Internal Audit Report

Implementation of Whistleblowing and Assurance Actions

5 March 2025

CD2411

Overall Assessment	Reasonable Assurance

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This Internal Audit review is conducted for the City of Edinburgh Council under the auspices of the 2024/25 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2024. The review is designed to help the City of Edinburgh Council assess and refine its internal control environment. It is not designed or intended to be suitable for any other purpose and should not be relied upon for any other purpose. The City of Edinburgh Council accepts no responsibility for any such reliance and disclaims all liability in relation thereto.

The internal audit work and reporting has been performed in line with the requirements of the Global Internal Audit Standards (UK Public Sector) and as a result is not designed or intended to comply with any other auditing standards.

Although there are specific recommendations included in this report to strengthen internal control, it is management's responsibility to design, implement and maintain an effective control framework, and for the prevention and detection of irregularities and fraud. This is an essential part of the efficient management of the City of Edinburgh Council. Communication of the issues and weaknesses arising from this audit does not absolve management of this responsibility. High and Critical risk findings will be raised with senior management and elected members as appropriate.

Executive Summary

Overall Assessment	Reasonable Assurance

Engagement conclusion and summary of findings

There is a generally sound system of governance, risk management and control in place for the management of whistleblowing actions raised.

It is recognised that following the Tanner Independent review into whistleblowing, the roll out of an updated whistleblowing policy and new whistleblowing toolkit, and the establishment of the Whistleblowing Sub-Committee have strengthened the management of whistleblowing processes. In addition, the Governance Team have been actively reviewing processes to identify areas of improvement.

The following actions have been identified to further support this:

- the Governance Team should put in place an end-to-end process for management of whistleblowing actions to ensure clarity and consistency in the approach across the Council
- Place Directorate and the Health and Social Care Partnership should update current processes in place to reflect associated records management and risk management processes, aligned to the Governance process developed
- Corporate Services and Children, Education and Justice Services Directorates should document Directorate processes
- business partnering meetings between the Governance Team and Directorates should be held consistently and cover standard agenda points
- Directorates should consistently comply with agreed processes, such as the retention, review and provision of key data, evidence and reports as required and when due for all actions raised
- the Governance Team should pre-filter trackers provided to Directorates for quarterly updates and also investigate options for development of a system-based process for more effective management of actions
- the Governance Team should consider rationalising the tables of open actions included in committee reports to ensure a focus on overdue actions.

There is a gap in how the Council gets assurance over wider assurance actions, and this should be addressed to ensure that there is an understanding of completeness, and that evidence-based assurance is provided to support the annual assurance statement:

- Directorates including the Chief Executive's Office should implement a documented process to demonstrate that all current assurance recommendations are known of and are being actively managed by the services leading on them.

Areas of effective practice

- clear instructions are provided by the Governance Team when issuing reports, templates and trackers to Directorates, and the team are responsive to feedback from Operations Managers on how communications and processes could be improved
- the Governance Team recognise that non-compliance issues at Directorate level are driven by capacity issues rather than a lack of willingness to engage with the Team
- Directorate Operations Managers recognise the importance of whistleblowing processes, and were proactive during the audit to act on feedback provided, for example, in updating or drafting process notes where gaps were identified
- good working relationships between Directorates, and sharing of good practice
- central registers to improve monitoring of wider assurance actions are being developed in all Directorates, and the following also noted:
  - HSCP had an existing register to monitor some wider assurance actions, such as Mental Welfare Commission, Audit Scotland and EIJB Committee
  - creative solutions were being progressed by Corporate Services for their service areas
  - Children, Education & Justice Services monthly senior management team meetings include reviews of whistleblowing and other assurance activities.

Audit Assessment

Audit Area	Control Design	Control Operation	Findings	Priority Rating
Directorate compliance and assurance			Finding 1 – Procedures for Management of Whistleblowing Actions	Medium Priority
			Finding 2 – Directorate Completion of Whistleblowing Actions	Medium Priority
Oversight and monitoring arrangements			Finding 3 – Whistleblowing Action Trackers	Medium Priority
			Finding 4 – Whistleblowing Sub-Committee	Low Priority
		N/A	Finding 5 – Monitoring Wider Assurance Actions	High Priority

(N/A controls not tested due to missing controls)

See Appendix 1 for Control Assessment and Assurance Definitions

Background and scope

An internal audit of implementation of whistleblowing actions in 2022 highlighted the need for all Directorates to establish consistent processes to ensure there is adequate oversight of implementation progress and reporting for whistleblowing and assurance actions. Specific improvements identified included the need for Directorates to:

- consistently identify action owners and target dates, and effectively manage changes in ownership
- monitor implementation progress and provide regular updates to ensure actions are fully complete within agreed timescales
- centrally retain evidence to support implementation
- ensure consistent and accurate reporting of any actions plans developed to support implementation
- review reporting arrangements to ensure transparent Committee review and oversight.

This internal audit also referred to the 2020 audit 'Implementation of Assurance Actions and Linkage to Annual Governance Statements' which identified a lack of clearly established processes to support completion of all assurance actions.

Council Whistleblowing policy and procedures

The Council's revised Whistleblowing policy and new Whistleblowing toolkit was approved by Policy and Sustainability Committee on 9 January 2024.

A standard notification email is issued to Directorates to notify them of the closure of whistleblowing investigations prior to Committee, setting out any proposed management actions for each Directorate. Directorates are required to review proposed management actions, agree to accept them and confirm the officer responsible for implementation of each recommendation, or provide an explanation if any proposed actions cannot be delivered or are not required. Details of recommendations are also confirmed to Directorates post Committee to ensure that any changes agreed as a result of the Committee review are captured.

Whistleblowing management action trackers are maintained to monitor implementation of actions against target dates set by each Directorate. Directorates' Business Partners in the Governance team work with Directorate Operation Managers to ensure that all Directorate trackers are updated on a quarterly basis and all open actions reported to the Whistleblowing Sub-Committee meeting until they are closed.

Scrutiny of Whistleblowing investigation report recommendations

The GRBV Whistleblowing Sub-Committee was established in September 2023 and meets quarterly. The sub-committee has delegated authority to consider and scrutinise monitoring reports and investigation outcome reports, and to consider any other relevant matter related to the whistleblowing policy. On the conclusion of internal and external investigations, where requested by members at the agenda planning meeting, whistleblowing investigation case summaries are presented to the sub-committee for scrutiny, as well as approval of any management actions raised where appropriate.

Other Assurance Actions

Directorates are required to have processes in place to record, review and track internal audit, whistleblowing, and other assurance actions. Initial scoping meetings have highlighted there are inconsistent processes in place across Directorates and there are no centralised mechanisms within Directorates for monitoring progress with all internal and external assurance actions raised. Other assurance actions are progressed by relevant operational service areas, and service and committee reporting arrangements put in place dependent on the type of assurance activity.

Scope

In line with the Tanner Independent Review of the Whistleblowing and Organisational Culture of the City of Edinburgh Council, the objective of this bi-annual audit was to assess the completeness of a sample of implemented whistleblowing recommendations.

The review also considered the effectiveness of Directorate and Committee oversight and performance arrangements as well as Directorate arrangements for tracking of all assurance actions.

Alignment to Risks and Business Plan Outcomes

The review also provides assurance in relation to the following Corporate Leadership Team risk categories:

- Strategic Delivery
- Technology and Information
- Governance and Decision Making
- People
- Regulatory and Legislative Compliance
- Reputational Risk
- Fraud and Serious Organised Crime

Business Plan Outcomes:

The review is aligned to all business plan outcomes.

Limitations of Scope

Due to the lack of consistent processes across Directorates for tracking, monitoring and evidencing progress with wider assurance actions which was identified through scoping, the scope of this audit was limited to a sample of whistleblowing cases only, and relevant findings have been raised for assurance action arrangements.

The remit and effectiveness of the Whistleblowing Sub-Committee was not considered in detail in this review as this audit focused on corporate and directorate processes. The work of the sub-committee will be considered further in the next biennial audit due in 2026/27.

Reporting Date

Testing was undertaken 21 October 2024 and 20 December 2024.

Up until 20 December 2024, related controls for services now within the newly established Chief Executive's Office were part of the Corporate Services Directorate processes. However, from 20 December 2024 onwards, the Corporate Services Operations Manager will no longer be responsible for monitoring actions related to the services contained within the Chief Executive Office. Actions for audit recommendations will be agreed and tracked for the Chief Executive's Office to ensure consistency in the management of Whistleblowing actions across the Council.

Audit work concluded on 31 January 2025 and the findings and opinion are based on the conclusion of work as at that date.

Findings and Management Action Plan

Finding 1 – Procedures for Management of Whistleblowing Actions

Finding Rating	Medium Priority

Detailed templates, standard emails and guidance to support management of whistleblowing actions are used by the Governance Team, however, the end-to-end process including roles and responsibilities and linkage to committee requirements has not been documented. For example, the current guidance does not cover the approach to the following processes:

- determining which Directorate should own an action, where it requires the involvement of more than one Directorate to facilitate closure
- transferring action ownership between Directorates.

Sample testing also highlighted delays in providing updates on actions and closure reports. The Governance Team confirmed that understanding the impact of delays on reporting to the Whistleblowing Sub-committee was an issue across Directorates.

In addition, there was joint agreement on the need for more consistent and structured business partnering meetings between the Governance Team and Directorates; these meetings should include discussion of any service whistleblowing issues.

Review of Directorate processes also highlighted the following:

- **Place Directorate** – the process note in place includes the requirement for the action owner to provide appropriate evidence, however a review to ensure the supporting information is sufficient is not outlined, and the date of next review is not recorded
- **Health and Social Care Partnership** – the process note was reviewed in February 2024 but needs updated to reflect the Whistleblowing Sub-Committee arrangements. The requirement for officers to provide evidence is not embedded and again the process note does not prompt a review of evidence provided to ensure sufficient, and the date of the next review is not recorded.
- **Corporate Services and Children, Education and Justice Services** - no written processes have been developed for these two Directorates, however during the audit, Corporate Services started this work.
- **All Directorates**
  - no records management processes are in place in any Directorates for whistleblowing records held, and a lack of awareness of the records retention periods outlined in the whistleblowing policy and toolkit, and the Council's records retention policy
  - in addition, a direction to ensure risks associated with whistleblowing actions are identified and recorded within risk registers is not documented
  - feedback from Operations Managers also reflected concerns around expectations that they perform detailed validation of evidence provided by action owners.

Risks

Governance and Decision Making

- Formal processes have not been established in Directorates leading to lack of clarity over roles and responsibilities
- Directorate and Governance Team processes in place are not complied with.

Regulatory and Legislative Compliance

- Records held to support completion of whistleblowing are retained for longer than appropriate or disposed of too early.

Recommendations and Management Action Plan: Standard Operating Procedures

Ref.	Recommendations	Agreed Management Actions	Action Owner	Lead Officers	Timeframe
1.1	The Governance Team should document and communicate standard operating procedures for management of whistleblowing actions to ensure clarity and consistency in the approach across the Council, these should include: • the respective roles and responsibilities of the Governance Team and Directorates at each stage of the process, for example, actions required on conclusion of investigations pre and post committee, and on a quarterly basis until all recommendations are closed • deadlines for submission of management action updates, major case closure reports and any other reports or information required, in line with Committee lead times • expectations around the need for full information to be provided, including target implementation dates for all actions, to ensure effective Directorate and Committee review and challenge • expectations around the need for Directorates to ensure that appropriate officers attend Whistleblowing Sub-Committee meetings and are able to respond to specific member questions on cases, and are provided with papers in advance • escalation processes for managing missed deadlines • clear processes for determining lead ownership of cross directorate actions and for transferring	**Development of Whistleblowing Process Guide** – the Governance Team are currently developing a comprehensive step-by-step guide that will address all aspects of the recommendation. The guide will be socialised with Operations Managers in the various Directorates in order that they can provide constructive feedback prior to its introduction. This will ensure the process is understood and agreed. The document will have strict version control, be reviewed on an annual basis and will be updated as/when processes change. Directorates will be consulted in relation to reviews and amendments, where appropriate.	Chief Executive	Monitoring Officer Head of Governance and Democracy Governance Manager	30/06/2025

Ref.	Recommendations	Agreed Management Actions	Action Owner	Lead Officers	Timeframe
	actions between Directorates or when an officer leaves. This should include consideration of whether the action will still be completed as intended • clear processes for ensuring it is clear how recommendations from upheld investigations will be addressed, including where Directorates have only agreed to partially action them through whistleblowing processes. The documented procedure and associated templates should reflect clear version control, including the date of last review, and the date of the next scheduled review. Additional reviews should be undertaken and communicated where there are any significant changes to processes in the intervening period.				
1.2	The Governance Team should agree standard agendas and timeframes for business partnering meetings between the Governance Team and Directorates and include discussion of relevant whistleblowing casework and concerns.	It is accepted that business partnering meetings are integral to all aspects of governance and assurance, including the progression of whistleblowing actions. **Review of business partnering meetings** - work is ongoing to develop new terms of reference to add a clearer purpose to these meetings, including creating standard agenda items and the taking of minutes to capture agreed actions and discussion points. Relevant whistleblowing casework will be reviewed to ensure actions are progressing in line with agreed timescales, and that all issues identified are addressed in a timely manner.	Chief Executive	Head of Governance and Democracy Governance Manager	30/08/2025

Ref.	Recommendations	Agreed Management Actions	Action Owner	Lead Officers	Timeframe
1.3a - 1.3b	Following issue of the documented process by the Governance Team, Place Directorate and the Health and Social Care Partnership should update Directorate processes to reflect current arrangements, including the requirement for evidence submitted by action owners to be subject to sense checking prior to confirming completion of actions to the Governance Team. A direction to ensure risks associated with whistleblowing actions are identified and recorded within risk registers should also be added. It is not expected that this would include risks for all whistleblowing recommendations. The focus should be on identifying systemic issues and risks and recording when a risk has been accepted. The documented procedure should reflect clear version control, including the date of last review, and the date of the next scheduled review. Additional reviews should be undertaken where there are any significant changes to processes in the intervening period.	**Place:** Once developed, Place will review the Governance Team's Documented Process and incorporate any relevant changes to its current Directorate process. The Place process will be updated to include a periodic review of systemic themes to be captured in the Directorate or Divisional Risk registers when appropriate. Appropriate version control will be incorporated into the Place Process.	Interim Executive Director, Place	Operations Managers	30/11/2025
		HSCP: The Partnership processes note will be updated to ensure clear version control and requests for evidence. Communications will be drafted asking Service Directors and Head of Service (or equivalent) to consider any risks arising from whistleblowing and record on risk registers accordingly.	Chief Officer, HSCP	Operations Manager	30/08/2025
1.3c - 1.3d	Following issue of the documented process by the Governance Team, Corporate Services and Children, Education and Justice Services should document Directorate processes for management of whistleblowing actions which should be aligned to current requirements including: • the respective roles and responsibilities for Senior Managers, Operations Managers / Assurance Officers and assigned action owners within the Directorate	**Corporate Services:** Once the Governance Team process has been developed and communicated as per recommendation 1.1, Corporate Services will review the current draft Directorate Process to ensure that it is aligned and covers all necessary steps. Corporate Services will regularly remind Services that risks identified via whistleblowing should be appropriately considered and where necessary included in relevant risk registers. Corporate Services will ensure that their Directorate Process contains clear version control information, including details as to review cycles.	Executive Director, Corporate Services	Operations Manager	30/09/2025

Ref.	Recommendations	Agreed Management Actions	Action Owner	Lead Officers	Timeframe
	• the internal and committee deadlines and information requirements applicable at each stage of the process • the requirement for evidence to be submitted by action owners in support of closure of actions, and for this evidence to be subject to sense checking prior to confirming completion of actions to the Governance Team • the escalation process in place where deadlines for submission of updates and evidence are missed • the arrangements for central, secure and restricted retention of evidence submitted • processes for transfer of ownership of actions where a lead officer leaves the Council. A direction to ensure risks associated with whistleblowing actions are identified and recorded within risk registers should also be added. It is not expected that this would include risks for all whistleblowing recommendations. The focus should be on identifying systemic issues and risks and recording when a risk has been accepted. The documented procedure should reflect clear version control, including the date of last review, and the date of the next scheduled review. Additional reviews should be undertaken where there are any significant changes to processes in the intervening period.	**Children, Education and Justice Services:** Once the Governance Team have a documented process in place CE&JS will review this and build this onto our Directorate processes. We will also commence a quarterly review around whistleblowing governance and identify any emerging risks.	Executive Director, Children, Education and Justice Services	Operations Manager	30/09/2025
1.4a - d	All Directorates should establish records management processes for records related to management of whistleblowing actions.	**Place:** The Place process will be updated to include details of the recommended retention periods, aligned to the relevant toolkit/schedule.	Interim Executive Director, Place	Operations Managers	30/11/2025

Ref.	Recommendations	Agreed Management Actions	Action Owner	Lead Officers	Timeframe
	These should be clearly documented in the processes recommended at 1.3 and should be aligned to relevant policy requirements and guidance, such as the Council's whistleblowing policy and toolkit, and records retention schedule, as different retention periods apply to minor and major casework (with separate retention rules applicable but not limited to child protection matters).	**HSCP:** The Whistleblowing process note will be updated to include reference to records retention and link to records retention schedules.	Chief Officer	Operations Manager	30/08/2025
		Corporate Services: Corporate Services has a secure SharePoint / Teams Channel for the recording of all whistleblowing work. The draft Directorate Whistleblowing Procedure details the retention schedule for Major/Minor cases and the Operations Manager will work with colleagues in the Governance Team to ensure this is clearly identified for all cases going forward. Current records have an automated reminder set for records review based on the currently available information and records management requirements will be reiterated in the reviewed Directorate process.	Executive Director, Corporate Services	Operations Manager	11/11/2025
		Children, Education and Justice Services: CE&JS will have a restricted area in the G Drive to manage/track/update whistleblowing records, only accessible to Senior Officers. (Note: SharePoint would be more appropriate however Learning & Teaching colleagues are unable to access a SharePoint area set up via corporate colleagues. This has been raised with the Digital Education Team and if resolved, we will progress creation of Sharepoint). Record management processes will be incorporated into our Directorate process.	Executive Director, Children, Education and Justice Services	Operations Manager	30/08/2025

Finding 2 – Directorate Completion of Whistleblowing Actions

Finding Rating	Medium Priority

Review of a sample of Whistleblowing actions for all Directorates highlighted the following:

2.1 Place - while confirmation of actions taken is retained, evidence is not routinely requested to support closure of findings. This control gap was acknowledged, and written processes have been updated to require evidence collation from November 2024, where this is appropriate, although it was noted that Manager confirmation may be sufficient in some cases.

One action had been closed in July 2023, but updates noted a future action in 2024 associated with update of a handbook. The outstanding action is now considered not applicable, as the responsibility for this action transferred from one Directorate to another and management determined it would be handled in a different way, however this had not been documented or reported back to Committee.

For one closed action reviewed, which was one of six actions owned by the same Service Manager, all actions had been closed via a single management update confirming that they had all been completed through myLearning hub modules. Review of the actions determined that the update did not provide assurance that all elements had been covered.

Target dates for implementation were not noted in the whistleblowing tracker for 2 of 6 cases reviewed (marked as N/A or TBC). It was noted that target dates are always agreed with action owners for current cases.

2.2 Health and Social Care Partnership – scoping and fieldwork meetings established that while confirmation of actions taken was retained, evidence is not routinely requested to support closure of findings. Evidence was however provided for all 4 closed actions reviewed as a part of the Internal Audit sample when requested.

One closed action reviewed from a major whistleblowing case was the last action to be closed for this case. At this point, a closure report should be prepared by the Directorate for scrutiny at the next available Whistleblowing Sub-Committee meeting. A report was requested by the Governance Team in June 2024 for the September 2024 meeting however this was still outstanding in early December. The Directorate Operations Manager acknowledged that this was overdue.

Target dates for implementation were not noted in the whistleblowing tracker for 2 of 4 cases reviewed. It was noted that this is a legacy issue, and that dates are always obtained for current cases.

2.3 Corporate Services – there are no written processes in place requiring action owners to routinely submit evidence to support closure of actions. The Directorate Operations Manager noted that in general, if action owners confirm that they have completed an action, this is deemed sufficient assurance and no supporting evidence sought.

From a review of documentation centrally held for 3 Corporate Services closed actions selected for review, it was established that while confirmation of actions taken was retained, there was no confirmation that one recommendation had been fully implemented; this required highlighting guidance and policy information updated to NHS colleagues.

2.4 Children, Education and Justice Services – there are no written processes in place requiring action owners to routinely submit evidence to support closure of actions. While the Directorate Operations Manager noted an expectation that this will be done, they also noted that this is determined on a case-by-case basis.

From a review of documentation centrally held for 5 Children, Education and Justice Services closed actions selected for review, it was established that while confirmation of actions taken was retained, no supporting evidence was available for any of the 5 cases reviewed.

Auditor access was provided to relevant folders within Sharepoint to review updates and evidence held for the sample of closed actions selected. It was noted that folders do not reference supporting documents by specific action, making it difficult to establish which actions they relate to, and if updates and evidence is on file for all Directorate actions. The same management update and detail was provided for two closed actions for one case, and for four closed actions for another case. Target dates for implementation were not noted in the whistleblowing tracker for any of the 3 cases reviewed. It was noted that this might be a legacy issue, and that dates are always obtained for current cases.	The same management update was provided for three closed actions for the same case, confirming completion but with no further detail of specific actions taken. Target dates for implementation were not noted in the whistleblowing tracker for 3 of 5 cases reviewed. It was noted that this might be a legacy issue, and that dates are always obtained for current cases.
2.5 Cross Directorate Action - a review of a cross directorate closed action requiring all Directorates to consider establishing central registers to record requests for staff working from abroad identified inconsistencies in the approaches adopted, such as the level at which registers are maintained, the level of detail recorded, and the requirement for periodic updates to be sought from services. As the information contained in these registers is a frequent topic of freedom of information requests across the Council, registers need to be kept as complete and up to date as possible. Best practice was established for the Place Directorate register set up, which clearly set out Directorate and Digital approvals obtained.	

Risks

Governance and Decision Making

- Limited assurance can be provided that recommendations have been fully actioned.
- Records to support completion of whistleblowing and other assurance actions are not centrally held to confirm actions taken and evidence review and validation.

Recommendations and Management Action Plan: Directorate Completion of Whistleblowing Actions

Ref.	Recommendations	Agreed Management Actions	Action Owner	Lead Officers	Timeframe
2.1	**Place Directorate** • The rationale for closing the action transferred from Directorate to Directorate should be advised to the Governance team and reported to the Whistleblowing Sub-Committee. A related action on how actions are transferred between Directorates or when an officer leaves is covered at finding 1.	The Directorate Process will be strengthened to incorporate arrangements for transferring actions from Place. Additionally, will ensure that separate actions are noted against each recommendation, although there may be instances where one action can address all the recommendations. In such cases, this will be documented.	Interim Executive Director, Place	Operations Managers	30/09/2025

	• Whistleblowing processes in place should be revised to require action owners to provide separate management updates for each action they own, outlining how the evidence provided is sufficient to support closure of all points required in each recommendation made.				
2.2	**Health and Social Care Partnership** The outstanding major case closure report should be completed and tabled for review at the next Whistleblowing Sub-Committee meeting.	This will be progressed in collaboration with Customer (as joint owner) as quickly as possible and presented to the next Whistleblowing Sub-Committee.	Chief Officer, HSCP	Operations Manager	30/08/2025
2.3	**Corporate Services Directorate** The closed action that was not fully implemented should be re-opened, and the action owner requested to complete the actions required. If the agreed action is to be risk accepted, the reason for this should be advised to the Governance Team and tabled for review at the next Whistleblowing Sub-Committee meeting. Whistleblowing processes developed should include a requirement for action owners to provide separate management updates for each action they own, outlining how the evidence provided is sufficient to support closure of all points required in each recommendation made. Supporting documents held should be referenced to the specific action that they relate.	Corporate Services will review the indicated cases and actions and on discussion with applicable Service Directors will agree any further actions deemed necessary. The draft Directorate whistleblowing process will be updated as per 1.3 to include reference that where suitable (where actions are not interconnected) individual status updates should be provided and recorded clearly as such.	Executive Director, Corporate Services	Operations Manager	30/09/2025
2.4	**Children, Education and Justice Services** • The five closed actions should be reviewed by the Service and where no satisfactory evidence can be obtained to support actions confirmed as complete, this should be advised to the Governance team and reported to the Whistleblowing Sub-Committee. • Whistleblowing processes developed should include a requirement for action owners to	• CE&JS will review the relevant actions and provide reassurance to the Governance Team that the actions are completed – this will also be reported to the Whistleblowing Sub-Committee • This action is dependent on the completion of action 1.3. When a documented process is implemented by the Governance Team,	Executive Director, Children, Education and Justice Services	Operations Manager	30/09/2025

	provide separate management updates for each action that they own, outlining how the evidence provided is sufficient to support closure of all points required in the recommendations made.	CE&JS will align this to the Directorate processes to strengthen current processes.			
2.5a - d	**All Directorates** All Directorates should review their processes for management of staff working from abroad to ensure that accurate and complete records are held of all applications made and all requests approved by Management and Digital Services.	**Place:** A Halo form is proposed to enable all requests to be submitted through a central system and approved accordingly. If this is not possible, Place will review its processes for the management of people requesting to work abroad.	Interim Executive Director, Place	Operations Managers	30/03/2026
		HSCP: Process for working from abroad will be reviewed and enhanced to ensure complete records are held of all applications made and whether approved or not by both Digital Services and management.	Chief Officer	Operations Manager	30/08/2025
		Corporate Services: As per 2.5e. Corporate Services will work with colleagues across the Directorate to design a new process, to sit alongside the proposed new HALO form created by colleagues within Digital Services (2.5e) and this will be shared with colleagues across all Directorates.	Executive Director, Corporate Services	Operations Manager	30/03/2026
		Children, Education and Justice Services: CE&JS will review management processes around staff working abroad to ensure there is a Directorate record of requests and approvals. The Corporate Services Operations Manager is working with Digital Services to create a HALO form for Working from Abroad which will be rolled out to all Directorates.	Executive Director, Children, Education and Justice Services	Operations Manager	31/08/2025

2.5e	Consideration should be given as to whether a digital form could be created for request and approval, and for inclusion of the required information which could be used to support this.	**Corporate Services:** Corporate Services colleagues in Digital Services are looking at designing a HALO form that will capture all such requests. The relevant ORB pages will be updated to point colleagues to this form and information.	Executive Director, Corporate Services	Operations Manager	30/01/2026
2.6a - d	**All Directorates** The Directorate processes (refer Finding 1) should require action owners to submit evidence to Operations Manager in support of all actions completed. Evidence should be sense checked to ensure that it adequately covers all agreed actions. Where it does not, further evidence should be requested, in order to provide assurance to the Executive Director that all actions are fully implemented. Operations Managers should consult with action owners to agree target dates for implementation of actions and complete and return the Governance Team template.	**Place:** As per Recommendation 1.3, once developed, Place will review the Governance Team's Documented Process and will update the Directorate process if required.	Interim Executive Director, Place	Operations Managers	30/03/2026
		HSCP: Requests for evidence will be communicated when recommendations are allocated and followed up as part of closure process.	Chief Officer	Operations Manager	30/08/2025
		Corporate Services: As per Recommendation 1.3, once developed, Corporate Services will review the Governance Team's Documented Process and incorporate the relevant changes to our current draft Directorate process. This will include reference to the submission of evidence and the agreement of target implementation dates.	Executive Director, Corporate Services	Operations Manager	30/11/2025
		Children, Education and Justice Services: This action is dependent on action 1.3. When a documented process is implemented by the Governance Team, CE&JS will align this to the Directorate processes to strengthen current processes.	Executive Director, Children, Education and Justice Services	Operations Manager	30/09/2025

Finding 3 – Whistleblowing Action Trackers

Finding Rating	Medium Priority

A review of the Whistleblowing tracker issued by the Governance Team in October 2024 for updating identified that across all Directorates:

- 69% of entries included the name of an assigned action owner
- 38% included an implementation target date
- 66% of actions noted as implemented recorded the date that the action was completed.

For all actions closed in 2022/23, only 23% (29 of 128) had an associated target implementation date.

Where both target dates and completion dates were recorded (for 24 of the 29 actions with due dates), all had been confirmed as complete before or on the target date set. No reason was noted for one action which was still open 4 months after the due date set.

The requirement to record these key dates may not have been in place when some of the actions were first added to trackers, however, a review of the September 2024 Whistleblowing Sub-committee paper identified that some key dates / reasons for delays were missing or noted as TBC for open actions which had been through at least one previous committee cycle (12 issues were identified across 3 Directorates, excluding HSCP).

The review of a sample of whistleblowing actions, also highlighted that the whistleblowing tracker field 'evidence provided' was not used by Directorates.

Inconsistent use of the subject matter heading in the master whistleblowing tracker maintained by the Governance Team was noted, with some entries recording the type of allegation and some recording job roles, units or service, or a mix of both. The lack of consistency will make it more difficult to collate meaningful thematic information, for example fraud, for reporting to committee. In some cases, it also allows for the individual that the allegation relates to be identified if they hold a unique role in a unit named.

Challenges in the use of spreadsheets for tracking were also noted as the process is manual with reliance on the team keeping on top of deadlines and chasers. The need for a more automated process was recognised by both the Governance Team and Directorate leads. Consideration is being given to setting up an interim solution via MS365 for all Directorates to streamline processes and ensure consistency of management of records. At present, all Directorates have different arrangements.

In an effort to improve processes, changes to the single tracker issued from Q3 onwards were made, it was noted though that Directorate leads have access to information for all Directorates, some of which may be sensitive in nature, therefore pre-filtering by the Governance Team before issue is advised. The Governance Team have advised, this is being addressed through consideration of revised processes.

Delays in provision of Q2 / Q3 quarterly open management action updates were noted across 3 of 4 Directorates (CEJS, HSCP, Place). Confirmation was provided that two of four Q3 returns were still outstanding one week after the due date, and committee papers were due to be finalised the next working day.

Risks

Governance and Decision Making

- Trackers do not reflect all key data and lead officers leading to ineffective monitoring, review and accountability for actions being tracked.
- Directorates do not provide regular or full updates on progress with completion of whistleblowing actions when requested
- Inefficient processes for managing actions leading to errors, delays and impacts on officer time.

Recommendations and Management Action Plan: Whistleblowing Action Trackers

Ref.	Recommendations	Agreed Management Actions	Action Owner	Lead Officers	Timeframe
3.1a - d	In line with current Directorate, Governance Team and Committee requirements, Directorates should review all current open actions and ensure that action owners and target implementation dates are identified and recorded in whistleblowing trackers. Action completion dates should also be recorded in quarterly updates to the Governance Team for any actions confirmed as closed for that quarter. Reasons for delay in progressing any open actions should be noted in quarterly updates provided for all overdue actions.	**Place:** The Directorate will review all current open actions and ensure that action owners, target implementation dates, completion dates and reasons for delays are recorded in the whistleblowing tracker.	Interim Executive Director, Place	Operations Managers	30/09/2025
		HSCP: All actions allocated to the HSCP have agreed owners and implementation dates. The quarterly update will be reviewed and updated with rationale where actions are overdue.	Chief Officer	Operations Manager	30/08/2025
		Corporate Services: The Directorate will review all current open actions and ensure that action owners, target implementation dates, completion dates and reasons for delays are recorded as appropriate in the whistleblowing tracker.	Executive Director, Corporate Services	Operations Manager	30/08/2025
		Children, Education and Justice Services: CE&JS will review all current open actions and ensure that action owners, target implementation dates, completion dates and reasons for delays are recorded as appropriate in the whistleblowing tracker.	Executive Director, Children, Education and Justice Services	Operations Manager	31/07/2025
3.2a - d	The evidence provided field in whistleblowing trackers should be completed by Directorates to confirm receipt of evidence from action owners to support closure of all actions.	**Place:** The evidence provided field in the whistleblowing tracker will be completed, confirming receipt of evidence from action owners.	Interim Executive Director, Place	Operations Managers	30/03/2026
		HSCP: This will be completed by the Partnership going forward.	Chief Officer	Operations Manager	30/08/2025
		Corporate Services: The evidence provided field in the whistleblowing tracker for all ongoing open and new actions will be reviewed and completed as appropriate, confirming receipt of evidence from action owners.	Executive Director, Corporate Services	Operations Manager	30/08/2025
		Children, Education and Justice Services: CE&JS to ensure the whistleblowing tracker will be reviewed and	Executive Director, Children,	Operations Manager	31/07/2025

Ref.	Recommendations	Agreed Management Actions	Action Owner	Lead Officers	Timeframe
		completed as appropriate, confirming receipt of evidence from action owners is accurately recorded and reported.	Education and Justice Services		
3.3	The Governance Team should standardise descriptions applied to the whistleblowing tracker subject matter field to ensure that the nature of allegations are clearly stated and consistently applied, and able to be used to collate thematic information. The title should be clearly linked to the nature of the disclosure and job roles and names of units or services should not be reflected in this field.	It is accepted that current descriptions within the whistleblowing tracker are inconsistent, unclear and can sometimes include identifiable information such as job roles or department names. **Standardisation of tracker** – the Governance Team are currently reviewing options to introduce standard descriptions and content within the tracker. This will include the removal of personal data, where appropriate, and will more easily allow for the pulling of data to inform themes and trend analysis. If considered appropriate, we will liaise with the Convenor of the Whistleblowing Sub-Committee and/or other committee members to ensure any proposed changes to the tracker format is acceptable and provides the level of detail required.	Chief Executive	Monitoring Officer Head of Governance and Democracy Governance Manager	31/10/2025
3.4	The Governance Team should consider options for development of a system-based process to support the Council and Directorates to monitor whistleblowing actions and retain and track information including obtaining updates.	It is accepted that the current manual process for the tracking of whistleblowing actions can lead to ineffective management and missed deadlines. **Consideration of system-based process –** the Governance Team are exploring the feasibility of utilising Microsoft Lists to allocate actions, capture updates and issue reminders of deadlines. It is hoped that this software will provide efficiencies to both the Governance Team and Directorates as it has the capability to integrate with other Microsoft applications ensuring smooth collaboration across the Council.	Chief Executive	Monitoring Officer Head of Governance and Democracy Governance Manager	30/09/2025
3.5	The Governance Team should pre-filter quarterly trackers issued to Directorate for updates to ensure that they only include details of actions	It is accepted that quarterly trackers are currently issued with all management actions visible, which means that Directorates are able to view all actions, rather than only those relevant to them. Whilst it is accepted that this is a risk, it is important to note that the current process for the	Chief Executive	Monitoring Officer Head of Governance	30/11/2025

Ref.	Recommendations	Agreed Management Actions	Action Owner	Lead Officers	Timeframe
	relevant to that Directorate and consider associated reporting risks.	circulation of committee papers also contributes to this risk. **Review tracker and consider process for filtering –** the Governance Team will continue the work which commenced in Q3 2024 to refine the process for issuing the tracker and the option of pre-filtering. **Consideration of system-based process –** as detailed in our response to Recommendation 3.4, the Governance Team are exploring the possibility of utilising Microsoft Lists to assist with the issuing and management of actions. **Liaise with Committee Services to review circulation process –** the potential risks of the current process will be discussed to ascertain whether it is possible to limit/reduce circulation of certain documents within the committee pack.		and Democracy Governance Manager	

Finding 4 – Whistleblowing Sub-Committee

Finding Rating	Low Priority

Review of papers for the Whistleblowing Sub-committee found they are comprehensive and include minutes from the previous meeting, with all items covered, including confirmation of scrutiny of management action trackers for each Directorate. However, the following improvement points are noted for consideration:

- given the volume of papers, consideration should be given to highlighting / rationalising the management actions included in order to focus on any issues of concern, such as target dates not supplied, target dates not met, management updates that are unclear.
- where there is a mix of open and closed actions for any case, details for both are included in the action trackers presented to Committee which results in a large volume of papers and can be challenging to know what to focus on.

It is worth noting that the Whistleblowing Sub-Committee Convenor raised a motion at the January 2025 Governance, Risk and Best Value Committee meeting highlighting that there had been verbal updates on the agenda for recent Whistleblowing Subcommittee meetings and that this was raised by Councillors as an issue in the last APM and a request to record meetings was made.

Risks

Governance and Decision Making

- Large volume of information may result in a lack of focus which impacts effective committee oversight or scrutiny of implementation of actions taken to progress whistleblowing recommendations made
- Reliance on verbal updates in lieu of formal agenda items / papers may result in a lack of transparency and accurate record keeping.

Recommendations and Management Action Plan: Whistleblowing Sub-Committee

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
4.1	The Governance Team should consider filtering on open actions as this would allow for greater clarity and focus, similar to Internal Audit open and overdue reporting.	It is accepted that the inclusion of closed actions could inhibit focus and be unhelpful or confusing for committee members. **Review tracker and consider process for filtering –** in line with our response to Recommendation 3.5, the Governance Team will continue ongoing work to refine the tracker and consider how we can ensure open cases and cases of concern are more easily identified.	Chief Executive	Monitoring Officer Head of Governance and Democracy Governance Manager	30/11/2025

Finding 5 – Monitoring Wider Assurance Actions

Finding Rating	High Priority

A previous agreed management action from a 2020 internal audit on assurance actions required all Directorates to identify, process and monitor their assurance actions.

In addition, the assurance and monitoring of all assurance actions links into providing evidence for completion of sections 16 and 18 of the Director's Annual Assurance Statement. Therefore, consistent processes are required to ensure Service and Executive Directors have assurance of adequate controls to enable sign off.

During scoping for this audit, it was established that central mechanisms for collating and monitoring all assurance actions have not been established across Directorates. Discussions noted that Directorate Operations Managers have responsibility for some actions, for example, the HSCP Operations Manager monitors actions for the Mental Welfare Commission, Audit Scotland and EIJB Committee. Is it acknowledged that other actions for the HSCP such as Care Inspectorate improvement actions are monitored formally by Committee.

There was no overarching register for each Directorate covering all assurance actions. To obtain assurance that Directorates had knowledge of all their current assurance recommendations and that they were all being actively managed by the services leading on them, Operations Managers were asked by Internal Audit to complete a return providing details of all assurance actions currently being managed by each Directorate.

Returns providing details of all assurance actions currently being managed by each Directorate (where known) were provided by all Directorates, but feedback from all Directorate Operations Managers reflected uncertainty as to what to include, and also on the totality and completeness of the information provided.

Risks

Governance and Decision Making

- Assurance actions are not monitored or regularly reviewed to establish if progress for implementation is on track
- Declarations made in sections 16 and 18 of the Director's Annual Assurance Statement cannot be validated.

Regulatory and Legislative Compliance

- Records held to support completion of assurance actions are retained for longer than appropriate or disposed of too early.

Recommendations and Management Action Plan: Monitoring Wider Assurance Actions

Ref.	Recommendations	Agreed Management Actions	Action Owner	Lead Officers	Timeframe
5.1a - d	In order to ensure that Directors are provided with assurance that there is sufficient evidence to support the declaration made in sections 16 and 18 of the Director's Annual Assurance Statement, and as per agreed previous internal	**Place:** As part of efforts to improve assurance across the Directorate, we will review the current governance arrangements for other assurance actions and put in place improvements to existing processes if necessary.	Interim Executive Director, Place	Operations Managers	30/03/2026

Ref.	Recommendations	Agreed Management Actions	Action Owner	Lead Officers	Timeframe
	audit management actions, Directorates should implement and document a process to demonstrate that all current assurance recommendations are known of and are being actively managed by the services leading on them. Process should include the following: • the respective roles and responsibilities for management of assurance actions within each Directorate • development of a register to record details of the assurance body, report and associated recommendations raised, alongside responsible officers, Directorate and Committee oversight arrangements, risk management arrangements • a recording process for where assurance actions are being tracked through another formal method, for example by committee, and the Directorate deems tracking through a wider Directorate tracker is not required • arrangements for regular monitoring and review of each recommendation, and record of current status against target implementation dates set for each action • details of where evidence is held to support closure of actions for each assurance review • escalation processes to manage instances where updates on progress are not provided, or target dates are not met.	**HSCP:** The assurance actions tracker and process will be reviewed to ensure key points raised in the recommendation are incorporated for example, oversight arrangements, evidence required and formalising the escalation process.	Chief Officer	Operations Manager	30/08/2025
		Corporate Services: As part of efforts to improve Assurance across the Directorate, the new Service Director Quarterly Assurance Questionnaire, which is planned to be circulated from Q1 2025, will include sections to allow the capture of information relating to other assurance recommendations. Once the Directorate has clearly identified the requirements, a fuller process detailing the necessary requirements will be created.	Executive Director, Corporate Services	Operations Manager	28/02/2026
		Children, Education and Justice Services: To improve Assurance across the Directorate, CE&JS will develop a Directorate Assurance Tracker, this will be created and circulated across the Directorate quarterly to maintain regular monitoring and will include an area to allow the capture/update and removal of information relating to all assurance recommendations. Once the Directorate has clearly identified the requirements, a fuller process detailing the necessary requirements will be created.	Executive Director, Children, Education and Justice Services	Operations Manager	31/01/2026
5.2a - d	All Directorates should establish records management processes for records related to management of all assurance actions.	**Place:** Management of records for all assurance actions will be considered as part of our review in in recommendation 5.1.	Interim Executive Director, Place	Operations Managers	30/03/2026

Ref.	Recommendations	Agreed Management Actions	Action Owner	Lead Officers	Timeframe
	These should be clearly documented in the processes recommended at 5.1 and should be aligned to relevant policy requirements and guidance.	**HSCP:** The process will set out the records retention approach in line with the Council's records retention schedule.	Chief Officer	Operations Manager	30/08/2025
		Corporate Services: The process developed in recommendation 5.1 will detail appropriate records management processes.	Executive Director, Corporate Services	Operations Manager	28/02/2026
		Children, Education and Justice Services: The process developed in recommendation 5.1 will enable CE&JS to create appropriate records management processes.	Executive Director, Children, Education and Justice Services	Operations Manager	31/01/2026
5.3	Assurance registers developed should be tabled for review and discussion at regular business partnering meetings between the Governance Team and Directorates.	It is accepted that business partnering meetings are integral to all aspects of our work and there are currently missed opportunities within these meetings to ensure progress with all assurance actions assigned to Directorates. **Review of business partnering meetings –** as detailed in our response to Recommendation 1.2, we will also consider options to ensure that relevant assurance registers are reviewed on a regular basis and that all requirements are progressing in line with agreed timescales. This will provide greater confidence in the Council's Assurance Cycle to the Chief Executive and Committees.	Chief Executive	Head of Governance and Democracy Governance Manager	30/08/2025

Appendix 1 – Control Assessment and Assurance Definitions

Control Assessment Rating		Control Design Adequacy	Control Operation Effectiveness
Well managed		Well-structured design efficiently achieves fit-for purpose control objectives	Controls consistently applied and operating at optimum level of effectiveness.
Generally Satisfactory		Sound design achieves control objectives	Controls consistently applied
Some Improvement Opportunity		Design is generally sound, with some opportunity to introduce control improvements	Conformance generally sound, with some opportunity to enhance level of conformance
Major Improvement Opportunity		Design is not optimum and may put control objectives at risk	Non-conformance may put control objectives at risk
Control Not Tested	**N/A**	Not applicable for control design assessments	Control not tested, either due to ineffective design or due to design only audit

Overall Assurance Ratings	
Substantial Assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.
Reasonable Assurance	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.
Limited Assurance	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.
No Assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.

Finding Priority Ratings	
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.
Low Priority	An issue that results in a small impact to the achievement of objectives in the area audited.
Medium Priority	An issue that results in a moderate impact to the achievement of objectives in the area audited.
High Priority	An issue that results in a severe impact to the achievement of objectives in the area audited.
Critical Priority	An issue that results in a critical impact to the achievement of objectives in the area audited. The issue needs to be resolved as a matter of urgency.

Appendix 2 – Areas of Audit Focus and Control Objectives

Audit Areas	Control Objectives
Directorate compliance and assurance	All Directorates have established processes to ensure that appropriate measures are implemented and effectively sustained in response to all whistleblowing and other assurance recommendations actioned. All Directorates retain evidence centrally and securely to support the completion of whistleblowing and other assurance recommendations implemented, for an appropriate period. All Directorate trackers are kept up to date and complete, and actions implemented in line with target dates set. All Directorates provide the Governance Team with regular updates on progress in implementing whistleblowing recommendations implemented.
Oversight and monitoring arrangements	All Directorates have established processes to ensure that assurance outcomes are effectively monitored, and delays in progressing implementation of required actions escalated and resolved. Committee arrangements in place ensure effective oversight and scrutiny of recommendations made and actions implementation, including provision of accurate and timely updates from Directorates. Risks related to the management of whistleblowing and assurance actions are identified, recorded and managed within Directorate risk registers, and regularly reviewed to ensure appropriate mitigating actions are in place and remain effective.