Governance, Risk and Best Value Committee

10.00am, Thursday 5 March 2015

Internal Audit follow-up arrangements: status report from 1 October 2014 to 31 December 2014

Item number	7.4
Report number	
Executive/routine	
Wards	None

Executive summary

This report provides an overview of changes to the approach adopted by Internal Audit for following up the status of audit recommendations. It also identifies all the open audit recommendations at 31 December that are past their initial estimated closure date.

Links

Coalition pledges	
Council outcomes	
Single Outcome Agreement	

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THE CITY OF EDINBURGH COUNCIL

Report

Internal Audit follow-up arrangements: status report from 1 October 2014 to 31 December 2014

Recommendations

1.1 It is recommended that the Committee approves the revision in the audit follow up process.

1.2 It is recommended that the Committee notes the status of follow-up actions and determine with which, if any, officers they want to discuss the status.

Background

2.1 Where follow-up actions in response to Internal Audit recommendations have not been taken by management in relation to critical, high and medium risks, escalation is to the Corporate Management Team (CMT) and GRBV.

2.2 The Internal Audit team have not previously had sufficient management information to efficiently track the status of all open audit recommendations. As a consequence, all internal audit reviews which identified medium, high or critical findings were followed up on a review by review basis between 4-9 months after the issue of the audit report. Recommendations that remained outstanding at the end of a follow up review were not routinely subject to any further review by Internal Audit.

2.3 Enhancements to Internal Audit's management reporting processes and the increasing maturity of Internal Audit's electronic working papers have now allowed Internal Audit to identify and track the status of all open recommendations.

2.4 This has enabled Internal Audit, for the first time, to produce a complete listing of all open items and sort them by their initial estimated closure date. The availability of this information has allowed Internal Audit to adopt an enhanced approach to following up audit recommendations.

Main report

3.1 Internal Audit's revised approach to following up audit recommendations is to prepare at the end of every quarter, a complete listing of all open recommendations and share these with Management on a divisional or line of service basis. Internal Audit then invites management to identify which recommendations they consider to have been addressed or which are no longer relevant.

3.2 Internal Audit will review the evidence supporting recommendations that Management consider to be closed and feedback their view on whether this is the case. Recommendations that are agreed as closed, have their status updated in Internal Audit's records.

3.3 This revised approach has three distinct advantages over the previous methodology:

- It allows Internal Audit, management and elected members to have a complete picture over the status of all audit recommendations at any given time;
- It results in recommendations being followed up at the optimal time, rather than after the passage of an arbitrary amount of time, resulting in less disruption to the Council's operational activities; and
- The approach is more efficient for Internal Audit to operate and will free up Internal Audit officer time for alternative uses.

3.4 Internal Audit launched this revised approach in December 2014 and engaged with Management to explain and facilitate this change of approach.

3.5 The initial listing of open recommendations that were past their initial estimated closure date, produced in December 2014, resulted in the identification of 97 High & Medium recommendations.

3.6 Internal Audit worked with Management to close all recommendations identified by Management as closed and this resulted in the closure of 88 of these recommendations. Many of these actions had already been completed prior to this change in approach, but their closed status would not have previously been easily identifiable to Internal Audit.

3.7 Appendix 1 shows the total number of outstanding High or Medium recommendations that remained open beyond their initial estimated closure date at 31 December 2014.

3.8 Internal Audit always expected that the increased visibility of recommendations that these enhancements provide, would result in the highlighting of a significant number of open recommendations. Internal Audit will continue to work with Management to drive down the number of open recommendations in the next

quarter. This will result in a strengthening of the Council's overall internal control environment.

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Measures of success

4.1 The implementation and closure of Internal Audit recommendations within their initial estimated closure date. Where recommendations are not closed within this time period, the Committee can determine whether action to date is acceptable or if further action is required.

Financial impact

5.1 Not applicable.

Risk, policy, compliance and governance impact

6.1 If Internal Audit recommendations are not implemented, the Council will be exposed to the risks set out in the relevant detailed Internal Audit reports. Internal Audit recommendations are raised as a result of control gaps or deficiencies identified during reviews therefore overdue items inherently impact upon compliance and governance.

6.2 To mitigate the associated risks, the Committee should review the status of overdue recommendations presented and challenge responsible officers where there is concern that limited or no action has been taken.

Equalities impact

7.1 Not applicable.

Sustainability impact

8.1 Not applicable.

Consultation and engagement

9.1 An overview was provided at the Corporate Management Team (CMT) and each Director was made aware of responsibilities to implement and agreed internal audit recommendations.

Background reading/external references

Not applicable –

Richard Bailes

Chief Internal Audit and Risk Officer

Links

Coalition pledges	PO30 - Continue to maintain a sound financial position including long-term financial planning
Council outcomes	CO25 - The Council has efficient and effective services that deliver on objectives
Single Outcome Agreement	
Appendices	Appendix 1 – Status report: Outstanding Recommendations Detailed Analysis

No	Review & Risk Level	Finding & *Recommendation*	Agreed Management Action	Owner & Expected Implementation Date	Current Position & Status
Children and Families					
1	Financial Processes RS1222 Issue 7 **Medium**	There is no established framework for the periodic review, update and approval of corporate finance policies and procedures. Whilst there have been periodic updates to the Finance Rules since the document was prepared in November 2001, a log is not maintained to provide details of the date and nature of amendments made. Within Children and Families, some financial policies and procedures have been reviewed ad hoc, but there is no established framework to ensure consistency. Of the ten financial policies and procedures tested, we found that: - Five have been reviewed in the past two years but no date is set for future review; - There is no evidence of review of three of the ten tested. Future reviews were not scheduled; and - Two of the ten policies and procedures tested were under review at the time of our fieldwork. *As part of the arrangements to establish a corporate framework for the review, update and approval of policies and procedures, management should:* · *Ensure that review dates for policies and procedures are established on the basis of risk and operational priorities.* · *New or updated policies and procedures should be approved by the Head of Service responsible for the respective operational area.* *Responsibility should be allocated to confirm that review dates have been met, and staff are held accountable for failing to achieve these by reporting any failures to the directorate within each Service.* *The above matters should be formalised by preparing a documented procedure to cover actions and responsibilities.*	1.Going forward, the content of the Finance Rules will be reviewed on an at least half-yearly basis. This review will be undertaken and evidenced by the Corporate Finance Manager. Any resulting substantive changes will be highlighted and communicated to those parties affected. 2.A review of council policies has been undertaken to strengthen governance arrangements in this area. This is supported by Elected Members and CMT and aims to rationalise existing council policy, publish agreed policies for reference, and ensure an appropriate process of review and consistency going forward. This includes the development of a policy framework to clearly define policy, appropriate levels of authorisation, and the key elements that must be included. In short, all Council policies must be approved by a Council committee, reviewed on annual basis, and made accessible through a policy register. To support services, policy templates, guidance and training will be rolled out during the first half of 2014. 3.Children and Families maintain a record of all procedures and review dates. A red, amber, green status for review is used to identify and issue reminders to responsible/lead officers for procedures.	Director of Children & Families 29/08/2014	Evidence obtained 27/1/15 that work is underway to bring the version control of all policies and procedures in line with GRBV instruction in May 2014. Some policy reviews remain outstanding.

No	Review & Risk Level	Finding & *Recommendation*	Agreed Management Action	Owner & Expected Implementation Date	Current Position & Status
2	Information Security RS1223 Issue 2 **Medium**	Children & Families do not provide either regular awareness or an information security training programme. In addition, there is a general lack of recording of officer training. There are pockets of good practice within the department, but this is inconsistent and not widespread. *Information Security training should be well documented and more consistent throughout the Department. Although there are examples of good training practice within the Children and Families Department, it is currently problematic to gain assurance that individual officers have been appropriately trained to an acceptable standard. Robust and clearly demonstrable training procedures will not only reduce the likelihood of information breaches, but in the event of one, be a significant line of defence for the Council against ICO criticism and fines.* *Ideally, each officer should have their own record of information security training. The department must make use of the information security and data protection resource on e-learning (computer based training) for widespread and cost effective training.*	The service will promote the use of e-learning to all staff and encourage that this is undertaken on a regular basis. It is suggested that managers highlight that Information Security training is mandatory, ensure staff undertake it and keep records accordingly. Mandatory training will be part of PRD. It is expected that Internal Audit will include Information Security within planned audit visits and report back on good practice, any further areas of concern and required remedial actions.	Principal RM & BC Officer 30/06/2014	Internal Audit completed an Information Security Follow Up Report for Children & Families in October 2014 where a number of Information Security issues were raised and Children & Families responded with associated actions. The decision on mandatory training has to be taken at the Council's GLAD group to get a Council wide view and decision. This matter has not been raised yet by Information Security at the GLAD group. Promotion of the Councils e-learning will be undertaken in February 2015. The communication will be managed through the Children & Families Risk Management Group that manages Information Security risk strategy. Children & Families are unable to action mandatory training until a Council wide decision is made through the Council GLAD group. The matter is deferred to Information Security within Corporate Governance awaiting strategy and advice on next steps. Mandatory Information Security training would be promoted to staff through the Children & Families Risk Management Group. Transfer responsibility to Corporate Governance
Corporate Governance					
3	Continuous Testing-Payments FN1110 Issue 2 **Medium**	The Council's emergency measures to assist small businesses remain in force, although initial fears of the effects of the financial crash have subsided. No end date has been specified. *Payments and Procurements management should seek a review of the early payment measures* *to close or set an end date for the scheme. If and when assistance is ended,* *payments should be withheld until the payments' target dates.*	Payments Manager to take this matter up with the Head of Corporate and Transaction Services with a view of implementing programme review dates.	Head of Customer Services 30//5/14	Payments services are working with Commercial & Procurement to look at the implications of changing from payment to SME's within 10 days to paying to agreed terms and timescales. This may afford the Council with opportunities to achieve faster payment discounts or similar. A report will then be taken to Committee to approve any change to current policy. There are technology and workflow implications to ensure that the different suppliers are treated in the correct way, as well as ensuring consistency with wider Government policies and aims. The aim is to have this in place by May 2015 or earlier.

No	Review & Risk Level	Finding & *Recommendation*	Agreed Management Action	Owner & Expected Implementation Date	Current Position & Status
Health and Social care					
4	Review and Follow up of Direct Payments RS1224 Issue 4 **Medium**	Under the Direct Payments agreement all clients are required to maintain records relating to the financial management of the account. Clients who are in receipt of a Direct Payment directly into their bank account are required to complete hard copy returns of bank statements, including supporting evidence; to the FIT-Admin section on a quarterly basis. The 'cardsonline' spend and non-card returns are not being tracked effectively: FIT-Admin Staff complete the non-card 'Returns Tracking' spread sheet in order to monitor the number of returns received. However, there is no formal analysis of the number of non returns, particularly if a client had repeatedly failed to comply with the requirements of the agreement. A date is entered within a case note on the Swift system when the quarterly returns are issued to the client but there is insufficient evidence to show what action has been taken in respect of non returns. It is noted that the summary information within the returns spread sheet notes the number of errors for each quarter; however, there is no formal tracking / breakdown of the type of errors being found on three out of the four quarters on the spread sheet. In addition, there is no evidence of any management information being produced from this tracking spread sheet, in order to highlight trends in non returns and identified errors. Internal Audit carried out a high level analysis of the summary totals noted within the spread sheet and has highlighted that there is a significant percentage of non returns (38%) and a very high percentage of errors (48.7%) within quarter 4.	Both the existing standalone database for monitoring card spend and the new database for monitoring non-card spend will be used to monitor spend in the short term. In the longer term consideration will be given to monitoring returns via SWIFT. Target Date 01/12/2013 Card spend will be monitored monthly and non-care spend quarterly. As per the new procedures exceptions will be reported to FIT managers via a SWIFT case note and high balances will be reviewed at a monthly meeting including the Business Development Manager, Senior Social Worker, Senior Practitioner (Audit) and FIT Manager. Audit decisions will be recorded on SWIFT along with any follow up actions. Target Date 01/11/2013 Swift Programme Team to be contacted with regards to extracting management reports from SWIFT that would ensure exceptions are followed up and actioned. A reconciliation of information held between the standalone databases's and Swift will be undertaken to ensure information is accurately reflected on Swift. Target Date 31/01/2014	Sector Manager (Sector Services: South East) 31/1/14	In response to the audit, there are controls in place via the database that is being used to support the audit process. Due to the extensive requirements on the Swift development team, no date has been confirmed in relation to the questionnaire being available on Swift. However risks are being mitigated by the audit process which is in place Audit cases for review are highlighted from social workers raising concerns, through spreadsheet from RBS highlighting excess funding or high balances, through quarterly returns which are scrutinised by business support and then passed to FIT team for action. An annual report highlighting the amount of funds recovered is prepared for senior management. [The mitigating actions in place have allowed this Issue to be revised from High to Medium pending full implementation when resources permit]
		The summary figures of the returns noted as 'All ok' and Errors' did not add back to the number of returns received. *Consideration should be undertaken into establishing whether returns could be sufficiently tracked through the SWIFT system rather than via an excel spread sheet, as spread sheets are not considered to be secure and information would be better managed with one data source.* *In addition, consideration should also be undertaken regarding the effectiveness of using 'case notes' to extract management monitoring information from within the SWIFT system, i.e. how easy / difficult would it be to extract a management information report from within the Swift system using case notes.*			

No	Review & Risk Level	Finding & *Recommendation*	Agreed Management Action	Owner & Expected Implementation Date	Current Position & Status
5	Review and Follow up of Direct Payments RS1224 Issue 4 **Medium**	Under the Direct Payments agreement all clients are required to maintain records relating to the financial management of the account. Clients who are in receipt of a Direct Payment directly into their bank account are required to complete hard copy returns of bank statements, including supporting evidence; to the FIT-Admin section on a quarterly basis. The 'cardsonline' spend and non-card returns are not being tracked effectively: FIT-Admin Staff complete the non-card 'Returns Tracking' spread sheet in order to monitor the number of returns received. However, there is no formal analysis of the number of non returns, particularly if a client had repeatedly failed to comply with the requirements of the agreement. A date is entered within a case note on the Swift system when the quarterly returns are issued to the client but there is insufficient evidence to show what action has been taken in respect of non returns. It is noted that the summary information within the returns spread sheet notes the number of errors for each quarter; however, there is no formal tracking / breakdown of the type of errors being found on three out of the four quarters on the spread sheet.	a) As indicated under the Direct Payment Procedure heading, recommendation 2, the 'Returns Tracking' spreadsheet will be replaced with a standalone database for monitoring non card returns. The database will include a checklist for recording information from returns and details of non returns. The monitoring reports taken from the non-card database will highlight non-returns and errors relating to returns such as missing information. The monitoring reports will be reviewed at a quarterly meeting including FIT and Business Services staff. Action will be taken to follow up non-returns and missing information. b) The non card database will also be used to identify trends within non returns and error patterns. c) The tracking sheet is being replaced with standalone cards online and the non-card databases including clearly defined information requirements. The procedure manuals will be updated to include details of the databases and the information requirements. Target Date 31/03/14	Business Development Manager 31/3/14	In response to the audit, there are controls in place via the database that is being used to support the audit process. Due to the extensive requirements on the Swift development team, no date has been confirmed in relation to the questionnaire being available on Swift. However risks are being mitigated by the audit process which is in place. Audit cases for review are highlighted from social workers raising concerns, through spreadsheet from RBS highlighting excess funding or high balances, through quarterly returns which are scrutinised by business support and then passed to FIT team for action. An annual report highlighting the amount of funds recovered is prepared for senior management. [The mitigating actions in place have allowed this Issue to be revised from High to Medium pending full implementation when resources permit]
		In addition, there is no evidence of any management information being produced from this tracking spread sheet, in order to highlight trends in non returns and identified errors. Internal Audit carried out a high level analysis of the summary totals noted within the spread sheet and has highlighted that there is a significant percentage of non returns (38%) and a very high percentage of errors (48.7%) within quarter 4. The summary figures of the returns noted as 'All ok' and Errors' did not add back to the number of returns received. *The process for the monitoring of both cards online (as noted in action point 4), non-card returns and in particular the 'Returns Tracking' spread sheet should be reviewed.*			

No	Review & Risk Level	Finding & *Recommendation*	Agreed Management Action	Owner & Expected Implementation Date	Current Position & Status
Services for Communities					
6	Community Safety SFC1304 Issue 4 **High**	It was noted during interview with management that the mortuary capacity is at a critically high level. Originally the mortuary was built to facilitate the City of Edinburgh only, however this has now been expanded to accommodate the East of Scotland. In the event of emergencies the City of Edinburgh have three of Scotland's seven temporary body storage units(Nutwells). Over the Christmas period in 2013 two of these units were used for day to day purposes. The Bereavement Services Manager raised concerns that even if a business continuity plan is in place to deal with unforeseen hazards the mortuary capacity would prevent the plan from being effective. *Priority is given to alleviating the capacity pressures within Mortuary Services.*	A business continuity plan to be developed and approved. Report to SMT on issues, options and risks in alleviating capacity pressures within Mortuary Services.	Environmental Health & Scientific Services Manager 29/8/14	Business Continuity plan drafted. A report on options will be considered by Services for Communities Senior Management Team in March 2015. This will include interim solutions to increase capacity within the existing building, medium term options for additional Council sites and longer term strategic solutions with key partners.
7	Community Safety SFC1304 Issue 2 Medium	Currently Environmental Health Officers (EHO'S) are retained within service delivery areas, leading to specialisation, failure to develop and maintain the full range of professional competencies. EHO's are required to have regular training and development (CPD) to maintain their qualification status or to meet statutory requirements for food health and safety enforcement. Officers returning to food health and safety after a break of 3 or more years require a minimum of 3 months structured practical training in order to again be fully authorised. *EHO'S are rotated, trained and developed in all service delivery areas to maintain their competence and to maximise the use of the flexible resource they are able to provide.*	Proposals to be developed to maximise flexibility across EHO specialisms in line with ongoing evaluation of business need.	Environmental Health & Scientific Services Manager 31/10/14	Work on proposals is ongoing and is due to be completed by March 2015.
8	Planning Enforcements SFC1303 Issue 4 **Medium**	Confidential information including personal data must be held securely on IDox. However the Principal Planning Enforcement officer raised concerns over the risk that the IDox system defaults all documents as 'public' which are open to public viewing. To amend this there needs to be some assistance from BT ICT team, to date this has not been resolved. *Management should consider amending the default position to 'Sensitive' to reduce the likelihood that confidential data is accidently stored as a publicly accessible document.*	Investigation to take place between Principal Planner and Data Management to determine if the IDOX system can be altered to allow enforcement data to have a 'sensitive' default status.	Planning Principal 31/5/14	A solution has been identified and has been trialled in the test environment. This is due to be released to the live environment by March 2015 following sign off that the solution is acceptable to all parties.

No	Review & Risk Level	Finding & *Recommendation*	Agreed Management Action	Owner & Expected Implementation Date	Current Position & Status
9	Business Continuity Planning in Pest Control, Noise Services and CCTV SFC1401 Issue 2 **Medium**	There is a risk that the two alternative premises for the CCTV control room are inadequate and not able to provide the same level of service if relocation was required. The first alternative based at Fettes has been secured in the event of infrastructure failure. However it was noted that the premises do not contain sufficient monitors and concerns were raised that the residents of Edinburgh would not get the same level of CCTV protection. The second alternative is based in the same Council building. Effectiveness would be limited if an incident occurred that limited the access to this Council building. *As current business continuity procedures within the CCTV section would not provide the same level of City monitoring, attention to this matter should be considered. We recommend a review of the adequacy of alternative premises if they are needed for long term use.*	This will be reviewed as part of the CCTV business continuity plan, and through the likelihood of capital investment service. This has also been captured as part of the Councils' response to Counter-terrorism (CONTEST Action Plan) as a key risk to the city in the event of a major incident.	Head of Service - Community Safety 30/11/14	The business continuity plan is in development with the Business Continuity and Emergency Planning Officer and is due to be completed by the end of March 15. Work is also ongoing on options for investment in CCTV Services and location of the service will be considered as part of this work. A report on progress will submitted to Health, Social Care and Housing Committee in April 2015.