
- Regulatory and Legislative Compliance
- Reputational Risk.

Business Plan Outcomes: Core services for people in need of care and support are improved.

Limitations of Scope

Decisions made by the Education Resources Group on individual placement requests were not considered by Internal Audit.

Reporting Date

Testing was undertaken between 13 June and 6 September 2024

Audit work concluded on 6 September, and the findings and opinion are based on the conclusion of our work as at that date.

Findings and Management Action Plan

Finding 1 – Integrated Impact Assessments and Assessment of Risks

Finding Rating	High Priority

The Council's Equality and Diversity Framework 2021 – 2025 outlines how the Council will meet its legal duties under the Equality Act 2010 and the Public Sector Equality Duty. Under the Framework, Integrated Impact Assessments (IIAs) should be used to assess the impact of service decisions on the following areas:

- Equality and Human Rights
- Environment and Climate Change
- Economy, including socioeconomic disadvantage.

Guidance and a toolkit which clearly sets out the requirements and considerations for IIAs is provided on the Orb (the Council's intranet).

In addition, risk assessments can be used to determine the risks associated with service decisions and put in place appropriate mitigation.

Neither IIAs nor formal risk assessments were prepared in relation to the decision to transition from the Enhanced Support Base model to the Education Support Provision model. Whilst Internal Audit are not aware of any adverse equality impacts or emerging risks because of the transition, there is a risk that these have not been identified and are not being appropriately managed.

Risks

- **Service Delivery –** risks and adverse equality impacts have not been identified and appropriately managed, leading to the risk of poor service delivery
- **Regulatory and Legislative Compliance –** legislative requirements are not being complied with.

Recommendations and Management Action Plan: Integrated Impact Assessments and Assessment of Risks

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
1.1	A retrospective Integrated Impact Assessment should be performed in relation to the decision to transition from the Enhanced Support Base model to the Education Support Provision model. The guidance and toolkit available on the Orb should be followed which includes the requirement to publish the final IIA on the Council website.	Completion of a retrospective Integrated Impact Assessment in relation to the decision to transition from the Enhanced Support Base model to the Education Support Provision model.	Executive Director of Children, Education, and Justice Services	Head of Education (Inclusion)	31/12/2024

1.2	An assessment of risks should be performed in relation to the decision to transition from the Enhanced Support Base model to the Education Support Provision model. Once identified, relevant risks should be added to the Service risk register, together with mitigating controls to ensure risks are managed appropriately.	Completion of an assessment of risks in relation to the decision to transition from the Enhanced Support Base model to the Education Support Provision model. Relevant risks will be added to the Service risk register, together with mitigating controls to ensure risks are managed appropriately.			31/12/2024

Finding 2 – Identification of Lessons Learned

Finding Rating	Medium Priority

Following any significant service change or decision-making process, it is important to reflect on the process and identify what went well and where improvements could have been made. This enables continuous improvement across the Council.

A lessons-learned exercise to review the transition from the Enhanced Support Base model to the Education Support Provision model was not completed. Now that the new model of education support provision has been rolled out, there is an opportunity to reflect on the change and the decision-making process, and identify any lessons learned.

Risks

- **Governance and Decision Making** – opportunities for improvement in decision-making processes are not identified
- **Service Delivery –** opportunities for improvement in service delivery process are not identified**.**

Recommendations and Management Action Plan: Identification of Lessons Learned

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
2.1	A lessons-learned exercise should be undertaken to review the process of decision making and roll-out of the new model of education support provision and identify lessons learned to support further decisions for model and further service model reviews. Learning should be recorded within a log, with actions to ensure relevant learning is taken forward.	Completion of a lessons learned exercise to review the process of decision making and roll-out of the new model of education support provision and identify lessons learned to support further decisions for model and further service model reviews. Learning will be recorded within a log, with actions to ensure relevant learning is taken forward.	Executive Director of Children, Education, and Justice Services	Head of Education (Inclusion)	31/12/2024

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	(orange)	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

Audit Areas	Control Objectives
Decision Making and Planning Processes	• detailed options appraisal exercises were performed to identify and evaluate alternative options to the ESB model • the options appraisal exercise included a review of the additional provision needed to support children and young people within a mainstream setting, including staffing levels and physical spaces required, and was performed prior to the decision being made • appropriate consultations were held with key stakeholders (including parents) as part of the options appraisal, and the results were included in committee or group reporting • the decision was taken by an appropriate governance forum, and within relevant delegated authorities the decision taken by committee or group on which option to pursue was made taking into consideration the values of the Scottish Government's 'Getting It Right For Every Child' (GIRFEC) policy, was not purely based on the budgetary aims of reducing home to school transport costs, and included detailed review of the options appraisal exercise • all relevant risk assessments and equalities impact assessments were completed prior to making the decision.
Communications with Key Stakeholders	• communications were issued to parents, children and young people, and schools on a timely basis • communications included an appropriate level of information including details of what the ESP model would look like for each child, and officer contact details were provided to raise any queries or concerns • measures were put in place to collect and review feedback from all key stakeholders and address any concerns raised.
Lessons Learned	• lessons learned from the decision making, planning, and communication of the decision to move to the ESP model have been identified and captured • actions have been put in place to address any identified areas for improvement.
Risk Management	• risks related to the implementation of the Education Support Provision model have been 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.

Internal Audit Report

Early Years Cross-Boundary Places

25 September 2024

CEJ2404

Overall Assessment	Substantial Assurance

Contents

Executive Summary 3
Background and scope....................................4
Findings and Management Action Plan....................................6
Appendix 1 – Control Assessment and Assurance Definitions....................................11
Appendix 2 – Areas of Audit Focus and Control Objectives....................................12

This Internal Audit review was conducted for the City of Edinburgh Council under the auspices of an addition to the 2024/25 internal audit plan approved by the Governance, Risk and Best Value Committee in May 2024. 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	Substantial Assurance

Overall opinion and summary of findings

The Early Years Cross-Boundary Places arrangements are in line with statutory guidance, and controls are in place to ensure that all funding due is being received. Only some minor improvement actions were identified.

Specific improvements related to Early Years include ensuring that there is a formal record of approvals for proposals and ensuring the draft Early Years Delivery Plan 2024-27 is reviewed every two years and includes clear version control.

Wider improvements identified are related to the Strategic Programme Board (SPB) including obtaining evidence of formal approval of proposals from the Senior Responsible Officer and ensuring the current draft terms of reference for the SPB is finalised, is reviewed at agreed intervals, and version control included to detail the outcome of reviews. Also, guidance documents for projects and proposals on the Orb should be reviewed and updated.

Areas of good practice identified

- compliance with statutory guidance was confirmed by the Council's Legal Team
- financial modelling was in place and used to inform decision making on the cross-boundary placements decision
- the Council engaged with key stakeholders, including the Scottish Government and Private / Voluntary / Independent (PVI) providers
- the Council communicated the cross-boundary decision to PVI providers in sufficient time for implementation
- the cross-boundary decision proposal was submitted to and subsequently approved by the Strategic Programme Board.

Audit Assessment

See Appendix 1 for Control Assessment and Assurance Definitions

Audit Area	Control Design	Control Operation	Findings	Priority Rating
1. Policy and Governance			Finding 1 – Cross-Boundary Places Proposal: Formal Approval and Guidance	Medium Priority
			Finding 2 – Draft Early Learning and Childcare Delivery Plan	Low Priority
2. Stakeholder Engagement			No findings identified	N/A
3. Strategic Programme Board			Finding 3 – Strategic Programme Board: Terms of Reference	Low Priority
4. Risk Management			No findings identified	N/A

Background and scope

The City of Edinburgh Council (the Council) is required by statute to provide to eligible children 1140 hours of early learning and childcare over a period of at least 38 weeks and up to 52 weeks each year and will make available funding to providers in the private, voluntary and independent sectors within the Council area.

Due to a review of the overall funding distribution for early years learning and childcare, funding from the Scottish Government for Edinburgh's Early Learning and Childcare 1140 expansion was reduced from £46.4m in 2021-23 to £41.3m in 2022-23 and then reduced again to £40.4m in 2023-24. A further reduction of £1.9m is to be applied in 2024/25. The overall reduction of £7.9m is therefore a major budget pressure. To enable delivery of a high-quality service, the Council has revised the model of delivery for early years learning and childcare.

Section 47 (1) of the Children and Young People (Scotland) Act 2014, provides that each education authority must ensure that the statutory funded early learning and childcare entitlement is made available for each eligible young child belonging to (i.e. residing in) its area. As at March 2024, 174 children from nine other local authorities currently receive a funded place in Edinburgh with 150 of these places in private provider settings, at a cost to the Council of approximately £1.2 million to provide these places.

On 23 January 2023, information was shared with the Education, Children and Families Committee which considered a reported £6m cut in funding from the Scottish Government for provision of the Early Years Service, and how to maximise the use of local authority places by reducing the need to commission external provision and providing places for children from other local authorities whose parents/carers work in Edinburgh. This resulted in a determination by the Council's Strategic Programme Board on 30 November 2023 to remove cross-boundary families in 1140 funded hours private/voluntary/independent (PVI) nurseries provision.

A decision was taken to continue to fund existing cross boundary places in private settings but phase this option out from August 2024. Existing funded children who are not Edinburgh residents will continue to be funded. If they have a younger sibling who attends the setting and will be eligible for funding during session 2024-25, the Council will also fund this child to prevent the need for the parent to use more than one early years setting. Parents who are not Edinburgh residents and require full day all year-round provision to work in the city will be able to access this in one of the full year 8am – 6pm local authority settings. If they need additional hours beyond their funded entitlement, they will also be able to purchase these from a local authority setting.

On 21 March 2024, Full Council approved a motion titled Early Years Provision and Out of Catchment which requested that "*the Chief Internal Auditor should commission an urgent audit of early years funding and cross boundary places to ensure that the arrangements meet the Statutory Guidance and that the Council is ensuring that all funding due is being received or is otherwise offsetting the costs to the children's home authorities*". The request for the audit as an addition to the 2024/25 internal audit plan, was subsequently approved by GRBV in May 2024.

In the motion, Members raised concerns about the potential impact on PVI nurseries who may rely on funded hours placements from families outwith the Edinburgh Council area.

At the March 2023, Full Council meeting, Members also requested a report on the decision of the Strategic Programme Board to bring all cross boundary funded early learning and childcare places in house and remove the need to pay external providers to deliver this provision. The report was presented to the Education, Children and Families Committee on 16 April 2024.

The Strategic Programme Board is an officer led forum chaired by the Executive Director of Corporate Services, which is responsible for the Council's Change Programme and has delegated responsibility to ensure the Council meets the budget challenges as set out in the Financial Strategy and Medium-Term Financial Plan as reported the Finance and Resources Committee on 20 June 2023.

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 early years funding and cross boundary places arrangements meet the Statutory Guidance and that the Council is ensuring that all funding due is being received or is otherwise offsetting the costs to the children's home authorities.

The audit was be conducted in line with the motion and subsequent discussions held at Full Council, Education, Children and Families Committee and GRBV Committee meetings.

Alignment to Risks and Business Plan Outcomes

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

- Strategic Delivery
- Financial and Budget Management
- Programme and Project Delivery
- Supplier, Contracts and Partnership Management
- Governance and Decision Making
- Service Delivery
- Regulatory and Legislative Compliance
- Reputational Risk

Business Plan Outcomes:

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

Limitations of Scope

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

- consideration of the decisions on individual placements.

Reporting Date

Testing was undertaken between 12 August and 9 September 2024.

Audit work concluded on 10 September 2024, and the audit findings and opinion are based on the conclusion of our work as at that date.

Findings and Management Action Plan

Finding 1: Cross-Boundary Proposal: Formal Approval and guidance

Finding Rating	Medium Priority

Schools and Lifelong Services advised that, prior to submission to the Strategic Programme Board (SPB), all proposals should have authorisation to proceed recorded by either the Service Director or the Head of Service. Although the Service Director advised that they verbally approved the cross-boundary places proposal ahead of submission to the SPB on 30 November 2023 and it is confirmed that they attended this meeting, there is no formal record of this approval, recorded in the proposal document as required.

In addition, the proposal document, titled Project High Level Scoping Document (referred to as the 'mini PID'), is required for Strategic Programme Board proposals, but the document is not contained within the project management and change portfolio guidance on the Orb.

Risks

- **Strategic Delivery** – proposals are not thoroughly scrutinised before submission which could hinder service delivery and strategic objectives
- **Programme and Project Delivery** - if proposals provided to the SPB are not formally recorded as approved by the relevant senior officers, there is an increased risk that they have not been fully reviewed and approved by these officers
- **Governance and Decision Making** – reduced oversight from senior management on submitted proposals to the SPB.

Recommendations and Management Action Plan: Approval of SPB Proposals and guidance documents

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
1.1	All proposals that are provided to the Strategic Programme Board for approval should include a formal record of approval by the Senior Responsible Officer before submission, in line with the requirements of the 'Project High Level Scoping Document' (referred to as the mini PID).	The Corporate PMO agreed that the approval process currently tracked in emails, would also be formally recorded on the Project High Level Scoping Document. Effective immediately.	Executive Director – Corporate Services	Corporate Programme Management Office Manager	31/10/2024
1.2	The project management and change portfolio guidance on the Orb should be reviewed to ensure it contains all necessary guidance and templates. In particular, the document titled 'Project High Level Scoping Document' (referred to as the mini PID) should be added to toolkit with guidance.	The Change Portfolio section of the Orb was created by previous Change Portfolio, which has been disbanded. The information included on the pages is still relevant to wider change projects across the Council. We have considered this recommendation but	N/A	N/A	N/A

		would not publish the Project High Level Scoping Document on this page. It has been created specifically for Medium-Term Financial Plan projects and is only issued if it is deemed that specific cashable savings will be the outcome of the project and that the project is eligible for inclusion in that Portfolio			

Finding 2 – Draft Early Learning and Childcare Delivery Plan

Finding Rating	Low Priority

All local authorities are required to publish an Early Learning and Childcare Delivery Plan, in line with the requirements of Children and Young People (Scotland) Act 2014 (the Act). The Council's Early Learning and Childcare (ELC) Delivery Plan 2024-27 is currently in draft and includes information on improvement projects, workforce development, and reducing health and wellbeing inequalities. The final ELC Delivery Plan is expected to be published on the Council's website in September 2024. As this is an operational document it will not require committee approval.

In line with the Act, the ELC Delivery Plan should be reviewed every two years. Schools and Lifelong Services advised that the Plan was developed for implementation in 2020 but, due to the Covid-19 pandemic, the implementation of the plan was pushed to 2023, with the view that a new Plan would be published in 2024.

The current version of the draft ELC Delivery Plan does not include version control, and does not state when it was last reviewed, who undertook the review, and when it should next be reviewed.

Risks

- **Strategic Delivery –** there is an increased risk that key plans are not reviewed at the required frequency, and by the correct colleagues
- **Regulatory and Legislative Compliance** – there is no formal evidence that legislative requirements are being complied with
- **Governance and Decision Making** – without evidence of a regularly-reviewed plan there is a risk that it is not up-to-date, which could affect decision making.

Recommendations and Management Action Plan: Early Learning and Childcare Delivery Draft Plan

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
2.1	The draft Early Learning and Childcare Delivery Plan should be updated to include a version control table which includes the following as a minimum: • name and date for committee approval (if relevant) • lead officer responsible for review • date of the next scheduled review.	Publish the EY delivery plan on the early years website with details of the lead officer and review date. The Delivery Plan will be reviewed every two years in line with the bi-annual parental consultation, and the next review will be scheduled for 2026.	Executive Director – Children, Education, and Justice Services	Head of Education - Early Years, Parents & Operations	20/09/2024 31/12/2026

	In addition, the Plan should be reviewed every two years in line with the bi-annual parental consultation, and the next review should be scheduled for 2026.				

Finding 3 – Strategic Programme Board: Terms of Reference

Finding Rating	Low Priority

The Strategic Programme Board (SPB) is responsible for the portfolio of programmes, projects and initiatives falling within the remit of the Council's Change Programme. The SPB has a Terms of Reference (ToR) that sets out the purpose of the Board, its governance structure, programme objectives, and Board membership.

The ToR states that it should be reviewed every quarter and, although this requirement is being complied with, the most recent reviews have not been recorded in the ToR's revision history and approvals table. In addition, it is noted that the ToR is still in draft, and a final version has not been issued.

Risks

- **Strategic Delivery –** Strategic Programme Board objectives may be outdated and not fit for purpose, and do not clearly outline responsible officers and the related scheme of delegation
- **Governance and Decision Making -** without a regularly reviewed terms of reference there is a risk that it is not up-to-date and aligned with remits and authorities, which could affect decision making
- **Programme and Project Delivery** – roles and responsibilities for colleagues are not clear, and members of the Strategic Programme Board do not fully understand their roles and responsibilities.

Recommendations and Management Action Plan: Review of Strategic Programme Board: Terms of Reference

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
3.1	The current draft Strategic Programme Board Terms of Reference should be updated in line with its quarterly review schedule and should be issued as a final version. Additionally, the ToR should include a version control table to clearly record the date of reviews, and any revisions and amendments made as a result.	The Management Team agree that the recommendations in this section will be implemented. A review schedule will be created. A finalised version will be approved. A version Control table will be added.	Executive Director – Corporate Services	Change and Delivery Manager	30/11/2024

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 – Areas of Audit Focus and Control Objectives

Audit Areas	Control Objectives
Policy and Governance	• there is a clear and accurate understanding of the relevant statutory guidance for early years funding and cross boundary places • proposals to remove the cross-boundary funding were supported by a clear and accurate analysis of current local authority and PVI needs, use and funding arrangements • financial modelling is in place to aid understanding, monitor and inform decision making on cross boundary placements including funding due and being received from children's home authorities and any arrangements for offsetting such costs, where relevant • a manageable and affordable delivery plan for delivery of early learning and childcare within available funding is in place and reviewed every 2 years in line with requirements.
Stakeholder Management	• the Council has engaged with relevant stakeholders including the Scottish Government, local authorities, potentially impacted families and PVI providers during proposals to understand impacts and explore potential solutions • clear communications have been issued to advise potential future families and other PVI providers of the decision and timeline for implementation.
Strategic Programme Board	• a terms of reference is in place for the Strategic Programme Board which sets out the delegated authority on programme and project decision making • a clear proposal on maximising use of local authority places and the removal of cross-boundary places for private/voluntary/independent (PVI) nurseries provision was presented and approved by the SPB.
Risk Management	• current and emerging risks related to early years funding and cross boundary places are identified, recorded, and managed within a service risk register, and are regularly reviewed to ensure appropriate mitigating actions are in place and remain effective, with escalation to divisional and directorate level risk committees where required.

Internal Audit Report

City Region Deal – Managing Cost Inflation

30 July 2024

PL2402

Contents

Executive Summary 3
Observations, Recommendations and Management Actions 6
Appendix 1 – Priority Ratings and Definitions 12

This Internal Audit review is conducted for the City Region Deal by the City of Edinburgh Council under the auspices of the 2024/25 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2024. 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 members as appropriate.

Executive Summary

Summary of review and observations

Cost inflation is recorded as a high risk for the City Region Deal (CRD). In recognition that there are limited formal controls in place for managing cost inflation, the audit approach was a workshop-based advisory review which considered a review of risks associated with cost inflation and scrutiny of project costs set out in business cases rather than a traditional assurance review of established controls.

The workshop-based review identified the following improvement opportunities:

- development of a strategy to set out the CRD's approach to managing the risks of cost inflation and wider cost increases. including risk tolerance, appetite and escalation processes, documenting the cost inflation returns process, and ensuring there is a consistent level of detail from all projects within the CRD programme
- adoption of a risk-based approach to reporting on and scrutiny of project cost inflation returns
- alignment between the cost inflation strategy and relevant grant offer letter clauses
- further development of the CRD's risk registers to align them to the risk profile of the Accountable Body (City of Edinburgh Council) and partner organisations, where relevant
- development of fraud monitoring and reporting arrangements to support the CRD's focus on the risk of fraud and irregularity associated with the Deals projects.

Areas of good practice identified

- Quarterly performance meetings are held with the Scottish Government (SG), and the UK Government (UKG) with supporting information provided by partner organisations on a regular basis to inform these discussions
- A national PMO networking group is used to engage collegiately with the SG/UKG on areas of risk across all Deals, including the impact of cost inflation
- A finance sub-group led by the ESESCR (Edinburgh and South East Scotland City Region) Accountant also meets regularly to compare best practice.

Findings	Priority Rating
Finding 1 – Cost Inflation Strategy and monitoring arrangements	Medium
Finding 2 – Risk Management including managing risk of fraud	Medium

See Appendix 1 for Priority ratings and definitions

Management Response to Executive Summary

We welcome the findings of this review and are committed to addressing the risks highlighted. We're grateful to Internal Audit for the recommendations to help further strengthen our controls around cost inflation, which is what we have deemed to be our highest City Region Deal risk. We will implement all the recommendations as per our agreed management actions, which will include engaging with the Council's Corporate Risk Management and Finance teams, as well as the Scottish Government and Transport Scotland.

Background and scope

City Region Deals are packages of funding and decision-making powers agreed between the Scottish Government (SG), the UK Government (UKG) and local partners, designed to bring about long-term strategic approaches to improving regional economies. The six local authorities for the Edinburgh and South East Scotland (ESES) City region, together with regional education and training providers and the private sector, signed a 15-year Deal with SG and UKG in August 2018, with a value of £1.3 billion (now worth £1.5 billion).

The top risk as at June 2024 within the ESES City Region Deal's Programme Management Office (PMO) risk register was cost inflation affecting the ability to deliver projects, for example, the project:

- may not be delivered on budget or on time
- may no longer be viable
- may have to be reduced in scope and benefits.

During discussions on cost inflation, the SG/UKG confirmed to the City Region Deal Network group that there is no additional funding available from SG/UKG within the Deals programme beyond their existing commitment (£600m for ESES City Region Deal) and that price inflation remains the responsibility of delivery bodies as set out in grant offer letters.

To establish how partners handle cost inflation for their programmes and projects, the PMO issues six monthly surveys for completion. Results are summarised in a report which is used to provide verbal updates to Board and Committee meetings. The survey is non-mandatory, and information provided is not subject to validation.

In addition, the PMO advised that underestimation of project costs together with significant cost inflation may have resulted in higher actual project costs.

The SG/UKG scrutinise the cost estimates, funding profiles, contingencies, etc, and raise queries/ concerns before approving business cases. The PMO currently has more of an intermediary role in helping to resolve these queries, as opposed to scrutinising, and challenging to the same degree as government.

Scope

As there were limited formally established controls in place for managing cost inflation, the audit approach was a workshop-based advisory review to consider a review of risks associated with cost inflation and scrutiny of project costs set out in business cases. As the review is advisory, an overall engagement opinion is not provided, however priority ratings are applied to audit recommendations made.

Alignment to Risks and Business Plan Outcomes

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

- Financial & Budget Management
- Programme & Project Delivery
- Health & Safety
- Resilience
- Supplier, Contractor & Partnerships Management
- Governance & Decision Making
- Regulatory & Legislative Compliance
- Reputational Risk

Business Plan Outcomes:

Edinburgh has a stronger, greener, fairer economy and remains a world leading cultural capital.

Reporting Date

Workshops were undertaken between 11 to 24 June 2024. Our audit work concluded on 28 June 2024, and observations are based on the conclusion of audit work as at that date.

Observations, Recommendations and Management Actions

Observation 1 – Cost Inflation Strategy and monitoring arrangements

Priority Rating	Medium

The City Region Deal (CRD) has identified cost inflation as the highest risk, and while there are some measures in place such as periodic review of individual projects' progress, financial position and issues, management of cost inflation key risk is not underpinned by a formal framework which outlines the strategic approach to cost inflation, the risk appetite and tolerances, and identifies the roles and responsibilities for the PMO, partners, and government bodies in relation to managing cost inflation or wider cost increases.

Cost Inflation Returns

The PMO issues six monthly surveys to partners to establish how cost inflation is affecting projects, however responses from partners are not compulsory. When submitting cost inflation or other financial returns, there is currently no requirement for partner organisations to:

- confirm that the information provided is complete and accurate and has been subject to internal validation
- provide a statement that work carried out by the partner organisations and contractors is being completed to the agreed standards
- confirm that they have quality monitoring processes in place to alert management where work is not being completed to the agreed standards.

In addition, the PMO does not require partner organisations to provide details of their project cost increase modelling/methodologies to support the cost inflation information submitted.

The information provided by partners is not subject to validation by the PMO team, and it is verbally reported to the Chief Financial Officers' forum and other Boards as appropriate. Returns are used by the PMO to better understand the impact within individual projects.

The cost inflation returns process is not currently documented within the City Region Deal Financial Procedure Notes.

Consistency of information provided

The PMO has advised that there is increased scrutiny on returns where there is an indication of increased cost inflation risk, however the level of information and the frequency of the request for information remains the same for all projects, regardless of whether the return has indicated there is an issue.

The A720 Sheriffhall Roundabout CRD project is managed and delivered by Transport Scotland with an estimated cost of £120m. The funding and project information is not directly overseen by the PMO team, and no six monthly cost inflation return is provided. As a result, the PMO team have considerably less visibility over financial and risk information associated with this project.

Transport Scotland provide a report to the CRD Joint Committee on a six-monthly basis, and it is noted that concerns over timescales and increasing costs have been raised by members at the Joint Committee. The PMO Manager has also raised concerns directly with Transport Scotland.

Risks

- **Strategic Delivery** - lack of a strategic approach to cost inflation may result in lack of clarity over the PMOs approach and methodology, partner roles and responsibilities
- **Financial and Budget Management** - lack of a strategic approach may result in lack of a clear understanding of funding constraints and visibility of finances to forecast the impacts of cost inflation
- **Financial and Budget Management** - PMO financial reporting to City Region Deal and the Government may provide inaccurate information, assurances, and estimates and not reflect the actual position or associated risks.

Recommendations and Management Action Plan: Cost Inflation Strategy and monitoring arrangements

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
1.1	The PMO team should consider developing a cost inflation strategy, which includes: • the approach to managing risk including risk assessment, risk tolerance and risk appetite for both the overall programme and on an individual project basis • an agreed approach to risk management and reporting, including enabling the PMO to request additional information for individual projects when required • the reporting thresholds/ triggers for partner organisations to provide additional detail on their individual projects in the cost inflation returns • details of the modelling/methodology used by partner organisations to calculate cost increases for each project and agreement from the partner organisation that the PMO is notified if the methodology changes. The cost inflation strategy should be clearly linked to relevant risks outlined in the CRD risk register (see Finding 2).	The Accountant in the PMO will coordinate the drafting of the strategy document, considering the recommendations noted. They will work with the Programme manager and the rest of the PMO team, along with Finance colleagues, SG/UKG, and any other key personnel required.	Executive Director of Place	Programme Manager Accountant (PMO)	30/06/2025
1.2	As an appendix to the strategy, the PMO team should document the current cost inflation returns process, including the roles and responsibilities of each individual, frequency, and level of detail/scrutiny applied. The outcomes of the returns should also be reported formally to an agreed governance forum.	The Accountant in the PMO will coordinate the drafting of the cost inflation returns process, considering the recommendations noted. They will work with the Programme Manager and the rest of the PMO team, along with Finance colleagues, SG/UKG, and any other key personnel required.			30/06/2025

1.3	As part of the strategy development, the PMO team should consider adopting a risk-based approach for review and scrutiny of the cost inflation returns - with projects that indicate increased risks, providing further detailed information, and/ or more frequent reporting.	The Accountant in the PMO will coordinate the review and consider taking a risk-based approach. They will work with Programme Manager and the rest of the PMO team, along with Finance colleagues, SG/UKG, and any other key personnel required.			30/06/2025
1.4	Following development of the cost inflation strategy, the PMO team should review the grant offer letters to ensure there are sufficient clauses to cover the following: • the formalised thresholds/ trigger, as agreed in recommendation 1.1 above, with the partner organisations • a statement from the partner organisation that all information provided to the PMO is complete and accurate and has been subject to internal validation • a statement to confirm that all work carried out by the partner organisations and contractors is being completed to the agreed standards, and the partner organisation has processes in place to monitor quality standards and escalation processes where work is not being completed to the agreed standards.	The Accountant in the PMO will lead on this, working with Legal colleagues to review the Grant Offer Letter and consider relevant clauses where appropriate for the 25/26 Grant Offer Letters (the Grant Offer Letters for 24/25 have already been issued). The 25/26 Grant Offer Letters won't be finalised until Q1 2025.			30/09/2025
1.5	As part of the development of the cost inflation strategy, the PMO team should engage with Transport Scotland to discuss and determine what additional information could be obtained to provide assurance on the risks, including financial risks, and current status of the A720 Sheriffhall Roundabout project.	The PMO will engage with Scottish Government and Transport Scotland to seek additional information where possible.			30/06/2025

	Where possible, information provided should be aligned to the level of detail provided by other partner projects. The agreed approach, including reporting to Joint Committee, should be set out in the cost inflation strategy document.	All information received will be reflected in the Strategy document.			

Observation 2 – Risk management including managing risk of fraud

Priority Rating	Medium

Risk management arrangements

The PMO currently has four risk registers: the City Region Deal risk register, a Regional Prosperity Framework risk register, and two risk registers covering the Integrated Regional Employability and Skills Programme.

As part of the audit, the Council's Corporate Risk Team were engaged to support a review of objectives, risks and mitigating controls in relation to cost inflation.

It will be beneficial for the PMO team to continue working with the Corporate Risk Team to further develop their risk management arrangements, align risk registers to the Council's Risk Management Framework, including streamlining or consolidation of risk registers where appropriate.

Managing the risk of fraud and serious organised crime

The construction industry is known to be particularly vulnerable to the threat of fraud and corruption. Cost inflation and associated impacts such as increased costs and lower profit margins may lead to an increased risk of fraud and serious organised crime including inadequate or unsafe working practices and use of substandard materials in order to realise savings.

The 2024/25 grant offer letter requires the grantee to notify the Council in the event they become "aware of any irregular or fraudulent activity" within the project, however there is no statement included to require any fraud identified to be dealt with in line with the partner organisations' fraud policies.

There is also no formal process in place for the PMO team to consider fraud risks or the risk of serious organised crime associated with the delivery of projects.

City Region Deal (CRD) financial procedures include reference to City of Edinburgh Council policies, including fraud and anti-money laundering, however, there is no detail of a supporting process, or a reference to wider fraud arrangements covering managing conflicts of interest; gifts and hospitality; whistleblowing and complaints for the CRD Programme.

Risks

- **Strategic Delivery and Service Delivery -** risks to objectives and services delivery including thematic risks which may impact across projects may not be identified, managed or escalated appropriately
- **Health and Safety** - work may not be completed to specified quality standards or inadequate / poor quality materials used
- **Fraud and serious organised crime** – potential fraud risks and risks associated with serious organised crime may not be identified, assessed, recorded and managed.

Recommendations and Management Action Plan: Risk management including managing risk of fraud

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
2.1	The PMO should continue to work with the corporate risk team to further develop their risk management arrangements.	The PMO will work with the corporate risk team and conduct a review to assess the noted recommendations to determine the best approach for the risk registers.	Executive Director of Place	Programme Manager Accountant (PMO)	30/06/2025

	As part of this process, a review of the number of team risk registers in place should be undertaken, with a view to reducing, consolidating, or streamlining them, in order to improve visibility and understanding of risks.			Senior Programme Officer	
2.2	The PMO should consider adding a statement to the grant offer letter to provide a clear expectation that any irregularity/ fraud identified should be dealt with in line with the relevant partner organisation's fraud policy.	The Accountant in the PMO will lead on this, working with Legal colleagues to review the Grant Offer Letter and consider relevant clauses where appropriate for the 25/26 Grant Offer Letters (the Grant Offer Letters for 24/25 have already been issued). The 25/26 Grant Offer Letters won't be finalised until Q1 2025.			30/09/2025
2.3	To ensure there is visibility of attempted and actual fraud, the PMO should review the current financial procedures to ensure they set out clear expectations for a regular review of risks related to fraud and serious organised crime, relevant to those which pose a threat in the construction industry.	The Accountant in the PMO will review the current financial procedures. They will also engage with partners to confirm fraud procedures for each organisation.			30/06/2025
2.4	The PMO should introduce a register which records centrally any attempted or actual fraudulent incidents on a regular basis (such as six-monthly) with reporting including nil returns where relevant to governance forums such as the Chief Financial Officers meeting and the Joint Committee.	The Accountant in the PMO will review and create a register which records any fraudulent incidents. This will be presented to CFOs six-monthly and to joint committees as appropriate.			30/06/2025

Appendix 1 – Priority Ratings and Definitions

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

Non-Contracted Spend and Waivers

1 October 2024

CD2402

Overall Assessment	Reasonable Assurance

Contents

Executive Summary 3
Background and scope....................................4
Findings and Management Action Plan....................................6
Appendix 1 – Control Assessment and Assurance Definitions....................................13
Appendix 2 – Areas of Audit Focus and Control Objectives....................................15

This Internal Audit review is conducted for the City of Edinburgh Council under the auspices of the 2024/25 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2024. 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

There is a generally sound system of governance, risk management and control in place for non-contracted spend and waivers. Some scope for improvement has been identified which, if not addressed, may put at risk the achievement of objectives in the area audited.

The following improvement actions were identified:

- directorate-level implementation plans would help to provide a clear direction and align directorates with Business Plan objectives and Council goals
- there should be improved reporting on non-contracted spend and waivers
- a process to monitor individuals persistently raising retrospective waivers and further investigation of the rationale, would support active management and reduction in waiver usage
- increased management oversight and monitoring of feeder systems is required to provide assurance that spend within these areas is within contract and budgets.

Areas of good practice identified

- four-monthly compliance reporting is issued by Commercial and Procurement Services (CPS) to directorates to provide an overview of non-contracted spend, new waivers and waivers set to expire in 18-months' time
- the Place directorate use a Microsoft Teams rooms to provide CPS reports and other non-contracted spend information to service managers
- the CPS Waiver guidance document is well-written, and easy to find on the Orb, the Council's intranet, providing a clear, simple explanation of the process and lists acceptable reasons for waivers to be requested.

Audit Assessment

Audit Area	Control Design	Control Operation	Findings	Priority Rating
1. Polices and Guidance	(orange)	(orange)	See Finding 1	Medium Priority
2 & 3. Non-Contracted Spend and Waivers	(orange)	(orange)	Finding 1 – Directorate-Level Plans to Manage Non-Contracted Spend and Use of Waivers	Medium Priority
			Finding 2 – Oversight and Management of Retrospective Waivers	Medium Priority
			Finding 3 – Oversight and Management of Directorate Feeder Systems	Medium Priority
4. Governance and Council-Level Controls	(light green)	(orange)	Finding 4 – Reporting and Scrutiny of Non-Contracted Spend and Waivers	Low Priority
5. Risk Management	(orange)	(orange)	See Finding 4	Medium Priority

See Appendix 1 for Control Assessment and Assurance Definitions

Background and scope

The 2023/24 Internal Audit plan included a review of Supplier and Contract Management which highlighted concerns related to the levels of 'non-contracted spend' and compliance with the Council's Contract Standing Orders (CSOs) requirements.

Non-contracted spend occurs when the purchase of goods, services or works has not followed Council CSOs. As a result, there is a risk that purchases/contracts are not compliant with Procurement legislation, subsequent increased risk of legal challenge, Best Value not achieved (with a consequent financial impact on budgets and ability to control these) and a heightened risk of fraud.

Non-contracted spend arises primarily when contracts are not recorded on the Council's contract register. In addition, the use of feeder systems (such as Swift or Tranman) for purchases in some divisions across the Council is not subject to oversight by Commercial and Procurement Services (CPS). This means that compliance with CSOs and procurement legislation cannot be enforced by CPS as the governance for this purchasing is the responsibility of services and sits within the approval hierarchy within each feeder system. A certain level of non-contracted spend is expected because of low value purchasing and aggregation where the financial value of the contract/purchase is below the threshold for recording on the Council's contract register (£5,000 for goods and services and £10,000 for works contracts).

The Council's CSOs state that Executive Directors have responsibility to ensure that for contracts of a value greater than £5,000 for goods and services and £10,000 for works, the Contract Register record is updated within 5 working days following issue of contract award and in any event prior to start date of contract. The total spend on the top 100 non-contracted spend suppliers during 2022/23 was £91m, with total non-contracted spend in 2022/23 being £134m, and the total non-contract spend in 2023/24 was estimated to be approximately £176m, of which £158m related the Edinburgh Health and Social Care Partnership.

Waivers of CSOs are required as an auditable trail for approval (subject to being 'in the Council's best interests') when a service or department purchase from a supplier where they consider circumstances prevent them following the Council's CSOs. Per the Council's CSOs and waiver guidance document, waivers should only be granted in exceptional circumstances. This can happen when there is only a single suitable supplier available, or during emergency situations when a contract must be put in place quickly, such as for PPE during the recent Covid-19 pandemic. Whilst waivers are required to be authorised in advance of any contract or instruction being placed or entered into with a supplier, currently 70% of Council waivers are submitted for review by CPS and subsequently 'authorisation' by Service/Executive Directors after the contract commenced and, in some circumstances, spend already incurred.

Scope

The objective of this review was to assess the adequacy of design and operating effectiveness of the key controls established to ensure the Council effectively manages and limits non-contracted spend and waivers.

Alignment to Risks and Business Plan Outcomes

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

- Strategic Delivery
- Financial and Budget Management
- Programme and Project Delivery
- Supplier, Contractor, and Partnership Management
- Governance and Decision Making
- Service Delivery
- Regulatory and Legislative Compliance
- Reputational Risk

- Fraud and Serious Organised Crime.

Business Plan Outcomes:

The Council has the capacity, skills, and resources to deliver our priorities efficiently, effectively and at lower cost.

Reporting Date

Testing was undertaken between 4 June and 20 August 2024.

Our audit work concluded on 20 August, and our findings and opinion are based on the conclusion of our work as at that date.

Findings and Management Action Plan

Finding 1 – Directorate-Level Plans to Manage Non-Contracted Spend and Use of Waivers

Finding Rating	Medium Priority

The Council's Contract Standing Orders (CSOs) set out the requirements for procurement work in the Council, and therefore form the basis of the Council's overall procurement approach. This includes the need to ensure spend is under contract and waivers are used only in appropriate circumstances.

Whilst Children, Education and Justice Services (CEJS) have processes in place to review and manage Directorate spend in line with CSOs, the other Directorates have not advised of any formal plans to reduce their usage of waivers and control the amount of non-contracted spend. The Edinburgh Health and Social Care Partnership (EHSCP) has had persistently high levels of non-contracted spend since April 2021 – being between 40-60% of total spend between April 2021 and April 2024. Non-contracted spend for the other three Council directorates has varied between 1-7% in the same period. Commercial and Procurement Services (CPS) has advised that the HSCP figure is now improving due to collaborative working between CPS and the EHSCP to add care contract frameworks to the contract register, and this is reflected in the most recent information, where EHSCP non-contracted spend is down to 18-20% of total spend for the period April – July 2024.

In addition, the Council's Procurement Handbook supplements the Contract Standing Orders (CSOs). While the CSOs set out the legal framework for procurement, the Handbook provides direction and guidance on the procurement process, and the requirements for each step in the process. The handbook was last updated in 2017 and was noted to include out-of-date information: for example, it includes references to EU law which is no longer applicable to the UK. Procurement advise that the legislation continues to be based on EU law and the Reform Act which has not materially changed and so the direction and guidance principles still apply.

Risks

- **Financial and Budget Management** – the Council may be spending more than required on suppliers who represent poor value for money
- **Regulatory and Legislative compliance** – non-contracted spend is spend that has may not undergone the standard procurement process, and therefore is open to greater legal challenge, and risk that legislation is not being complied with. In addition, an outdated handbook can result in failure of alignment by users to Council processes and best practice.

Recommendations and Management Action Plan: Directorate-Level Plans to Manage Non-Contracted Spend and Use of Waivers

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
1.1	Place, HSCP, and Corporate Services should develop their individual plans to ensure they are adhering to the Council's Contract Standing	**Place:** This will be discussed with Commercial and Procurement Services (CPS) alongside a review of Contract	Executive Directors of Place, HSCP	Operations Managers of Place, HSCP and	**Place:** 31/03/2025

	Orders in order to manage / reduce non-contracted spend and use of waivers. This should include clear links to directorate monitoring and reporting arrangements, escalation arrangements to the Budget and Accountability Board for persistent high usage and an action tracker to capture improvement actions to reduce spend/usage in areas where required with responsible officers, and implementation dates.	Standing Orders to identify any improvements necessary to improve compliance and to manage/reduce non-contracted spend and waiver usage. **HSCP:** A process will be put in place to review, manage and reduce non-contracted spend and use of waivers and will include a process for escalation for persistent waivers and action plans will be put in place for areas of non-compliant spend and waivers, moving to compliance with standing orders. **Corporate Services:** The Corporate Services Directorate will continue to regularly review compliance reports provided by the Procurement Team to allow for identification and action/escalation where non-contracted spend and inappropriate waiver usage has been advised. Where there are ongoing issues identified the Directorate will work with the relevant service areas to formulate and track improvement actions.	and Corporate Services	Corporate Services	**HSCP:** 31/03/2025 **Corporate Services:** 31/05/2025
1.2	The Procurement Handbook should be reviewed and any out-of-date information removed to ensure that officers have access to clear and up-to-date information and guidance on procurement.	CPS will review and update The Procurement Handbook accordingly.	Executive Director, Corporate Services	Head of Commercial and Procurement Services	31/03/2025

Finding 2 – Oversight and Management of Retrospective Waivers

Finding Rating	Medium Priority

Retrospective waivers are when Council colleagues have agreed to purchase goods or services from a supplier before the waiver has been reviewed by CPS and subsequently authorised by Service/Executive Directors. This presents an increased risk that the Council's Contract Standing Orders (CSOs) are not being complied with, and that the Council may be subject to legal challenge if the decision to award the contract was unfair. Retrospective waivers made up 66% of all waivers made by the Council in the 2023/24 financial year with a total value of £20.3m.

Prior to 1 April 2024, there was no process in place to report the names of colleagues who made retrospective waivers to the relevant Directorates, but as of September 2024 (for the period April-July 2024), this information is now being shared with Directorates, including the name of the officer raising the waiver, the value of the waiver, and a summary of the requirement. Directorates have not yet established any processes to ensure this information is used to identify colleagues who are repeatedly making retrospective waivers with the aim of reducing usage.

Risks

- **Financial and Budget Management** – waivers may indicate that value for money is not being achieved by the Council, as they often continue a contract in lieu of re-tendering for a more competitive bid, and could reduce the ability of Directors to manage and control their budgets
- **Regulatory and Legislative Compliance** – increased risk of legal challenge for retrospective waivers.

Recommendations and Management Action Plan: Oversight and Management of Retrospective Waivers

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
2.1	Directorates should implement a process to review the information on retrospective waivers provided by CPS in order to identify trends and engage with colleagues repeatedly making retrospective waivers to understand the reasons for this and take action to reduce usage.	**CEJS:** The Commissioning Team in CE&JS will continue to work very closely with the HoS and the Directors to tackle concerning patterns of non-compliance, to prevent submission of waiver requests. However, the names of individuals will not be stated in directorate reporting but, instead, the titles of individual teams will be stated. In addition, any persistent issues will be raised with the line managers.	All Directorate Executive Directors	All Directorate Operations Managers	**CEJS:** 30/11/2024 **Place:** 30/09/2025 **HSCP:** 31/03/2025 **Corporate Services:** 31/05/2025

		Place: Information on retrospective waivers has been provided for the first time in September 2024. This will be monitored over the next 12 months to identify trends. Where necessary, engagement with colleagues will be undertaken to understand the reasons for retrospective waivers/trends and advice from CPS sought if required. **HSCP:** A process will be developed to ensure that appropriate scrutiny of non-contracted spend and waiver usage is in place and that it manages/ reduces non-compliance with standing orders. **Corporate Services:** The regular (4 monthly) compliance reports provided by Procurement will continue to be reviewed for any retrospective waivers; all such waivers will be followed up with the respective Service Directors/ Heads of Service for investigation with relevant teams to ensure satisfactory evidence is in place to justify the use of a waiver. All officers responsible will be reminded that retrospective waivers are not acceptable unless extenuating circumstances can be evidenced. Where there is evidence of a pattern or continue usage of inappropriate waivers full investigation will take place to understand why, with follow up to provide support to prevent ongoing usage.			

Finding 3 – Oversight and Management of Directorate Feeder Systems

Finding Rating	Medium Priority

Directorate feeder systems (for example Tranman and Swift) are systems set up for purposes other than procurement, but which can also be used to purchase goods or services. In 2023/24 feeder systems made purchases of £293.5m, the majority of which were in the Edinburgh Health and Social Care Partnership (£221m).

Although CPS has control over goods and services purchased through the Council's central purchasing system (Oracle), which enables them to block any spending which is not compliant with Council CSOs, they have no such control over feeder systems. This means that contracts can be entered into by services, which will go unnoticed by CPS until after the expenditure has been incurred.

While these feeder systems have approval hierarchies in place, there is no overarching oversight within the services responsible for these systems to review expenditure against the Council's CSOs, which would enable the services to prevent or detect off-contract and excessive contract spend in a timely manner. As a result of this lack of control, purchases could be made that do not comply with Council CSOs or procurement legislation.

Risks

- **Financial and Budget Management** – the Council may be spending more than required on suppliers who represent poor value for money
- **Regulatory and Legislative compliance** – spend that has not followed the standard procurement process, and therefore is open to greater legal challenge, and risk that legislation is not being complied with
- **Supplier, Contractor, and Partnership Management** – non-contracted expenditure may reduce value for money.

Recommendations and Management Action Plan: Oversight and Management of Directorate Feeder Systems

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
3.1	Services with feeder systems should introduce regular reviews of expenditure made through these systems to ensure compliance with Contract Standing Orders. In particular the reviews should ensure that expenditure is not exceeding contract or waiver financial limits, and that the	**CEJS:** CE&JS will ensure that groups working on the implementation of Mosaic capture this recommendation as part of their actions. **Place:** This will be discussed with Commercial and Procurement	Directorate Executive Directors	Directorate Operations Managers	**CEJS:** 30/06/2025 **Place:** 31/03/2025 **HSCP:** 30/08/2025 **Corporate Services:** N/A

	expenditure is not for off-contract goods or services. The approach to managing and reviewing spend on feeder systems should also be clearly set out in the directorate approach to managing and reducing non-contracted spend recommended at 1.1.	Services (CPS) in the first instance to identify areas where better communication with CPS can improve assurance over the use of feeder systems. **HSCP:** The contracts team and transactions team will put in arrangements to review on a regular basis, expenditure through the systems and expenditure is in line with contract and waiver financial limits. **Corporate Services:** The Corporate Services Directorate does not currently make use of any feeder systems and therefore this recommendation is not applicable.			
3.2	Services with feeder systems should add identify, assess, and record risks associated with the continued use of the feeder system from a procurement perspective to their risk register. The risk register should also include information on mitigating controls to address the risk with further actions required and should be reviewed regularly to provide assurance that the risks are being adequately managed.	**CEJS:** CE&JS will add this risk to the relevant risk registers **Place:** The risk(s) associated with the use of feeder systems will be discussed with CPS and any relevant risks will be added to the service area risk registers. **HSCP:** The Partnership will review the use of any Feeder systems. Where feeder systems are used for the Partnership, risks will be identified and recorded on relevant risk registers.			**CEJS:** 31/12/2024 **Place:** 31/03/2025 **HSCP:** 31/03/2025 **Corporate Services:** N/A

		Corporate Services: As noted in 3.1, this action is not relevant to Corporate Services			

Finding 4 – Reporting and Scrutiny of Non-Contracted Spend and Waivers

Finding Rating	Low Priority

The Council's Finance and Resources Committee do not receive any regular reports on non-contracted spend levels for the Council as a whole or on a Directorate basis, although they do receive a bi-annual report on new contracts awarded in the period, including new contracts awarded under waivers across the whole Council. This means that the Committee does not have information to enable them to provide effective scrutiny over the levels of non-contracted spend and ensure best value is being achieved.

In addition, reports for waivers and non-contracted spend are provided to the Corporate Leadership Team on an ad-hoc basis, with the last report being provided on 9 August 2023.

Risks

- **Financial and Budget Management** – if there is insufficient scrutiny of non-contracted spend and waivers then there is a greater likelihood that the Council is not achieving value for money.

Recommendations and Management Action Plan: Reporting and Scrutiny of Non-Contracted Spend and Waivers

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
4.1	CPS should provide the Finance and Resources Committee (FRC) and Council Leadership Team (CLT) regular reports on non-contracted spend and waivers. In addition, CPS should consider aligning the reporting frequency for non-contracted spend and waivers information going to both CLT and the FRC.	CPS will provide contract/non-contract spend information to Finance & Resources (F & R) Committee on an annual basis. Reporting in relation to waivers will also continue to be reported in the bi-annual Contract Award Report to F & R Committee. CPS will report non-contract spend and waiver information to CLT through the new Budget Accountability Board on a bi-annual basis.	Executive Director, Corporate Services	Head of Commercial and Procurement Services	31/10/2025

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	(orange)	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

Audit Areas	Control Objectives
Policies and Guidance	• Clear policies, guidance, and procedures aligned to relevant regulatory requirements are in place for procurement of goods, services and works across the Council • Directorates are contacted when non-contracted spend/ retrospective waivers occur to ensure they are aware of non-compliance issues and the reasons, to prevent repeat occurrences where possible.
Non-Contracted Spend	• Directorate-level controls are in place to actively identify, record, monitor, and reduce non-contracted spend • Directorate-level controls are in place to ensure purchases are compliant with Council CSOs and procurement legislation to mitigate the risk of legal challenge, fraud, and ensure Best Value • Non-contracted spend is regularly reported to directorate management teams, and sufficient challenge is provided by senior management to ensure that non-contracted spend is reduced, and effectively managed, in line with Council policy • directorate management review non-contracted spend on a regular basis to consider why compliant procurement process was not followed to ensure compliance with CSOs and to ensure the Council can address this and demonstrate value for money moving forward • Services are aware of and have considered and documented the risks of continued use of feeder systems with consideration of which systems are necessary and where use of these could be replace through introduction of central purchasing via the Oracle system.
Waivers	• Directorate-level controls are in place to identify, record, monitor, and reduce the use of waivers • Controls are in place to report waivers to Directorate SMTs, and sufficient challenge is provided by senior management to ensure waivers are only used when necessary, and in line with Council guidance • Directorate management are taking steps to ensure that waivers are requested and approved in advance of spend occurring • Directorate management are actively taking steps to support officers with any training needs relating to purchasing, and where required, hold officers to account where CSOs are not being followed and mitigate/reduce the volume of waivers occurring.
Governance and Council-level Controls	• There is a Council wide approach to reducing non-contracted spend and waiver usage across the Council with information on non-contracted spend and waivers reported to CLT on a regular basis and a requirement for directorates to take appropriate action • Information relating to procurement spend, contract awards, and waivers of CSOs is regularly reported to Council Committee • Sufficient challenge is provided by CLT and Council committees to ensure that non-contracted spend and waiver usage is reduced and effectively managed

	• Each Directorate has developed a strategy to reduce non-contracted spend and the use of waivers in their area, with an associated implementation plan and oversight arrangements.
Risk Management	• Risks related to non-contracted spend and waivers are identified, recorded, and managed within service risk registers, 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.