Education, Children and Families Committee

10.00am, Tuesday 1 March 2022

Internal Audit: Overdue Findings and Key Performance Indicators as at 5 November 2021 – referral from the Governance, Risk and Best Value Committee

Executive/routine	Executive
Wards	
Council Commitments	

1. For Decision/Action

1.1 The Governance, Risk and Best Value Committee has referred the attached report to the Education, Children and Families Committee for ongoing scrutiny of relevant overdue management actions.

Stephen S. Moir
Executive Director of Corporate Services

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EDINBVRGH
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Referral Report

Internal Audit: Overdue Findings and Key Performance Indicators as at 5 November 2021 – referral from the Governance, Risk and Best Value Committee

2. Terms of Referral

2.1 On 14 December 2021, the Governance, Risk and Best Value Committee considered a report on the Internal Audit: Overdue Findings and Key Performance Indicators as at 5 November 2021. The report confirmed the three-month completion date extension agreed by the GRBV Committee in September 2021 had been applied to all open and overdue agreed management actions, with revised dates reflected.

2.2 The Governance, Risk and Best Value Committee agreed:

2.2.1 To note the status of the overdue Internal Audit findings as at 5 November 2021;

2.2.2 To note that the three-month completion date extension agreed at the September 2021 Committee reflecting ongoing Covid-19 pressures across the Council had now been applied to all open and overdue agreed management actions;

2.2.3 To note the status of IA Key Performance Indicators for audits that were either completed or in progress as at 5 November 2021;

2.2.4 To refer the report to the relevant Council committees for ongoing scrutiny of their relevant overdue management actions;

2.2.5 To refer the report to the Edinburgh Integration Joint Board Audit and Assurance Committee for information in relation to the current Health and Social Care Partnership position.

2.3 Following requests for clarification on the specific Internal Audit overdue findings that parent executive committees should focus on, an exercise has been completed that maps the findings included in this report to the specific committee based on their responsibilities detailed in the Council's committee terms of reference.

2.4 This exercise has identified an anomaly as there is currently no linear relationship between individual audit reports and committees, as it is possible for scrutiny of the actions in one Internal Audit report to be allocated across a number of Committees.

For example, a review of Planning or Licensing could potentially result in operational service delivery actions being allocated to the Planning Committee and/or Regulatory Committee, with actions that relate to the ICT arrangements that these teams use being allocated to the Finance and Resources Committee.

2.5 As part of preparations for the new Council following the May 2022 Local Government elections, we will complete further work on this area to determine whether there is a more effective way of ensuring a more linear allocation of responsibility for executive committee and oversight of overdue IA actions.

2.6 In the meantime, the information provided to each committee is based upon the allocation of agreed management actions in line with each committee's current terms of reference. A copy of the full report is also available online, with a link include in the background section of this referred report for reference.

3. Background Reading/ External References

3.1 Minute of the Governance, Risk and Best Value Committee – 14 December 2021

3.2 Governance, Risk and Best Value Committee – 14 December 2021 webcast

3.3 Internal Audit: Overdue Findings and Key Performance Indicators as at 5 November 2021 – full report to GRBV Committee

4. Appendices

Appendix 1 – report by the Chief Internal Auditor

Governance, Risk and Best Value Committee

10:00am, Tuesday, 14 December 2021

Internal Audit: Overdue Findings and Key Performance Indicators as at 5 November 2021

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

1. Recommendations

1.1 It is recommended that the Committee:

1.1.1 notes the status of the overdue Internal Audit (IA) findings as at 5 November 2021;

1.1.2 notes that the three-month completion date extension agreed at the September 2021 Committee reflecting ongoing Covid-19 pressures across the Council has now been applied to all open and overdue agreed management actions;

1.1.3 notes the status of IA Key Performance Indicators (KPIs) for audits that are either completed or in progress as at 5 November 2021;

1.1.4 refers this paper to the relevant Council Executive committees for ongoing scrutiny of their relevant overdue management actions; and,

1.1.5 refers this paper to the Edinburgh Integration Joint Board Audit and Assurance Committee for information in relation to the current Health and Social Care Partnership position.

Lesley Newdall

Chief Internal Auditor

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Report

Internal Audit: Overdue Findings and Key Performance Indicators as at 5 November 2021

2. Executive Summary

2.1 The three-month completion date extension agreed at the September 2021 Committee has now been applied to all open and overdue agreed management actions, with revised dates reflected in this report.

2.2 The impact of the extension is that completion dates for all open management actions that were not currently overdue in October (when the extension was applied) were extended by three months, and all overdue findings had their revised completion dates extended by three months. These revised dates are reflected in Appendix 2.

Progress with Closure of Open and overdue Internal Audit findings

2.3 The overall progress status for closure of overdue IA findings is currently amber (stable with limited change) as at 5 November 2021, based on the average position across the last three months.

2.4 Increasing trends in the proportion of open IA findings that are overdue (KPI 3 in Appendix 1); the proportion of low rated overdue findings (KPI 7); and the proportion of findings that are between 90 – 180 days overdue are evident in the last month, together with a decrease in the number of overdue findings currently being reviewed by IA to determine whether they can be closed (KPI 4).

2.5 These increasing trends in the last month are partially offset by improvement in the proportion of IA findings that are between six months and one year overdue.

2.6 Whilst progress with implementation of agreed management actions has remained relatively stable across the last quarter, there has been an increase in the proportion of overdue management actions in the last month.

2.7 Positive progress with management actions where the latest date has been missed, or the date revised more than once in the last month, is mainly attributable to application of the three month completion date extension.

2.8 These outcomes confirm that further sustained focus is required on closure of overdue findings, particularly those more than one year, and between three and six

months overdue. It is also important to ensure that open findings that are not overdue are closed by their originally agreed implementation dates.

2.9 Further detail on the monthly trends in open and overdue findings is included at Appendix 1.

Current position as at 5 November 2021

2.10 A total of 108 open IA findings remain to be addressed across the Council as at 5 November 2021. This excludes open and overdue Internal Audit findings for the Edinburgh Integration Joint Board and the Lothian Pension Fund.

2.11 Of the 108 currently open IA findings:

2.11.1 a total of 53 (49%) are open, but not yet overdue;

2.11.2 55 (51%) are currently reported as overdue as they have missed the final agreed implementation dates. This reflects a decrease of 2% in comparison to the August 2021 position (53%).

2.11.3 69% of the overdue findings are more than six months overdue, reflecting a decrease of 9% in comparison to August 2021 (78%) with 16% aged between six months and one year, and 53% more than one year overdue.

2.11.4 evidence in relation to 5 of the 55 overdue findings is currently being reviewed by IA to confirm that it is sufficient to support closure; and,

2.11.5 50 overdue findings still require to be addressed.

2.12 The number of overdue management actions associated with open and overdue findings where completion dates have been revised more than once since July 2018 is 44, reflecting a decrease of 4 when compared to the August 2021 position (48). This excludes the two completion date extensions applied to reflect ongoing Covid-19 impacts across the Council.

Annual Plan Delivery and Key Performance Indicators

2.13 IA Key Performance Indicators (KPIs) to support effective delivery of the 2021/22 IA annual plan has confirmed that action is required to ensure that services are aware of the KPIs that apply to the audit process and engage proactively with IA to ensure that any potential impacts that could cause delays are identified and effectively managed.

2.14 The KPIs also highlight areas where IA has not achieved their reporting delivery timeframes.

2.15 Reasons for delayed IA annual plan delivery that underpin KPI outcomes were discussed at the November 2021 Committee.

3. Background

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.

3.3 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.

3.4 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.

3.5 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.

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

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

3.9 An operational dashboard has been designed to track progress against the key performance indicators included in the IA Journey Map and Key Performance Indicators document that was designed to monitor progress of both management and Internal Audit with delivery of the Internal Audit annual plan. The dashboard is provided monthly to the Corporate Leadership Team and quarterly to the Committee to highlight any significant delays that could potentially impact on delivery of the annual plan.

4. Main report

4.1 As at 5 November 2021, there are a total of 108 open IA findings across the Council with 55 findings (51%) now overdue.

4.2 The movement in open and overdue IA findings during the period 11 August to 5 November 2021 is as follows:

Analysis of changes between 11/08/2021 and 05/11/2021				
	Position at 11/08/21	**Added**	**Closed**	**Position at 05/11/21**
Open	96	20	8	108
Overdue	51	8	4	55

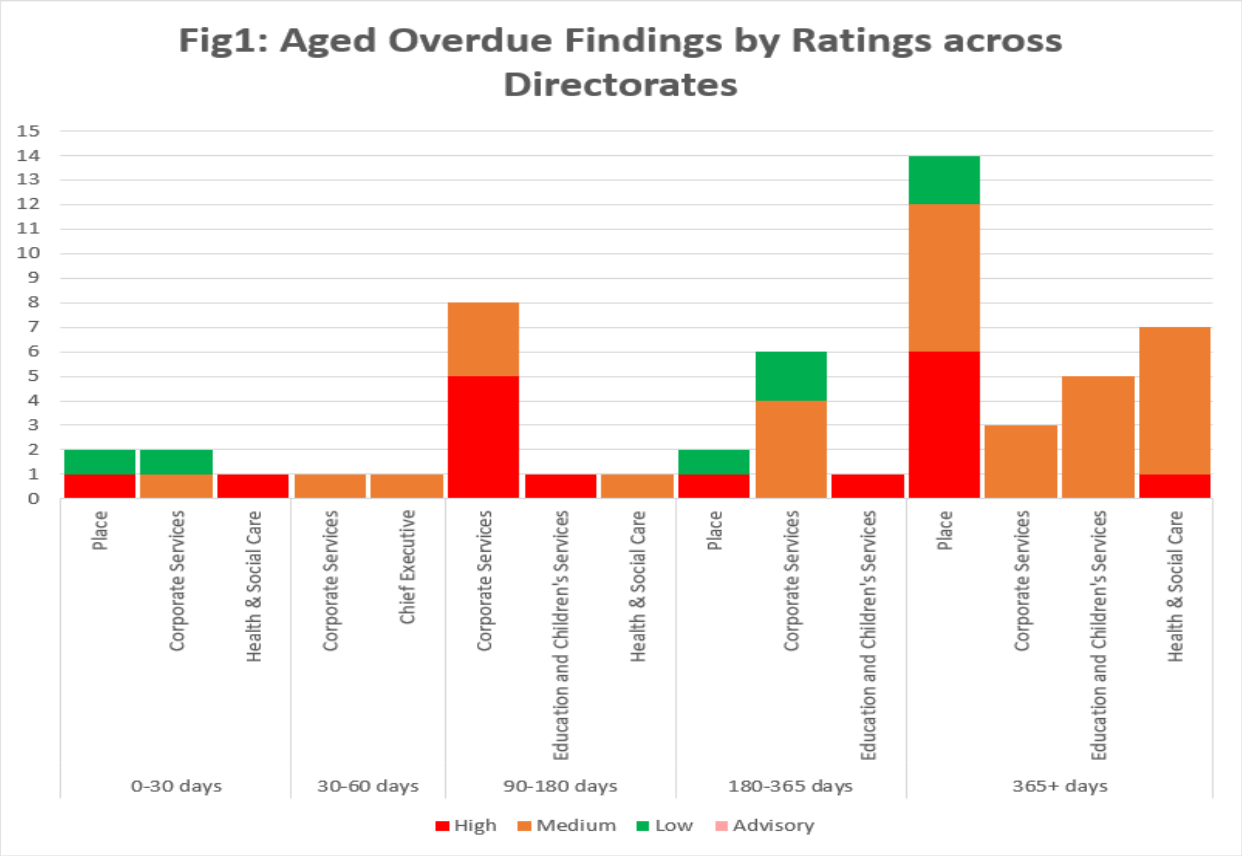
Overdue Findings

4.3 The 55 overdue findings comprise 17 High; 31 Medium; and 7 Low rated findings.

4.4 However, IA is currently reviewing evidence to support closure of 5 of these findings (2 High; 1 Medium; and 2 Low), leaving a balance of 50 overdue findings (15 High; 30 Medium; and 5 Low) still to be addressed.

Overdue findings ageing analysis

4.5 Figure 1 illustrates the ageing profile of all 55 overdue findings by rating across directorates as at 5 November 2021.



4.6 The analysis of the ageing of the 55 overdue findings outlined below highlights that Directorates made good progress last quarter with resolving findings less than three months and between six months and one year overdue, as the proportion of these findings has decreased. However, this is offset by an increase in the proportion of findings overdue between three and six months, and a consistent position with findings that are more than one year overdue.

- 7 (13%) are less than 3 months (90 days) overdue, in comparison to18% as at August 2021;
- 10 (18%) are between 3 and 6 months (90 and 180 days) overdue, in comparison to 4% as at August 2021;
- 9 (16%) are between 6 months and one year (180 and 365 days) overdue, in comparison to 25% as at August 2021; and,
- 29 (53%) are more than one year overdue, which remains the same as the position reported in August 2021.

Management Actions Closed Based on Management's Risk Acceptance

4.7 During the period 11 August to 5 November 2021, the following management action has been closed on the basis that management has retrospectively accepted either the full or residual elements of the risks highlighted by IA in the original audit report.

4.7.1 Council Wide (all Directorates) First Line Project Governance – Project Management Skills Matrix (medium) - management has accepted the risks associated with not implementing and maintaining a centralised project management skills matrix to ensure that employees with appropriate project management skills and experience are allocated to projects, as this would require resource from both the Strategic Change and Delivery and Human Resources teams. Management has advised that this additional resource is not available, and that existing Strategic Change and Delivery team resources should continue to focus on continuing to support teams across the Council to deliver change.

Agreed Management Actions Analysis

4.8 The 108 open IA findings are supported by a total of 259 agreed management actions. Of these, 141 (54%) are overdue as the completion timeframe agreed with management when the report was finalised has not been achieved. This reflects a 2% decrease from the August 2021 position (56%).

4.9 Of the 141 overdue management actions, 28 have a status of 'implemented' and are currently with IA for review to confirm whether they can be closed, leaving a balance of 113 to be addressed.

4.10 Appendix 2 provides an analysis of the 141 overdue management actions highlighting:

- their current status as at 5 November 2021 with:

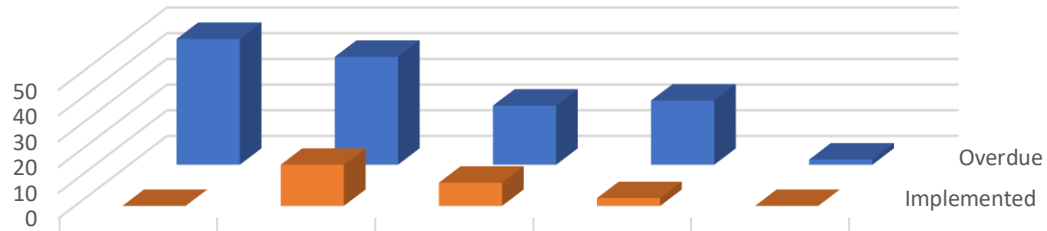
- 28 implemented actions where management believe the action has been completed and it is now with IA for validation;
- 101 started where the action is open, and implementation is ongoing; and
- 12 pending where the action is open with no implementation progress evident to date.

- 34 instances (24%) where the latest implementation date has been missed; and
- 44 instances (31%) where the implementation date has been revised more than once.

4.11 Appendix 2 has also been updated to reflect the relevant Executive Committees that should be responsible for ongoing scrutiny of the overdue management actions.

4.12 Figure 2 illustrates the allocation of the 141 overdue management actions across Directorates, and the 28 that have been passed to IA for review to confirm whether they can be closed.

Figure 2: Overdue and Implemented Management Actions by Directorate



	Place	Corporate Services	Education and Children's Services	Health & Social Care	Chief Executive
Implemented	0	16	9	3	0
Overdue	49	42	23	25	2

4.13 IA has continued to achieve its established KPI for reviewing all implemented management actions within four weeks of the date they are proposed for closure by management.

4.14 Where implementation dates longer than four weeks occur, these are supported by feedback to management requesting either additional evidence or a discussion to explain the context of the evidence provided. Where this is not provided by services within a further four weeks, the status of the action is reverted to 'started' until the further information requested is provided.

More Than One Revised Implementation Date

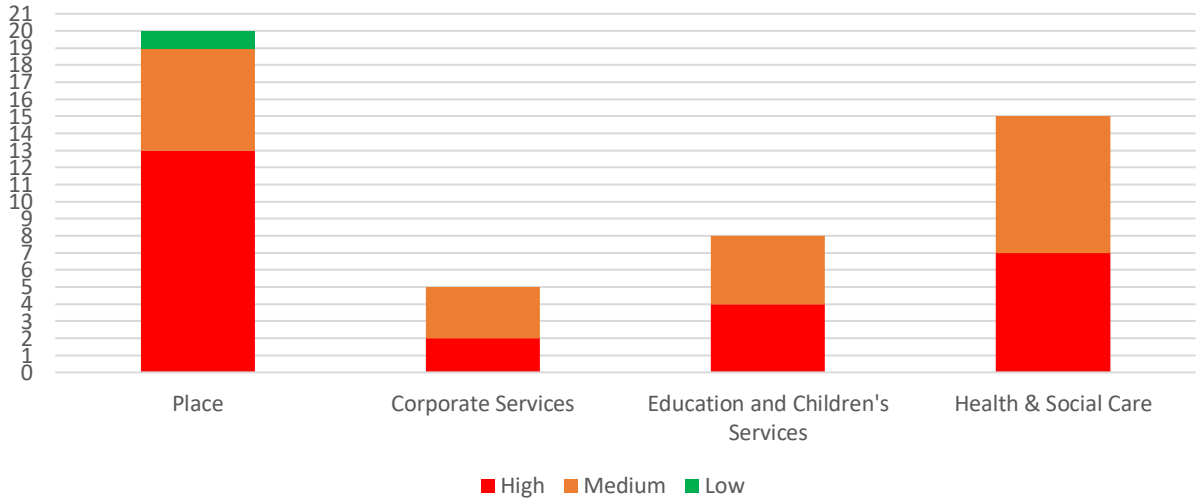
4.15 Figure 3 illustrates that there are currently 48 open management actions (including those that are overdue) across directorates where completion dates have been

revised between two and six times since July 2018. This number excludes the two automatic extensions applied by IA to reflect the impact of Covid-19.

4.16 This remains aligned with the position reported in August 2021 (48).

4.17 Of these 48 management actions, 26 are associated with High rated findings; 21 Medium; and 1 Low, with the majority of date revisions in the Place directorate.

Figure 3 - management actions with more than one revised completion date since July 2018



Key Performance Themes Identified from the IA Dashboard

4.18 The IA key performance indicator dashboard has been reinstated for 2021/22 to support delivery of the annual plan by both services and the IA team; and prevent delays in completion of audits and finalisation of the IA annual opinion.

4.19 Reintroduction of the KPIs supported by monthly reporting to the Corporate Leadership Team and quarterly to the Committee will highlight any significant delays that could potentially impact on delivery of the annual plan, and is aligned with the requirements of both the motion and addendum agreed at Committee in August 2021 requesting that audits will be carried out in line with the timescales set out in the agreed audit plan.

4.20 Two audits that were included in the dashboard presented to the Committee in September (Health and Social Care Partnership: Management of Waiting Lists and Assessments; and Place: Active Travel) have been paused and carried forward into the 2022/23 IA annual plan following the rebase of the annual plan approved by the Committee in November 2021, and have now been remove from the dashboard.

4.21 The dashboard included at Appendix 3 reflects the current status for the 11 audits in progress where terms of reference detailing the scope of the planned reviews have been issued. This highlights that:

4.21.1 Services are consistently taking longer than the 5 day KPI for feedback on draft IA terms of reference, with feedback received within the 5 days for only 2 audits.

4.21.2 Executive Directors are generally providing feedback on draft terms of reference within the agreed 5 day response times. Delays are mainly attributable to Council wide audits where responses are not consistently received from all Executive Directors.

4.21.3 Internal Audit reporting delays for the Planning and Performance Framework and Health and Safety audits were highlighted in the report presented to Committee in September, and has experienced a further delay with preparing and issuing the Parking and Traffic Regulations audit report. This was mainly attributable to the timing of annual leave.

4.21.4 There have also been significant delays with receipt and finalisation of management responses for the Implementation of Asbestos Recommendations and Parking and Traffic Regulations audits, and a delay in finalising Executive Director approval of the Planning and Performance Framework report.

5. Next Steps

5.1 IA will continue to monitor the open and overdues findings position and delivery against key performance indicators, providing monthly updates to the CLT and quarterly updates to the GRBV Committee.

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 Overdue Findings and Key Performance Indicators as at 11 August 2021 – Paper 8.1

8.2 Capacity to Deliver the 2021/22 IA Annual Plan – Paper 8.3

8.3 Internal Audit Journey Map and Key Performance Indicators - Paper 7.6 Appendix 3

9. Appendices

9.1 Appendix 1 – Monthly Trend Analysis of IA Overdue Findings and Management Actions

9.2 Appendix 2 – Internal Audit Overdue Management Actions as at 5 November 2021

9.3 Appendix 3 – Internal Audit Key Performance Indicators as at 5 November 2021

Appendix 1 - Monthly Trend Analysis of IA Overdue Findings and Management Actions

Stable with limited change **As at 5 November 2021**

	Key Performance Indicator (KPI)		11/06/2021			07/07/2021		11/08/2021		23/09/2021		05/11/2021		Trend
	IA Findings													
1	Open findings		89	100%		85	100%	96	100%	113	100%	108	100%	Not applicable
2	Not yet due		34	38%		32	38%	45	47%	64	57%	53	49%	Not applicable
3	Overdue findings		55	62%		53	62%	51	53%	49	43%	55	51%	
4	Overdue - IA reviewing		12	22%		8	15%	3	6%	9	18%	5	9%	
5	High Overdue		18	33%		18	34%	17	33%	16	33%	17	31%	
6	Medium Overdue		30	55%		29	55%	28	55%	29	59%	31	56%	
7	Low Overdue		7	13%		6	11%	6	12%	4	8%	7	13%	
8	<90 days overdue		7	13%		9	17%	9	18%	6	12%	7	13%	
9	90-180 days overdue		8	15%		3	6%	2	4%	6	12%	10	18%	
10	180-365 days overdue		10	18%		15	28%	13	25%	11	22%	9	16%	
11	>365 days overdue		30	55%		26	49%	27	53%	26	53%	29	53%	
	Management Actions													
12	Open actions		236	100%		218	100%	233	100%	277	100%	259	100%	Not applicable
13	Not yet due		96	41%		83	38%	103	44%	154	56%	118	46%	Not applicable
14	Overdue actions		140	59%		135	62%	130	56%	123	44%	141	54%	
15	Overdue - IA reviewing		40	29%		28	21%	17	13%	35	28%	28	20%	
16	Latest date missed		77	55%		43	32%	70	54%	52	42%	34	24%	
17	Date revised > once		60	43%		51	38%	48	37%	46	37%	44	31%	

Trend Analysis - key

Adverse trend - action required

Stable with limited change

Positive trend with progress evident

No trend analysis is performed on open findings and findings not yet due as these numbers will naturally increase when new IA reports are finalised.

Appendix 2 - Internal Audt Overdue Management Actions as at 5 November 2021

Glossary of Terms

1. Executive Committee – This is the relevant Executive Committee that should have oversight of completion of agreed management actions
2. Project Name – This is the name of the audit report.
3. Issue Type – This is the priority of the audit finding, categorised as Critical; High; Medium; or Low
3. Issue Title - this is the titel of the issue in the Origina IA Report
4. Owner – The Executive Director responsible for implementation of the action.
5. Recommendation Title - this is the title of the recommendation in the original IA report
6. Agreed Management action – This is the action agreed between Internal Audit and Management to address the finding.
7. 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).
8. Estimated date – the original agreed implementation date.
9. Revised date – the current revised date. **Red** formatting in the dates field indicates the last revised date is overdue.
10. Number of revisions – the number of times the date has been revised since July 2018.
11. **Amber** formatting in the dates field indicates the date has been revised more than once.
12. Contributor – Officers involved in implementation of an agreed management action.

Executive Committee	Project Name	Issue Type	Issue Title	Owner	Recommendation Title	Agreed Management Action	Status	Estimated Implement Date	No of Revisions	Revised Implement Date	Contributors
All Executive Committees	Assurance Actions and Annual Governance Statements	Medium	CW1903 Issue 1:Assurance Management Framework	Stephen Moir, Executive Director, Corporate Services	CW1903 Issue 1.1c: Develop and implement an assurance management framework	An assurance management framework will be developed and implemented that covers the points raised by Internal Audit and includes: liaison with directorates to assess current and best practice; clearly defined roles and responsibilities for first line directorates and the second line Corporate Governance team; process flow; monitoring / reporting / closure requirements; an assessment of existing automated tools to determine whether they can support the process; issue guidance; The framework will be implemented and rolled out across Council divisions and directorates to support completion of the 2021/22 annual governance statement for inclusion in the Council's 31 March 2022 annual financial statements.	Started	31/12/20	3	30/12/21	Chris Peggie Gavin King Hayley Barnett Laura Callender Layla Smith Michelle Vanhegan Mirka Vybiralova Nick Smith
Education, Children and Families	Health and Safety – Managing Behaviours of Concern	Medium	CF2003 - Issue 3 - Governance and Management Information	Julien Kramer, Interim Director of Communities and Families	CF2003 - Recommendation 3.1 - Committee Terms of Reference	Terms of reference will be refreshed for the Education and Children's Services (formerly C&F) Risk Committee and Health and Safety Group that clearly define: the roles and responsibilities of both committees; and the level of scrutiny to be performed on health and safety incidents (including problematic behaviour).	Implemented	30/09/21	0	30/12/21	Anna Gray Gillian Barclay Kirsty Spence Liz Harrison Lorna French Lynn Paterson Michelle McMillan Nickey Boyle
Education, Children and Families	Health and Safety – Managing Behaviours of Concern	Medium	CF2003 - Issue 3 - Governance and Management Information	Julien Kramer, Interim Director of Communities and Families	CF2003 - Recommendation 3.5 - Education and Children's Services Risk Register	Risk Register will be updated to reflect ongoing work. The volume of referrals should be seen as positive as this was the aim of the campaign in 2019/20. Analysis will be undertaken to establish the severity of the incidents reported. This will be discussed at Education Management Team meeting in September.	Implemented	30/09/21	0	30/12/21	Anna Gray Gillian Barclay Kirsty Spence Liz Harrison Lorna French Lynn Paterson Michelle McMillan Nickey Boyle
Education, Children and Families	Health and Safety – Managing Behaviours of Concern	Medium	CF2003 - Issue 3 - Governance and Management Information	Julien Kramer, Interim Director of Communities and Families	CF2003 - Recommendation 3.3 - SHE Assurance Portal Training	The Corporate Health and Safety team are currently updating SHE training to provide information about the revisions to the portal, the new SHE app and how to extract meaningful reports. Further agreed actions are: This will be shared with headteachers; Business Managers and Quality Improvement and Education Officers; Quality Improvement Managers; Senior Education Managers at the start of the new session.	Started	30/09/21	0	30/12/21	Anna Gray Gillian Barclay Kirsty Spence Liz Harrison Lorna French Lynn Paterson Michelle McMillan Nickey Boyle

Executive Committee	Project Name	Issue Type	Issue Title	Owner	Recommendation Title	Agreed Management Action	Status	Estimated Implement Date	No of Revisions	Revised Implement Date	Contributors
Education, Children and Families	Records Management - LAAC	Medium	CW1705 Issue 1: Project file review process	Julien Kramer, Interim Director of Communities and Families	CW1705 Issue 1.3: Quality assurance checks	Project management information will be monitored weekly to identify the volume of files that have been reviewed by the project team and an independent risk based quality assurance approach developed and implemented that focuses on files that have not been 'split' by the project team, to confirm that they have been accurately classified as files that have not been merged prior to their return to Iron Mountain for archiving. Quality assurance sample sizes will be selected at the start of each week and will depend on the volumes of files reviewed by the project team and the relevant proportion of non-merged and merged files. Where merged files have been identified and split by the project team, a lighter touch approach involving peer reviews will be adopted to ensure that the project file review process has been consistently applied and appropriate actions implemented. Quality assurance outcomes will be recorded and all significant errors (for example failure to identify merged files), areas of good practices, and areas for improvement will be shared with the project team. Availability of quality resource will be monitored throughout the project to ensure that it remains adequate to complete an appropriate number of QA reviews based on file outcomes. A retrospective sample of cases already reviewed by the project team will also be selected for retrospective review based on the approach outlined above. The project team will work to an end of February date for implementation of quality assurance within the project team with an end of March date for Internal Audit to review the process applied.	Started	31/03/20	4	30/06/22	Alison Roarty Ani Barclay Freeha Ahmed Jackie Irvine John Arthur Liz Harrison Louise McRae Nichola Dadds Nickey Boyle Nicola Harvey Stephen Moir
Education, Children and Families	Records Management - LAAC	Medium	CW1705 Issue 3: Pre destruction business as usual file review process	Julien Kramer, Interim Director of Communities and Families	CW1705 Issue 3.3a (ECS): Quality assurance process	A joint risk based quality assurance process will be established between Business Support and Team Managers in Localities. Quality assurance outcomes will be recorded, and learnings shared with team managers at Children's Practice Team meetings, enabling city wide service improvement actions to be identified and implemented where appropriate.	Implemented	30/06/20	1	30/11/21	Alison Roarty Ani Barclay Freeha Ahmed Jackie Irvine John Arthur Liz Harrison Louise McRae Nichola Dadds Nickey Boyle Nicola Harvey Stephen Moir
Education, Children and Families	Records Management - LAAC	Medium	CW1705 Issue 3: Pre destruction business as usual file review process	Judith Proctor, Chief Officer - HSCP	CW1705 Issue 3.3b (H&SCP): Quality Assurance Process	A joint quality assurance process will be established between Business Support and Team Managers in Localities. The new Health and Social Care Partnership Chief Nurse and Head of Quality will be responsible for managerial oversight of the quality assurance processes, ensuring that lessons learned are fed back to the Localities and outcomes reported to the Clinical and Care Governance Committee for scrutiny and oversight.	Implemented	30/06/20	1	30/11/21	Alison Roarty Angela Ritchie Louise McRae
Education, Children and Families	Records Management - LAAC	Medium	CW1705 Issue 3: Pre destruction business as usual file review process	Julien Kramer, Interim Director of Communities and Families	CW1705 Issue 3.2a (ECS): Communication and training	Children's Practice team managers have already been briefed regarding the outcomes of the audit and a refreshed process will soon be implemented. The process will be co-produced with Business Support Team Managers, communicated and uploaded to the Orb. Given the scale of training to be provided, a CECiL based approach will be applied with support provided by Business Support and requested from Learning and Organisational Development (Human Resources), with divisions requested to track completion of the CECiL module. Locality Management teams will also receive face to face training on the new process.	Started	30/06/20	3	30/11/21	Alison Roarty Ani Barclay Freeha Ahmed Jackie Irvine John Arthur Liz Harrison Louise McRae Nichola Dadds Nickey Boyle Nicola Harvey Stephen Moir
Education, Children and Families	Records Management - LAAC	Medium	CW1705 Issue 3: Pre destruction business as usual file review process	Judith Proctor, Chief Officer - HSCP	CW1705 Issue 3.2b (H&SCP): Communication and training	Health and Social Care will adopt a similar approach to Communities and Families with the new process communicated and uploaded to the Orb. A CECiL based approach will also be applied with support provided by Business Support and requested from Learning and Organisational Development (Human Resources), with completion of the CECiL module by the relevant teams tracked. Locality Management teams will also receive face to face training on the new process.	Started	30/06/20	1	30/11/21	Alison Roarty Angela Ritchie Louise McRae

Executive Committee	Project Name	Issue Type	Issue Title	Owner	Recommendation Title	Agreed Management Action	Status	Estimated Implement Date	No of Revisions	Revised Implement Date	Contributors
Education, Children and Families	School admissions, appeals and capacity planning	High	CF1901: School admissions, appeals and capacity planning - Issue 1: Policies, Procedures & Guidance	Julien Kramer, Interim Director of Communities and Families	CF1901: Issue 1.1(b) - Review of Admissions Operational Procedures	A working group led by the Communities and Families Senior Education Officer with representation from all service areas involved in school admissions, appeals and capacity planning, will be established to undertake a review of all procedural documents. This will include consideration of amalgamation of existing procedures where appropriate and implementation of a review schedule and version control.	Implemented	31/08/20	2	31/01/22	Alison Roarty Arran Finlay Gavin King Hayley Barnett Layla Smith Liz Harrison Lorna French Matthew Clarke Michelle Vanhegan Neil Jamieson Nick Smith Nickey Boyle Nicola Harvey Sheila Haig Stephen Moir
Education, Children and Families	School admissions, appeals and capacity planning	High	CF1901: School admissions, appeals and capacity planning - Issue 1: Policies, Procedures & Guidance	Julien Kramer, Interim Director of Communities and Families	CF1901: Issue 1.1(d)/(e) - Communicating Guidance on Website & Orb	Following review and completion of working group actions, all policies and procedures will be published on the Council's website and Orb, and communicated to all relevant officers, with changes highlighted.	Implemented	30/09/20	1	31/01/22	Alison Roarty Arran Finlay Gavin King Hayley Barnett Layla Smith Liz Harrison Lorna French Matthew Clarke Michelle Vanhegan Neil Jamieson Nick Smith Nickey Boyle Nicola Harvey Sheila Haig Stephen Moir
Education, Children and Families	School admissions, appeals and capacity planning	High	CF1901: School admissions, appeals and capacity planning - Issue 1: Policies, Procedures & Guidance	Julien Kramer, Interim Director of Communities and Families	CF1901: Issue 1.2 - Review & Update of School Websites	A communication will be issued to all schools to request a review of their school website to ensure: current academic year handbooks are published; links to relevant content on the Council website remain current; only standard approved Council forms are published; and all privacy notices published on School websites are directly linked to the Council's statement.	Started	31/12/20	0	01/08/21	Arran Finlay Claire Thompson Liz Harrison Lorna French Michelle McMillan Nickey Boyle
Education, Children and Families	School admissions, appeals and capacity planning	High	CF1901: School admissions, appeals and capacity planning - Issue 2: Operational Processes - Admissions & Appeals	Julien Kramer, Interim Director of Communities and Families	CF1901 Issue 2.2: Waiting List Management	The remit of the working group led by the Communities and Families Senior Education Officer, will include a review of waiting list management. The working group will consider the risks outlined in this report and should the creation of a centralised system not be feasible, alternative arrangements will be developed to improve customer experience, and the effectiveness and efficiency of waiting list management. The review will consider if the new SEEMIS schools system currently under development will improve current processes.	Implemented	30/06/21	0	01/02/22	Arran Finlay Claire Thompson Liz Harrison Lorna French Michelle McMillan Nickey Boyle
Education, Children and Families	School admissions, appeals and capacity planning	High	CF1901: School admissions, appeals and capacity planning - Issue 2: Operational Processes -	Julien Kramer, Interim Director of Communities and Families	CF1901 Issue 2.3(b): Quality Assurance Checks in Schools	Schools business managers will be instructed to undertake sample quality assurance checks of evidence obtained from parents to support applications to ensure compliance with procedures. This will include completion of checks prior to completion of enrolment processes. Checking of completion will form part of the Communities and Families Self-Assurance Framework from 2021 onwards.	Implemented	30/06/20	2	28/02/22	Arran Finlay Claire Thompson Liz Harrison Lorna French Michelle McMillan Nickey Boyle

Executive Committee	Project Name	Issue Type	Issue Title	Owner	Recommendation Title	Agreed Management Action	Status	Estimated Implement Date	No of Revisions	Revised Implement Date	Contributors
Education, Children and Families	School admissions, appeals and capacity planning	High	CF1901: School admissions, appeals and capacity planning - Issue 2: Operational Processes - Admissions & Appeals	Julien Kramer, Interim Director of Communities and Families	CF1901 Issue 2.5: Placing Request Appeals - key resource dependencies	The working group led by the Communities and Families Senior Education Officer, will establish key dependencies and resource planning requirements. This will include interdependencies and resources required to support preparation of key reports. Changes will be trialled in the current year and the updated process implemented for 2021.	Implemented	31/03/21	0	01/11/21	Alison Roarty Arran Finlay Gavin King Hayley Barnett Layla Smith Liz Harrison Lorna French Matthew Clarke Michelle Vanhegan Neil Jamieson Nick Smith Nickey Boyle Nicola Harvey Sheila Haig Stephen Moir
Education, Children and Families	School admissions, appeals and capacity planning	Medium	CF1901: School admissions, appeals and capacity planning - Issue 3: Process Documentation & Delivery Responsibilities	Julien Kramer, Interim Director of Communities and Families	CF1901 Issue 3.1(b): Internal Partnership Protocols	Internal partnership protocols will be prepared and implemented for services delivered by other divisions on behalf of Schools and Lifelong Learning, incorporating the scope of services and roles and responsibilities defined in the new end to end process documentation. Where relevant, current internal charging arrangements will be reviewed to ensure that it accurately reflect the levels of support provided. Partnership protocols and associated key performance measures / indicators will be reviewed at least every two years to ensure they remain aligned with service delivery, operational processes and relevant regulatory and professional standards. Governance arrangements to support ongoing performance monitoring will be designed and implemented to ensure that both Schools and Lifelong Learning and the service areas that support them are satisfied with the quality of services provided.	Started	31/08/20	1	22/05/21	Alison Roarty Arran Finlay Gavin King Hayley Barnett Layla Smith Liz Harrison Lorna French Matthew Clarke Michelle Vanhegan Neil Jamieson Nick Smith Nickey Boyle Nicola Harvey Sheila Haig Stephen Moir
Education, Children and Families	School admissions, appeals and capacity planning	Medium	CF1901: School admissions, appeals and capacity planning - Issue 3: Process Documentation & Delivery Responsibilities	Julien Kramer, Interim Director of Communities and Families	CF1901 Issue 3.1(d): Roles & Responsibilities Outwith Annual Process	The working group will review the roles and responsibilities for any tasks performed outwith the annual P1/S1 admissions, appeals and capacity planning process. These will be documented and communicated to all teams involved in the process. The review will include identifying key contacts for common non-annual admissions queries, for example, home schooling; private schooling; dealing with refugees; and requests for current or future capacity information, to ensure that they can be appropriately redirected and resolved.	Started	31/08/20	3	22/05/21	Alison Roarty Arran Finlay Gavin King Hayley Barnett Layla Smith Liz Harrison Lorna French Matthew Clarke Michelle Vanhegan Neil Jamieson Nick Smith Nickey Boyle Nicola Harvey Sheila Haig Stephen Moir
Education, Children and Families	School admissions, appeals and capacity planning	Medium	CF1901: School admissions, appeals and capacity planning - Issue 4: Data Access, Security & Retention	Julien Kramer, Interim Director of Communities and Families	CF1901: Issue 4.4(a): Document Retention & Disposal; All Services	The Information Governance Unit will be engaged to confirm data retention and disposal requirements. Where necessary the data retention schedule will be updated. Document retention and disposal requirements will be reinforced across all services processing admissions and appeals including schools. All appeals information currently retained outwith the relevant period will be destroyed in line with the Council's disposal guidelines and a retention schedule and destruction log maintained.	Started	30/06/20	2	30/12/21	Alison Roarty Arran Finlay Gavin King Hayley Barnett Layla Smith Liz Harrison Lorna French Michelle Vanhegan Neil Jamieson Nickey Boyle Nicola Harvey Sheila Haig Stephen Moir
Education, Children and Families	Unsupported Technology (Shadow IT) and	High	CW1914 Issue 2: Ongoing shadow IT and end user	Julien Kramer, Interim	CW1914 Rec 2.1c - Second line assurance and	The following actions were discussed and agreed by the Council's Corporate Leadership Team and will be applied by all first line divisions and directorates. 1. divisions and directorates will confirm whether they are consistently applying shadow IT framework and	Started	30/07/21	1	31/08/22	Crawford McGhie Jackie Irvine Liz Harrison

Appendix 3 - Internal Audit Key Performance Indicators as at 5 November 2021

Directorate	Department	Review	Audit Status	Terms of Ref Service Resps <=5 days post	Terms of Ref Director Resps <=5 days post issue	Close out meet <=5days after fieldwork complete	Report Issued by IA <=10 days post close out meeti	W/Shop <=5 days after report issued	Mgt Resps Agreed <=5days post w//shop	Final Draft to Directors <=5 days post Mgt Resps	Director Approval <= 3 days from receipt	Final Report issued by IA <= 5 days post Director Appr	Team Central Updated by IA <=5 days of final report	Comments
Corporate Services	Legal and Assurance	Elections in Covid Environment - design review	Complete	3	2	1	10	N/A	N/A	2	1	1	7	Final report issued to AK 31.5.21 Draft report comments requested by 21/05
Corporate Services	Human Resources	Scottish Local Govt Living Wage - design review	Complete	17	1	8	9	4	1	1	2	5	N/A	Final report issued on 28.10.21. Survey issued on 29.10.21.
Corporate Services	Human Resources	Employee Lifecycle and Data Management	Reporting	13	2	0	0	0	0	0	0	0	0	Fieldwork now complete. Waiting for responses from HR on fieldwork outcomes prior to drafting report.
Corporate Services	Strategic Change and Delivery	Planning and Performance Framework design review	Reporting	26	2	3	35	15	13	9	0	0	0	Report issued to Exec Director on 24th September; awaiting responses.
Council Wide	CHS; P&FM; HPS	Health and Safety - Implementation of asbestos recommendations	Reporting	6	6	34	17	4	0	0	0	0	0	Management responses were due 3 November - not all have been received.
Council Wide	Council Wide	Fraud and Serious Organised Gavin	Fieldwork	74	64	0	0	0	0	0	0	0	0	Draft Tor to Executive Directors 06.09.21, final responses received (Place) 20.10.21. No responses received from some services.
Council Wide	N/A	Implementation of Whistleblowing and Child Protection Recommendations	Fieldwork	7	4	0	0	0	0	0	0	0	0	Fieldwork in progress
Educ & Child Servs	Criminal Justice	Criminal Justice	Fieldwork	12	1	0	0	0	0	0	0	0	0	Fieldwork will commence 8/11/21 ToR updated to reflect Covid-19 and issued 21/9 - Key contact on leave until 4/10 so due back 8/10
Place	Place Mgt, Transport	Parking and Traffic Regulations	Reporting	4	2	3	24	2	0	0	0	0	0	Ongoing discusson re management responses since 18/10/21. Delay in issuing report was due to annual leave in service which delayed confirmation of factual accuracy of findings.
Corporate Services	Digital Services	Digital and Smart Cities Strategy	Fieldwork	49	4	0	0	0	0	0	0	0	0	Fieldwork in progress and ongoing engagement with Executive Director re terms of reference.
Corporate Services	Customer	Council Tax and Business Rates	Fieldwork	7	5	0	0	0	0	0	0	0	0	Fieldwork delayed due to time required to extract data from source systems to support data analytics work.