Governance, Risk and Best Value Committee

10.00am, Tuesday, 16 January 2018

Internal Audit: Overdue Recommendations and Late Management Responses: as at 26 October 2017

Item number	7.5
Report number	
Executive/routine	
Wards	
Council Commitments	

Executive summary

This report sets out all overdue Internal Audit recommendations across the Council providing further status updates and likely implementation dates where they have been provided by Service Areas (Appendix 1).

There were 65 open Internal Audit recommendations across Service Areas as at 26 October 2017. Of these 31 (48%) are overdue. This remains the same as the position reported to CLT on 4 October 2017 (as at 22nSeptember). During the period 6 overdue recommendations were closed and a further 6 are now reporting as overdue.

This report also highlights audit reports that have been issued in draft where final management responses have not been received within our two-week service standard. There were currently 2 draft reports where management responses were not received within the two-week requirement, and 1 report that has been delayed due to changes in the Internal Audit team. Further details are provided at 3.14

EDINBVRGH
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Report

Internal Audit: Overdue Recommendations and Late Management Recommendations: as at 26 October 2017

1. Recommendations

1.1 The Governance Risk and Best Value (GRBV) Committee is requested to:

1.1.1 Note the status of the overdue Internal Audit recommendations as at 26th October 2017;

1.1.2 Note that there are currently 2 reports issued in draft where management responses have not been received within our two-week service standard, and 1 report that has been delayed due to changes in the Internal Audit team; and

1.1.3 Note the proposals approved by the Corporate Leadership Team (CLT) included at section 3.2 to address challenges associated with timing of audit responses received and quality of evidence provided to support closure of recommendations.

2. Background

2.1 The GRBV Committee and CLT have both expressed concerns about the number of overdue Internal Audit recommendations. Currently, the status of overdue recommendations is reported monthly to CLT and quarterly to GRBV.

2.2 It is anticipated that the greater visibility that this monthly reporting provides will result in more Internal Audit recommendations being closed off in a timely manner.

2.3 At the CLT meeting on 10 July 2017, revised proposals for monitoring and reporting on overdue Internal Audit recommendations were approved. This paper provides an update on overdue recommendations in line with the revised approach.

2.4 The Internal Audit definition of an overdue recommendation is any recommendation where all agreed actions have not been implemented by the final date agreed and recorded in Internal Audit reports.

3. Main report

3.1 The revised Internal Audit Process to obtain updates from Service Areas on all open recommendations by the 15th of each month was implemented in September

2017. This has resulted in more proactive engagement on both open and overdue recommendations Service Areas, however, a number of updates were received late which delayed our reporting. For future reports, the cut off previously agreed with CLT (15th of the month or nearest Friday) will be strictly applied.

3.2 Quality of evidence provided to support validation remains a challenge. Agreed actions are often confirmed as completed by Senior Management whilst subsequent Audit validation confirms that controls have not been fully and effectively implemented. This results in Audit providing further advice and often reperforming validation work to support final closure. The following actions are proposed to address this challenge:

- Each Service Area to nominate a representative who will be responsible for coordination of all audit updates and responses (including provision of evidence).
- IA to facilitate a workshop with all representatives explain the validation process and expectations in relation to quality of evidence to support closure of recommendations.
- Wider Leadership Team (WLT) slot has been requested to focus on validation of Audit recommendations with WLT members. The Communications Team has advised that the WLT meeting structure and content is being reviewed and this may not be the most appropriate forum. CLT decision is required on whether to progress.
- The audit guidance that was developed and distributed in September is being discussed with Service Areas when finalising audit reports and issued with each final report.

3.3 There were 65 open Internal Audit recommendations across Service Areas within the Council as at 26th October 2017. Of these 31 (48%) are overdue (5 High; 23 Medium; and 3 Low). This remains the same as the position reported to CLT on 4 October 2017 (as at 22 September). During the period 6 overdue recommendations were closed and a further 6 are now reporting as overdue.

3.4 Six Medium rated overdue recommendations have been closed across the following Service Areas:

- Strategy and Insight (3 Medium)
- Resources (1 Medium)
- Place (1 Medium)
- Integration Joint Board (1 Medium)

3.5 Six recommendations became overdue as at 26 October 2017. These are:

- Strategy and Insight (1) – 1 High (HSC1604ISS.2 – IJB Data Integration and Sharing)
- Resources (3) – 1 High (RES1704ISS.5 - Starters); 1 Medium (RES1608ISS.2 – Risk Management); 1 Low (RES1608ISS.4 – Risk Management)

- Investment and Pensions (1) – 1 Medium (RES1614ISS.2 – Cyber Security)
- Health and Social Care (1) – 1 Medium (SW1601ISS.4 – Social Work pre-employment verification)

Progress updates and revised implementation dates have been provided for 5 of these recommendations. The Chief Executive LPF is committed to ensuring that an update is provided on the overdue Investments and Pensions recommendation for next month.

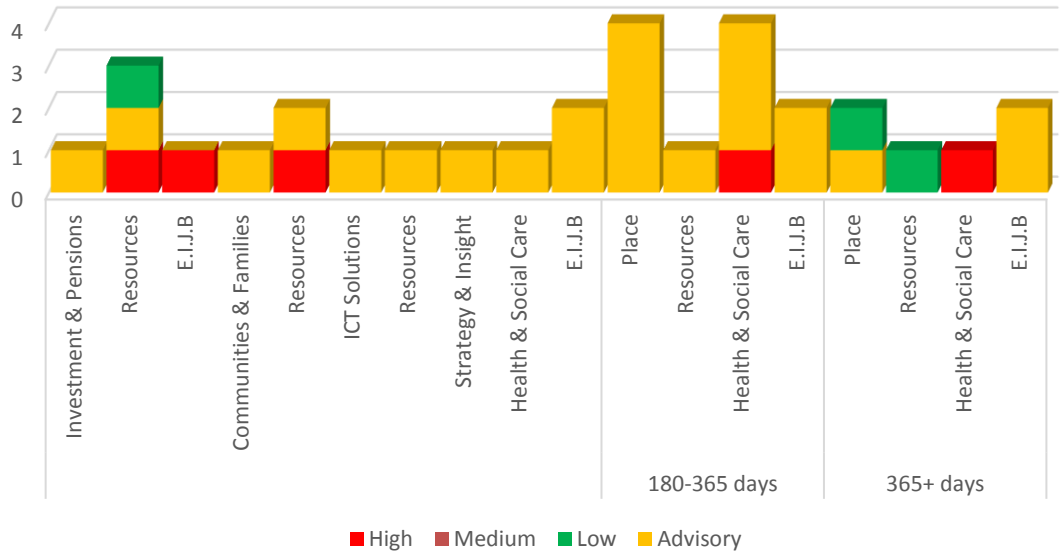
3.6 Eleven recommendations are due for completion by 31st October 2017. These are:

- Integration Joint Board (1) – 1 High (HSC1604ISS.1 – IJB Data Integration and Sharing)
- Place (1) – 1 High (PR1701ISS.1 – Ross Band Stand)
- Resources (1) – 1 High (RES1603ISS.3 – Leavers);
- Safer and Stronger (2) – 2 High (SSC1701ISS2 and ISS4 - Homelessness)
- Council Wide (6) – 6 Low actions across all Service Areas (RES1605ISS.1 – Service Level Agreements). Note that Health and Social Care action has been completed.

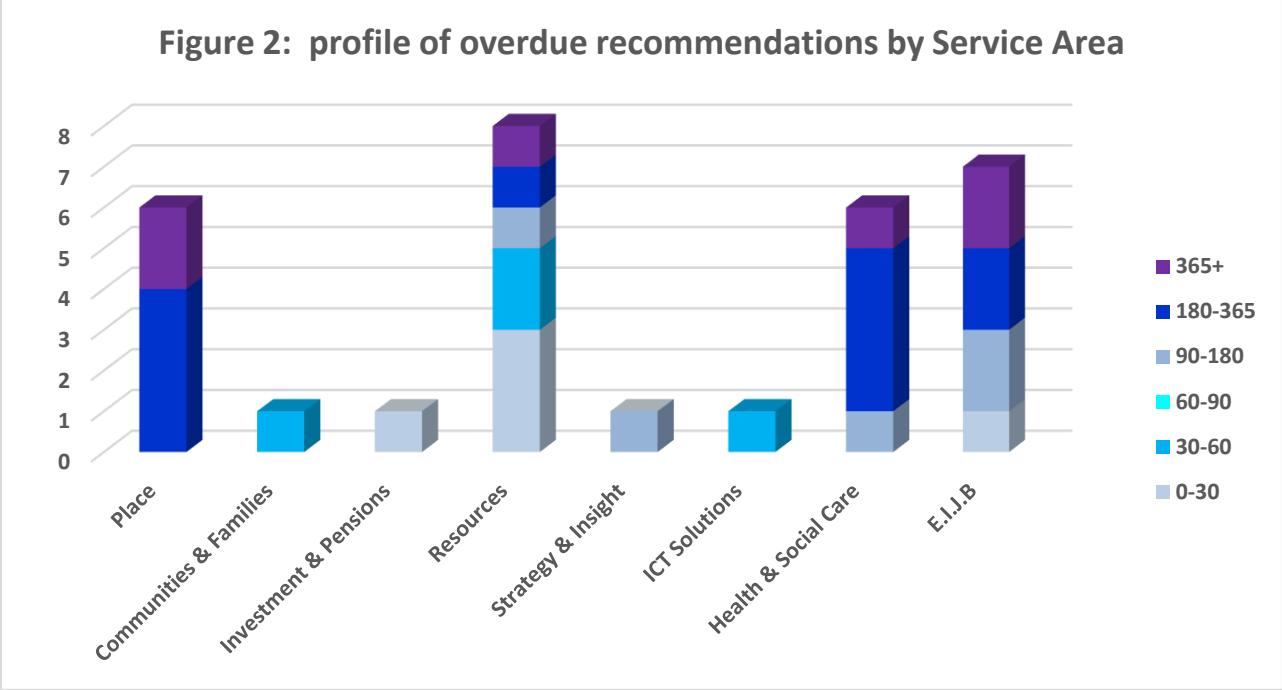
3.7 No recommendation ratings have been downgraded since the last CLT report.

3.8 Figure 1 illustrates the ageing profile of all overdue recommendations by rating across Service Areas. Of the 31 overdue items, 17 are more than 180 days overdue (2 High; 13 Medium; and 2 Low) in comparison to 12 last month, with 6 of the 12 (1 High, 3 Medium and 2 Low) more than 365 days overdue in comparison to 5 last month.

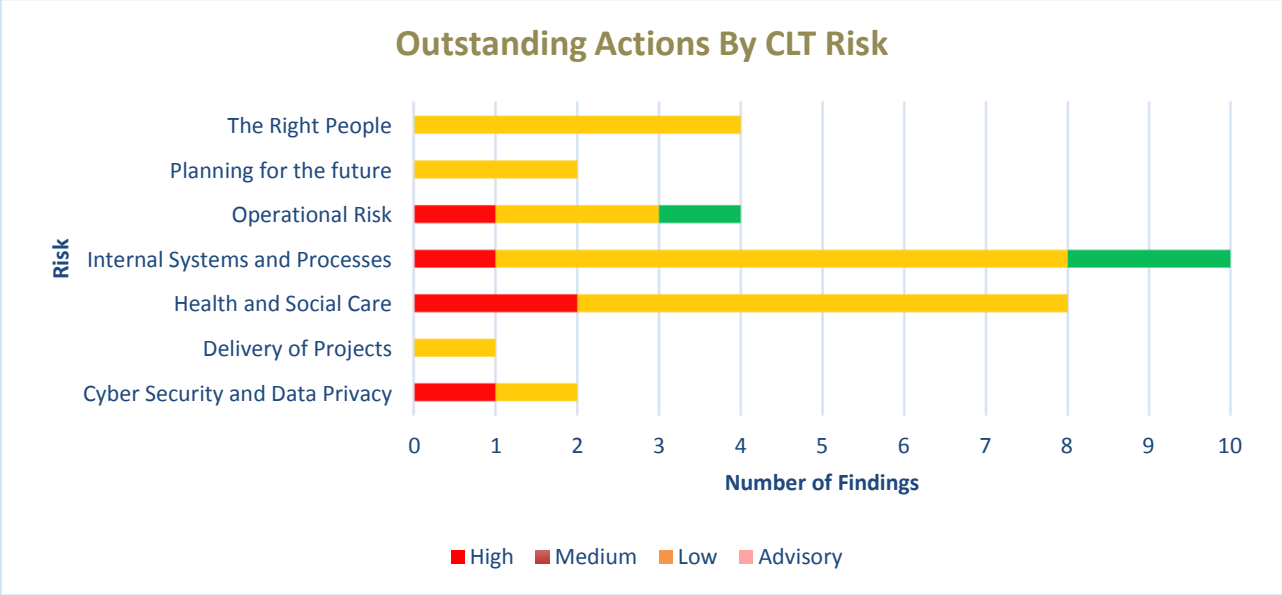
Figure 1: Aged profile of overdue recommendations by ratings across Service Areas



3.9 Figure 2 highlights the ageing profile of overdue Internal Audit recommendations for each Service Area.

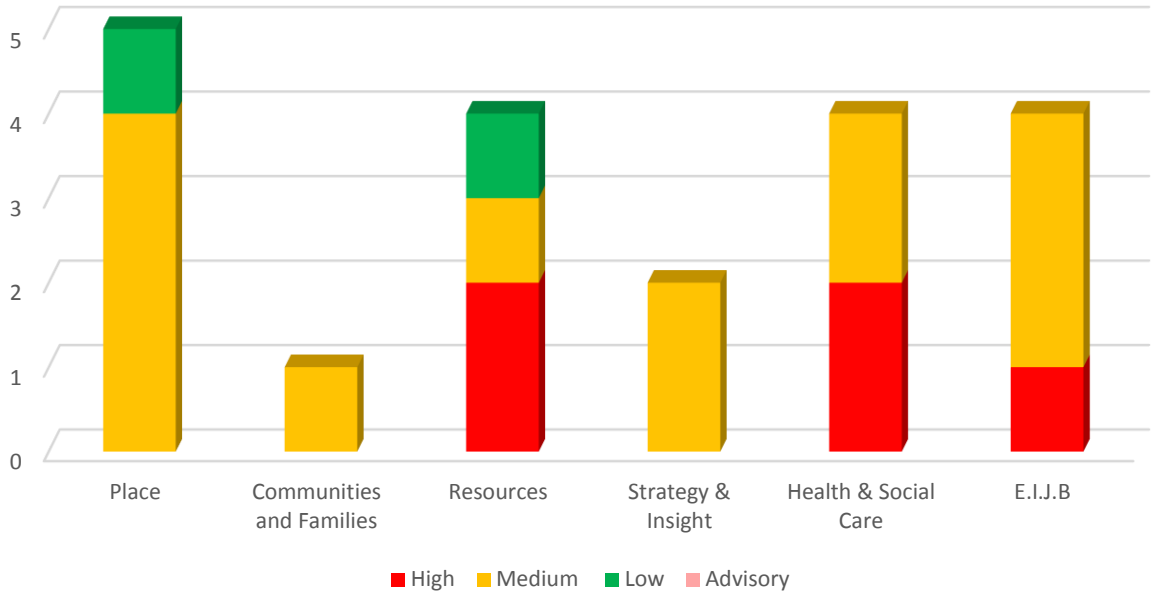


3.10 Figure 3 correlates the current top Corporate Leadership Team risks with the relevant overdue Internal Audit recommendations. The Council's primary risk exposures as a result of overdue recommendations are Health and Social Care and Internal Systems and Processes.



3.11 Figure 3 illustrates that there are 20 overdue recommendations where completion dates have been revised more than once since the implementation dates agreed with Service Areas when finalising audit reports. This is an increase of 5 in comparison to last month. This increase is driven by Place (1); Resources (2) and Strategy and Insight (1).

Figure 3 : More than one revised completion date across Service Areas



3.12 There were 4 recommendations across Lothian Pension Fund (1) and Resources (3) where closure was originally dependent on implementation of the new Business World System.

These have now been closed and validated based on implementation of alternative (manual) controls.

3.13 There are 4 open (not overdue) recommendations where agreed dates for specific actions have been missed. These are:

- Integration Joint Board – Data Integration and Sharing (HSC1604ISS.1 – High). Initial action date 30 August, the full recommendation is due for closure by 31 October.
- Strategy and Insight – Complaints Process (CF1619ISS.1 – Medium). Initial action date was 31 August. This action date has been revised to 31 July 2018, the full recommendation is due for closure by 31 March 2019.
- Strategy and Insight - ICO Follow Up (RES1606ISS.2 – Medium). Initial action date was 30 May. This action date has now been revised to 31 August, with the full recommendation due for closure by 31 March 2018.

- Safer and Stronger Communities – Homelessness (SSC1701ISS.4 – Medium). Initial action date was 30th September 2017, the full recommendation is due for closure by 31st October.

3.14 Internal Audit has categorised all overdue Internal Audit actions by Directorate showing the latest status updates where received. The detailed results of this categorisation are set out in Appendix 1.

3.15 There were 3 Internal Audit reports issued in draft where management responses have not been received within our two-week service standard. These are:

- Resources - Lothian Pension Fund – Information Governance – report has now been issued in final.
- Resources – Property and Asset Management Strategy – impacted by annual leave during the October week for schools. Management responses have now been received and we are aiming to finalise by Friday 3 November.
- Resources – Customer Transformation Programme. Review was subject to handover from the Principal Audit Manager who left in August to the Chief Internal Auditor. Further work was required and has now been completed with a report out in draft for management comment. Audit should have been completed by end August 2017.

4. Measures of success

4.1 An increase in the implementation and closure of Internal Audit recommendations within their initial estimated closure date.

5. Financial impact

5.1 Not Applicable.

6. 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 effective risk management, compliance, and governance.

7. Equalities impact

7.1 Not Applicable.

8. Sustainability impact

8.1 Not Applicable.

9. Consultation and engagement

9.1 Not applicable.

10. Background reading/external references

10.1 Not Applicable.

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11. Appendices

Appendix 1 – Status report: Outstanding Recommendations Detailed Analysis

Unique No	Project Code	Project Name	Group	Issue Cod	Rating	Finding	Business Implication	Recommendation	Agreed Management Action	Status	Due Date	Revised Date	Revisions	Status Update	Owner
Communities & Families															
CF1619 ISS.3	CF1619	Complaints Process	C&F	ISS.3	Medium	The Chief Social Work Officer conducted a review of complaints handling for secondary schools in 2015, and surveyed the head teachers of the 18 secondary schools which had not recorded a complaint in the previous 2 years. 9 head teachers responded that they were unsure what type or level of complaint should be shared with the Advice and Complaints (Education) Service; and 4 acknowledged that they had not followed the complaints procedure. Perhaps as a result of increased a wareness of the complaints procedure following the Chief Social Work Officer ' s review, at least one Stage 1 complaint was recorded by each secondary school in 2015/16 or 2016/17. However, 29 primary schools have not recorded a Stage 1 complaint in 2015/16 or 2016/17. This represents 32% of the primary school estate. It seems unlikely that these schools did not receiv e any complaints in that period. This suggests that the Communities & Families complaints performance data is likely to be incomplete.	Performance information is inaccurate as it does not include all Stage 1 complaints; There is a risk that complaints are not being reported / handled approp riately by the schools, meaning problems are not addressed early on and may escalate; Communities and Families do not have complete management information on complaints, so can not identify and address common service issues.	We recommend the Advice & Complaints (Education) Service issues guidance to schools on what is considered a complaint, and how a complaint should be handled and recorded. This may be delivered most effectively through forums such as the Communities & Families Risk Group or Head Teachers Groups. We note that complaints recording is more difficult in schools as they cannot use Capture and complaints can only be recorded on Jadu once resolved. As noted in Finding 1 , the Council is procuring a new complaints handling system and will o verhaul the complaints handling process as part of this. We recommend that Communities & Families Advice & Complaints (Education) Service works with Strategy Insight to ensure that their complaints handling processes are aligned, and messages to head teach ers are consistent.	The current Jadu form will be reviewed, in consultation with the wider work ongoing within Strategy & Insight, to ensure that complaint information can be collected at an earlier stage in the process.	Overdue	31/08/17	31/07/18	31/08/17 31/07/18	October Update : The complaints action cannot progress in isolation as there is a Council wide complaints project underway which will determine the way our complaints are recorded. The update provided in September which is recorded in the spreadsheet provides the details. There is nothing further we can add at this time. September Update : 11/09/17 - The current Jadu form will be reviewed, in consultation with the wider work ongoing within Strategy & Insight, to ensure that complaint can be collected at an earlier stage in the process. As a result of the Corporate Review of Complaints, a Corporate Complaints Improvement Plan has been developed. The action for Education will be covered by the following workstream within the Improvement Plan: "Agree a strategy to minimise the number of databases currently being used across service areas to record, manage and report complaints" This will involve meeting with all services that do not use Capture or Confirm, research possible solutions, consult services affected by recommendations to agree future arrangements and to review training provided on alternative systems to ensure alignment with standardised complaints training. The timescale for this action is November 2017 – July 2018. Please note the procurement of a new CRM (customer relationship management) is currently on hold	Frances Smith, Advice & Complaints Officer (Education)
E.I.J.B and Health & Social Care															
HSC1503 ISS.3	HSC1503	Personalisation SDS - Option 3	E.I.J.B.	ISS.3	Medium	Scottish Government collects data on SDS users through annual and quarterly statistical surveys of local authorities. The answers to survey questions are based on data held in Swift. The accuracy and completeness of data input is therefore essential. There have been several changes in the assessment process and data captured in the past year such as: Eligibility for services (on which data is required by Scottish Government) has been recorded since January 2015; ' Initial steps to support ' assessments were in use for new contacts between August 2014 and May 2015 but are now used only for crisis care; A new personal support plan was introduced in October 2015. Where a new personal support plan is used, ' Option 4 ' is now recorded as a combination of Optio ns 1, 2 and 3. There was no cut-off date after which all assessments would be carried out using new templates. The full process of assessment and arranging care can be lengthy. This means that there are several different ways of recording assessments running concurrently, with different data captured in each one. It is therefore difficult to extract complete and accur ate data for management information and for reporting to Scottish Government.	Data on Swift is used to provide internal and external reporting which is likely to be incorrect. Data quality is affected where several processes to capture the same information are in use. There are over 500 practitioners completing assessments on Swift: multiple process cha nges over a short period of time increase the likelihood of errors in data input.	Further changes to the assessment process are expected over the next year as a result of the Transformation Programme and integration with the NHS. A change management process should be in place to minimise the number of process and recording changes through the year, implement clear cut-off dates, and to ensure changes are communicated to staff clearly. In the meantime, Research and Information should be aware of the likely inconsistencies in data recorded and ensure th at reports are thoroughly reviewed before issue.	A change management process will be established and overseen by the SDS Infrastructure Steering Group. The inconsistencies in data recording are as a result of numerous changes to processes and trying to reduce the recording burden of implementing these on frontline practitioners. The Research and Information Team are aware of all changes to recording practice and take these into account. A summary of all changes and the impact on data extraction has also been produced.	Overdue	30/06/16	31/12/17	31/12/17 30/06/17	January 2018 update Compliance and Data Quality Team Manager now in place, rest of the Team starts on 8/1/18. Draft project plan agreed by Assessment and Review Board (copy supplied to Internal Audit). Current Position at 21/11/17 - The establishment of the Compliance and Data Quality Team has been agreed; the manager will take up post on 4/12/17 and the rest of the Team on 8/1/18. A prioritised work plan will be drawn up for the Team and include the development and implementation of a change management process. Delivery date to be extended to 31/3/18.	Mary McIntosh, Business Services Manager
HSC1503 ISS.6	HSC1503	Personalisation SDS - Option 3	E.I.J.B.	ISS.6	Medium	Since October 2015, all personal care plans must be signed off by a senior. This is a measure introduced to improve the quality of personal support plans. We obtained a report of all personal support plans completed between October 2015 and January 2016. We identified 44 cases out of 811 (5.4%) where the system recorded that the assessor who prepared the personal support plan also signed it off. This was reflected in the variable quality of the 25 personal care plans we reviewed as part of our audit work.	The quality of personal support plans is a vital aspect of delivering SDS and ensuring that people receive the care that they choose and need. A lack of review may affect the quality of care received.	All personal care plans should be signed off by a senior, as required by HSC policy. 'Workarounds' on Swift should be deactivated to prevent this breach of segregation of duties recurring.	Ensure that there is a mechanism in place on SWIFT for the senior to record that they have signed off the support plan. At present any edits made by the senior at the time of the review will show that the senior has both prepared and reviewed the plan. Data quality reports will be set up to identify any support plan signed off by the assessor who produced the plan. Sector Managers and seniors to ensure appropriate oversight and sign off by senior for the personal care plans	Overdue -	30/06/16	31/12/17	31/12/17	January 2018 update Compliance and Data Quality Team Manager now in place, rest of the Team starts on 8/1/18. Draft project plan agreed by Assessment and Review Board (copy supplied to Karen Sutherland). Current Position at 21/11/17 - Overdue The establishment of the Compliance and Data Quality Team has been agreed; the manager will take up post on 4/12/17 and the rest of the Team on 8/1/18. A prioritised work plan will be drawn up for the Team and include the outstanding tasks in order to address this recommendation. Delivery date to be extended to 30/6/18.	Mary McIntosh, Business Services Manager
HSC1504 ISS.1	HSC1504	Care Sector Capacity	E.I.J.B.	ISS.1	Medium	A Joint Strategic Needs Assessment (JSNA) has been drafted by the Research and Information team in preparation for health and social care integration. This analyses demographics across the city and the attendant pressures on social care provision such as life expectancy, morbidity, deprivation, prevalence of unpaid carers and employment levels (affecting both need for social care and the availability of carers). While the JSNA gives a sophisticated analysis of the current demographic and economic profile of the city, it is a snapshot based on historic statistics. Forecast ing is limited to percentage growth according to the N ational R ecords of S cotland population projections by age group. The demographic trends and pressures on social care provision identified in the JSNA have not been translated into the likely effect they will have on demand for services in the medium- to long- term. This means that the Council does not have a robust forecasting model of demand for social care in the City to inform its strategic planning.	Lack of robust forecasting models impedes informed strategic planning of future service provision; New service structures and initiatives may be c reated in an attempt to address current problems which are not suitable for changing demands caused by foreseeable mov ements and trends in the population.	Forecasting The JSNA should be developed into a robust forecasting m odel for demand for social care in the City. This should involve an appropriate level of scrutiny of t he reliability of the data used and the assumptions used in the model. We recommend that an officer from Health and Social Care is involved in the development of the JSNA in order to assess the assumptions used. The forecasting model should include a sensitivity analysis to assess the likely impact of variation in forecast trends. This is particularly important given the recognised breadth and complexity of social and economic factors affecting demand for care. Gap Analysis Once demand for homecare services has been forecasted, the Service should identify the gap between current and required capacity. If the forecast is sufficiently nuanced, the Service will be able to identify the gap between available resources and need fo r different groups, types of care, and localities. Implementation To date, population projections have generally been used to illustrate the need for service reform. The forecasting model and gap analysis should be used to inform strategic planning of Health and Social Care services.	Forecasting The Edinburgh Health and Social Care Partnership ' s Strategic Plan includes as a priority the improvement of our understanding of the strengths and needs of the local population through the ongoing development of the JSNA . A working group has been established to carry out this work. Members include colleagues from Public Health in NHS Lothian as well as from the Health and Social Care Partnership . One of the work streams which ha ve been identified for the group is to further investigate methods of forecasting needs among specific groups , and our P ublic Health colleagues are supporting this work. Sensitivity analyses will be built into forecasting models. Gap Analysis Existi ng methods enable the gap to be identified between demand and supply in broad terms. Further work will be done in conjunction with Strategic Planning and Contracting colleagues to provide analyses in relation to specific service models. Implementation Improved understanding of the strengths and needs of local populations, and the gap between demand and supply, will be used to develop service models and will inform strategic planning.	Overdue -	30/04/17	31/12/17	31/12/17	November Update: - Ovedue - IA Validation in progress Further evidence supplied by Eleanor Cunningham for validation by Hugh Thomson January 2018 update - pending verification Discussed with Internal Audit who will speak to Strategy and Insight (Eleanor Cunningham) on the final points.	Wendy Dale, Strategic Commissioning Manager
HSC1601 ISS.6	HSC1601	Care Home Debt Management	E.I.J.B.	ISS.6	Medium	Section 22(2) of the National Assistance Act 1948 states that "the payment (which a person is liable to make) for any such accommodation shall be in accordance with a standard rate fixed for that accommodation by the council managing the premises in which it is provided (and that standard rate shall be represent the full cost to the authority of providing the accommodation)." Historically the Council have not charged the full cost of accommodation provision and provided the accommodation at a discount to the full unit cost. The Chief Officer of the Edinburgh Health and Social Care Partnership is responsible for reviewing charges on an annual basis. Unit costs are updated regularly by Finance and are available to Health and Social Care senior management to inform decisions on charges. Rates charged to residents for Care Homes are currently based on a historic costs exercise thought to have been completed in approximately 2005, then updated by "inflationary" increases in subsequent years. These uplifts were not linked to the actual cost increases in delivering accommodation and in 2015/16 a cohort of 9 residents receiving specialist dementia care at the North Merchiston Care Home appear to have been charged £9.80 per week in excess of the Home's unit cost of care provision for all or part of the year (total over-charge: £3,059), an apparent breach of the National Assistance Act 1948. This situation did not recur in 2016/17 due to the contract changes with the company running the care home on behalf of the Council. The unit cost of care increased by 3.9% in 2016/17 while the rate charged to residents remained constant, resulting in the unit cost of care being greater than the unit cost for patients in this category at the North Merchiston Care Home.	The Council appears to have charged this cohort of residents a sum in excess of what is permitted under the National Assistance Act 1948. The rates charged to residents in all Council provided accommodation needs to be reviewed for 2017/18 to ensure that they better reflect the actual cost of the care provided and prevent a similar recurrence.	The incident of apparent overcharging requires to be investigated and if substantiated, refunds provided to the individual residents affected.	The Team Manager – Social Care Finance – Transactions, will identify the clients who have been overcharged for 2015/16 by the Billing Team and make the appropriate refunds.	Closed and Verified				January 2018 update a briefing paper has been produced for the Interim Chief Officer setting out recommendations to be adopted regarding the setting of full cost charges for Council managed care homes on an annual basis. A copy of the briefing note will be sent to Internal Audit by separate email. Clarification has now been received that Committee approval is required a report will therefore be produced for Corporate Policy and Strategy Committee on 27 February 2018. The due date therefore needs to be revised to 28/2/2018. November update: briefing paper for SMT drafted to be finalised following a meeting of key players on 20/11/17. Evidence of meeting and draft paper submitted to IA.	Elizabeth Davern, Team Manager: Social Care Finance - Transactions
								The rates charged to residents in all Council provided accommodation needs to be reviewed for 2017/18 to ensure that they better reflect the actual cost of the care provided and prevent a similar recurrence.	The rates charged to residents in all Council provided accommodation will be reviewed for 2017/18 to ensure that they better reflect the actual cost. Finance will update unit costs to inform this review.	Overdue	31/03/17	31/12/17	30/06/17 31/12/17	January 2018 update a briefing paper has been produced for the Interim Chief Officer setting out recommendations to be adopted regarding the setting of full cost charges for Council managed care homes on an annual basis. A copy of the briefing note will be sent to Internal Audit by separate email. Clarification has now been received that Committee approval is required a report will therefore be produced for Corporate Policy and Strategy Committee on 27 February 2018. The due date therefore needs to be revised to 28/2/2018. November update: briefing paper for SMT drafted to be finalised following a meeting of key players on 20/11/17. Evidence of meeting and draft paper submitted to IA.	Katie McWilliam, Strategic Planning and Quality Manager for Older People
HSC1603 ISS.4	HSC1603	Management Information [EIJB]	E.I.J.B.	ISS.4	Medium	There is one member of the NHS Data Set Team responsible for pulling together and circulating delayed discharge reports to locality managers each week. We selected a sample of 5 weeks and confirmed that the report had been generated and circulated. We identified: One week where no delayed discharge report was circulated as the officer responsible was on annual leave; One week where additional information was missing as the officer responsible did not have time to complete it.	Locality managers do not have sight of delays if the staff member responsible for preparing management information is absent. There is a risk that this means resources cannot be targeted effectively, and the number of delays increases. There is a reliance on existing NHS and Council professional support arrangements which may not meet the needs of the EIJB.	Delayed Discharge At least one other member of the NHS or Council Data Set Teams should be trained in preparing delayed discharge reports to provide cover in the event of staff absence. Lessons Learned In developing the Performance Management Framework, the Edinburgh Health and Social Care Partnership should identify re sources required to collect and analyse performance data and maintain a consistent quality of reporting to locality managers, the Executive Board, and the EIJB.	The resource requirements to meet the performance management requirements of the IJB will be identified as part of the development and implementation of the new operating structure in Health and Social Care.	Overdue	31/03/17	31/12/17	31/07/17 31/12/17	October update: Resourcing issues in respect of performance management to be addressed as part of Phase 3 of the Health and Social Care transformation. Owner for this action to be changed to Michelle Miller	Michelle Miller, Interim Chief Officer, EH&SCP
HSC1604 ISS.2	HSC1604	IJB Data Integration & Sharing	E.I.J.B.	ISS.2	High	During interviews conducted with NHS and CEC, it was noted that two processes (specifically access management and communication protocols for data sharing) do not fully support the objectives of the IJB. Responsibilities for ensuring that access rights to NHS and CEC systems remains appropriate have not been established. Currently, managers within NHS should notify CEC and vice versa of staff joiners, leavers or movers. This allows access rights to be updated in line with revised operational requirements. However, there is no formal documented process or guidance that sets out the requirement to notify the two bodies of staff changes , and interviewees reported that access control is inconsistently applied (for example not all managers notify their ' non-home ' organisation ' of staff changes). Currently, communication protocols for data sharing are in place. However, we observed that these protocols were not fully established and not sufficiently mature enough on data protection to properly support the objectives of IJB.	There is a risk of managers not being aware of their responsibilities to notify their 'non-home' organisation of staff changes. This could lead to access rights not being updated for leavers or movers and result in confidentiality of sensitive citizen data being put at risk, leading to regulatory fines or censure. Immature data sharing protocols increase the risk of data being inappropriately handled or misused, putting the confidentiality of sensitive citizen data at risk, leading to regulatory fines or censure.	IJB should ensure the communication protocols for data sharing are fully established and mature on data protection.	A pan Lothian General Data Sharing Protocol that facilitates trust among all parties (NHS Lothian, Edinburgh, East, West and Mid Lothian Councils and IJBs) is now in place and the Memorandum of Understanding (MOU) defining the joint data controller responsibilities between the City of Edinburgh Council, NHS Lothian and the EIJB is in the final draft. It is envisaged that the MOU will be signed off by all parties by the end of June 2017. Once sign off has been achieved details will be shared with staff through the regular staff newsletter.	Overdue	31/07/17	31/01/18	31/10/17	December update: The Pan Lothian Agreement (final draft) has been circulated to respective Lothian Council legal teams for comment and CEO sign-off. IGU comment: CEC Legal Services have agreed document; other legal teams are holding up the process. Meeting has been arranged for mid-January to hopefully get agreement from all signatories and organisations involved. Suggested revised date: Jan 2018.	Kevin Wilbraham, Information Governance Manager, Corporate Governance.
								The processes for notifying system owners of staff changes should be well defined and communicated to stakeholders. Controls should be implemented to ensure access to CEC and NHS systems remain appropriate. This should include processes to ensure that changes are applied in a timely manner and access rights are regularly recertified. This would provide assurance to system owners over the operating eff e ctiveness of these controls.	The existing processes within the Council and NHS Lothian for notifying system owners of staff changes will be communicated to all managers of integrated teams. Establishing an integrated system setting out the systems access requirements for all posts and the mechanism for gaining access for new staff and notifying system owners of leavers and changes in role will be a priority for the nominated officer to be identified in respect of ICT and Information Governance.	Overdue	30/09/17	31/03/18		November update: an individual has now been appointed to the post. funded by Resources and will begin to develop a work plan. A hand over will be arranged with the existing action owner. January 2018 update - Handover meetings have been arranged for the week commencing 8/1/2018	Wendy Dale, Strategic Commissioning Manager

Unique No	Project Code	Project Name	Group	Issue Cod	Rating	Finding	Business Implication	Recommendation	Agreed Management Action	Status	Due Date	Revised Date	Revisions	Status Update	Owner
HSC1604 ISS.3	HSC1604	IJB Data Integration & Sharing	E.I.J.B.	ISS.3	Medium	During our audit procedures, we observed there are compatibility and connectivity issues when using CEC hardware at NHS locations or to access NHS owned systems and vice versa. CEC staff have experienced difficulties in connecting through Wi-Fi at NHS sites (and vice versa) in order to access their emails, and some systems cannot be accessed using specific hardware such as mobile devices (i.e. tablets, mobile phones).	There is a risk of the operational efficiency and effectiveness being impacted by an inability to access system in a timely manner.	The IJB should ask for a review of connectivity and hardware compatibility to be conducted in NHS and CEC sites, to ensure all staff can be fully operational wherever they are located.	The ICT and Information Governance Steering Group will request a review of connectivity and hardware compatibility to be conducted across all sites housing integrated teams and consider any recommendations arising from that review.	Overdue	30/06/17	31/12/17		January 2018 update - the ICT and Information Governance Steering Group tasked specific individuals to produce the Survey Monkey questions for agreement at the next meeting of the Group on 22/1/2018. Revised implementation date 31/3/2018. November update : following discussion with ICT colleagues in CEC and NHSL it will be recommended to the ICT and Information Steering Group on 21/11/17 that all staff in integrated teams where access to both CEC and NHSL systems are required are asked to take part in a survey (via Survey Monkey) to identify any issues relating to access to systems.	Wendy Dale, Strategic Commissioning Manager
HSC1503 ISS.1	HSC1503	Personalisation SDS - Option 3	H&SC	ISS.1	High	The Social Care (Self-directed Support) (Scotland) Act 2013 states that the authority must "inform the supported person of the amount that is the relevant amount for each of the options for self-directed support from which the authority is giving the person the opportunity to choose, and the period to which the amount relates." The "relevant amount" is defined as "the amount that the local authority considers is a reasonable estimate of the cost of securing the provision of support for the supported person". At present, the supported person is not informed of their assessed budget when they are asked to choose their option. They are only told of the resources available to them when they receive their personal support plan after they have selected their option.	There is a risk of non-compliance with The Social Care (Self-directed Support) (Scotland) Act 2013. The supported person may not have sufficient financial information to make an informed decision on the feasibility and affordability of arranging their own care under Option 1.	Management should seek clarification from Scottish Government on how the legislation should be applied where the supported person is allocated the same budget whichever option is chosen. Management must then ensure that the SDS assessment process is compliant with Scottish Government's instructions. This may mean informing the supported person of their personal budget at an earlier stage of the assessment process.	Scottish Government have been approached on this issue through the Social Work Scotland SDS Sub-group and have indicated that they are prepared to consider issuing further guidance and in particular revisit the issue of whether local authorities need to notify individuals of the indicative budget for each of the four options or just provide a single indicative budget which is what most authorities seem to be doing in practice. These discussions will take place through the Social Work Scotland SDS Sub-group and Senior management will ensure that Edinburgh is involved in these discussions. The current processes and practice in relation to providing individuals with an indicative budget will be reviewed and updated and clear guidance issued to staff taking account of any change in guidance from the Scottish Government. In either case, an indicative budget will be given to individuals before they are asked to select their preferred option.	Overdue	31/10/16	31/12/17	31/12/17 30/06/17	January 2018 update - progress in delivering this action has been slower than anticipated. A revised completion date on 31/3/18 is requested. Current Position at 21/11/17 - Overdue: The working group is due to meet again to update on progress and agree next steps on 29/11/17.	Wendy Dale, Strategic Commissioning Manager
HSC1503 ISS.2	HSC1503	Personalisation SDS - Option 3	H&SC	ISS.2	High	The Social Care (Self-directed Support) (Scotland) Act 2013 states that the authority must give the person "in any case where the authority considers it appropriate to do so, information about persons who provide independent advocacy services (within the meaning of section 259(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13))." When researching advocacy services for people affected by SDS the only place we were able to find information was on the Council's Edinburgh Choices website which is an online directory of local care and support services , which includes details of independent advocacy services. However, we were unable to find links to the Edinburgh Choices website in key communications to service users and the general public about SDS. The Council has produced detailed pamphlets and leaflets which explain SDS to service users and carers but advocacy services are not covered, and readers are not directed to the Edinburgh Choices website. Practitioners we spoke to could not direct us to advocacy services.	There is a risk of non-compliance with the Social Care (Self-directed Support) (Scotland) Act 2013	The service should ensure that information about advocacy services is available to service users. Possible options may include: Providing practitioners with information about available advocacy service and what they do; Directions to Edinburgh Choices in guidance materials for service users; or Names of advocacy services in pamphlets and leaflets for service users.	Existing leaflets and information materials to be reviewed to make reference to Edinburgh Choices Information to be produced for dissemination to practitioners regarding the duty to identify people who may benefit from advocacy and support them to access this services and the agencies that the Council has commissions to provide advocacy services.	Overdue	31/08/16	31/12/17	31/12/17 31/10/17 30/09/17	January 2018 update - changes have now been made to SWIFT to allow the recording of people who would benefit from independnet advocacy and monitoring of actions taken to support them to access this service. This facility went live on 3/1/2018. Guidance has been put on the Orb and an email sent to all staff by the Interim Chief Officer, drawing their attention to the guidance and the need for compliance. Leaflets have been made available for the general public. Evidence submitted to Karen Sutherland - pending verification Current Position at 21/11/17 - Overdue Discussions have been taking place about the set up of the questions on SWIFT (as detailed in October update below); a firm proposal has been put forward and a firm timescale requested for implementation. Supporting Evidence of proposed questions have been by IA via email.	Wendy Dale, Strategic Commissioning Manager
SW1601 ISS.4	SW1601	Social Work: Pre-Employment Verification	H&SC	ISS.4	Medium	There was insufficientevidence to support the PVG checks of three nominated candidates who were 'existing Council employees'. The original PVG certificate is destroyed at the initial point of employment. Therefore recruiting managers of nominated candidates, who are existing employees, may not be aware of the 'vetting information' included in the original PVG Check. This restricts managers' ability to make an informed decision to proceed with the employment. It should be noted that Scheme Record Updates (which carry out a check betwe en the original PVG Certificated issued; to the date of the requested update) do not include details of any 'vetting information' held within the original certificate. The current "Recruitment and Selection Guidance for Managers Pre-Employment Checks fo r Nominated Candidates" states that "no further check is required if the individual is a PVG Scheme member in the Council for the same type of 'regulated work'. There is potential for staff to be recruited to a role which is not appropriate given their previous convictions. For example; a person with fraud convictions may properly be recruited to a care home if they are not handling cash but a future appointment to the homecare service; with access to vulnerable people's funds may be approved without due consideration of the risk.In October 2016 a carer in East Lothian was convicted of Fraud amounting to £46,000 from two clients.	Recruiting managers may have insufficient evidence of PVG 'vetting information' to allow them to make an informed decision over whether to proceed with employment. This may lead to recruitment of staff not appropriate to the role.	The "Recruitment and Selection Guidance for Managers Pre-Employment Checks for Nominated Candidates" should be updated to reflect the above change in procedure.	Employees should currently retain vetting information received as a result of a PVG disclosure check for regulated work. If an existing employee working in regulated work is the nominated candidate for another position within the Council which is also regulated work then that candidate should evidence the vetting information for the original PVG check. It should be noted that Disclosure Scotland have confirmed that Scheme Record updates now contain original vetting information. Employees who fail to evidence the original vetting information will result in the Council requiring to pay for a Scheme Record update. The cost of this update is £18, this will be an additional cost to the Council. The vetting information will continue to be destroyed by the People Support Recruitment Team as it is not deemed efficient to retain huge amounts of vetting information on a 'just in case basis'. The required documentation will be sought on a 'need' basis In the first instance the responsibility to provide information will be the employees. The requirement to evidence vetting information when recruiting staff internally will be included in the guidance at its next review.	Closed - Verified					Grant Craig, People Support Manager
								All nominated candidates should be requested to bring their copy of the PVG certificate to the pre-employment checks meeting; in order to allow mangers to make an informed decision as to whether to proceed with the recruitment process or to rescind the offer.	Locality Managers to obtain confirmation from their recruiting managers that nominated candidates are being requested to bring their PVG certificate to the pre-employment checks meeting. This requirement has been effectively communicated to all relevant managers / staff and a mechanism will be introduced to ensure that the requirement is being adhered too. This procedure will be embedded within the HSC and Safer & Stronger Communities protocol.	Overdue	31/03/17	30/11/17	30/11/2017	Current Position at 26/10/17 - Overdue IA met with Executive Business Support Manager 25.10.17 and was advised that this work is still on-going. Action has a revised implementation date of 30.11.17.	Cathy Wilson, Executive Business Support Manager
SW1601 ISS.5	SW1601	Social Work: Pre-Employment Verification	H&SC	ISS.5	Medium	Testing identified that working practices between recruiting managers, HSC Recruitment, and HR Recruitment are not fully documented and this has led to inconsistencies including: - bypassing the HSC Recruitment Co-ordination Team; - inadequate recording of Criminal Convictions form (CCF) and PVG information; - inappropriate record management; and - no clear formal procedure has been issued to Recruiting Managers to advice them of the requirement to formally document the decision to proceed with or recind the offer of employment; following receipt of 'vetting information' in respected of the nominated candidate.	Key information may not be retained. HSC Recruitment Staff and Recruiting Managers may not be aware of what is expected of them. Risk of non-compliance with Disclosure Scotland's 'Code of Practice'.	All relevant policies and procedures should be updated with the requirement to formally record the 'Recruiting Managers' decision on the "PVG / Disclosure Risk Assessment form" and "Record of Meeting on PVG / Disclosure Information" form in order to show clear evidence of the decision made. Once complete these procedures should be formally communicated to all relevant staff / Recruiting Managers. This should include the safe storage and retention periods of both forms.	The forms "PVG / Disclosure Risk Assessment form" and "Record of Meeting on PVG / Disclosure Information" should be forwarded to the Council Recruitment Team checked then retained as part of the employees personal file. This will evidence the decision of the recruiting manager to offer or rescind employment. A process review will be carried out and implemented by 31/12/2016 As part of the process review between the HSC Team and HR Recruitment the HSC Team have made a commitment to communicate to all relevant staff and recruiting managers.	Closed - Verified					Grant Craig, People Support Manager
								Procedures should be produced by the HSC Recruitment Co-ordination Team in conjunction with HR Recruitment Team and senior HSC Management to ensure the recruitment process is safe, consistent and compliant with appropriate legislation and CEC policies. This should include the requirement to complete the 'PVG/Disclosure Risk Assessment Form' and ' Record Of Meeting on PVG/Disclosure Form'	HSC Recruitment Co-ordination Team will work with HR Recruitment Team to develop safe and consistent procedure including the requirement to update both of the PVG / Disclosure Forms noted. Procedures to be strengthened to ensure that we are up to date to reflect safe storage and retention procedures. HSC to formally communicate this to all relevant staff and recruiting managers, including the safe storage and retention periods of both forms. Confirmation of this to be sent to Locality Managers.	Overdue	31/03/17	30/11/17	30/11/17 31/5/17	Current Position at 26/10/17 - Overdue IA met with Executive Business Support Manager 25.10.17 and was advised that this work is still on-going. Action has a revised implementation date of 30.11.17. September Update: Further work required to support closure. Revised Implementation date of 30/11/2017 agreed.	Cathy Wilson, Executive Business Support Manager
SW1601 ISS.7	SW1601	Social Work: Pre-Employment Verification	H&SC	ISS.7	Medium	The HSC Recruitment Co-ordination Team carry out 'Bulk Interviews' on a monthly basis for Care Home and Homecare posts where there are a number of different posts required at different locations around the city. This is due to a high volume of staff movement within these posts, which due to the nature of the posts are required to be filled timeously. However; it was established that the 'Location Manager' who the nominated candidate reports to on their first day of work is not necessarily the same manager who has interviewed the candidate or taken the candidate through the pre-employment checks to check their identification. It is acknowledged that this carries the risk that the person who turns up for work may not be the person that was interviewed.	Risk of identification fraud resulting in the Council employing a candidate who does not have the skills or experience required to fulfil the duties of the post. Risk of financial sanctions re Right to Work in UK Legislation	All nominated candidates be requested to bring photographic identification with them which should be checked and verified by the 'Location Manager' on the candidates first day of work. Failure to bring the appropriate identification should result in the candidate being refused to start work within the Council. This should be embedded within H&SC and Safer and Stronger Communities procedures and communicated to all relevant staff.	Locality Managers to seek confirmation from either recruiting managers and/or location managers to ensure that candidates are being requested to bring photographic ID on their first day of work. This process will also be embedded within the H&SC and Safer & Stronger Communities procedures and communicated to all relevant staff.	Overdue	31/03/17	30/11/17	30/11/17 31/5/17	Current position at 27/10/17 - Overdue Communication has gone to all Locality Managers to ensure compliance with mandatory first day ID verification for new employees on first day. Work is still ongoing to ensure that this is being adhered to. Verification process to be completed throughout November. September Update: Further work required to support closure. Revised Implementation date of 30/11/2017 agreed.	Cathy Wilson, Executive Business Support Manager
SW1601 ISS.8	SW1601	Social Work: Pre-Employment Verification	H&SC	ISS.8	Medium	The Council's Recruitment and Selection Policy states that "all individuals in the recruitment and selection of potential candidates on behalf of the Council" must receive Council training in equality issues, Safer Selection, and the application of the policy". The CECIL Competency Based Recruitment and Selection module under "Safer Selection and Pre-employment Checks; notes the Council's approach to safer selection includes 'Mandatory training for all recruiters' and that if a manager recruits on a regular basis they should repeat the modules every 2 years. Checks were carried out on twenty individual managers who were involved in the recruitment of the nine nominated candidates whose PVG check had returned 'vetting information'. Testing highlighted that seven of the twenty managers have either not received the mandatory training or the fact that they have completed the training, has not been recorded on the iTrent system. Details of the seven managers noted above were subsequently provided to the HSC Business Manager.	Managers are not complying with Council Policy. Managers may be undertaking the recruitment process without having the required skills to make an informed decision as to whether the candidate is suitable for the post.	All managers identified through audit testing as not complying should be contacted to establish whether they have completed the mandatory training. The iTrent system should be updated with the date completed.	The HSC Business Manager will resolve this issue with the individual Locality Managers and ensure iTrent is updated on satisfactory completion.	Overdue	31/05/17	30/11/17	30/11/2017	Current Position at 26/10/17 - Overdue T he Interim Chief Officer has instructed and communicated to all HSC Partnership managers that the 'Recruitment and Selection' module on CeCil must be completed. Non-compliance will result in managers being unable to be part of the recruitment process. Control Following agreement at October SMT , there is now a new recruitment process for all HSC Partnership posts: - Managers must now submit a vacancy business case to the Chief Officer's generic mailbox (healthsocialcareintegration@edinburgh.gov.uk). - If the business case has been approved, managers must provide evidence that all members of the recruitment panel have successfully completed the Council recruitment and selection eLearning module before final approval will be given to advertise the post. - To verify this, a CeCil screenshot of the completion record for each panel member to an email addressed to healthsocialcareintegration@edinburgh.gov.uk. Once confirmed, only then will managers receive final approval to advertise a vacancy. This also applies to NHS managers, where these are managing Council employees. IA Note: Partial evidence has been received 25.10.17 and is in the process of being validated. Further evidence has been requested. September Update : Managers have been reminded that mandatory training must be completed before undertaking any recruitment activity and to ensure that the iTrent system needs to be updated with the date training was completed. Awaiting evidence from the Locality Managers. Revised implementation date of 30/11/17.	Cathy Wilson, Executive Business Support Manager

Unique No	Project Code	Project Name	Group	Issue Cod	Rating	Finding	Business Implication	Recommendation	Agreed Management Action	Status	Due Date	Revised Date	Revisions	Status Update	Owner
								A review of the iTrent information held for each recruiting manager within Health and Social Care should be undertaken to establish any manager who has not completed the Recruitment and Selection training within the last 2 years. Any manager who is identified as not having complied with this training requirement should be requested to complete the training as soon as possible and not recruit staff until they have undertaken the training. A mechanism for monitoring the mandatory requirement should be introduced. In the interim, Locality Managers and Safer and Stronger Communities Senior Managers should remind all recruiting managers that they are required to have completed the training before undertaking any further recruitment.	Locality Managers have been requested to remind all recruiting managers that they are required to have completed the training before undertaking any further recruitment and confirm that this has been completed. The H&SC Partnership has been going through an organisational re-design, with staff being appointed to posts within the new structure under Phase 1, 2 and 3. The organisational re-design of the team has inevitably meant changes to recruiting managers. It is envisaged that Phase 2 of the organisational re-design will be completed by January 2017. Under phase 2, new recruiting managers will be appointed. Once these appointments have been made, a review of their recruitment and selection training will be reviewed by the respective Locality Managers and the appropriate measures taken, to ensure full compliance.	Overdue	31/05/17	30/11/17	30/11/17	Current Position at 22/10/17 - Overdue See above update. September Update: Interim Chief Officer – Edinburgh Health and Social Care Partnership issued email to managers which highlights the required actions to be taken in order to implement the recommendation.	Cathy Wilson, Executive Business Support Manager
Place															
PL1601 ISS.2	PL1601	Recycling Targets	Place	ISS.2	Medium	Contractors submit weighbridge tonnage data each month, which is used to calculate the recycling and landfill tonnage reported to the Transport and Environment Committee, and to prepare the annual SEPA submission. The current system for logging weighbridge tonnage submissions is manual as contractors provide their submissions in varying formats, some of which require further calculations to be made by Waste Services to establish the required figures. The data is entered manually into three separate databases, twice by the admin assistant and once by the Waste Collection Route Manager. The same data is entered into each database, with no significant differences in functionality between them.	Manual input could lead to errors in raw data used to calculate key performance measures; and Inefficient use of resources due to duplication of manual data input.	Automated data submission Contractors should be required to submit monthly weighbridge tonnage data in a prescribed format to support batch uploads of data to the tonnage database and reduce the need for manual data entry. Many contractors now have weighbridges which can produce tonnage data electronically and in real time. Management should investigate whether it is feasible to obtain this data directly. In the short term, a single database should be used for analysis and reporting. This will mean data only needs to be entered once.	There will be a review of the current process with the aim of implementing the recommendation of reducing the number of times data is inputted. This action will be taken forward on completion of the transformation process and once team structures are in place.	Overdue	31/10/16	31/03/18	30/09/17	Current Position at 25/10/17 - Overdue October update: Inputting of tonnage data is being tied into the business process automation project to seek automatic uploading of data on a more regular basis. September update : EY are now working with the Service area to determine how the inputting of data can be streamlined. This is part of their Waste Service Contract management project.	Lesley Sugden, Waste Strategy Manager
PL1601 ISS.4	PL1601	Recycling Targets	Place	ISS.4	Medium	There are a number of Council service areas and divisions effected by the waste management strategy but are unaware of key issues, regulation changes and decisions. This appears to have been as a result of key stakeholders not having been appropriately identified and engaged in all areas of the process. The key stakeholders for the Council's overall waste management strategy are wide ranging, affecting related strategies and span both across the Council and externally.	Key stakeholders not appropriately engaged leading to inefficiencies Lack of joined up working within the Council Regulation changes not appropriately communicated resulting in breaches Related strategies suffer from a lack of co-ordination.	A key stakeholder identification exercise should be performed to ensure all required individuals are included in the process. Key groups identified could include: Waste Services, Sustainability Team, Property Services and other external groups. In alignment with the creation of an internal waste management policy, stakeholders could be engaged through an overarching steering group with representation from each key group. This group would help ensure that relevant information is appropriately disseminated and that all stakeholders needs are considered. It would also enable stakeholders to monitor and challenge performance against the overall waste management strategy.	As outlined within the response to Action 2, it is our intention to refresh the existing strategy and to consult with both internal and external stakeholders to help shape the final strategy. A series of commitments/actions will be a key output from the strategy and progress against individual actions/commitments will form a key part of reporting progress to stakeholders.	Overdue	31/03/17	31/03/18	30/09/2017	Current Position at 25/10/17 - Overdue An internal working draft will be circulated to management within the service by the end of this year (2017) with a view to sign off and approval by elected members by spring 2018. Thereafter we will carry out an approximately annual "light touch" review, with a more in depth review every 3-5 years, albeit this will be flexible in the event that we need to account for policy changes (e.g. resulting from a change of government). August Update : Information has been provided to Internal Audit regarding the process of strategy review, this is unlikely to be ready for Committee before the revised September implementation date and a new date is to be provided. July Update: Work is continuing on the new Waste and Recycling strategy, this is not due to be presented to the Transport and Environment Committee until October at the earliest. A commitment to the date that the Waste and Recycling strategy is to be presented to committee, the committee papers and the outcome of the committee are to be provided to audit. The action can be reduced to low on the satisfactory receipt of this information. The strategy will then need to be communicated to stakeholders before the action can be closed Draft new Waste and Recycling strategy is not yet finalised. Communication of this strategy will form part of a delivery plan for implementation.	Angus Murdoch, Strategy Officer
PL1601 ISS.5	PL1601	Recycling Targets	Place	ISS.5	Medium	Although there is considerable recycling internally within the council, there is currently no internal waste management policy. The Waste and Recycling Strategy 2010 - 2025 focuses on external, public waste but there is no supporting policy which specifically states how the Council itself as major local employer, plans on reducing waste arising from its own operations (e.g. schools, council offices) and increasing recycling participation. The Council's strategic aim is to reduce overall waste being sent to landfill within the local authority by increasing recycling participation. Budgets have been set aside for schemes to increase public awareness and participation in an effort to achieve this strategic aim; however, a group of contributors to Edinburgh's overall waste (i.e. Council employees themselves) is being overlooked by not allocating sufficient resource to internal waste management schemes. In addition, there is a lack of data on how much waste is sent to landfill as a result of Council operations; therefore it cannot be accurately quantified how much the internally generated waste is costing the Council in landfill charges.	Lack of clarity over Council's own waste contribution that results in financial and environmental impact: - Risk of reputational damage due to lack of own strategy; and - Opportunity cost lost on not providing an overarching framework to support the Council's own recycling participation.	The Council should allocate sufficient resources to create and action an internal waste management or resource efficiency policy that embraces reducing, reusing and recycling. Many staff members will live in the City of Edinburgh Council, therefore generating waste at work and at home. Providing this awareness at work could realise additional benefits for the Council as a potential reduction for both internally generated waste and household generated waste within the local authority. With the continued future increases in landfill tax, it is advisable that the Council leads by example and gives consideration to monitoring its own waste data to ensure effective targeting of effort.	Our proposed management action is to approach the Sustainable Development Unit and Facilities Management to establish a working group to review any existing internal waste policy, the purpose being to incorporating this within, and consult on, a refreshed Waste Strategy Document (Ref Action 2). The inclusion of the Sustainable Development Unit is critical in moving forward this action as they hold responsibility for development of the Council's internal waste policy and recording data on internal waste arisings. Waste & Fleet Services will commit to taking the lead in establishment of the internal working group. Opportunities to improve the way in which the Council gathers and records data on its own waste arisings will be a key outcome of the working group. The Council's Trade Waste Service (part of the Waste & Fleet structure) has already met with Facilities Management to identify opportunities to increase the range of recycling opportunities across the Council estate. New services such as food waste recycling will be available in major Council offices such as Waverley Court and is already available across a number of schools.	Overdue	30/09/16	31/12/17	30/04/17	Current Position at 25/10/2017 - Overdue No change from September Update. September Update: - Information provided to IA regarding the Changeworks SLA requirement to "Develop awareness among staff of the correct procedures and contact points to improve and resolve waste management problems within schools." A revised date of the 31/12/17 to develop the internal waste management policy. Working group now established between Facilities Management and Waste and Cleansing Services. This group meets regularly. July Update : -meeting held 10/7/17 to discuss Recycling bins have been provided to corporate buildings. A Factsheet or Cecil leaning module could be provided and tracked to evidence that users know how to use the recycling bins. If it can be evidenced that 70% of buildings have recycling bins the action rating can potentially be reduced to low risk.	Karen Reeves, Technical Team Leader
PL1603 ISS.3	PL1603	Mortuary Services	Place	ISS.3	Medium	The current Bereavement Services risk register, dated July 2015, outlines a range of controls in place as part of the mitigation strategy to manage the body holding capacity risk. The risk was escalated to the Place risk register, and as at April 2016 was in the top 10 Departmental residual risks, categorised as one of the most controlled risks due to the controls noted as being in place. The mitigation strategy includes the following: Mortuary plan in place; and Staff training and participation in a Service quality action group. The Scientific, Bereavement and Registration Services Senior Manager noted that there are no formal mortuary plans in place covering arrangements to minimise storage times, and no such training is currently being delivered. In addition, no Service KPIs or performance / service standards are currently produced. Quality documents for the Mortuary covering forms, plans and procedures are being drafted . The mitigation strategy also notes that Funeral Directors are contacted to increase collection rates, but this does not recognise that Mortuary staff are limited i n the actions that they can take in this respect until the Funeral Director makes contact , as their service is assigned by the next of kin. The risk register does not reflect other issues outwith Council control, for example, The daily cap on the number of post mortems undertaken means there is always a backlog ; and The uncertainty around service delivery post Crown Office contract expiry in 2020.	The lack of an accurate risk register and formal mortuary plan increases the risk that intended controls are not implemented in practice leading to inefficient use of resources and demand not being managed effectively.	The Bereavement Services risk register requires to be updated to reflect current controls in place. Issues currently outwith Council control should be added to facilitate wider discussion on ways to better manage these. A mortuary plan should be prepared covering the management of body holding capacity. The plan should include: An outline of current arrangements; An outline of all key stakeholders; Service standards expected of Mortuary staff to ensure an efficient, prompt and respectful service; Standards expected of key stakeholders, for example, processes to be followed by Police when storing a body out of hours, prompt notification from Funeral Directors when assigned, and prompt collection by Funeral Directors when notified that a body has been released for uplift; and A programme of regular staff training sessions to ensure that Mortuary staff are aware of their responsibilities to minimise storage. The plan should incorporate contingency arrangements for business as usual during periods of extended closure, for example, at Easter and Christmas.	Work with Environment Service and Place Directorate to update the risk register post transformation review. A mortuary plan is under development and should be completed before the end of December 2016. Implementation by 31/01/2017 is anticipated.	Overdue	31/03/17	31/10/17		Current Position at 25/10/17 - Overdue No change from September update. September Update The Risk Register is being updated in collaboration with the Council's Risk team this is anticipated to be complete by the end of September. Demand forecasts for future years have been made. Demand forecast(s) for seasonal variation within a year are to be completed by the end of October 2017. August Update: - Information was provided on the 22/8/17 and is currently being reviewed by Internal Audit. July Update: - meeting held 10/7 to discuss 1) A risk register is to be created. 2) Operational plan to be produced to track and forecast demand. This could be high risk as the Council is providing services to other local authorities and may not be able to meet the additional demand. 3) A contingency plan is to be produced to ease pressure on the council mortuary at times of high demand and it should be evidenced that this has been tested. 4) Potential for rating to be reduced to low if the risk register and operational plan can be evidenced. 5) Action can be closed on the receipt of evidence that that the risk register, operational plan and contingency plan have been implemented and tested.	Robbie Beattie, Scientific, Bereavement & Registration Services Senior Manager
PL1603 ISS.5	PL1603	Mortuary Services	Place	ISS.5	Medium	The City Mortuary is a key stakeholder in the following plans: City of Edinburgh Council (CEC) Emergency Plan; interim update Jul 2014; CEC Corporate Business Continuity Plan; Oct 2013; CEC Corporate Pandemic Influenza Business Continuity Plan; Jul 2009 (re-issue due Apr 2017); Emergency Mortuary Management Arrangements Module of CEC Emergency Plan; draft Apr 2015; Services for Communities Contingency Plan (Bereavement Services); draft Jul 2015; and Services for Communities Business Continuity Plans for Bereavement Services; Dec 2013. There are inconsistencies and gaps between the plans including; The Bereavement Services contingency plan includes no detailed action plan covering body storage arrangements in the event of an extensive emergency, such as a pandemic, where National / reciprocal body storage resources will not be available. This area is currently under review nationally via the Scottish Government Silver Swan exercise; and The Emergency Mortuary Management Arrangements module, covering arrangements in response to intensive emergencies outlines the locations and number of body storage units within the Council and externally. This does not reflect: The basic storage available at the Mortuary; The current location of the Council emergency units; Average spare capacity for NHS Lothian, as determined at Easter 2016; and Average spare capacity of the Queen Elizabeth Hospital in Glasgow (the 300 quoted includes day to day usage and gives no indication of any potential capacity issues here). Significant staff and organisational changes within Place and Bereavement Services over the past year have impacted on the preparation of, and key roles and responsibilities outlined within Place contingency documents. The Scientific, Bereavement and Registration Services Senior Manager recognises that all local plans need revised, with separate plans set up for Mortuary and Crematorium services.	If contingency plans in place are not comprehensive, with accurate and up to date capacity information, the required actions to be undertaken by Council staff may be unclear, increasing the risk of inappropriate treatment of fatalities.	All Mortuary Service contingency plans require to be reviewed and redrafted to ensure that they are up to date, comprehensive and reflect current government guidance. Capacity and location information within contingency documents should be corrected to reflect current arrangements. Following review and update of plans in place: Training should be rolled out to staff; and The Corporate Resilience Unit should be provided with updated extracts.	Work with Corporate Resilience Unit to update contingency plans drafted before transformation review . Work with NHS Lothian to support them taking on the role of host mortuary for mass fatalities, thus easing pressure on Council mortuary.	Overdue	31/03/17	31/12/17	30/4/17	Current Position at 25/10/2017 - Overdue Work continuing on the update of contingency plans. Scottish Government continue to progress a national mortuary review to reassess the most suitable organisations to assume statutory responsibility. Arrangements with NHS Lothian for contingency provision are well progressed with a licence agreement drawn up. A trial of the use of the NHS facility was undertaken recently to allow for essential maintenance of the CEC mortuary. September Update: A stakeholder plan has been evidenced. A contingency plan for mass fatalities events (either intensive or extensive) an agreement is in place that the RIE would be the control centre with the support of the council's staff. A memorandum of understanding advising of this arrangement has been submitted to members of the EoS RRP group. The draft contingency plan at the time of the audit has been provided to the service area to deal with busy periods that are not designated as mass fatalities incidents, this is to be updated due to changes in the Council structure and is anticipated to be complete by December 2017.	Robbie Beattie, Scientific, Bereavement & Registration Services Senior Manager

Unique No	Project Code	Project Name	Group	Issue Cod	Rating	Finding	Business Implication	Recommendation	Agreed Management Action	Status	Due Date	Revised Date	Revisions	Status Update	Owner
SFC1403 ISS.2	SFC1403	Community Recycling Centres	Place	ISS.2	Low	The current CRC site policy appears very basic and inappropriate to adequately safeguard Council resources. Having such a basic policy exposes the CRCs to increased risk of commercial waste being passed off as household waste. The current policy may not be appropriate for modern CRC facilities and as a consequence, user guidance on the Council website is not sufficiently prescriptive or accurate to inform the CRC site user.	Loss of income to the Council Increased cost of disposal of commercial waste passed off as domestic waste Failure to meet residents expectation and reputational damage	CEC should consider a detailed and modern policy document to reflect the increased costs and environmental demands of providing this service. This should be considered at the same time as the chargeability of certain types of household items (i.e. reclassification of waste created from improvements, repairs and alterations to a household). Once the policy has been modernised and approved, an accompanying user guidance document and customer charter should be created and published. This should cover the following: Items accepted Permitted vehicles (including hired vehicles, trailers, vans) Household and commercial waste requirements When customers need to register with the Council to use the sites Charging policy and methods of payment Hazardous waste Charity waste Health and safety requirements General information (contact, opening times, etc.)	A policy and procedures document is to be drafted and consulted upon before being released.	Overdue	31/03/15	30/04/18	31/07/17	Current Position at 22/10/17 - Overdue No Change from September update. September Update: CRC Improvement Plan being developed. Focus will be on improving signage and user information as well as developing more robust internal procedures.	Bob Brown, Waste & Cleansing Operations (Waste) Manager
Resources, ICT Solutions and Investment & Pensions															
CF1402 ISS.1	CF1402	School Meals	Resourc	ISS.1	Low	For the school meals service delivered by SfC, the roles and responsibilities of key officers within SfC and C&F were not clearly defined in a formal document such as a service level agreement (SLA) or working protocol. Although processes have not been formalised, good cross departmental working was evidenced between the C&F Development Officer and SfC Catering Performance Officer. This collaboration was specifically noted within the menu planning process. Similarly Facilities Managers (FMs) and Kitchen Supervisors work closely with School Business Managers to resolve issues on site. It is understood that Corporate Facilities Management are producing SLAs for cleaning and janitorial services, however catering is not in scope at present. It is viewed differently as the end user of the service delivered is external, i.e., the pupils rather than Council staff.	In the absence of any documentation the service is reliant on the knowledge of key members of staff and staff changes may impact on the effectiveness of the service.	Consideration should be given to preparing an SLA to outline the respective responsibilities within key cross departmental processes in delivery of the school meals service.	As part of a wider Facilities Management Review for the clarity on roles and responsibilities of key offices within SfC who have responsibility for delivering the schools meals service it is proposed that an SLA between C&F and SfC be put in place to ensure a first class school meals service is delivered.	Overdue	30/04/15	31/12/17	30/09/17 31/12/17	Oct 17 Update from Gohar Khan: The Service Delivery Plan is with C&F for consultation and we are still awaiting feedback. It is, however, anticipated that the SDP will be signed off and in place by December 2017. Outwith the SDP, the catering service has a detailed strategic blueprint which outlines its aims, objectives and strategic goals going forward and it is anticipated that this blueprint will be shared and agreed with all relevant stakeholders. Sept Update from Gohar Khan: A Service Delivery Plan (SDP) that includes the catering service is currently out to consultation with key stakeholders and feedback is awaited. The SDP is designed to provide key stakeholders with an overview of the services that will be provided by the FM team to High Schools and includes clarity on staff roles and responsibilities. The overarching objective of the services is to provide the right resources at the right place at the right time, with the flexibility to respond to the requirements of each Directorate as and when required. It is envisaged that the SDP will be agreed by the key stakeholders by 31.12.17.	Christopher Ross, Catering Manager
MIS1601a ISS.2	MIS1601a	Non Housing Invoices	Resourc	ISS.2	Medium	A fixed-price quote is obtained from prospective contractors for repairs estimated to cost more than £1,000. Any variance between the quote and the invoice is challenged before the technical officer will approve payment. Estimates and quotes are not routinely requested for repairs likely to cost less than £1,000 (and we would not expect this). The technical officer is expected to be experienced enough to make a reasonably accurate assessment of the likely cost of a repair, and challenge or approve payment of the contractor's invoice accordingly. It is understood that a schedule of rates exists for the non-housing contract framework, but is not referred to. This means that: The authorising manager does not know the value of works that they are approving (see Section 2: variance between actual and estimate); The Council may not have access to commercially advantageous rates for common repairs; and Elevated charges may not be identified by the technical officer as they have no benchmark.	There is a risk that the Council is not achieving best value on non-housing repairs and maintenance.	We recommend that a schedule of rates is built into the next non-housing contract framework.	The non-Housing contractor framework will be re-tendered during 2017. The inclusion of detailed best-value and due-diligence options will be considered as part of the process. This may include schedule of rates, gain share, penalties etc or a combination.	Overdue	31/08/17	31/12/18		October Update : Agreement reached with Corporate Procurement that due to the Procurement Plan being revised, the new implementation date will now be December 2018. However, in the meantime, in order to mitigate the risk from Medium to Low, a proposal is being worked on and will be reported at the next cycle. September Update: The non - Housing contractor framework will be re - tendered due to the value and EU regulations. This is being led by Corporate Procurement with a revised timescale.	Murdo MacLeod, Maintenance Standards Officer
MIS1601a ISS.3	MIS1601a	Non Housing Invoices	Resourc	ISS.3	Medium	The system used to manage repairs and maintenance to operational buildings, AS400, is due to be replaced in the Autumn/Winter 2016. The system is over 40 years old and is limited in its capabilities and links to other Council systems. This means it is difficult to obtain information about repairs carried out. Only one officer is able to use AS400 reporting functions, and none we spoke to in Corporate Property knew how to access information about EBS non-housing recharges through the Frontier financial reporting system. This limits the management information available to Corporate Property about the volume and value of repairs. It also delayed our audit fieldwork and restricted the scope of our audit. For example, the AS400 (works ordering), Total (billing) and Oracle (finance) systems do not use the same reference numbers. A manual log is kept to record the invoice number for each works order raised on AS400. This was not consistently updated, so , despite the help of the non-housing administration team and Accounts Payable, we were able to trace invoices for only 4 of the 60 charges reviewed. We also identified occasions where details of works orders charged to Corporate Property had not been transferred into the Oracle data warehouse. This means we (and Corporate Property) were unable to validate the accuracy of the charge for those periods. The total charge only was recorded.	Lack of management information about the volume and value of non-housing repairs.	Management will not have ready access to accurate and reliable information about the volume and cost of repairs and maintenance until AS400 is replaced by CAFM in Autumn/Winter 2016. We note that the introduction of CAFM has been delayed, and every effort should be made to meet the new target implementation date.	It is anticipated that CAFM will be in operational use (services being implemented on a rolling programme thereafter) in early 2017 with a non-Housing R&M implementation process in place for FY 2017/18	Overdue	01/04/17	01/04/18		October Update: The use of CAFM to monitor and report on R&M work / expenditure is still expected to be operational in time for the start of the new financial year 2018/19. Work is progressing to review, cleanse and align the FM cost centres with the new hub models as being implemented by the FM Transformation programme. Engagement with key stakeholders with regards to implementing CAFM for R&M works management is due to commence shortly. September Update : The CAFM asset condition and helpdesk modules are now fully operational, however, the use of CAFM to monitor and report on R&M work / expenditure is now scheduled to be operational in time for the start of the new financial year 2018/19. This will include having the ability to produce MI reports on R&M activity at site level, which at this moment in time, only Frontier is able to produce this information	Peter Watton, Acting Head of Corporate Property
RES1603 ISS.5	RES1603	Leavers Process	Resourc	ISS.5	Medium	We selected a sample of 45 employees who left the Council in August 2016. Security passes held by 18 of those employees (40%) had not been returned or disabled.	Security passes could be used to fraudulently gain access to Council buildings putting sensitive data and mobile assets at risk.	Security passes should be collected from payroll and non-payroll leavers and returned to the Facilities Management Hub. We recommend that Facilities Management are also provided with a daily or weekly list of leavers, so security passes can be deactivated.	An expiry date will be set for all cards issued to temporary staff, agency staff and contractors at 6 months unless otherwise specified by the line manager.	Closed - Verified					Mark Stenhouse, Facilities Management Senior Manager
									All security passes which have not been used for 3 weeks will be deactivated on 1 April. Cardholders will need to contact Security to reactivate them.	Closed - Verified					Mark Stenhouse, Facilities Management Senior Manager
									All temporary passes will be deactivated on 1 April. Cardholders will need to contact Security to reactivate them.	Overdue	30/04/17	31/10/17	30/06/17	Current Position at 18/10/17 - Overdue FM security team are liaising with contractors responsible for the system to ascertain if non CEC staff cards can be marked for future auditing and monitoring purposes. This will include all agency staff and contractors. Further amendments to the Orb forms will restrict all non-CEC cards to 90 days without exception. The practice of surrendering cards to the FM security HUB could be promoted by a formal comms via the Chief Executive.	Mark Stenhouse, Facilities Management Senior Manager
									The Management Information team will provide Security with a list of leavers each week. Security will deactivate passes.	Closed - Verified					Edel McManus
RES1608 ISS.2	RES1608	Risk Management	Resourc	ISS.2	Medium	The successful embedding of risk management throughout an organisation is achieved when staff of all levels are: aware of their risk management responsibilities; understand their responsibilities; and are motivated to act in accordance with their organisation's risk management framework. The Risk Function and CRO have delivered risk training to the CLT, their respective Senior Management Teams (' SMTs ') and to GRBV Councillors. Feedback indicates that this training has been effective in securing buy-in and understanding at the senior manager level and above. However, risk training has not recently been provided to middle management levels, nor have senior managers within directorates been trained to provide risk management training to their teams. This represents a potential gap in the understanding and embedding of risk management below senior manager level . The Risk Function have designed CEC specific risk management training as well as an internal controls module which teaches staff how to manage risks. These modules are available to everyone through CEC's interactive learning platform (' CECIL'), however, there is no mandatory requirement for staff to complete this training . Within CECIL there is also a generic risk management training module , designed by the external system provider. This is not CEC specific and there is a risk that this may cause confusion amongst staff. From discussions with the Head of HR, we understand that all staff will be required to complete ' essential learning ' when on-boarding and on an annual basis going forward . Good practice is achieved when HR have an important role in facilitating risk training so that it is considered alongside other key training and communications. More importantly, good practice is when HR have an active role in fully embedding responsibilities and accountabilities for risk across an organisation. Therefore, to align with best practice, HR should play an active role in embedding risk, however there are currently no risk management modules within the essential learning suite. CEC's risk register template is available to all staff via the staff intranet. However, this document is not used consistently across all service areas. For example, the Place Directorate uses a different style of risk	The risk management embedding gap below senior management level presents the risk that CEC may be exposed to a degree of undue risk: at times of significant change, people can unintentionally revert to behaviours that are not in keeping with expectations. If the generic risk management training module within CECIL is completed by staff, there is a risk that staff's understanding is inconsistent with CEC's risk management approach. If risk register templates are not used consistently across all Directorates, key information may be missed or reported incorrectly when consolidated by the Risk Function for CLT and GRBV. This undermines the quality of information present to CLT and GRBV. It makes management of risk and risk reporting less efficient and potentially less effective.	The Risk Function, supported by the new full-time CRO, should invest time and resource to embed risk management below senior management level. It is important to reflect on what contributed to the success of ' buy-in ' and education of the senior team. Additionally, there needs to be pragmatic consideration given to the large numbers of staff across the council. We recommend a training and communications plan is drafted reflecting the above and approved by the appropriate committee. This should involve input from HR and other relevant non-risk functions. Consideration should be given as to whether training senior management, to equip them to provide risk management training to their teams would held drive understanding and accountability below senior management level. Human Resources should include risk management and internal controls training modules as part of CEC's essential learning. Individual's scores from the end of module assessments can be used to confirm staff's understanding of their responsibilities. The system provider's risk management module should be removed to avoid confusion. In keeping with policy, all service areas should use the CEC risk register template, with any other versions removed to avoid inaccurate information being reported to CLT and GRBV and improve the efficiency of the aggregation and reporting process.	As identified, we are in an 'embedding' phase with respect to the journey to develop risk management. Prior to transformation a risk steering group was in place whereby risk 'champions' from each directorate could drive messaging the need for training and maintain momentum. With the substantial organisational changes this arrangement was suspended and we are currently re-establishing such ownership within the Service Area Risk Management Groups as indicated within the response to finding 3.3.	Closed - Verified					Rebecca Tatar, Principal Risk Manager
									For clarity two risk modules exist on the Council's eLearning site. One is generic and the other specific to CEC. We agree with the finding that the generic risk management module is not helpful from the perspective of specific messaging. Management will work with HR to ensure that only the single tailored solution is accessible.	Closed - Verified					Rebecca Tatar, Principal Risk Manager
									HR is currently reviewing the requirements of induction and essential learning throughout the Council. The latest timing for go-live is likely to be prior to the commencement of FY18. The plan with HR will be confirmed shortly.	Closed - Verified					Rebecca Tatar, Principal Risk Manager
									The 'different' risk register template was adopted as a temporary measure in Place as part of a learning exercise to prompt focus on cause and effect in the articulation of risks. This version is now being superseded.	Closed - Verified					Rebecca Tatar, Principal Risk Manager

Unique No	Project Code	Project Name	Group	Issue Cod	Rating	Finding	Business Implication	Recommendation	Agreed Management Action	Status	Due Date	Revised Date	Revisions	Status Update	Owner
						register , and a s a result of the Transformation Project, some of the service areas which were previously part of Place have been moved to other Directorates , widening the inconsistent use of the template.			A training and communications plan involving input from HR and Communications teams was drafted within the last two years, however due to reorganisation of staff, teams and service delivery these plans had to be put on hold and will need to be reviewed once structures settle.	Overdue	30/09/17	31/01/18		October Update from CRO - Ongoing discussions between CRO and CIA to clarify and reword Agreed Management Actions and revised due dates. September Update: Embedding risk management throughout the organisation is one of my key objectives. The current draft Annual Audit Report from Scott Moncrieff notes that: "Overall, we were satisfied that risk management arrangements appear to be embedded across the organisation" The following points describe some of the mechanisms which help embed risk management across CEC: Through the Risk Management Groups/Committees/Steering Group. Through 1-2-1 conversations between the CRO and several HoS/Directors. Individuals in the Corporate Risk Team and others have attended external training sessions on different aspects of risk management. Risk management workshops take place across the services, often at team locations away from Waverley Court. 'Risk Matters' newsletters highlight particular risk topics within schools. Risk management is one of the subjects covered at the Leaders' Induction events. Following the office move in Sep/Oct 2017 I intend installing a risk noticeboard to publicise information. I have created quarterly 'risk themes' to publicise the work of several areas. An internal comms and training plan can be developed and rolled out within an appropriate timescale to address this action but the measures described are having a greater effect	Rebecca Tatar, Principal Risk Manager
RES1608 ISS.4	RES1608	Risk Management	Resourc	ISS.4	Low	CEC's risk management 'toolkit' represents the key documents and system available to staff via the orb (intranet) to support risk management. Key documents include risk management policy and procedures and the risk appetite statement. Upon review of these documents and following interviews with staff, a number of inconsistencies have been identified: The Covalent system was introduced to support and encourage proactive and consistent management of performance, governance and risk. It offers the functionality to electronically consolidate information and make it simple and efficient for user to update and analyse data. This system is not used consistently throughout Directorates and CEC will be withdrawing Covalent in early 2017. Therefore, a manual and inconsistent approach to risk management is likely to ensue across Directorates upon withdrawal. The risk management policy and procedure documents are dated February 2015 and March 2014 respectively and do not reflect CEC's current operating structure. These documents are also inconsistent with CEC' s risk appetite statement (dated February 2014) . For example, the categories of 'risk' considered in the risk appetite statement are not consistent with the categories of 'impact ' in the policy and procedure document . Indeed , CEC' s risk appetite statement explicitly refers to reputational and development / regeneration risks which are not included in the impact assessment.	Manual risk management processes are labour-intensive and require an increased reliance on interpretation and judgement if there is a need to consolidate information based on different assessment criteria of formats. When risk MI is collated on this basis, vital information may be missed and not escalated on a timely basis. Use of an enterprise risk management system should increase the efficiency of collating and reporting data, and increase capacity to focus on analysis of risk. Risk Management policies and procedures coupled with a consistent risk appetite statement form the foundations for a sound risk framework . If an organisation is going through strategic change, its risk environment is also continuously changing. Therefore, annual review and updating of this information is important to ensure staff are provided with guidance and direction to manage risks in accordance with CEC's expectations and requirements.	CEC should consider implementation of a replacement systemised risk management tool to drive efficiencies and consistency in risk management practices and provide the opportunity to generate risk MI without the need for manual intervention. The business case for an enterprise wide risk management system should be prepared and integrated with the wider IT change programme. In line with best practice, CEC risk documentation should be updated as soon as the new structure has been finalised, with updated versions communicated and circulated to staff.	CEC's Risk Management Policy is updated annually in December.	Closed - Verified				Rebecca Tatar, Principal Risk Manager
									The guidance set out in CEC's Risk Management Procedure is scheduled to be updated by January 2017 once the Council's new structure and associated risk escalation path has been clarified and confirmed. These will then be available to all staff on the CEC Intranet.	Closed - Verified					Rebecca Tatar, Principal Risk Manager
									The Risk Management team is currently reviewing options with regard to a 'GRC' (Governance Risk and Compliance) solution that is fit-for-purpose for the Council. The new CGI contract identifies the need to introduce such a solution by the Summer of 2017. As such a business case will be developed in line with this critical path. In the meantime, risk registers for SMT and CLT are updated quarterly on consistently formatted spreadsheets and stored on a shared drive for version control.	Overdue	30/09/17	31/03/18		October Update (CRO): Ongoing discussions between CRO and CIA to clarify and reword Agreed Management Actions and revised due dates September Update (CRO): As I understand it there was no requirement or provision for a GRC tool within the CGI contract. Risk registers and reports are currently produced using Microsoft Word, Excel and Visio. For the Jan 2018 GRBV report I intend to have updated the reporting format and have an appropriate risk register developed in Excel (which I have personally done before). There is no industry-standard for risk management software – the quality of input defines the quality of output. Given the difficulties in ICT procurement/development currently experienced at CEC and pressure on budgets I intend maintaining risk management documentation in the current software, while undertaking work to evaluate the business case of using a commercial application. The timescale for this is likely to be Q1 2018.	Rebecca Tatar, Principal Risk Manager
									Updating the Risk Appetite Statement is scheduled as part of a broader exercise on embedding improved understanding and consistency around risk appetite and tolerance levels once the new CRO is in place. It was always considered that the risk appetite would be further refined after two years once the risk management framework had been embedded and maturity of the organisation had developed with respect to risk management.	Overdue	30/09/17	31/01/18		October Update: Ongoing discussions between CRO and CIA to clarify and reword Agreed Management Actions and revised due dates September Update (CRO) Work has focused on maintaining quality output for new councillors and the new membership of the GRBV. The current risk appetite statement is fit for purpose, though this will be updated and included in the annual refresh of the risk management policy and procedure which is due around Jan 2018.	Rebecca Tatar, Principal Risk Manager
RES1704 ISS.4	RES1704	Starters	Resourc	ISS.4	High	Whilst responsibilities for completion of new employee 'on boarding' process and contract generation is segregated between different sections within the team, there are no established technology controls to prevent a single officer from completing the end to end on boarding process, including creation of iTrent and payroll employee accounts. Additionally, existing payroll exception reports will not identify variances in salaries between ' on boarding ' documentation and salary details recorded on iTrent. There is a reliance on manual independent checks performed by Team Leaders to confirm that only authorised new start salary details have been completely and accurately recorded on the payroll system. Customer Service Advisors review all files to ensure all required documents have been provided prior to making a formal offer of employment and 'on boarding ' can be concluded. No additional independent sample testing is performed between 'on boarding ' files and iTrent records to confirm that correct details have been entered either before or after the payroll run. Review of manual 'on boarding ' files for Council employees recruited between April 2016 and January 2017 demonstrated that the on-boarding process is not consistently and accurately performed. 100% of the 25 'on boarding' files sample failed due one or more of the following errors being identified; One file did not include a mandatory vacancy eform. Recruitment and 'on boarding ' had progressed with no evidence of formal confirmation of a vacancy from the authorised vacancy manager. Three files contained unauthorised Nominated Candidate forms which should be signed as evidence of line manager approval to recruit the preferred candidate. Four files contained checklis ts that had not been signed by the CSA or supervising officer to confirm that all necessary 'on boarding' documentation had been received. For one employee there were differences in employment start date details between their Itrent system account and those noted on the file checklist, which could result in inaccurate calculation of initial salary. Five files failed to state the Salary Scale point or banding for the post One file showed a difference between the salary banding and Itrent, and One file indicated that a 'Salary Placement' form was required but was not present	Addition of fictitious employees to the Itrent and payroll systems would not be identified. New employees receive incorrect salary payments. Weaknesses in references or missing right to work documents are not identified and addressed during the on boarding process. Customer Service Advisors training requirements and are not identified and resolved. Risk: The CLT and Resources risk registers were checked to identify the relevant risks for our findings High on completeness and accuracy of payroll data against the CLT 'Internal Controls' risk (risk 24 on the CLT register)	The 'On Boarding' process should be reviewed and updated to ensure it is performed consistently, accurately and robustly. Consideration should be given to ensuring the revised process includes the following controls; Appropriate segregation of duties in relation to systems access rights. Regular additional independent review of on boarding files prior to offer of employment to ensure that all mandatory forms are present and completed in full. Independent check to ensure that iTrent and payroll accounts have been established accurately in accordance with information provided during the 'On boarding' process, including authorised Salary Placement Forms where a candidate is placed on a scale point higher than the base of the grade.	The on boarding process will be updated: System cannot be configured to restrict access to specific elements of the end to end task. This will be built into the new Business World system configuration. To ensure appropriate interim controls, a manual check will be undertaken by Senior Transactions Administrators (these staff will have iTrent systems update access removed) to ensure tasks are undertaken by appropriate/restricted officers, supported by the necessary paperwork Files content will b e reviewed by Senior Transaction Administrators to ensure accuracy and consistency. A full process of checks and procedures will be documented and signed off at Team Leader level for each transaction cycle. Newly created compliance team will undertake independent sample checks with recruiting managers to ensure new starts are known and correct. An independent check to reconcile on boarded files to payroll new starts reports for each payroll cycle will be carried out and jointly countersigned by the Team Leaders in Payroll and Recruitment. Authorised salary placement forms will be part of the check.	Overdue	31/08/17	10/11/17	24/10/17 12/10/17	IA Update October Following discussion with the recommendation owner, Head of HR and HR IA workstream lead a further discussion and walkthrough to clarify and agree requirements and ensure they are fully understood. Revised implementation date of 10/11/17 has been agreed. IA Update September: As at August, management had confirmed that the 10% check of files would not be performed due to resource constraints, and a retrospective review would be performed by the Compliance Team (starting October 17). However the 10% check has now been implemented within the HR Service Centre Team. Review of the 20 checks between paper files and iTrent completed by the HR Service Centre confirmed that 13 (65%) of the checks had failed. There was no evidence to confirm that these failed checks had been rectified. Additionally the process changes had not been documented and communicated to the team. Audit has advised the HR Service Centre of the changes that are required to ensure that controls are implemented and support closure. Recommendation cannot be reduced given the control gaps noted from our walkthrough. Management to confirm whether Compliance team check swill commence in October in addition to the 10% check noted above.	Cheryl Hynd, Transactions Team Manager
RES1704 ISS.5	RES1704	Starters	Resourc	ISS.5	High	Manual 'on boarding' files are maintained in Waverley Court for all new starts until, a new employee account is created on the iTrent system; two payroll periods have passed; and an employment contract is generated. These manual on boarding files include sensitive personal data about prospective employees. The current contract preparation process involves automated creation of contracts via a mail merge' process. Source data for the mail merge is a spreadsheet that is extracted from the iTrent system in Excel format and used as the basis of the mail merge Review of the record management processes supporting on boarding and contract generation established that: Nine of our requested sample of 46 manual ' on boarding ' files could not be immediately located . It was noted that a further 3 files were located between completion of our testing and the time of writing this report. The missing 6 files is attributable to the fact that the record management and retention process for manual on boarding files is dated, incomplete and not consistently applied. Review of a sample of 25 on boarding files identified 16 archived files that had been sent to Iron Mountain containing sensitive personal data such as bank details; PVG applications; criminal conviction questionnaires; and equal opportunities questionnaires. These documents should have been removed and destroyed prior to archiving , in line with the agreed process within the team and standard best practice. There are no reconciliation controls in place between manual on boarding files and data recorded on the spreadsheet used as the basis for the 'mail merge' to ensure that the full population of contracts is produced; and The newly introduced 'mail merge' process results in an inability to automatically upload employment contracts on employee iTrent accounts, or to generate manual / electronic copies of the contracts for retention. Evidence is not retained to confirm that all new starts have received their employment contract within 8 weeks of their start date.	Breach of Data Protection legislative requirements and non compliance with the Council's Records Management Policy Breach of employment law requirement to issue full terms and conditions within 8 weeks of employee starting. Regulatory fines and penalties for breach of legislation Risk: the CLT and Resources risk registers have been checked to identify the relevant risks for our findings: High on Record Management against the Resources 'Information Governance' risk (risk 8 in the risk register.	Record management processes should be defined and implemented to ensure that manual files are managed, retained and archived in line with Data Protection legislation and the Council's Records Management Policy. This should include requirements for secure storage; recording of the location and transfer of all manual files and a process supporting either electronic or manual retention of employment contracts. There is no mandatory requirement to destroy sensitive personal information prior to archiving however this approach, supported by retention of a completed checklist was confirmed as good practice by the Information Governance team. An investigation should be performed to establish the full population of missing files and ensure that they are located and either securely stored or archived. A reconciliation should be performed to confirm that the 'mail merge' spreadsheet includes data from the full population of on boarding files to ensure that no contracts are missed.	Change in the storage procedure initiated with secure, central storage and indexed records, detailing location and where appropriate details of transfer of manual files to other 3rd parties (internally and Iron Mountain). Guidance from the home office recommends retention of some sensitive personal data which evidence right to work etc. This data will be required moving forward to evidence Council compliance with "Right to Work" legislation. Appropriate document retention will be agreed with Information Governance A retrospective Compliance Project commences on 10/7/17 for 8 weeks to check all 18,500 personal files. Remedial action to be taken to identify any missing files and ensure securely filed in future. The 'mail merge' process for issuing contracts now includes a reconciliation of on boarding files to contracts issued. This is recorded and signed off for each cycle by TL. 12/9/17	Overdue	29/09/17	10/11/17	25/10/17 12/10/17	IA Update October Two walkthroughs had previously been performed that confirmed that the revised controls were not operating effectively. Following discussion with the recommendation owner, Head of HR and HR IA workstream lead a further discussion and walkthrough to clarify and agree requirements and ensure they are fully understood. Raised implementation date of 10/11/17 has been agreed.	Cheryl Hynd, Transactions Team Manager
CW1603 ISS.5	CW1603	External Vulnerability Assessment	ICT Solu	ISS.5	Medium	For projects that involve the implementation of new technologies or information management, the Council have implemented processes such as 'Security Assurance Statements' that ensure security considerations are acknowledged prior to project initiation and 'Privacy Impact Assessments' that assesses the use and management of sensitive data. However there is currently no Design Authority or appropriate governance forum in place within CGI to manage the introduction of new technologies and systems into the Council' s existing infrastructure. As new projects and systems are being developed, there is not a suitable forum that would support the identification of IT security and technical considerations associated with these technologies, or the suitability of integration with existing IT infrastructure. There is also a lack of consistency in the approach of project teams to the performance of security assessments on project deliverables, which results in project delays. This is symptomatic of not having an established design authority and embedded IT adoption processes in place, as well as sufficient awareness within the Council of the need to consider security requirements when implementing new technologies.	Without a Design Authority in place, there is a risk that issues with new technologies and systems are not identified in a timely manner leading to wasted resources, duplication of effort and project delays.	The Council, with the support of CGI, should implement a Design Authority that has appropriate oversight and governance to consider whether new technologies comply with the Council's security requirements, existing security architecture and aligns with the Council's strategic IT objectives.	The existence of a Design Authority is a contractual requirement in the CGI contract. The creation of this Authority will be progressed with CGI as a matter of priority.	Overdue	31/08/17	30/03/18		September Update: CGI have yet to deliver a cohesive Design Authority despite concerted effort and escalations by ICT Solutions management. Meeting with CGI Solution Architect on 14/09/2017 resulted in agreed approach and plan for the creation of an effective Design Authority. Revised implementation date is 30/03/2018.	Neil Dumbleton, ICT Enterprise Architect

Unique No	Project Code	Project Name	Group	Issue Cod	Rating	Finding	Business Implication	Recommendation	Agreed Management Action	Status	Due Date	Revised Date	Revisions	Status Update	Owner
RES1614 ISS.2	RES1614	Lothian Pension Fund Cyber Security	I&P	ISS.2	Medium	We found that: · Security was not fully considered at time of procurement of third party systems; and · There is no formal, ongoing security governance for these third parties. Without effective oversight, LPF cannot gain assurance that controls in place at third parties are appropriate based on the services and data hosted. LPF outsources the provision of the Pension Administration System, the hosting of the infrastructure that it sits on, and at the time of review was in the project phase for contracting with another 3rd-party supplier – Civica – to provide the 'Employer Data Transfer Portal'. By formally reviewing security requirements and the provisions at third parties, LPF will understand if controls at the supplier mitigate risks to an acceptable level, taking into account compliance with the security objectives, requirements, regulations, and contractual obligations that are important to LPF. The companies that provide these services to LPF are all ISO 27001 certified, and as such can demonstrate that they have a framework for managing security. However, ISO 27001 certification does not provide a report on information security controls that are in place within the organization. It is therefore important that LPF is satisfied that the controls in place at third parties are proportionate to the risks faced and that these controls protect LPF member data adequately. Regulators are increasingly focusing on oversight of third parties and the FCA recently published Third Party Outsourcing Guidance that highlights areas that should be considered, including: · Firms should understand the risks of outsourcing and identify steps to mitigate them; and · Ensure contracts have appropriate provisions for breach notification and remediation. With regard to oversight, the FCA notes: "Firms retain full accountability for discharging all of their responsibilities and cannot delegate responsibility to the service provider." And: "Firms should carry out a security risk assessment that includes the service provider and the technology assets administered by the firm."	If LPF do not routinely consider the security of their suppliers, the impact and likelihood of a data breach, system compromise, or loss of service are increased. This may result, in adverse media coverage for LPF, loss of stakeholder confidence, an impact on financial results and could impact core services provided. Additional consequence can include increased vulnerability to litigation and the possibility of regulatory enforcement actions.	LPF should consider implementing a Supplier Risk Management Framework. Effective Supplier Risk Management will help LPF maintain consistency and visibility of the risks they face from the third parties that they contract with. It will also allow LPF to demonstrate to stakeholders, regulators and management that supplier risk is considered consistently LPF should review existing third party contracts to ensure that security provisions are appropriate.	LPF agrees to implement both recommendations. Existing third party contracts will be reviewed on a risk prioritised basis.	Overdue	30/09/17			October Update (IA) No evidence provided in relation to implementation of the supplier management framework which is the main reason for recommendation not closing. Evidence has been provided that review of security provisions in contracts has been performed.	Struan Fairbairn, Chief Risk Officer, LPF
Strategy & Insight															
RES1607 ISS.1	RES1607	Online Customer Services	Strategy	ISS.1	Medium	Communication with the Head of Service and Service Manager for Licensing about the development and delivery of the HMO Licensing work stream has been irregular and limited to date. There was a 2-week consultation period in winter 2015 at the beginning of the project, but there has been limited communication since. There is no representative from the service area on the Project Board, and key programme documents have not been shared with the service area including: The Project Initiation Document (PID); The design document (which maps both the existing and the proposed processes); ICT and Transformation n Service Level Agreements:, Risk registers (with no process of escalation of the risks from the Service Area to the programme) ; Agendas and minutes from Project Board and other key group meetings; and Support available to the service area during and post-implementation. There is no stakeholder engagement stage in corporated in the project plan. We note that the design document for the HMO licensing onlin e platform states that ' [the] Licensing Team [is] to own policy and guidance documents development to accommodate an online platform . ' It is unclear how they can do this effectively without involvement in its design and implementation.	Stakeholder expectations are not adequately managed as critical stages of the project are not communicated; The Project Board may not have a full understanding of the service requirements for each work stream , meaning that it may not deliver the expected benefits ; The needs of users are not considered in the development of the system , meaning that it may not deliver expected benefits ; Barriers to implementation that the service area is able to identify from experience, but which may not be obvious to the programme team (for example, legislative requirements) are not captured; Service Area leads may not buy-in to the project which risks slowing project progress.	Stakeholder Engagement The Project Board should include representatives from the live Service Area projects to ensure all critical documentation is shared and service and legislative requirements are considered, managing stakeholder expectations at each stage of the project . The Project Board may decide that this is most effectively managed through the creation of working groups for key work streams.	As part of the Programme rest (detailed in the 'Current Status Update' above), the programme governance and model used for business engagement is being reviewed, clarified and improved. This will include standardised documentation. When the detailed plan is received from CGI/Agilisys in April 2017 Working Groups for each " Dr op" will be convened to include Subject Matter Experts from each of the relevant service areas. Re-engagement across senior and frontline stakeholders is currently being planned to refresh the message and planned outcomes of the Programme to support buy-in across the organisation.	Overdue	31/05/17	29/12/17	31/08/17 29/12/17	September Update: Greg Malkin has taken over the responsibility for this project. It has been placed on hold until there is further action by CGI towards setting up the new platform and technical solutions such as Web or CDE. The customer journey is being reviewed by a project manager with the support of an officer from comms. they are looking at the website and enhancing signposting for existing digital transactions. There is clarity over the coms approach, representation on the working group supporting agile sprints. Head of Comms is attending Web and CDE board so there are people in place to develope detailed plans when the programme is formally restarted. Revised date amended from 31/8/17 to 29/12/17 Governance structure was put in place before project was placed on hold. This will be adapted based on whatever the new development partner structure may be.	Clare Mills, Project Manager