Policy and Sustainability Committee

10:00am, Tuesday, 22 February 2022

Internal Audit Overdue Findings More Than One Year Old as at 11 August 2021

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

1. Recommendations

1.1 It is recommended that the Committee notes:

1.1.1 the current status of the Internal Audit (IA) overdue findings within the purview of this Committee, that were more than a year old as at 11 August 2021; and,

1.1.2 actions proposed to close these findings.

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EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

Report

Internal Audit Overdue Findings More Than One Year Old as at 11 August 2021

2. Executive Summary

2.1 The Internal Audit report, as considered by this Committee on the 5th October 2021, and referred from the Governance, Risk and Best Value (GRBV) Committee on the 21st September 2021, reported that there were 96 Internal Audit (IA) findings with 51 (53%) of these overdue as at the 11th August 2021.

2.2 Of the findings reported overdue at the time of this report 27 (53%) were recorded as being a year or more past their implementation date.

2.3 The 96 findings reported are supported by a total of 233 management actions, of which 130 (56%) were overdue; 17 of these were reported as being implemented and with IA for review.

2.4 There were 18 findings identified as within the purview of this Committee, representing 37 management actions. Of which, 13 were over a year past their original implementation date.

2.5 It is recognised that further action is required to ensure that all overdue IA findings are addressed, and that open and future IA findings are effectively implemented by management within agreed timeframes.

2.6 Since the report that was considered at the October meeting of this Committee further work has been undertaken to address the overall picture of open and overdue IA findings with additional resource being recruited across the Directorates to support the work required to address these. Whilst this has been put in place the temporary capacity allocated in November 2020 has remained in place to assist.

2.7 A key objective of the refreshed governance and assurance model is to ensure that first line divisions and directorates are supported by teams with sufficient capacity and appropriate skills to provide proportionate ongoing focus on governance; risk management; and controls across all Council service areas and activities.

3. Background

Quarterly IA Reporting

3.1 Overdue findings arising from IA reports are reported monthly to the Corporate Leadership Team (CLT) and quarterly to the GRBV Committee.

3.2 This report specifically excludes open and overdue findings that relate to the Edinburgh Integration Joint Board (EIJB) and the Lothian Pension Fund (LPF). These are reported separately to the EIJB Audit and Assurance Committee and the Pensions Audit Sub-Committee respectively.

Policy and Sustainability Committee Request

3.3 The Committee reviewed the referred quarterly IA Overdue Findings report in October 2021. The report confirmed that, as at 11 August 2021, there were a total of 96 open IA findings across the Council. Of these 51 (53%) were reported as overdue; with 27 (53%) which were more than a year overdue.

3.4 Following review of the report, the Committee requested that further information on those actions which were within the purview of this Committee, and which were more than a year old, would be reported for further review

Process Applied

3.5 Directorates were provided with details of those overdue actions which were recorded as being under the purview of this Committee and were requested to provide an update.

3.6 The feedback from Directorates was combined with information from IA to provide a combined update which is included at Appendix 1.

IA Methodology and Definitions

3.7 The following definitions from IA methodology have been included to support understanding of the descriptions included in this report:

3.7.1 Findings raised by IA in audit reports typically include more than one agreed management action to address the risks identified. IA methodology requires all agreed management actions to be closed in order to close the finding.

3.7.2 The IA definition of an overdue finding is any finding where all agreed management actions have not been evidenced as implemented by management and validated as closed by IA by the date agreed by management and IA and recorded in relevant IA reports.

3.7.3 The IA definition of an overdue management action is any agreed management action supporting an open IA finding that is either open or overdue, where the individual action has not been evidenced as implemented by management and validated as closed by IA by the agreed date.

3.7.4 Where management considers that actions are complete and sufficient evidence is available to support IA review and confirm closure, the action is marked as 'implemented' by management on the IA follow-up system. When IA has reviewed the evidence provided, the management action will either be 'closed' or will remain open and returned to the relevant owner with supporting rationale provided to explain what further evidence is required to enable closure.

3.7.5 A 'started' status recorded by management confirms that the agreed management action remains open and that implementation progress ongoing.

3.7.6 A 'pending' status recorded by management confirms that the agreed management action remains open with no implementation progress evident to date.

4. Main report

4.1 Some progress towards closure of the 13 IA actions that were more than one-year overdue is evident with one of the actions now implemented, with the balance of 12 still to be fully addressed.

4.2 Of the remaining 12 findings to be addressed, 2 had been proposed for closure by management but after review by IA additional evidence has been requested and the actions subsequently reopened.

4.3 Revised implementation dates for the remaining 12 actions have been provided by management (where required), all open actions have also received a three-month extension as per agreement at GRBV in September 2021.

4.4 Further detail on findings now closed and remaining findings to be addressed is included below and also at Appendix 1, which includes combined management and IA information on progress towards closure.

Findings Now Implemented

4.5 The action which has been closed was a medium rated action relating to a partnership protocol as part of the Emergency Prioritisation and Complaints audit and which had an original implementation date of November 2019.

Remaining Findings to be Addressed

4.6 Of the 13 remaining actions to be addressed:

4.6.1 2 actions that were proposed for closure by management (implemented) were subsequently reopened by IA as further evidence was required to support their closure.

4.6.2 Directorates are confident that 3 of the remaining actions will be implemented within the revised timeframe agreed.

4.6.3 There have been additional extensions to implementation dates requested by Directorates for another three of the remaining actions so that they may ensure that additional information may be gathered.

4.6.4 Four of the remaining actions are related to the Resilience Business Continuity audit and these have been impacted considerably by the ongoing call on the Resilience Team to support Covid-19 work; the team are confident that they will meet the revised deadline of December this year.

5. Next Steps

5.1 IA will continue to monitor the open and overdues findings position, providing monthly updates to the CLT and quarterly updates to the Governance, Risk and Best Value Committee which will be referred on to the appropriate parent Committee's.

6. Financial impact

6.1 There are no direct financial impacts arising from this report, although failure to close findings and address the associated risks in a timely manner may have some inherent financial impact.

7. Stakeholder/Community Impact

7.1 If agreed management actions supporting closure of Internal Audit findings are not implemented, the Council will be exposed to the service delivery risks set out in the relevant Internal Audit reports. Internal Audit findings are raised as a result of control gaps or deficiencies identified during reviews therefore overdue items inherently impact upon effective risk management, compliance and governance.

8. Background reading/external references

8.1 Internal Audit Open and Overdues Report P&S October 2021

9. Appendices

9.1 Appendix 1 – Analysis of IA Overdue Findings More Than One Year Old under the purview of P&S Committee

Appendix 1 – Update on Internal Audit Overdue Management Actions as at 11 August 2021 (P&S Committee)

Glossary of terms

1. Project – This is the name of the audit report.
2. Owner – The Executive Director responsible for implementation of the action.
3. Issue Type – This is the priority of the audit finding, categorised as Critical; High; Medium; or Low
4. Issue – This is the name of the finding.
5. Status – This is the current status of the management action. These are categorised as:
   - Pending (the action is open and there has been no progress towards implementation),
   - Started (the action is open, and work is ongoing to implement the management action), and
   - **Implemented** (the service area believes the action has been Implemented and this is with Internal Audit for validation).
6. Agreed Management action – This is the action agreed between Internal Audit and Management to address the finding.
7. Estimated date – the original agreed implementation date.
8. Revised date – the current revised date. **Red** formatting in the dates field indicates the last revised date is overdue.
9. Number of revisions – the number of times the date has been revised since July 2018.
10. **Amber** formatting in the dates field indicates the date has been revised more than once.
11. Contributor – Officers involved in implementation of an agreed management action.

Ref	Project/Owner	Issue Type	Issue/Status	Agreed Management Action	Dates	Directorate Update
3	Asset Management Strategy and CAFM system 18/19 RES1813 Asset Management Strategy and CAFM: Issue 3 - Property and Facilities Management Data Completeness; Accuracy; and Quality Paul Lawrence, Executive Director of Place	**High**	3.2 Resolution of known data quality issues Started	A reconciliation of the two lists has been performed and there are no obvious discrepancies other than properties which are out with the scope of the survey team. The viability of establishing a referencing system for concessionary lets in the CAFM system will be explored. The volume and value of known concessionary lets across the Council Estate will form part of the Annual Investment Portfolio update which is reported to the Finance and Resources committee. There is an ongoing work stream looking at vacant and disposed properties and the systems updates required.	**Estimated Date: 31/03/2016 Revised Date: 01/11/2022**	A revised completion date has been agreed to allow for further work to be carried out to explore the viability of establishing a referencing system for concessionary lets in the CAFM system and progress of workstream looking at vacant and disposed properties.
21	Edinburgh Alcohol and Drug Partnership (EADP) – Contract Management Key Person Dependency and Process Documentation Judith Proctor, Chief Officer - HSCP	**Medium**	Rec 5 - Records Management Policy Started	Records retention policy: Direction will be requested from the Information Governance team in relation to Records Management Policy requirements and how they should be applied to retention, archiving and destruction of contract management information. Any lessons learned will be shared with the Health and Social Care contracts management team.	**Estimated Date: 30/03/2018 Revised Date: 28/02/2022**	All contracts are now retained in line with the current retention policies. On track for delivery by 28.02.22 which is the revised date (including the three months extension approved by GRBV in October 21).
22	Emergency Prioritisation & Complaints CW1806 Issue 1: ATEC 24 Operational Framework Judith Proctor, Chief Officer - HSCP	**Medium**	CW1806 Issue 1.2(3): ATEC 24 Service Level Agreements - Partnership Protocol Started	3. A partnership protocol will be approved and implemented for the Fallen Uninjured Person Service to reflect the current operations, funding arrangements and any planned process improvements.	**Estimated Date: 29/11/2019 Revised Date: 01/03/2021**	This action has now been implemented.

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23	Emergency Prioritisation & Complaints CW1806 Issue 1: ATEC 24 Operational Framework Judith Proctor, Chief Officer - HSCP	**Medium**	CW1806 Issue 1.4(3): ATEC 24 Quality Assurance - Outcomes, supervision and key themes/improvements Started	1) Quality assurance outcomes will be linked to supervision and training and performance objectives, with regular one to ones scheduled to ensure action is taken to address any competence issues or gaps identified.2)Where systemic themes or trends are identified from quality assurance reviews, management will consider whether existing operational processes should be revisited.	**Estimated Date: 30/04/2020 Revised Date: 31/03/2022**	This is on track for delivery by 31.03.22 (which is the revised date including the three-month extension agreed by GRBV in October 2022)
25	Emergency Prioritisation & Complaints CW1806: Issue 2: Third Party Service Provision - Health & Social Care Partnership Judith Proctor, Chief Officer - HSCP	**Medium**	CW1806: Issue 2(2): Partnership Protocol HSCP/Contact Centre Started	Agreed, once the SLA is finalised, a Partnership Protocol will be developed in conjunction with Customer Contact Centre colleagues.	**Estimated Date: 28/02/2020 Revised Date: 30/12/2021**	This is dependent on sign-off by East and Mid Lothian Council in relation to our Social Care Direct call handling service. This action has been extended by a further six months (Delivery date – 28/08/22)
32	H&SC Care Homes - Corporate Report A3.1: Training Judith Proctor, Chief Officer - HSCP	**Medium**	A3.1(1) Manager review of training Started	As per audit recommendation: · Care home managers should perform a six-monthly review to confirm that all employees have completed mandatory, induction and refresher training and that completion has been recorded on the iTrent human resources system. Where training has not been completed, this should be discussed with employees and reflected (where appropriate) in their annual performance discussions.	**Estimated Date: 30/06/2019 Revised Date: 31/03/2022**	This was initially implemented by the team, however Internal Audit required additional evidence to support implementation, and the team need to undertake further work to support closure, therefore an extension

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						to March 2022 was agreed.
33	H&SC Care Homes - Corporate Report A3.3: Performance & Attendance Management Judith Proctor, Chief Officer - HSCP	**Medium**	A3.3(4) Health & Social Care Teams - quarterly review of absence and performance management Started	This is the responsibility of the Unit manager for their direct reports. The Business Support Officer will ensure that the Unit Manager is aware on a monthly basis for Domestics and Handymen reporting to them The Business Support Officer is required to monitor and report through the Customer process on a monthly basis. The staff nurse / charge nurse to be appointed at Gylemuir will ensure that this is performed for all NHS staff. (No longer relevant as Gylemuir is now closed).	**Estimated Date: 30/06/2018 Revised Date: 31/10/2022**	This was initially implemented by the team, however Internal Audit required additional evidence to support implementation, and the team need to undertake further work to support closure, therefore an extension to March 2022 was agreed.
34	H&SC Care Homes - Corporate Report A3.4: Agency Staffing Judith Proctor, Chief Officer - HSCP	**Medium**	A3.4(2) Analysis of the agency staff and hours worked charges Started	The BSO will assist the UM (See A2.1). A paper is being presented to the Health and Social Care Senior Management Team week commencing 15th January 2018 that proposes a solution where information will be provided to Locality Managers who will prepare reports for Care Homes. If this solution is agreed, it will be implemented immediately.	**Estimated Date: 31/03/2018 Revised Date: 31/03/2022**	Discussions are ongoing with HR teams who provide some of the intelligence on agency spend. Therefore, an extension to March 2022 was agreed.
64	Resilience BC Completion and adequacy of service area business impact assessments and resilience arrangements Paul Lawrence, Executive Director of Place	**High**	Rec 3.1 a) Place - Development of resilience protocols for statutory and critical services Started	In line with the approach agreed by the Council's Policy and Sustainability Committee in October 2020, the Council has shifted from a plan-based resilience approach to a protocol-based approach. Resilience protocols will be developed for high risk services as required, with support from Corporate Resilience. All Directorates will aim to have this complete by 31 December 2022.	**Estimated Date: 19/06/2020 Revised Date: 31/03/2023**	A revised completion date has been agreed to allow for resilience protocols to be developed for high risk services as required with support from the Corporate Resilience Team.

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65	Resilience BC Completion and adequacy of service area business impact assessments and resilience arrangements Stephen Moir, Executive Director of Corporate Services	**High**	Rec 3.1b Corporate Services - Development of Resilience Plans/protocols for statutory and critical services Started	Rebased action October 2020Following a refresh of Business Impact Assessments and the new organisational structure, resilience plans/protocols will be developed, with support and training from Resilience, for high-risk essential services. A list of these services is to be provided by Resilience for approval by CLT. Date revised to 31 December 2022.	**Estimated Date: 19/06/2020 Revised Date: 31/03/2023**	A revised completion date has been agreed to allow for resilience protocols to be developed for high risk services as required with support from the Corporate Resilience Team.
66	Resilience BC Completion and adequacy of service area business impact assessments and resilience arrangements Judith Proctor, Chief Officer - HSCP	**High**	Rec 3.1c H&SC - Development of Resilience Plans/protocols for statutory and critical services Started	Rebased action October 2020Following a refresh of Business Impact Assessments and the new organisational structure, resilience plans/protocols will be developed, with support and training from Resilience, for high-risk essential services. A list of these services is to be provided by Resilience for approval by CLT. Date revised to 31 December 2022.	**Estimated Date: 19/06/2020 Revised Date: 31/03/2023**	A revised completion date has been agreed to allow for resilience protocols to be developed for high risk services as required with support from the Corporate Resilience Team.

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67	Resilience BC Completion and adequacy of service area business impact assessments and resilience arrangements Amanda Hatton, Executive Director of Education and Children's Services	**High**	Rec 3.1d Education and Children's Services - Development of Resilience Plans/protocols for statutory and critical services Started	Rebased action October 2020Following a refresh of Business Impact Assessments and the new organisational structure, resilience plans/protocols will be developed, with support and training from Resilience, for high-risk essential services. A list of these services is to be provided by Resilience for approval by CLT. Date revised to 31 December 2022.	**Estimated Date: 19/06/2020 Revised Date: 31/03/2023**	A revised completion date has been agreed to allow for resilience protocols to be developed for high risk services as required with support from the Corporate Resilience Team.
116	Social Work Centre Bank Account Reconciliations Corporate Appointee Client Fund Management Judith Proctor, Chief Officer - HSCP	**High**	Recommendation 1a - Health & Social Care Started	1. Health and Social Care: Given the considerable business support and social worker resources implications, the above recommendations will take time to design, implement and maintain. Business Support is resolving problem appointee arrangements as we go along, however, the backlog of reviews will need a programme management approach to rectify errors and support the governance required. In the meantime, associated risks will be added to the Partnership's risk register to monitor controls and progress on a monthly basis, given its high finding rating. Following the Care Home Assurance Review, the Partnership is developing a self-assurance control framework. Locality Managers have agreed for corporate appointee arrangements to be included in the assurance framework – which if found to be successful and useful, can be mirrored by the other applicable services in this report. Business Support is working on new guidelines for the administration of Corporate Appointeeship (e.g. new procedures,	**Estimated Date: 28/06/2019 Revised Date: 01/11/2021**	Locality Teams have undertaken 90% of CA reviews, however due to the impact of COVID 19 and an increase in Adult Protection cases, staff have been dealing with urgent business only. This was granted a 3 months extension by GRBV in October 2021. However due to system pressures, a further three months extension has been agreed to complete the remaining 10% of CA

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				monthly checklists, etc.), which will support the effective delivery of the framework.		reviews (delivery date 28/05/22).