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To: Councillor Flynn, Convener; Councillor Yuill, Vice-Convener, and Councillors Cameron, Cooney, Crockett, Dickson, Donnelly, Jackie Dunbar, Graham, Greig, Lawrence, Malik, Jean Morrison MBE, Nathan Morrison, Reynolds, Samarai and Townson.

Town House,
ABERDEEN 16 November 2016

# AUDIT, RISK AND SCRUTINY COMMITTEE

The Members of the **AUDIT, RISK AND SCRUTINY COMMITTEE** are requested to meet in Committee Room 2 - Town House on **THURSDAY, 24 NOVEMBER 2016 at 2.00 pm**.

FRASER BELL
HEAD OF LEGAL AND DEMOCRATIC SERVICES

## B U S I N E S S

1 Determination of Exempt Business

2 Deputation Requests

None at present

3 Minutes, Workplan and Decision Tracking Sheet

3.1 Minute of Previous Meeting of 27 September 2016 (Pages 5 - 18)

3.2 Workplan (Pages 19 - 26)

3.3 Decision Tracking Sheet (Pages 27 - 28)

3.4 Minute of the Corporate Health and Safety Committee of 26 August 2016 (Pages 29 - 38)

4 Performance and Improvement

4.1 Internal Audit Progress Report - Report by the Internal Auditor (Pages 39 - 50)

4.2 Scottish Public Services Ombudsman and Inspector of Crematoria Complaint Decisions - Report by the Interim Director of Corporate Governance (Pages 51 - 58)

4.3 Solar Photovoltaic Agreement - Report by the Director of Communities, Housing and Infrastructure (Pages 59 - 64)

5 Risk Management System

5.1 Review of Risk Management System - Report by the Interim Director of Corporate Governance (Pages 65 - 108)

6 Control Environment and Assurance - Internal

6.1 Budget Monitoring - Report by the Internal Auditor (Pages 109 - 126)

6.2 Bank Reconciliations - Report by the Internal Auditor (Pages 127 - 134)

6.3 Following the Public Pound - Report by the Internal Auditor (Pages 135 - 144)

6.4 Business Rates - Report by the Internal Auditor (Pages 145 - 154)

6.5 Purchasing and Creditors - Social Work - Report by the Internal Auditor (Pages 155 - 168)

6.6 Self Directed Support - Report by the Internal Auditor (Pages 169 - 186)

6.7 Carefirst - Report by the Internal Auditor (Pages 187 - 200)

7 Control Environment and Assurance - Audit Follow Up

7.1 Audit Recommendations Outstanding pre 2015 (PWC) - Report by the Internal Auditor (Pages 201 - 206)

7.2 Internal Audit Outstanding Recommendations against the 2015/16 Audit Plan - Report by the Internal Auditor (Pages 207 - 226)

8 Value for Money

8.1 Audit Scotland Value for Money National Reviews - Report by the Chief Executive (Pages 227 - 240)

**ITEMS THE COMMITTEE MAY WISH TO CONSIDER IN PRIVATE**

9 Referral from Communities, Housing and Infrastructure

9.1 Update on current gas central heating maintenance framework contract - Report by the Director of Communities, Housing and Infrastructure (Pages 241 - 252)

10 Matters Under Investigation

Website Address: www.aberdeencity.gov.uk

Should you require any further information about this agenda, please contact Karen Rennie, tel 01224 522723 or email karrennie@aberdeencity.gov.uk

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# AUDIT, RISK AND SCRUTINY COMMITTEE

ABERDEEN, 27 September 2016. Minute of Meeting of the AUDIT, RISK AND SCRUTINY COMMITTEE. Present:- Councillor Flynn, Convener; Councillor Yuill, Vice-Convener; and Councillors Cameron, Carle (as substitute for Councillor Nathan Morrison), Crockett, Dickson, Donnelly, Jackie Dunbar, Graham, Greig, Lawrence, Malik, Jean Morrison MBE, Samarai, Taylor (as substitute for Councillor Reynolds from item 4.4), Townson and Young (as substitute for Councillor Cooney).

The agenda and associated documents for this meeting can be found using the following link:
http://committees.aberdeencity.gov.uk/ieListDocuments.aspx?CId=507&MId=3869&Ver=4



## DETERMINATION OF EXEMPT BUSINESS

**1.** The Convener proposed that item 10.1 of today's agenda (article 28 of this minute) be considered with the press and public excluded.

**The Committee resolved:-**
in terms of Section 50(A)(4) of the Local Government (Scotland) Act 1973, to exclude the press and public from the meeting for item 10.1 so as to avoid disclosure of exempt information of the class described in paragraph 14.

## MINUTE OF PREVIOUS MEETING OF 27 JUNE 2016

**2.** The Committee had before it the minute of its previous meeting of 27 June 2016.

**The Committee resolved:-**
to approve the minute as a correct record.

## WORKPLAN

**3.** The Committee had before it the workplan prepared by the clerk which set out the future schedule of reports.

**The Committee resolved:-**
to note the content of the workplan.

## DECISION TRACKING SHEET

**4.** The Committee had before it the decision tracking statement as prepared by the clerk.

**The Committee resolved:-**
(i) to delete items 1 (Fraud Annual Report); 3(ii) (Social Work Tendering Internal Audit Report); 4 (Strategic Infrastructure Plan Progress Update); 6 (Audit Outstanding Recommendations – Carefirst); and
(ii) to otherwise note the content of the decision tracking sheet.

## MINUTE OF THE CORPORATE HEALTH AND SAFETY COMMITTEE OF 20 MAY 2016

**5.** The Committee had before it for information the minute of meeting of the Corporate Health and Safety Committee of 20 May 2016.

**The Committee resolved:-**
(i) in relation to a question from Councillor Yuill regarding the number of violent incidents against staff and whether these were included in the total of 565 near miss incidents, to note that the Interim Director of Corporate Governance would liaise with colleagues and provide a response to the Committee;
(ii) in relation to a question from the Convener regarding the MOT pass rate for O License vehicles and what was being done to increase the pass rate figures, to note that the Interim Director of Corporate Governance would liaise with colleagues and provide a response to the Committee; and
(iii) to otherwise note the content of the minute.

## INTERNAL AUDIT PROGRESS AND PERFORMANCE

**6.** The Committee had before it a report by the Internal Auditor which provided an update on progress against the 2015/16 and 2016/17 Internal Audit Plans.

**The report recommended:**
That the Committee -
(a) review, discuss and comment on the issues raised within the report and the attached appendices;
(b) agree to the sharing of Aberdeen City Council Adult Social Work Internal Audit reports with the Aberdeen City Integration Joint Board Audit and Performance Systems Committee; and
(v) agree to receive Aberdeen City Integration Joint Board Internal Audit reports for information.

**The Committee resolved:-**

(i) in response to a question from Councillor Greig relating to the Self-Directed Support audit, to note that the audit report would be presented to the next meeting of this Committee;
(ii) in relation to a question from Councillor Cameron regarding the number of red actions within individual internal audit reports, to note that the Interim Director of Corporate Governance would discuss the issue with the responsible Directors to ensure responses were provided to internal audit;
(iii) in response to questions from Councillors Samarai and Young in relation to the Bank Reconciliations audit, to note that the meeting with Finance had taken place and that it was the methodology around bank reconciliations that required more detail not the financial position; and
(iv) to otherwise approve the recommendations contained in the report.

## EXTERNAL AUDIT PROGRESS AND PERFORMANCE

**7.** The Committee had before it a report by Audit Scotland, External Auditor, which provided an update on the progress with the external audit of the 2015/16 financial year.

**The Committee resolved:-**
to note the content of the report.

## INFORMATION GOVERNANCE MANAGEMENT AND REPORTING ARRANGEMENTS - CG/16/109

**8.** The Committee had before it a report by the Interim Director of Corporate Governance which sought approval of the proposed Council's information governance management and reporting arrangements.

**The report recommended:**
That the Committee –
(a) note the information contained in the report; and
(b) approve the proposed changes for oversight and reporting of information governance.

**The Committee resolved:-**
(i) in response to a question from Councillor Dickson relating to the integration of the various systems and the security of the data, to note that the Information Governance Group would work through the methodology for the different elements to ensure all of the systems had the appropriate security as required as part of data management and that as part of the review, a top of the range cyber security system would be installed to help eliminate any threats to the Councils systems;

(ii) to note the positive feedback received from Councillor Jackie Dunbar relating to the improved reporting method; and
(iii) to otherwise approve the recommendations contained in the report.

**DECLARATIONS OF INTEREST**

**Councillors Dickson and Lawrence declared an interest in the subject matter of the following article by virtue of their position as a Council appointed Director to the Board of Sport Aberdeen.**

**Councillor Jean Morrison, MBE, declared an interest by virtue of her position as an Aberdeen City Council representative at Aberdeen Heat and Power.**

**Councillor Crockett declared an interest by virtue of his position as a Council appointed Director to the Board of Aberdeen Exhibition and Conference Centre.**

**Councillor Donnelly declared an interest by virtue of his positions as a Council appointed Director to the Board of Sport Aberdeen, the Board of Aberdeen Exhibition and Conference Centre and Aberdeen Performing Arts.**

**Councillor Taylor declared an interest by virtue of her position as a Council appointed Director to Garthdee Alpine Sports.**

**The Councillors chose to remain in the meeting as the bodies were companies established wholly or mainly for the purpose of providing services to the local authority, and which had entered into a contractual arrangement with the local authority for the supply of goods and/or services to the local authority, as set out in paragraph 5.18(2)(d)(i) and (ii) of the Councillors' Code of Conduct.**

**Councillor Cameron declared an interest in the subject matter of the following article by virtue of his position as a Board member of Aberdeen Sports Village and chose to leave the meeting during discussions relating to Aberdeen Sports Village.**

## ALEO GOVERNANCE HUBS - CG/16/125

**9.** The Committee had before it a report by the Interim Director of Corporate Governance which provided a summary of the significant matters raised at the August 2016 meetings of the Arm's Length External Organisations (ALEO) Governance Hub.

**The report recommended:**

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That the Committee –
(a) consider the issues raised in both the report and the appended minutes for each ALEO and identify any areas of concern;
(b) note the content of the report and the appended minutes;
(c) note that specific covering reports would be prepared by the responsible Heads of Service and submitted to the appropriate service committees to consider ALEO service delivery and performance against agreed performance indicators and contract.

Members sought additional information relating to the finances of Bon Accord Care, Aberdeen Exhibition and Conference Centre, and Aberdeen Performing Arts, wherein Officers advised that the annual accounts for those ALEO's would be presented to the next meeting of the ALEO Governance Hub.

In relation to Bon Accord Care Ltd, Councillor Cameron enquired as to whether the Health, Safety and Wellbeing Manager had received the additional information relating to the health and safety audit, wherein Mr Robertson advised that the scores had been issued however the detail behind the scores had not been presented at that meeting.

In relation to Aberdeen Exhibition and Conference Centre, Councillor Cameron enquired in relation to the Tender for the new venue's operator, and why the detailed tender had been issued to the Council without the AECC Board making comment, wherein Mr MacBeath advised that a sub group of the Board had been set up and had delegated authority to manage the tender process to avoid conflicts of interests with Aberdeen City Councillors who were members of the Board.

In relation to Aberdeen Exhibition and Conference Centre, Councillor Greig enquired in relation to an item in the risk register relating to low staff morale and how this was affecting staff productivity, wherein Mr MacBeath advised that there was a small group of staff with an additional pool of staff employed for assisting at events and that there was currently no measurements in place relating to productivity.

In relation to Aberdeen Performing Arts, Councillor Cameron enquired as to whether there was anything in particular to be concerned about regarding financial implications reported to the Board, wherein Mr MacBeath advised that the information was reported to the Board however the report template did not have a specific section to outline any financial implications to make these clear within the report and that they had been asked to consider using asset template to include this section.

In relation to Garthdee Alpine Sports, Councillor Cameron enquired (1) as to whether the Business Continuity Plan had been compiled, wherein Mr MacBeath advised that further work was required on the plan to provide assurance to officers; and (2) as to the current position with the formal expenses policies and procedures, wherein Mr MacBeath advised that Finance colleagues and requested amendments to be made to

the procedures and that these would be reported to the next ALEO Governance Hub meeting.

In relation to Aberdeen Heat and Power Ltd, Councillor Greig sought assurance that the Service Level Agreement would be reviewed as soon as possible, wherein the Head of Legal and Democratic Services advised that the Commercial and Procurement Service timeline for reviewing the Service Level Agreement was May 2017.

Councillor Graham enquired as to the level of support that Aberdeen City Council provided to ALEO's, wherein Mr MacBeath advised that the larger ALEO's had their own staff to provide the necessary support with the smaller ones receiving more input from Aberdeen City Council staff.

**The Committee resolved:-**
(i) in response to questions from members relating to the finances of some of the ALEO's to note that the annual Accounts for those ALEO's would be presented to the next round of ALEO Governance Hub Meetings to allow further scrutiny;
(ii) to note the questions and responses provided for the individual ALEO's; and
(iii) to otherwise approve the recommendations as contained in the report.

## THIRD DON CROSSING - CG/16/108

**10.** With reference to article 19 of the minute of meeting of the Finance, Policy and Resources Committee of 19 April 2016, the Committee had before it a report by the Interim Director of Corporate Governance which (1) provided an external view of the contractual arrangements that were put in place to construct the Third Don Crossing, known as the Diamond Bridge; and (2) explained that the remit of the review was to establish why the overall project was delivered late and over budget and to identify key lessons learned that the council should consider in relation to similar contracts in the future.

**The report recommended:**
That the Committee –
(a) refer the report to the Strategic Asset Capital Board to develop an Action Plan based on the conclusions contained in the report; and
(b) request that officers submit a report on the Action Plan to this Committee in six months time.

**The Committee resolved:-**
(i) in response to various concerns raised by members relating to the contract and decision making process, to request the Internal Auditor to undertake an audit to ascertain where the responsibilities and accountability sat in relation to the 3rd Don Crossing and whether the appropriate level of scrutiny and records were in place throughout the project; and

(ii) to otherwise approve the recommendations contained in the report.

## COMMUNITIES, HOUSING AND INFRASTRUCTURE RISK REGISTER - CHI/16/088

**11.** The Committee had before it a report by the Director of Communities, Housing and Infrastructure which presented the Risk Register for the directorate.

**The report recommended:**
That the Committee –
(a) note the content of the risk register, the current status of each risk's control compliance and the mitigating actions through which enhanced control will be delivered; and
(b) advise on any further action as appropriate.

**The Committee resolved:-**
(i) to note that there were some errors in the report that would be rectified for future reports;
(ii) to request that an update on the risk register be provided to this Committee within six months; and
(iii) to otherwise approve the recommendation contained in the report.

## EDUCATION AND CHILDREN'S SERVICES RISK REGISTER - ECS/16/059

**12.** The Committee had before it a report by the Director of Education and Children's Services which presented the Risk Register for the directorate.

**The report recommended:**
That the Committee –
(a) note the content of the Education and Children's Services Risk Register;
(b) note the mitigating actions that are present to manage and reduce the service risks;
(c) note that the content of the Educations and Children's Services Risk Register is reviewed by the Directorate Leadership team on a monthly basis and amended where appropriate; and
(d) to otherwise note the content of the report.

**The Committee resolved:-**
to approve the recommendations contained in the report.

## DATA PROTECTION

**13.** The Committee had before it a report by the Internal Auditor, which presented an audit in relation to data protection which involved reviewing the arrangements in place across the Council to consider whether Data Protection legislation was being complied with.

**The Committee resolved:-**
to note the content of the report and endorse the recommendations for improvement.

## INFOSMART SYSTEM

**14.** The Committee had before it a report by the Internal Auditor which presented an audit in relation the Infosmart System which involved considering whether appropriate control was being exercised in relation to the Infosmart System, including contingency planning and disaster recovery, the data input and the interfaces to and from other systems were accurate and properly controlled.

**The Committee resolved:-**
to note the content of the report and endorse the recommendations for improvement.

## SCOTTISH WELFARE FUND

**15.** The Committee had before it a report by the Internal Auditor which presented an audit in relation to the Scottish Welfare Fund and considered whether administration arrangements were robust and being complied with and involved reviewing written procedures, interviewing staff and analysing a sample of grant awards made over the last twelve months.

**The Committee resolved:-**
to note the content of the report and endorse the recommendations for improvement.

## BUILDING SERVICES RE-CHARGES

**16.** The Committee had before it a report by the Internal Auditor which presented an audit in relation to charges within Building Services. The report advised that Internal Audit had been approached by the management requesting assistance to determine whether or not it was possible for incorrect charges to be levied through the use of the current systems and procedures. The review undertaken looked at the job and time recording, stock control and any discrepancies between actual billing and expected billing.

**The Committee resolved:-**
to note the content of the report and endorse the recommendations for improvement.

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## BUILDING SERVICE PROCUREMENT

**17.** The Committee had before it a report by the Internal Auditor which presented an audit in relation to the procurement of materials within Building Services and considered whether adequate controls were in place regarding the procurement of materials and involved a review of the procedures and analysis of procurement spend by Building Services during the financial year 2015/16.

**The Committee resolved:-**
to note the content of the report and endorse the recommendations for improvement.

## CLEANING PAYROLL

**18.** The Committee had before it a report by the Internal Auditor which presented an audit in relation to the payroll systems in place within the Cleaning Service and considered whether adequate controls and procedures were operating in relation to new starts or leavers and levels of additional/overtime hours within the cleaning service and included the co-ordination of additional hours to minimise overtime costs.

**The Committee resolved:-**
(i) in response to a question from Councillor Jackie Dunbar relating to the number of errors identified with NSWW allowances and whether Internal Audit were assured by the service response provided, to note that the Service were making progress and that Internal Audit were satisfied that the issues would be fully rectified;
(ii) in response to a question from Councillor Cameron relating to the overtime payment rates and whether Internal Audit were satisfied with the responses provided, to note that once all of the processes had been implemented Internal Audit would be satisfied that the overtime rates applied would be at the correct level;
(iii) in relation to all of the internal audit reports, to note that the majority of recommendations made had been agreed by management which was a positive step forward for improvement; and
(iv) to otherwise note the content of the report and endorse the recommendations for improvement.

## ROADS PAYROLL

**19.** The Committee had before it a report by the Internal Auditor which presented an audit in relation to the payroll systems in place within the Roads Service which

considered whether adequate controls and procedures were operating in relation to new starts and leavers and levels of additional overtime hours within the Roads Service.

**The Committee resolved:-**
to note the content of the report and endorse the recommendations for improvement.

## FAMILY AND COMMUNITY SUPPORT - FAMILY CENTRES

**20.** The Committee had before it a report by the Internal Auditor which presented an audit in relation to Family Centres which considered whether income and expenditure, payroll records, inventories and computer security was being adequately controlled and completed within Family Centres and included visits to three centres.

**The Committee resolved:-**
to note the content of the report and endorse the recommendations for improvement.

## PUBLIC RECORDS (SCOTLAND) ACT

**21.** The Committee had before it a report by the Internal Auditor which presented an audit in relation to whether the arrangements in place to ensure compliance with the Public Records (Scotland) Act were adequate. The report advised that the Council were in the process of changing their information governance and reporting arrangements through the Information Governance Group who would report to the Corporate Management Team and to this Committee which would provide assurance on areas covered in the Act.

**The Committee resolved:-**
to note the content of the report and endorse the recommendations for improvement

## MANAGING CAPITAL PROJECTS

**22.** The Committee had before it a report by Audit Scotland, External Auditor which provided a summary of findings from their review of the Council's progress against the recommendations contained in Audit Scotland's national performance audit report 'Major Capital Investment in Councils' which was initially published in March 2013. The report advised that the work was based on the review of the project management arrangements in place for a sample of four projects which were all linked to the Strategic Infrastructure Plan (SIP), the operation and the management of the SIP were also examined.

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**The Committee resolved:-**
(i) in relation to a question from the Convener relating to the appendix contained in the report which stated that the target date was pending the governance review and when the Committee would be provided with an update, to note that a report would be submitted to the Committee within six months as the work would be included in the 3rd Don Crossing action plan; and
(ii) to otherwise note the content of the report and endorse the recommendations for improvements.

## AUDIT RECOMMENDATIONS OUTSTANDING PRE 2015/16 (PWC)

**23.** The Committee had before it a report by the Internal Auditor which provided an update on the progress Services had made with implementing recommendations agreed in the Internal Audit reports issued by the previous internal auditors, PWC.

**The report recommended:**
That the Committee –
(a) review, discuss and comment on the issues raised within the report and the attached appendix; and
(b) consider whether the remaining action relating to ALEOs Tier 2 Review be amended to 'The Council will ensure that Councillors appointed to ALEO Boards following the Local Government Elections in May 2017 attend training appropriate to the role', and that this be addressed by June 2017, and that progress be monitored by Internal Audit through its routine report on recommendations made since 1 April 2015.

**The Committee resolved:-**
to approve the recommendations contained in the report.

## INTERNAL AUDIT OUTSTANDING RECOMMENDATIONS AGAINST THE 2015/16 AUDIT PLAN

**24.** The Committee had before it a report by the Internal Auditor which provided an update on progress with implementing agreed recommendations contained in Internal Audit reports since April 2015.

**The report recommended:**
that the Committee review, discuss and comment on the issues raised within the report and the attached appendices.

**The Committee resolved:-**
to note the content of the report.

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## EXTERNAL AUDIT OUTSTANDING RECOMMENDATIONS

**25.** The Committee had before it a report by Audit Scotland, External Auditor which presented the list of issues and risks that had been agreed by Management as part of the 2014/15 audit.

**The Committee resolved:-**
to note that the majority of the outstanding actions had been completed with the remaining action having a revised date of March 2017.

## ANNUAL REPORT TO MEMBERS AND THE CONTROLLER OF AUDIT ON THE 2015/16 AUDIT

**26.** The Committee had before it a report by Audit Scotland, External Auditor which (1) presented a summary of their findings arising from the 2015/16 audit of Aberdeen City Council and the associated Charitable Trusts; and (2) advised that the responsibility as external auditor for the Council was to undertake an audit in accordance with the Internal Standards on Auditing, the principles contained in the Code of Audit Practice issued by Audit Scotland in May 2011 (and revised in 2016) and the ethical standards issued by the Auditing practices Board.

**The Committee resolved:-**
(i) to note that an unqualified independent auditor report had been issued for the annual accounts and the registered charities for the financial period 1 April 2015 to 31 March 2016;
(ii) to note that this was the last meeting for Audit Scotland as the Council's external auditors and to note the thanks given to the Chief Executive and members of the Finance team for the supportive working relationship over their term as external auditors;
(iii) to note the thanks offered to Audit Scotland for the work undertaken over their term as external auditors; and
(iv) to otherwise note the content of the report.

## AUDITED ACCOUNTS 2015/16

**27.** The Committee had before it a report by the Interim Director of Corporate Governance which presented (1) the Council's audited Annual Accounts for the financial year 2015/16; and (2) the audited Annual Accounts for those registered charities where the Council is the sole trustee and is subject to statutory requirements for separate accounts and audit opinions for the financial year 2015/16.

**AUDIT, RISK AND SCRUTINY COMMITTEE**
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**The report recommended:**
That the Committee –
(a) approve the Council's audited Annual Accounts for signature by the Head of Finance, Chief Executive and the Council Leader; and
(b) approve the audited Annual Accounts for those registered charities where the Council is the sole trustee, for signature by a trustee.

**The Committee resolved:-**
(i) to note the thanks from the Head of Finance to all staff involved with the preparation of the annual accounts;
(ii) to otherwise approve the recommendations contained in the report.

**EXEMPT INFORMATION**

**In accordance with the decision taken at article 1 of this minute, the following item of business was considered with the press and public excluded.**

## CORPORATE INVESTIGATION TEAM UPDATE

**28.** The Committee had before it a report by the Interim Director of Corporate Governance which provided (1) an update on activity by the Corporate Investigation Team (CIT) and (2) an update in relation to the National Fraud Initiative (NFI).

**The report recommended:**
That the Committee -
(a) note the progress report in Appendix A;
(b) continue to endorse and sponsor progress towards meeting the objectives contained within the National Fraud Authority checklist as contained in Appendix B;
(c) continue to endorse and sponsor progress towards meeting the objectives contained within the National Fraud Initiative self-appraisal checklist as contained in Appendix D; and
(d) note the progress against the CIT business plan as contained in Appendix E

**The Committee resolved:-**
to approve the recommendations contained in the report.

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# AUDIT, RISK and SCRUTINY COMMITTEE

# WORKPLAN

| No. | Minute Reference | Item | Committee decision/ Update | Lead Officer(s) |
|---|---|---|---|---|
| **24 NOVEMBER 2016** | | | | |
| **Performance and Improvement** | | | | |
| 1. | 09/03/16 Article 9 | Internal Audit Progress and Performance | Standing Item | Internal Auditor |
| 2. | | Scottish Public Services Ombudsman and Inspector of Crematoria Complaint Decisions | | Customer Experience Officer |
| **Risk Management System** | | | | |
| 3. | | Review of Risk Management System | | Performance and Risk Manager |
| **Control Environment and Assurance – Internal** | | | | |
| 4. | 26/02/15 article 9 | Finance Budget Monitoring | Internal Audit Plan agreed | Internal Auditor |
| 5. | 26/02/15 article 9 | Finance Bank Reconciliations | Internal Audit Plan agreed | Internal Auditor |
| 6. | 09/03/16 article 9 | Following the Public Pound | Internal Audit Plan agreed | Internal Auditor |
| 7. | 09/03/16 article 9 | Business Rates | Internal Audit Plan agreed | Internal Auditor |
| 8. | 09/03/16 Article 9 | Cash Receipting System | Internal Audit Plan agreed | Internal Auditor |
| 9. | 09/03/16 article 9 | Purchasing and Creditors – Social Work | Internal Audit Plan agreed | Internal Auditor |
| 10. | 26/02/15 | Adult Social Work/Integrated Joint | Internal Audit Plan agreed | Internal Auditor |

| No. | Minute Reference | Item | Committee decision/ Update | Lead Officer(s) |
|---|---|---|---|---|
| | article 9 | Board<br>Self Directed Support | | |
| 11. | 09/03/16<br>article 9 | Carefirst | Internal Audit Plan agreed | Internal Auditor |
| **Control Environment and Assurance – External** | | | | |
| 12. | | | | |
| **Control Environment and Assurance – Audit Follow Up** | | | | |
| 13. | 09/03/16<br>Article 9 | Internal Audit Recommendations Outstanding | Standing Item | Internal Auditor |
| **Financial Reporting** | | | | |
| 14. | | | | |
| **Value for Money** | | | | |
| 15. | | Audit Scotland Value for Money National Reviews | Standing Item | Policy Performance & Parliamentary Liaison Manager |
| **Exempt Report** | | | | |
| 16. | | Matters Under Investigation | Standing Item | |
| **FEBRUARY 2017** | | | | |
| **Performance and Improvement** | | | | |
| 1. | 09/03/16<br>Article 9 | Internal Audit Progress and Performance | Standing Item | Internal Auditor |
| 2. | | Internal Audit Plan 2017/18 | | Internal Auditor |
| 3. | | External Audit Plan 2016/17 | | External Auditor |
| 4. | | ALEO Governance Hubs | Standing Item | Senior Democratic Services Manager |
| **Risk Management System** | | | | |
| 5. | | System of Risk Management | To report elements of the system of risk to each Committee Meeting | Performance and Risk Manager |
| **Control Environment and Assurance – Internal** | | | | |

| No. | Minute Reference | Item | Committee decision/ Update | Lead Officer(s) |
|---|---|---|---|---|
| 6. | 09/03/16 article 9 | Council Owned Land and Property | Internal Audit Plan agreed | Internal Auditor |
| 7. | 09/03/16 article 9 | ALEO's | Internal Audit Plan agreed | Internal Auditor |
| 8. | 09/03/16 article 9 | Compliance with Procurement related Legislation and Financial Regulations | Internal Audit Plan agreed | Internal Auditor |
| 9. | 09/03/16 article 9 | Timesheets/Allowances | Internal Audit Plan agreed | Internal Auditor |
| 10. | 09/03/16 article 9 | Treasury Management | Internal Audit Plan agreed | Internal Auditor |
| 11. | 09/03/16 article 9 | Budget Setting Process | Internal Audit Plan agreed | Internal Auditor |
| 12. | 09/03/16 article 9 | Agency Staff | Internal Audit Plan agreed | Internal Auditor |
| 13. | 09/03/16 article 9 | Primary School Visits | Internal Audit Plan agreed | Internal Auditor |
| 14. | 09/03/06 article 9 | Vehicles and Driver Records | Internal Audit Plan agreed | Internal Auditor |
| 15. | 09/03/16 article 9 | Integration of Health and Social Care | Internal Audit Plan agreed | Internal Auditor |
| **Control Environment and Assurance – External** | | | | |
| 16. | | | | |
| **Control Environment and Assurance – Audit Follow Up** | | | | |
| 17. | 09/03/16 Article 9 | Internal Audit Recommendations Outstanding | Standing Item | Internal Auditor |
| **Financial Reporting** | | | | |
| 18. | | Annual Accounts 2016/17 – Action Plan and Key Dates | | Head of Finance |
| **Value for Money** | | | | |
| 19. | | | | |

| No. | Minute Reference | Item | Committee decision/ Update | Lead Officer(s) |
|---|---|---|---|---|
| **Exempt Report** | | | | |
| 20. | | Matters Under Investigation | Standing Item | |
| **JUNE 2017** | | | | |
| **Performance and Improvement** | | | | |
| 1. | 09/03/16 Article 9 | Internal Audit Progress and Performance | Standing Item | Internal Auditor |
| 2. | 09/03/16 Article 11 | External Audit Progress and Performance | Standing Item | External Audit |
| 3. | | ALEO Governance Hubs | Standing Item | Senior Democratic Services Manager |
| **Risk Management System** | | | | |
| 4. | | System of Risk Management | To report elements of the system of risk to each Committee Meeting | Performance and Risk Manager |
| 5. | 28/04/16 Article 9 | Corporate Investigation Team - Fraud Annual Report 2016/17 and Business Plan 2017/18 | | Counter Fraud Officer |
| **Control Environment and Assurance – Internal** | | | | |
| 6. | 09/03/16 article 9 | Benefits | Internal Audit Plan agreed | Internal Auditor |
| 7. | 09/03/16 article 9 | Disclosure Checks | Internal Audit Plan agreed | Internal Auditor |
| 8. | 09/03/16 article 9 | Commissioning of Children's Social Work Services | Internal Audit Plan agreed | Internal Auditor |
| 9. | 09/03/16 article 9 | Fostering and Adoption Allowances | Internal Audit Plan agreed | Internal Auditor |
| 10. | 09/03/16 article 9 | Transportation - Tendering Procedures | Internal Audit Plan agreed | Internal Auditor |
| **Control Environment and Assurance – External** | | | | |
| 11. | | | | |
| **Control Environment and Assurance –** | | | | |

| No. | Minute Reference | Item | Committee decision/ Update | Lead Officer(s) |
|---|---|---|---|---|
| **Audit Follow Up** | | | | |
| 12. | 09/03/16 Article 9 | Internal Audit Recommendations Outstanding | Standing Item | Internal Auditor |
| **Financial Reporting** | | | | |
| 13. | | Unaudited Annual Accounts 2016/17 | | Head of Finance |
| **Value for Money** | | | | |
| 14. | | Audit Scotland Value for Money National Reviews | Standing Item | Policy Performance & Parliamentary Liaison Manager |
| **Exempt Report** | | | | |
| 16. | | Matters Under Investigation | Standing Item | |
| **PLEASE NOTE THAT THE WORKPLAN WILL BE FULLY POPULATED FOR SEPTEMBER ONWARDS FOLLOWING THE APPROVAL OF THE INTERNAL AUDIT PLAN FOR 2017/18** | | | | |
| **26 SEPTEMBER 2017** | | | | |
| **Performance and Improvement** | | | | |
| 1. | | Internal Audit Progress and Performance | Standing Item | Internal Auditor |
| 2. | | External Audit Progress and Performance | Standing Item | External Audit |
| 3. | | ALEO Governance Hubs | Standing Item | Senior Democratic Services Manager |
| 4. | | Information Governance Management | Annual Report | Information Manager |
| **Risk Management System** | | | | |
| 5. | | System of Risk Management | To report elements of the system of risk to each Committee Meeting | Performance and Risk Manager |
| **Control Environment and Assurance – Internal** | | | | |
| 6. | | | | |
| **Control Environment and Assurance – External** | | | | |

| No. | Minute Reference | Item | Committee decision/ Update | Lead Officer(s) |
|---|---|---|---|---|
| 7. | | | | |
| **Control Environment and Assurance – Audit Follow Up** | | | | |
| 8. | | Internal Audit Recommendations Outstanding | Standing Item | Internal Auditor |
| **Financial Reporting** | | | | |
| 9. | | Audited Annual Accounts 2016/17 | | Head of Finance |
| 10. | | Annual Report to Members and the Controller of Audit on the 2016/17 Audit | | External Audit |
| **Value for Money** | | | | |
| 11. | | | | |
| **Exempt Report** | | | | |
| 12. | | Matters Under Investigation | Standing Item | |
| **23 NOVEMBER 2017** | | | | |
| **Performance and Improvement** | | | | |
| 1. | | Internal Audit Progress and Performance | Standing Item | Internal Auditor |
| 2. | | External Audit Progress and Performance | Standing Item | External Audit |
| 3. | | ALEO Governance Hubs | Standing Item | Senior Democratic Services Manager |
| 4. | | Information Governance Management | Annual Report | Information Manager |
| **Risk Management System** | | | | |
| 5. | | System of Risk Management | To report elements of the system of risk to each Committee Meeting | Performance and Risk Manager |
| **Control Environment and Assurance – Internal** | | | | |
| 6. | | | | |
| **Control Environment and Assurance – External** | | | | |

| No. | Minute Reference | Item | Committee decision/ Update | Lead Officer(s) |
|---|---|---|---|---|
| 7. | | | | |
| **Control Environment and Assurance – Audit Follow Up** | | | | |
| 8. | | Internal Audit Recommendations Outstanding | Standing Item | Internal Auditor |
| **Financial Reporting** | | | | |
| 9. | | | | |
| **Value for Money** | | | | |
| 10. | | Audit Scotland Value for Money National Reviews | Standing Item | Policy Performance & Parliamentary Liaison Manager |
| **Exempt Report** | | | | |
| 11. | | Matters Under Investigation | Standing Item | |

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**AUDIT, RISK and SCRUTINY**

**DECISION TRACKING SHEET**

**24 November 2016**

Please note that this statement contains a note of the decisions allocated to other Committees or to Officers to enable this Committee to track that audit recommendations and recommendations from the Committee are being actioned.

| No. | Minute Reference | Committee Decision | Lead Officer(s) | Responsible Service | Decision or Update |
|---|---|---|---|---|---|
| 1. | AR&S<br>28 April 16<br>Article 11 | **Best Value Audit**<br>(i) to receive regular updates on the implementation of actions to address the findings of the 2015 Audit of Best Value and Community Planning | M Murchie | Office of Chief Executive | |
| 2. | AR&S<br>28 April 16<br>Article 17 | **Social Work Tendering – Internal Audit Report**<br>(iii) in relation to a question from Councillor Greig regarding receiving updates on the progress of implementing the recommendations, to note that a report will be coming back to the September Committee and the Commissioning Framework for Children's Services will be reported to the June meeting of Education and Children's Services Committee | D Hughes<br><br>D Bliss | Internal Audit<br><br>Children's Social Work Internal Audit | Report due by November 2016.<br><br>The Commissioning Framework for Children's Services will be reported to the November meeting of Education and Children's Services Committee |
| 3. | AR&S<br>27 June 16<br>Article 15 | **Compliance with Procurement Related Legislation and Financial Regulations – Internal Audit Report**<br>(v) to request the Head of Land and Property Assets to submit a report to this Committee presenting the | J Quinn | Land and Property Assets | **A report is on the agenda** |

| No. | Minute Reference | Committee Decision | Lead Officer(s) | Responsible Service | Decision or Update |
|---|---|---|---|---|---|
| | | circumstances relating to the solar panel incident specifically around the financial implications and the total loss to the Council. | | | |
| 4. | AR&S<br>27 Sept 16<br>Article 10 | **Third Don Crossing**<br>in response to various concerns raised by members relating to the contract and decision making process, to request the Internal Auditor to undertake an audit to ascertain where the responsibilities and accountability sat in relation to the 3rd Don Crossing and whether the appropriate level of scrutiny and records were in place throughout the project. | D Hughes | Internal Audit | |
| 5. | AR&S<br>27 Sept 16<br>Article 11 | **Communities, Housing and Infrastructure Risk Register**<br>to request that an update on the risk register be provided to this Committee within six months | M Hearns | Communities, Housing and Infrastructure | **Report due in June 2017 (no meeting in April)** |
| 6. | AR&S<br>27 Sept 16<br>Article 22 | **Managing Capital Projects**:<br>(i) in relation to a question from the Convener relating to the appendix contained in the report which stated that the target date was pending the governance review and when the Committee would be provided with an update, to note that a report would be submitted to the Committee within six months as the work would be included in the 3rd Don Crossing action plan**.** | R Ellis<br>S Whyte | Corporate Governance | **Report due in June 2017 (no meeting in April)** |

# CORPORATE HEALTH AND SAFETY COMMITTEE

ABERDEEN, Friday, 26 August 2016. Minute of Meeting of the CORPORATE HEALTH AND SAFETY COMMITTEE. Present:- Councillor Mike Middleton Chairperson; and Councillor Gordon Graham, Vice Chairperson. City Council Representatives:- Councillor Copland.

Trade Union Representatives:- Joe Craig (UNITE) (from item 5a), Mishelle Gray (UNITE), George Ferguson (UNISON), Deirdre Macdonald (UNISON) (as substitute for Alison Robertson) Paul Nesbitt (UCATT) (from item 5a), Jason Currie (SSTA) (as substitute for Sid Sandison), Carole Thorpe (EIS) and David Willis (GMB).

Officers in attendance:- Mary Agnew (Health, Safety and Wellbeing Manager), Colin Leaver (Team Leader), Andrew Moat (Health and Safety Adviser), Bruce Findlater (Admin Officer), Michael Hearns (Directorate Support Manager), Vivienne Amakiri (Health and Safety Co-ordinator), Lesley Kirk (Directorate Support Manager), Kate Mackay (Business Manager), Fraser Bell (Head of Legal and Democratic Services), Euan Couperwhite (Head of Policy, Performance and Resources), Tom Cowan (Head of Joint Operations) (Social Care and Wellbeing) (for item 4a), Jeff Capstick (HR Manager) (for item 4b), Steven Inglis (Solicitor) (for item 4b), Andrew Jones (Service Manager (Assets / Finance)) (Education, Culture and Sport), Martin Murchie (Head of Performance Management and Quality Assurance), Paul Reid (Fleet Compliance Manager), William Whyte (Fleet Services Manager) and Dave Young (Account Manager) (for item 4b).

## APOLOGIES

**1.** Apologies were intimated on behalf of Councillors Donnelly and Finlayson; Alison Robertson, UNISON, Sid Sandison, SSTA; and Angela Scott, Richard Ellis, Pete Leonard, Ewan Sutherland and Mark Reilly.

## MINUTE OF PREVIOUS MEETING OF 20 MAY 2016

**2.** The Committee had before it the minute of its previous meeting of 20 May 2016.

**The Committee resolved:-**

(i) to amend the minute at article 3, second paragraph, last word on line two, to PCV; and

(ii) to otherwise approve the minute as a correct record.

## MATTERS ARISING

**3.** With reference to article 9, resolution (ii), The Health, Safety and Wellbeing Manager advised that the information requested had been provided to Councillor Finlayson.

With reference to articles 9, 10 and 11, resolutions (i) to note that the format of all three reports had been amended for this meeting.

**The Committee resolved:-**
to note the information provided.

## COMMITTEE BUSINESS STATEMENT

**4.** The Committee had before it a statement of outstanding business as prepared by the clerk.

**The Committee resolved:-**
to remove items 1 (Improvements to School Security – Public Footpaths); 2 (Corporate Fleet Management Performance and Compliance) resolutions (iii) and (iv); and 3 (Annual Corporate Health and Safety Report (Data Sharing)).

## ADULT SOCIAL CARE ANNUAL HEALTH AND SAFETY REPORT

**5.** The Committee had before it a report by the Chief Officer for the Health and Social Care Partnership which presented the annual health and safety report for the Adult Social Care Service for the period 1 July 2015 to 30 June 2016.

The report contained the following statistics:

- there were 32 accidents reported of which one third party accident was reportable to the enforcing authority
- the main cause of injury was physical assault which has shown an increase on previous years reporting
- employees within establishments were trained on how to deal with physical assaults (Strategies for Crisis Intervention and Prevention Training (PROACT SCIPr UK)) with regular meetings taking place at the establishment to discuss further measures to reduce the potential for physical assault from clients
- there were 67 near miss incidents reported with the highest being against violence (41)
- the scores for the individual elements of the health and safety matrix for the Service were: 100% for Workplace Inspections Returned, First Aid and Accident/Incidents; 98% for Emergency Precautions, Machinery, Plant and Equipment; 97% for Housekeeping and Cleaning, Slips, Trips and Hazards and Welfare; and 89% for Environment
- the main issues raised during workplace inspections related to inappropriate lighting in 2 0r 3 workplaces, variance in workplace temperature and replacement carpeting to reduce the potential for trip hazards
- 678 employees attended health and safety training across a variety of topics
- long term absence had a current figure of 11.5 days lost which was a reduction from the previous year (13.5)
- the number of short term absences (under 28 days) had an average figure of 57.83 which was a reduction from the previous year (60.27)
- during the winter months the figures are higher due to respiratory problems which had been identified as a trend since 2013
- the main reason for absences were respiratory (201) and gastrointestinal (121)

- the highest reason for the number of days lost due to sickness absence related to psychological (1689)

**The report recommended:**
that the Committee note the contents of the report.

Deirdre Macdonald sought clarification as to whether there had been any progress made with the lighting within the office at Kaim Court, wherein the Business Manager advised that the lighting standards for offices and general rooms were different and that employees had been offered desk lamps to improve visibility whilst working in the room, now used as an office.

**The Committee resolved:-**
(i) in relation to a question from Deirdre Macdonald, Unison, to note the update provided in relation to the lux levels within Kaim Court in the area staff used as an office; and
(ii) to otherwise approve the recommendation contained in the report

## EARLY WARNING SYSTEM UPDATE

**6.** With reference to article 12, resolution (ii) of the minute of its previous meeting, the Committee had before it a report by the Director of Communities, Housing and Infrastructure which presented an update on the progress made with the development of an Early Warning System intended to provide staff with a means of checking whether the client/customer is already known to the Council as being potentially dangerous or violent prior to any meetings with them.

The report advised that currently individual services held details of potentially violent clients or customers within their own IT systems however there was no mechanism in place to allow for that information to be shared across the organisation.

The report explained that discussions had taken place with various services with the aim to develop a system that would hold the information taking into account the provisions set out in the Data Protection Act 1998. The Council have a duty of care to all employees to ensure their health, safety and wellbeing whist at work therefore sharing the information relating to potential risks from service users would fall under this duty, however the requirements of the Act would need to be carefully considered to ensure the Council were still compliant.

The project is currently at the stage of ensuring that the data held within the various systems is accurate before they are transferred into the new database.

The Business Manager advised that the timescales for delivering the project were a bit clearer with the validating of the information held nearing completion, with the transfer of information and then a go live date in the very near future.

**The report recommended:**
that the Committee note the progress in the development of such a system.

**The Committee resolved:-**
(i) to note the update provided in relation to the timescales related with the project; and

(ii) to note that an update would be provided within the business statement for the next meeting; and
(iii) to otherwise approve the recommendation contained in the report.

**CORPORATE FLEET MANAGEMENT PERFORMANCE AND COMPLIANCE - UPDATE**

**7.** With reference to article 6 of the minute of its meeting of 20 May 2016, the Committee had before it a report by the Director of Communities, Housing and Infrastructure which provided the progress to date through a suite of performance indicators and presented information in relation to the resolutions from its previous meeting.

The report advised that (1) whilst waiting for the new vans with the onboard weigh systems, Building Services had carried out weight checks on 94 vans, with 2 of those having slight overloading issues; (2) Environmental Services currently used a loading matrix which had been shared with Building Services to enable them to carry out weight checks; (3) 75 operators had received Master Reversing training since March 2016, which would continue until all operators had received the training; (4) the Waste and Recycling Service were carrying out comprehensive route risk assessments across the city to identify hazards including reversing requirements; and (5) all new Refuse Collection Vehicles were fitted with camera's that had all round vision with the latest having received a reversing radar detection system fitted.

The report provided details on the training and development that had been undertaken; the progress made with the vehicle workshop refurbishment and the programme of fleet replacement.

The report presented the KPI's for Fleet which included:

- MOT % First Time Pass Rate (O' Licence Vehicles) – year to date average for 2016/17 was 96.43% which was above the national average (85.34%)
- Roadside Inspections/resulting prohibitions – year to date for 2016/17, one inspection and one prohibition
- Licence Issues as % of Licence Checks – 93% of LGV drivers were checked with 6% having some issues
- Vehicle Accidents and Incidents recording – for quarter one of 2016/17, 67 had been recorded

**The report recommended:**
That the Committee -
(a) note the actions taken and progress measures put in place in Fleet Services for monitoring performance of corporate Fleet Compliance;
(b) note the actions taken and measures put in place to resolve concerns on van weights as presented in section 5.2 of the report; and
(c) note the actions taken and measures put in place to resolve concerns on vehicles reversing as presented in section 5.3 of the report.

David Willis, requested that staff be trained using the tachograph simulator not just for infringements but as routine training to ensure staff were fully familiar and compliant with tachograph requirements.

The Chairperson sought clarification in relation to cameras fitted onto vehicles, specifically replacing damaged cameras on vehicles and whether vehicles would be used whilst cameras were defective, wherein the Fleet Services Manager advised that vehicles would not be used until the cameras were in working order and that the Service did have a limited number of cameras in storage.

The Vice Chairperson sought clarification regarding risk assessments of drivers routes and whether the routes were followed, wherein the Flett Services Manager advised that the routes were planned and followed in line with the risk assessments carried out to ensure they were as safe as possible and to reduce the reversing required whilst on the roads.

**The Committee resolved:-**

(i) in relation to a question from the Chairperson regarding replacing damaged cameras on vehicles and whether vehicles would be used whilst cameras were defective, to note that vehicles would not be used until the cameras were in working order and that the Service did have a limited number of cameras in storage;

(ii) in relation to a question from the Vice Chairperson regarding risk assessments of routes and whether the routes were followed, to note that the routes were planned and followed in line with the risk assessments carried out; and

(iii) to otherwise approve the recommendations contained in the report.

## SAFETY OF DRIVERS

**8.** With reference to article 6, resolution (iv) of the minute of their meeting of 20 May 2016, the Committee had before it a joint report by the Interim Director of Corporate Governance and the Director of Communities, Housing and Infrastructure which provided an update with actions taken and proposals regarding the safety of drivers following the publication of the Glasgow Bin Lorry Fatal Inquiry report published in December 2015.

The report advised that the following recommendations from the Fatal Accident Inquiry Report and from a letter to the Chief Executive from the Director of Serious Casework from the Crown Office were of relevance to Aberdeen City Council:

- **Recommendation 5.2** When a doctor is advising an organisation employing a driver as to that driver's fitness to drive following a medical incident whilst driving, that organisation should provide all available information about the incident to the doctor and the doctor should insist on having it prior to giving advice to the organisation and the driver.
- **Recommendation 5.3** Glasgow City Council, when employing a driver, should not allow employment to commence before references sought have been received.
- **Recommendation 5.4** Glasgow City Council should carry out an internal review of its employment processes with a view to ascertaining potential areas for improvement in relation to checking medical and sickness absence information provided by applicants, for example by having focussed health questions within reference requests for drivers and obtaining medical reports in relation to health related driving issues from applicants' GPs.

- **Recommendation 5.5** Glasgow City Council should provide its refuse collection operators with some basic training to familiarise them with the steering and braking mechanisms of the vehicles in which they work.
- **Recommendation 5.6** Local Authorities and any other organisations which collect refuse, when sourcing and purchasing refuse collection vehicles which are large goods vehicles, should seek to have AEBS fitted to those vehicles wherever it is reasonably practicable to do so.
- **Recommendation 5.7** Local Authorities and any other organisations which collect refuse, and which currently have large goods vehicles without AEBS but to which AEBS could be retrofitted, should explore the possibility of retrofitting with the respective manufacturer.
- **Recommendation 5.8** Glasgow City Council should seek to identify routes between refuse collection points which, so far as is reasonably practicable, minimise the number of people who would be at risk should control be lost of a refuse collection lorry.
- **Recommendation 5.9** The potential for the presence of exceptional numbers of pedestrians at particular times should be taken account of a part of route risk assessment in refuse collection.
- **Matter for Consideration 6.1** Occupational health doctors performing D4 examinations and providing advice to employers on applicant drivers, and employers of drivers who facilitate their staff applying for renewal of group 2 licences without the involvement of GPs, should consider whether to require the applicant to sign a consent form permitting release by any GP of relevant medical records to the occupational health doctor.

The report stated that the Council had proposed actions to mitigate the risks of such an accident happening in Aberdeen and that those actions went beyond the recommendations of the Fatal Accident Inquiry. The report contained details of the proposed actions in the form of an action plan.

**The report recommended:**
that the Committee note and endorse the actions taken to date which were detailed in the report in respect of the recommendations of the Glasgow Fatal Accident Inquiry.

Mr Capstick advised that in relation to recommendation 5.4, that the change to driver's employment contracts would be delayed.

**The Committee resolved:-**
(i) to note the update provided in relation to the timescales for notifying employees of the additional contractual clause relating to driving as part of their duties; and
(ii) to otherwise approve the recommendation contained in the report.

## ACCESS TO SCHOOL GROUNDS

**9.** With reference to article 3 of their minute of its meeting of 20 May 2016, the Committee had before it a report by the Director of Education and Children's Services which provided an update on the planned work to be undertaken to address security concerns regarding access to footpaths through school grounds.

The report advised that in relation to accessing school grounds outwith school hours that (1) the Council adopted an Open Grounds Policy in 1992 which allows members of the public to use school grounds including sports pitches, playgrounds and play

equipment outwith school hours; (2) during June 2016, 31 incidents of vandalism or graffiti were reported having occurred in external areas of school grounds with 17 schools being affected and likely to have taken place outwith school hours; and (3) other concerns such as broken glass being left on school grounds have also been reported.

The report advised that in relation to accessing school grounds during school hours that (1) the Open Grounds Policy did not prevent a school from restricting public access to its grounds during the school day, where schools would lock gates during the day and re-open them in the evenings and over the weekends; (2) some of the schools within the Councils estate currently did not have fences or gates which could be used to prevent members of the public accessing school grounds; (3) it is often perceived by members of the public that a path leading through school grounds is a public footpath and that they have a right to use it; and (4) officers have discussed this with the Environmental Policy Team who have provided advice on how to tackle the footpath situation.

The report explained that an action plan had been implemented to address the issues relating to accessing school grounds and that a variety of options had been identified based on the information gathered from the schools.

**The report recommended:**
that the Committee note the content of the report.

The Head of Policy, Performance and Resources advised that the Open Grounds Policy was being looked at as part of the School Estates Review.

**The Committee resolved:-**
to approve the recommendation contained in the report.

## CORPORATE HEALTH AND SAFETY REPORT - APRIL TO JUNE 2016

**10.** With reference to article 9 of the minute of its previous meeting of 20 May 2016, the Committee had before it a report by the Interim Director of Corporate Governance which presented details of the number and types of accidents, incidents and occurrences during April to June 2016.

The report provided statistical information broken down into the following categories:

**Incidents, Near Misses and Accident Rates**

- 106 employee incidents were reported of which 3 were reportable to the enforcing authority
- 65 third party incidents were reported of which 2 were reportable to the enforcing authority
- 19 of the 63 non reportable third party incidents related to school pupils taking part in sporting activities
- the reportable employee incident rate was 0.35 which was a decrease from the same quarter in 2015 (0.88)
- 191 near misses were reported with the highest attributed to violence against school staff (41) (a near miss is an unplanned event that did not cause injury, illness or damage but had the potential to do so)

**Health and Safety Training and Cancellations**

- 372 employees attained health and safety training
- 354 e-learning health and safety course had been completed
- there were 52 late cancellations or no shows which resulted in £3068.00 being back charged to services for externally provided courses
- there had been 127 feedback responses received (55%)

**Fire Risk Assessment**

- 33 fire risk assessments had been carried out within the Education and Children's Services (18) and Communities, Housing and Infrastructure (4) directorates
- 11 of those were for premises managed by Bon Accord Care therefore the findings for those are not included in this report

**Health and Safety Audits**

- there had been 11 compliance visits carried out on a variety of topics

**Compliance Monitoring**

- there had been 6 compliance monitoring visits carried out within the Communities, Housing and Infrastructure directorate
- the compliance checks were in place to look at the higher risk activities within the Council and also any higher profile incident could inform the areas which would require a compliance visit

**The report recommended:**

That the Committee refer the report to the Corporate Management Team -

(a) to discuss and encourage review of statistics by Heads of Service with Service specific detail to be discussed at Service Management Team meetings;

(b) to support actions to reduce accidents and work related ill health in line with health and safety targets; and

(c) to disseminate and take action on the health and safety information contained in the report.

**The Committee resolved:-**

(i) to note that the Clerk would issue the Employee Good Health Group information that had been missed off of the agenda in error; and

(ii) to otherwise approve the recommendations contained in the report.

## OCCUPATIONAL HEALTH REPORT - APRIL TO JUNE 2016

**11.** With reference to article 10 of the minute of its meeting of 20 May 2016, the Committee had before it a report by the Interim Director of Corporate Governance which presented the utilisation statistics for the period 1 April to 30 June 2016.

The report provided the following statistics:

- 575 referrals had been received
- 41 referrals were received from the Education and Children's Services Directorate and 55 from the Communities, Housing and Infrastructure Directorate
- 30% of the referrals related to Mental Health and Behavioural Disorders

- There were 111 short notice cancellations with the majority of those related to health surveillance being from the Communities, Housing and Infrastructure Directorate due to poor communication between management and employees in terms of bulk health surveillance bookings
- 41 physiotherapy assessments had been carried out

**The report recommended:**
that the Committee refer the report to the Corporate Management Team -
(a) to discuss and encourage review of utilisation statistics by Heads of Service with Service specific detail to be discussed at Service Management Team meetings;
(b) to advertise and support the use of the service; and
(c) to disseminate and take action on the information contained in the report.

Trade Union members raised concerns relating to the lack of face to face appointments, in particular to ill health retirement and also where the provider were not seeking information from the employees GP or other medical consultant. The Health, Safety and Wellbeing Manager advised that there was a process in place for the provider to seek information from GP's and other medical consultants to enable a detailed report and conclusion to be formed. She further advised that face to face appointments were still being held where necessary. She requested that specific details be provided to her outwith the meeting so that she could discuss these with the provider.

**The Committee resolved:-**
to approve the recommendation contained in the report.

## EMPLOYEE ASSISTANCE PROGRAMME REPORT - APRIL TO JUNE

**12.** With reference to article 11 of the minute of its previous meeting of 20 May 2016, the Committee had before it a report by the Interim Director of Corporate Governance which presented the utilisation statistics of the Employee Assistance Programme for the period 1 April to 30 June 2016.

The report provided the following statistics:

- 41 referrals had been received, of which 40 related to employees and 1 to a family member
- The highest number of referrals came from the Education and Children's Services Directorate (25)
- 30 referrals related to personal issues with two thirds of those relating to personal stress/depression/anxiety/anger
- There were 27 face to face consultations and 4 telephone consultations

**The report recommended:**
That the Committee refer the report to the Corporate Management Team -
(a) to discuss and encourage review of utilisation statistics by Heads of Service with Service specific detail to be discussed at Service Management Team meetings;
(b) to advertise and support the use of the service to employee's. their immediate family (those over the age of 16 and living at the same address), foster parents and elected members; and
(c) to disseminate and take action on the information contained in the report.

**The Committee resolved:-**
to approve the recommendation contained in the report.

**DATE OF NEXT MEETING - 18 NOVEMBER 2016**

**13.** The Committee noted that the next meeting was scheduled for Friday 18 November at 10am.

- **MIKE MIDDLETON, Chairperson**

**ABERDEEN CITY COUNCIL**

| | |
|---|---|
| COMMITTEE | Audit, Risk and Scrutiny Committee |
| DATE | 24 November 2016 |
| DIRECTOR | N/A |
| TITLE OF REPORT | Internal Audit Progress |
| REPORT NUMBER | N/A |
| CHECKLIST COMPLETED | Yes |

## 1. PURPOSE OF REPORT

1.1 This report advises the Committee of Internal Audit's progress against the approved 2015/16 and 2016/17 Internal Audit plans.

## 2. RECOMMENDATIONS

2.1 The Committee is requested to review, discuss and comment on the issues raised within this report and the attached appendices.

## 3. FINANCIAL IMPLICATIONS

3.1 There are no financial implications arising as a result of this report.

## 4. INTERNAL AUDIT PROGRESS

4.1 The Internal Audit plan for 2015/16 was approved by this Committee on 26 February 2015. The plan included an indicative Committee date for each audit and progress against the plan has been reported to each subsequent meeting of the Committee. Appendix A to this report shows progress with the remaining outstanding audits contained in the plan and a summary is shown in the following table. Updates shown in the attached appendix that are in italics are those that have been reported to Committee previously.

| Planned Audit Status | As at 11 November 2016 by Original Target Committee Date | | | | | %age |
|---|---|---|---|---|---|---|
| | 29.09.15 | 26.11.15 | 25.02.16 | 28.04.16 | Total | |
| Complete | 7 | 7 | 7 | 3 | 24 | 75.0 |
| Draft Report Issued | 0 | 0 | 0 | 0 | 2 | 0.0 |
| Work in Progress | 0 | 0 | 0 | 0 | 0 | 0.0 |
| (*) Cancelled | 1 | 1 | 3 | 3 | 8 | 25.0 |
| Total | 8 | 8 | 10 | 6 | 32 | 100.0 |

(*) As agreed at the Audit, Risk and Scrutiny Committee on 9 March and 28 April 2016, these audit were either moved to the 2016/17 plan or cancelled.

4.2 The Internal Audit plan for 2016/17 was approved by this Committee on 9 March 2016. The plan included an indicative Committee date by when it was planned to report each audit.

4.3 Appendix B to this report shows progress with the audits contained in the plan and a summary is shown in the following table:

| Planned Audit Status | As at 11 November 2016 by Original Target Committee Date | | | | | | %age |
|---|---|---|---|---|---|---|---|
| | Jun 16 | Sep 16 | Nov 16 | Feb 17 | Jun 17 | Total | |
| Complete | 5 | 4 | 2 | 0 | 0 | 11 | 40.7 |
| Draft Report Issued | 0 | 0 | 2 | 0 | 0 | 2 | 7.4 |
| Work in Progress | 0 | 1 | 1 | 3 | 0 | 5 | 18.5 |
| To Start | 0 | 0 | 0 | 4 | 5 | 9 | 33.4 |
| Total | 5 | 5 | 5 | 7 | 5 | 27 | 100.0 |

## 5. REPORT AUTHOR DETAILS

David Hughes, Chief Internal Auditor
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**APPENDIX A**

## PROGRESS WITH 2015/16 INTERNAL AUDIT PLAN REVIEWS NOT PREVIOUSLY REPORTED TO COMMITTEE

***Note – where updates have been seen by Committee previously these are shown in italics***

| SUBJECT / SCOPE | OBJECTIVE | Progress as at 11 November 2016 | | Red Amber Green | Comment where applicable |
|---|---|---|---|---|---|
| **CORPORATE GOVERNANCE** | | | | | |
| **Finance** | | | | | |
| Bank Reconciliations | Review procedures to ensure that accurate, timely reconciliations are produced using a robust methodology. | *Draft report due to be issued*<br>*Draft report issued* | *08.04.16*<br>*18.04.16* | *Amber* | *Delays in Internal Audit caused by Auditor leaving the Council and clearing other Internal Audit reports.* |
| | | *Management response due*<br>*Management response received* | *09.05.16*<br>*11.05.16* | *Amber* | *Internal Audit is currently awaiting a meeting with the Service to discuss processes and the draft report.* |
| | | *Meeting held to discuss*<br>*Further information provided by Finance* | *18.08.16*<br>*25.08.16* | *Red* | |
| | | Final draft report issued<br>Management response received | 13.10.16<br>07.11.16 | Amber | Internal Audit progressing other work |
| | | Final report issued | 07.11.16 | Green | |
| | | *Original target Committee date*<br>*Anticipated submission to Committee*<br>Actual submission to Committee | *25.02.16*<br>*24.11.16*<br>24.11.16 | *Amber* | |

| SUBJECT / SCOPE | OBJECTIVE | Progress as at 11 November 2016 | | Red Amber Green | Comment where applicable |
|---|---|---|---|---|---|

## CORPORATE GOVERNANCE

### Finance

| | | | | | |
|---|---|---|---|---|---|
| Budget Monitoring | Review procedures used for monitoring the Council's revenue budget. | *Draft report issued* | *30.08.16* | *Amber* | *See below:* |
| | | *Management response due*<br>Management response received | *20.09.16*<br>05.10.16 | <br>Amber | |
| | | Final draft report issued<br>Management response | 19.10.16<br>07.11.16 | Green | |
| | | Final report issued | 08.11.16 | Green | |
| | | *Original target Committee date*<br>*Anticipated submission to Committee*<br>*Revised to*<br>Actual submission to Committee | *28.04.16*<br>*27.09.16*<br>*24.11.16*<br>24.11.16 | *Amber* | |
| *Finance requested that this audit be delayed in recognition that Finance staff are required to prioritise year end work in order that timescales in relation to the 2015/16 Annual Accounts are achieved. Although work has commenced, the resultant report will be delayed. Provision of information requested from Finance to allow completion of testing was delayed. As a result, completion of the draft report for discussion was delayed.* | | | | | |

| SUBJECT / SCOPE | OBJECTIVE | Progress as at 11 November 2016 | | Red Amber Green | Comment where applicable |
|---|---|---|---|---|---|

## ADULT SOCIAL WORK / INTEGRATION JOINT BOARD

| | | | | | |
|---|---|---|---|---|---|
| Self Directed Support | Consider whether adequate control is exercised over direct payments made in advance to clients. | *Draft report due to be issued*<br>*Draft report issued* | *04.03.16*<br>*23.03.16* | *Amber* | *Audit delayed at request of Service due to external inspection* |
| | | *Management response due*<br>*Management response received* | *13.04.16*<br>*13.04.16* | *Green* | |
| | | *Updated draft report issued* | *14.04.16* | *Green* | *Agreed with Service, however, due to the current workload within Finance and specific project work the Head of Finance has been unable to review and sign off the report* |
| | | *Specific comments from Finance received* | *17.08.16 and 25.08.16* | *Red* | |
| | | *Updated draft report issued*<br>Agreed with Finance<br>Agreed with Service<br>Agreed with IJB CFO | *02.09.16*<br>06.09.16<br>10.10.16<br>21.10.16 | Green<br>Green<br>Amber<br>Amber | |
| | | Final report issued | 24.10.16 | Green | |
| | | *Original target Committee date*<br>*Anticipated submission to Committee*<br>*Revised to*<br>Actual submission to Committee | *25.02.16*<br>*27.09.16*<br>*24.11.16*<br>24.11.16 | *Amber* | |

**APPENDIX B**

## PROGRESS WITH 2016/17 INTERNAL AUDIT PLAN REVIEWS NOT PREVIOUSLY REPORTED TO COMMITTEE

| SUBJECT / SCOPE | OBJECTIVE | Progress as at 11 November 2016 | | Red Amber Green | Comment where applicable |
|---|---|---|---|---|---|
| **CROSS SERVICE** | | | | | |
| Council Owned Land and Property | Review systems / procedures in place across the whole Council estate for ensuring that the Council has surety over the land and buildings it owns including title. | Draft report due to be issued | 16.12.16 | Green | |
| | | Original target Committee date | 23.02.17 | Green | |
| ALEOs | Consider how Services manage their ALEOs including payments and performance. | Original target Committee date | 23.02.17 | Green | Not yet commenced |
| Compliance with Procurement related Legislation and Financial Regulations. | To review payments made via the Creditors System to ensure that a sample of payments in excess of £5,000 have been made in compliance with Legislation and Financial Regulations and that, where appropriate, Value for Money has been achieved by challenging management regarding the purchase. This review will also focus on orders placed close to year end deadlines to ensure that they represent essential spend. | Draft report due to be issued | 23.12.16 | Green | |
| | | *Original target Committee date Changed to* | *27.09.16 23.02.17* | *Green* | |
| | | *The 2015/16 review of this area was concluded in June 2016 so Internal Audit considers that it would be beneficial to delay this review, with reporting to Committee in February 2017.* | | | |

| SUBJECT / SCOPE | OBJECTIVE | Progress as at 11 November 2016 | | Red Amber Green | Comment where applicable |
|---|---|---|---|---|---|

## CROSS SERVICE (continued)

| | | | | | |
|---|---|---|---|---|---|
| Timesheets and Allowance claim forms | Consider whether terms and conditions are being complied with and that timesheets submitted for payment are accurate. Where appropriate, confirm claims to Service documentation and challenge management regarding overtime / additional hours worked. | Draft report due to be issued | 16.12.16 | Green | |
| | | Original target Committee date | 23.02.17 | Green | |

| | | | | | |
|---|---|---|---|---|---|
| Following the Public Pound | Review arrangements in place to ensure that public funds are awarded against set criteria which complies with the principles of following the public pound requirements. | *Draft report due to be issued*<br>*Draft report issued* | *18.05.16*<br>*23.06.16* | *Amber* | *Allocated auditor, having commenced audit, absent due to illness.* |
| | | *Management response due*<br>*Reminder sent*<br>*Management response received* | *21.07.16*<br>*15.08.16*<br>*25.08.16* | *Amber* | *Delayed due to annual leave in Finance* |
| | | *Updated draft report issued*<br>Met with Finance<br>Final response received | *31.08.16*<br>23.09.16<br>26.10.16 | *Green*<br>Amber | |
| | | Final draft issued<br>Response from management | 27.10.16<br>03.11.16 | Green | |
| | | Final report issued | 04.11.16 | Green | |
| | | *Original target Committee date*<br>*Anticipated submission to Committee*<br>*Revised to*<br>Actual submission to Committee | *27.06.16*<br>*27.09.16*<br>*24.11.16*<br>24.11.16 | *Amber* | |

| SUBJECT / SCOPE | OBJECTIVE | Progress as at 11 November 2016 | | Red Amber Green | Comment where applicable |
|---|---|---|---|---|---|

## CORPORATE GOVERNANCE

| | | | | | |
|---|---|---|---|---|---|
| Budget Setting Process | Review procedures used in setting the Council's budget. | Draft report due to be issued<br>Draft report issued | 03.10.16<br>N/A | Green | Delayed pending resolution of budget monitoring audit |
| | | Original target Committee date<br>Revised date | 24.11.16<br>23.02.17 | Green | |
| Treasury Management | Consider whether the Council's Treasury Management Policy complies with the CIPFA Code of Practice and if the Policy is complied with. | Draft report due to be issued | 20.12.16 | Green | |
| | | Original target Committee date | 23.02.17 | Green | |
| Business Rates | Consider whether billing and collection arrangements are robust and adequately applied. | Draft report due to be issued<br>Draft report issued | 29.09.16<br>28.09.16 | Green | |
| | | Management response due<br>Management response received | 21.10.16<br>10.10.16 | Green | |
| | | Final report issued | 18.10.16 | Green | |
| | | Original target Committee date<br>Actual submission to Committee | 24.11.16<br>24.11.16 | Green | |
| Cash Receipting System | Consider whether appropriate control is being exercised over the system, including contingency planning and disaster recovery, and that interfaces to and from other systems are accurate and properly controlled. | Draft report due to be issued<br>Draft report issued | 29.09.16<br>29.09.16 | Green | |
| | | Management response due<br>Management response received | 21.10.16<br>07.11.16 | Amber | Further discussion required between Finance and C&PS |
| | | Final report issued | N/A | N/A | |
| | | Original target Committee date<br>Actual submission to Committee | 24.11.16 | N/A | |

| SUBJECT / SCOPE | OBJECTIVE | Progress as at 11 November 2016 | | Red Amber Green | Comment where applicable |
|---|---|---|---|---|---|

## CORPORATE GOVERNANCE (continued)

| | | | | | |
|---|---|---|---|---|---|
| Benefits | Consider whether benefits being paid to claimants are supported by appropriate documentary evidence, that the calculation of benefit is accurate, and that it has been properly recorded for subsidy purposes. To use Audit Scotland documentation to allow specific reliance to be placed on work done. | Original target Committee date | 22.06.17 | Green | Not yet commenced |

| | | | | | |
|---|---|---|---|---|---|
| Disclosure Checks | Consider whether arrangements in place to ensure that appropriate employees / volunteers have been checked are adequate. Specific testing will be targeted at staffing groups working with particularly sensitive groups. | Original target Committee date | 22.06.17 | Green | Not yet commenced |

| | | | | | |
|---|---|---|---|---|---|
| Agency Staff | Ensure that agency staff are being appointed through appropriate channels and that arrangements for their induction are robust. Partial follow up to a previous audit and extended to include roads specifically. | Draft report due to be issued<br>Draft report issued | 23.09.16<br>23.09.16 | Green | Management has requested further time to respond to the draft report to enable further consideration of the issues raised. |
| | | Management response due<br>Management response received | 21.10.16<br>20.10.16 | Green | |
| | | Updated draft issued<br>Management response received | 25.10.16<br>N/A | Green<br>Amber | |
| | | Final report issued | N/A | N/A | |
| | | Original target Committee date<br>Anticipated submission to Committee | 24.11.16<br>23.02.17 | Amber | |

| SUBJECT / SCOPE | OBJECTIVE | Progress as at 11 November 2016 | | Red Amber Green | Comment where applicable |
|---|---|---|---|---|---|

## EDUCATION AND CHILDREN'S SERVICES

| | | | | | |
|---|---|---|---|---|---|
| Commissioning of Children's Social Work Services | Consider whether arrangements in place are adequate. | Original target Committee date | 22.06.17 | Green | Not yet commenced |
| Primary School Visits | Consider whether income and expenditure, payroll records, inventories, and computer security are adequately controlled and completed. | Original target Committee date | 23.02.17 | Green | Not yet commenced |
| Fostering and Adoption Allowances | Consider whether adequate procedures are in place to control calculation, award and payment of allowances, and that correct rates are applied and any overpayments are recovered timeously. | Original target Committee date | 22.06.17 | Green | Not yet commenced |

## COMMUNITIES, HOUSING AND INFRASTRUCTURE

| | | | | | |
|---|---|---|---|---|---|
| Vehicle and Driver records | Ensure that the procedures put in place to address concerns raised by the Traffic Commissioner have been implemented and are operating in a satisfactory manner. To include random, unannounced visits to check vehicles. | Original target Committee Date | 23.02.17 | Green | Not yet commenced |

| SUBJECT / SCOPE | OBJECTIVE | Progress as at 11 November 2016 | | Red Amber Green | Comment where applicable |
|---|---|---|---|---|---|

## COMMUNITIES, HOUSING AND INFRASTRUCTURE (continued)

| | | | | | |
|---|---|---|---|---|---|
| Internal Transport Tendering Procedures | Consider whether robust tendering procedures are in place and are operating satisfactorily. | Original target Committee Date | 22.06.17 | Green | Not yet commenced |

## ADULT SOCIAL WORK

| | | | | | |
|---|---|---|---|---|---|
| Purchasing and Creditors | Consider whether robust documented procedures are in place and are satisfactorily complied with throughout the service. Consider whether Value for Money is being achieved. | *Draft report due to be issued*<br>*Draft report issued* | *18.05.16*<br>*02.06.16* | *Amber* | *Delays in Internal Audit through prioritising other work.* |
| | | *Management response due*<br>*Management response received* | *30.06.16*<br>*05.08.16* | *Red* | Delayed pending receipt of procurement legal advice |
| | | *Updated draft issued*<br>C&PS advice received<br>Final response received | *10.08.16*<br>18.10.16<br>08.11.16 | Amber | |
| | | Final report issued | 08.11.16 | Green | |
| | | *Original target Committee date*<br>*Anticipated submission to Committee*<br>*Revised to*<br>Actual submission to Committee | *27.06.16*<br>*27.09.16*<br>*24.11.16*<br>24.11.16 | Amber | |

| | | | | | |
|---|---|---|---|---|---|
| Carefirst | Consider whether appropriate control is being exercised over the system, including contingency planning and disaster recovery, and its data input, and that interfaces to and from other systems are accurate and properly controlled. | *Draft report due to be issued*<br>*Draft report issued* | *26.08.16*<br>*24.08.16* | *Green* | |
| | | *Management response due*<br>Management response received<br>Meeting arranged to discuss | *21.09.16*<br>15.09.16<br>20.10.16 | Green | |
| | | Updated draft issued<br>Management response received | 25.10.16<br>08.11.16 | Green | |
| | | Final report issued | 08.11.16 | Green | |
| | | Original target Committee Date<br>Actual submission to Committee | 24.11.16<br>24.11.16 | Green | |

| SUBJECT / SCOPE | OBJECTIVE | Progress as at 11 November 2016 | Red Amber Green | Comment where applicable |
|---|---|---|---|---|

## INTEGRATION JOINT BOARD

*The following audits are now included in the Internal Audit plan for the Aberdeen City IJB and will be reported to the IJB Audit and Performance Systems Committee before being reported to the Audit, Risk and Scrutiny Committee for information.*

| | | | | | |
|---|---|---|---|---|---|
| Health and Social Care Partnership | Post Integration review of Health and Social Care Intervention as required by Integration Resource Advisory Group (IRAG) Guidance. | Original target Committee Date | 23.02.17 | Green | Not yet commenced |

| | | | | |
|---|---|---|---|---|
| Health and Social Care Partnership | Internal Audit provision for Health and Social Care Partnership to include consultancy on arrangements being introduced covering risk management, staff and information governance, and provision of assurance to stakeholders. | As required | N/A | N/A |

ABERDEEN CITY COUNCIL

| | |
|---|---|
| COMMITTEE | Audit, Risk and Scrutiny |
| DATE | 24 November 2016 |
| DIRECTOR | Richard Ellis (interim) |
| TITLE OF REPORT | Scottish Public Services Ombudsman and Inspector of Crematoria Complaint Decisions |
| REPORT NUMBER | CG/16/127 |
| CHECKLIST COMPLETED | Yes |

1. PURPOSE OF REPORT

This report provides information on all Scottish Public Services Ombudsman (SPSO) and Inspector of Crematoria decisions made during 2016/17 to date that relate to Aberdeen City Council complaints. The report also details the SPSO Local Authority 2015/16 annual statistics table.

2. RECOMMENDATION(S)

It is recommended that Committee notes the details of the report and recommends any additional actions as appropriate.

3. FINANCIAL IMPLICATIONS

There are no direct financial implications arising from this report.

4. OTHER IMPLICATIONS

N/A

5. BACKGROUND/MAIN ISSUES

Scottish Public Services Ombudsman (SPSO) Decisions

The Scottish Complaints Handling Procedure (CHP) has three stages:

- Stage 1 - Frontline Resolution
- Stage 2 - Formal Investigation
- Stage 3 - Independent External Review (SPSO)

The first two stages of the complaints handling process are dealt with internally by the council. The SPSO considers complaints from people who remain dissatisfied at the conclusion of the council's complaints procedure. The SPSO looks at issues such as service failures and maladministration (administrative fault), as well as the way the council has handled the complaint.

The ombudsman has the authority to make a final decision on the complaint. Following their investigation, the SPSO write to the council and the complainant with the outcome of their decision. Where necessary the SPSO will make recommendations that the council must implement to address a customer's dissatisfaction and / or to prevent the same problems that led to the complaint from happening again. The SPSO also instruct the timescales for implementing their recommendations.

To date during 2016/17, the SPSO have made 2 decisions relating to Aberdeen City Council complaints that were referred to the Ombudsman for consideration. 1 complaint was not upheld and 1 complaint was partially upheld.

Details of the complaints and any subsequent recommendations are provided in Appendix A. All recommendations have been implemented by Aberdeen City Council within the timescales required by the SPSO and there is one outstanding recommendation which is due for completion by the 29th November 2016.

In addition, the tables in Appendix B show the complaints that the SPSO handled about Aberdeen City Council in 2015/16. Table 1 shows complaints received by main subject area, both about Aberdeen City Council and overall in the sector for the past two years. Table 2 shows the outcomes of the complaints for the same period. Housing, Social Work, Finance, Planning, Roads and Transport are consistently the most common subject of complaints about Aberdeen City Council, with Housing ranked highest by a significant amount.

Inspector of Crematoria Decisions

The Inspector of Crematoria is responsible for providing appropriate oversight and scrutiny of practices within Scotland's crematoria and is also a point of contact for families who have any concerns about crematoria practices, anywhere in Scotland.

The Inspector of Crematoria responds to complaints or queries from the public about cremations. There have been no decisions by the

Inspector of Crematoria in relation to Aberdeen City Council cremations to date.

6. IMPACT

**Improving Customer Experience –**

Complaints are a valuable source of information about council services, which help to identify recurring or underlying problems and potential improvements. Reviewing complaints information provides opportunity to improve service delivery, whether in response to highlighted faults or as a proactive measure to increase efficiency and consequently customer satisfaction.

As part of the complaints handling procedure, services identify learning points so that they can be recorded and acted upon to improve the customer experience. Where appropriate, actions should be implemented across the Council, and not just in the service area that was the subject of the individual complaints. Therefore, all SPSO decisions are therefore shared with the appropriate service(s).

**Improving Staff Experience –**

The outcomes of complaint decisions are fed back to relevant staff. This includes both upheld and not upheld decisions to engage staff in complaints handling and ensure they are fully informed of outcomes. Complaint information is also used to inform changes in working practices and training provision for staff to improve their experience as well as that of the customer. SPSO recommendations relating to complaints handling are fed back to the responding officers to help develop the key skills required for good complaints handling.

**Improving our use of Resources –**

The organisation should look to solve the core issue which led to the complaint and learn from the outcome of complaints so to reduce the potential for more / similar complaints. This should lead to a reduction in repeat complaints and complaints investigation and handling time which can be a lengthy process for those involved.

**Corporate -**

This recommendation supports the Shaping Aberdeen 'triple aim' triangle in terms of improving the staff experience, improving the customer experience and improving the use of resources in delivering outcomes.

This requirement to share learning from complaints supports the Single Outcome Agreement; providing joined up working across the

organisation that will provide overall, an excellent customer experience.

It supports the smarter priorities of 'Smarter Governance – Participation'. Specifically;

"Smarter Governance – Participation: acknowledging the role that citizens can play in the evolution of the city.
Priority: we will encourage citizens to participate in the development, design and decision making of services to promote, civic pride, active citizenship and resilience.
Outcome: Citizens feel they can influence their communities through engagement in the development, design and decision making of services."

Senior management should review the information gathered from complaints regularly and lessons learnt from complaints should be fed back into individual service improvement plans.

**Public –**
N/A

7. MANAGEMENT OF RISK

No risks have been identified in this report.

8. BACKGROUND PAPERS

N/A

9. REPORT AUTHOR DETAILS

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Customer Experience Officer
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01224 34976

Appendix A

| Complaint Received Date | SPSO Decision Date | Complaints Investigated by the SPSO | Directorate | Decision | SPSO Recommendations | Date Implemented |
|---|---|---|---|---|---|---|
| 3 Feb 2016 | 7 Jul 2016 | 1. Aberdeen City Council failed to take steps to investigate, and act on, complaints of anti-social behaviour (not upheld) | Communities, Housing and Infrastructure | Not Upheld | None | Not applicable |
| 10 July 2015 | 30 Sept 2016 | 1. Aberdeen City Council unreasonably failed to communicate with the complainant after they completed actions agreed at a meeting with their flood team (upheld)<br>2. Aberdeen City Council failed to resolve the problem of water ingress from a culverted burn (not upheld) | Communities, Housing and Infrastructure | Partially Upheld | 1. Aberdeen City Council should apologise for the communication failings found.<br>2. The relevant staff should be reminded of the importance of documenting meetings (and in particular agreed outcomes)<br>3. The council should consider and address relevant staff training needs in relation to clear communication and managing expectations | 14 Oct 2016<br>14 Oct 2016<br>Due 29 Nov 2016 |

Appendix B

**TABLE 1**
**Complaints Received by Subject 2015-16**

| Subject Group | Aberdeen City Council | Rank | *Complaints as % of total* | Sector Total | Rank | *Complaints as % of total* |
|---|---|---|---|---|---|---|
| Housing | 42 | 1 | *52.5%* | 423 | 1 | *24.6%* |
| Social Work | 11 | 2 | *13.8%* | 231 | 2 | *13.4%* |
| Finance | 4 | 3= | *5.0%* | 179 | 3 | *10.4%* |
| Planning | 4 | 3= | *5.0%* | 172 | 5 | *10.0%* |
| Roads & Transport | 4 | 3= | *5.0%* | 120 | 7 | *7.0%* |
| Legal & Admin | 3 | 6 | *3.8%* | 61 | 8 | *3.5%* |
| Education | 2 | 7= | *2.5%* | 173 | 4 | *10.0%* |
| Environmental Health & Cleansing | 2 | 7= | *2.5%* | 126 | 6 | *7.3%* |
| Building Control | 1 | 9= | *1.3%* | 54 | 9 | *3.1%* |
| Recreation & Leisure | 1 | 9= | *1.3%* | 32 | 10 | *1.9%* |
| Land & Property | 1 | 9= | *1.3%* | 20 | 12 | *1.2%* |
| Other | 1 | 9= | *1.3%* | 17 | 13 | *1.0%* |
| Personnel | 1 | 9= | *1.3%* | 9 | 15= | *0.5%* |
| Welfare Fund - Community Care Grants | 0 | - | *0.0%* | 31 | 11 | *1.8%* |
| Economic Development | 0 | - | *0.0%* | 11 | 14 | *0.6%* |
| Welfare Fund - Crisis Grants | 0 | - | *0.0%* | 9 | 15= | *0.5%* |
| National Park Authorities | 0 | - | *0.0%* | 6 | 17= | *0.3%* |
| Valuation Joint Boards | 0 | - | *0.0%* | 6 | 17= | *0.3%* |
| Fire & Police Boards | 0 | - | *0.0%* | 5 | 19 | *0.3%* |
| Consumer Protection | 0 | - | *0.0%* | 4 | 20 | *0.2%* |
| Subject Unknown or Out Of Jurisdiction | 3 | - | *3.8%* | 33 | - | *1.9%* |
| Total | 80 | - | *100.0%* | 1,722 | - | *100.0%* |
| *Complaints as % of Sector* | *4.6%* | | | *100.0%* | | |

**Complaints Received by Subject 2014-15**

| Subject Group | Aberdeen City Council | Rank | *Complaints as % of total* | Sector Total | Rank | *Complaints as % of total* |
|---|---|---|---|---|---|---|
| Housing | 35 | 1 | *37.6%* | 468 | 1 | *24.9%* |
| Finance | 14 | 2 | *15.1%* | 174 | 4= | *9.3%* |
| Social Work | 8 | 3 | *8.6%* | 253 | 2 | *13.5%* |
| Planning | 7 | 4= | *7.5%* | 217 | 3 | *11.5%* |
| Roads & Transport | 7 | 4= | *7.5%* | 119 | 7 | *6.3%* |
| Environmental Health & Cleansing | 6 | 6 | *6.5%* | 148 | 6 | *7.9%* |
| Legal & Admin | 5 | 7 | *5.4%* | 76 | 8 | *4.0%* |
| Education | 4 | 8 | *4.3%* | 174 | 4= | *9.3%* |
| Building Control | 1 | 9= | *1.1%* | 61 | 9 | *3.2%* |
| Recreation & Leisure | 1 | 9= | *1.1%* | 24 | 11 | *1.3%* |
| Land & Property | 0 | - | *0.0%* | 29 | 10 | *1.5%* |
| Other | 0 | - | *0.0%* | 21 | 12 | *1.1%* |
| Welfare Fund - Community Care Grants | 0 | - | *0.0%* | 14 | 13 | *0.7%* |
| Welfare Fund - Crisis Grants | 0 | - | *0.0%* | 12 | 14 | *0.6%* |
| Personnel | 0 | - | *0.0%* | 10 | 15 | *0.5%* |
| Consumer Protection | 0 | - | *0.0%* | 8 | 16= | *0.4%* |
| Economic Development | 0 | - | *0.0%* | 8 | 16= | *0.4%* |
| Valuation Joint Boards | 0 | - | *0.0%* | 6 | 18 | *0.3%* |
| Fire & Police Boards | 0 | - | *0.0%* | 4 | 19 | *0.2%* |
| National Park Authorities | 0 | - | *0.0%* | 3 | 20 | *0.2%* |
| Subject Unknown or Out Of Jurisdiction | 5 | - | *5.4%* | 51 | - | *2.7%* |
| Total | 93 | - | *100.0%* | 1,880 | - | *100.0%* |
| *Complaints as % of Sector* | *4.9%* | | | *100.0%* | | |

TABLE 2
Local Authority Complaints Determined 2015-16

| | | 2015-16 | | 2014-15 | |
|---|---|---|---|---|---|
| Stage | Outcome Group | Aberdeen City Council | Sector Total | Aberdeen City Council | Sector Total |
| Advice | Not duly made or withdrawn | 15 | 321 | 22 | 380 |
| | Out of jurisdiction (discretionary) | 0 | 6 | 3 | 29 |
| | Out of jurisdiction (non-discretionary) | 0 | 5 | 2 | 25 |
| | Outcome not achievable | 0 | 6 | 1 | 42 |
| | Premature | 25 | 606 | 25 | 713 |
| | Resolved | 0 | 0 | 0 | 4 |
| | **Total** | **40** | **944** | **53** | **1,193** |
| Early Resolution 1 | Not duly made or withdrawn | 2 | 54 | 1 | 36 |
| | Out of jurisdiction (discretionary) | 6 | 104 | 8 | 56 |
| | Out of jurisdiction (non-discretionary) | 12 | 196 | 12 | 140 |
| | Outcome not achievable | 9 | 185 | 2 | 107 |
| | Premature | 5 | 58 | 1 | 42 |
| | Resolved | 2 | 29 | 3 | 35 |
| | **Total** | **36** | **626** | **27** | **416** |
| Early Resolution 2 | Fully upheld | 2 | 27 | 3 | 33 |
| | Some upheld | 0 | 20 | 2 | 18 |
| | Not upheld | 3 | 37 | 0 | 56 |
| | Not duly made or withdrawn | 0 | 1 | 0 | 0 |
| | Resolved | 1 | 1 | 0 | 3 |
| | **Total** | **6** | **86** | **5** | **110** |
| Investigation 1 | Fully upheld | 1 | 23 | 1 | 28 |
| | Some upheld | 3 | 36 | 1 | 26 |
| | Not upheld | 1 | 40 | 4 | 63 |
| | Not duly made or withdrawn | 0 | 4 | 0 | 1 |
| | Resolved | 0 | 4 | 0 | 1 |
| | **Total** | **5** | **107** | **6** | **119** |
| Investigation 2 | Fully upheld | 0 | 1 | 0 | 3 |
| | Some upheld | 0 | 0 | 0 | 1 |
| | Not upheld | 0 | 0 | 0 | 0 |
| | **Total** | **0** | **1** | **0** | **4** |
| **Total Complaints** | | **87** | **1,764** | **91** | **1,842** |

| | | | | |
|---|---|---|---|---|
| Total Premature Complaints | 30 | 664 | 26 | 755 |
| Premature Rate | 34.5% | 37.6% | 28.6% | 41.0% |
| | | | | |
| Fit for SPSO Total (ER2, Inv1 & Inv2) | 11 | 194 | 11 | 233 |
| Total Cases Upheld / Some Upheld | 6 | 107 | 7 | 109 |
| Uphold Rate (total upheld / total fit for SPSO) | 54.5% | 55.2% | 63.6% | 46.8% |

## Explanatory Note

**Table 1** describes the **subjects** about which the SPSO received complaints in 2015/16 and 2014/15. Both show the Aberdeen City Council figures beside the figures for the sector as a whole. Complaints received are shown ranked from most received to the least.

**Table 2** shows information about the **outcomes** of the complaints that the SPSO determined during 2015/16. The figures of complaints received (Table 1) and determined (Table 2) do not tally because at the end of each business year the SPSO are still working on some of the complaints received during that year.

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ABERDEEN CITY COUNCIL

| | |
|---|---|
| COMMITTEE | Audit, Risk & Scrutiny Committee |
| DATE | 24th November 2016 |
| INTERIM DIRECTOR | Marc Cole |
| TITLE OF REPORT | Solar Photovoltaic Agreement |
| REPORT NUMBER | CHI/16/286 |
| CHECKLIST COMPLETED | Yes/No |

1. PURPOSE OF REPORT

This report is in response to the Committee Decision from AR & S Committee dated 27th June 2016, relating to Compliance with Procurement Related Legislation and Financial Regulations – Internal Audit report requesting the Head of Land and Property Assets to present the circumstances relating to the solar panel incident specifically around the financial implications and the total loss to the Council.

2. RECOMMENDATION(S)

a) To note the circumstances leading to the payment of £275,000 to Our Generation Solar in 2015.

b) To request that a future report is submitted to the FP&R Committee with an action plan to mitigate any further contractual payments towards loss of income to Our Generation Solar.

3. FINANCIAL IMPLICATIONS

In April 2012 the council entered into a tripartite agreement with Mark Group Ltd and Our Generation Ltd for the supply and installation of PV panels to council buildings.

The Council has a contractual obligation to pay loss of generation income to Our Generation Solar, which includes loss of income from the electricity sales and Feed in Tariff, for sites that have Solar PV switched off and not generating electricity. These Solar PV installations were switched off on instruction by the Council due to health and safety

concerns following several thermal events involving the Solar PV installations. The eventual agreed loss of income amounted to £275,000 and was funded from the 2015/16 electricity budgets.

## 4. OTHER IMPLICATIONS

Mark Group Ltd., the company appointed in the 2012 Agreement to provide the ongoing operations and maintenance of the Solar PV installations, entered into administration in September 2015.

Our Generation have now taken over the ownership of the PV Installations and took over the responsibility for the operation and maintenance of the systems in Spring 2016 by appointing Effective Energy.

During this period the Council has also undertaken work to upgrade fire detection systems in specific properties. As a result of the Mark Group entering administration there are Legal and Financial issues that require to be resolved which may result in a further claim for loss of generation which will require to be evaluated. It is therefore suggested that a future report is submitted to the FP&R Committee with an action plan to mitigate any further contractual payments towards loss of income to Our Generation Solar**.**

## 5. BACKGROUND/MAIN ISSUES

In April 2011 the Finance & Resources committee approved to undertake a tendering exercise in relation to photovoltaic panels, and delegate authority to the Director of Enterprise Planning and Infrastructure to instruct officers to enter into the related agreements. The report was tabled due to the existence of favourable Feed In Tariffs (FITs) available from the government for renewable technologies.

In May 2011 Aberdeen City Council issued an invitation to tender to procure a contractor to “survey, supply, install, test, complete, monitor and maintain PV systems for the purpose of generating renewable electricity through the medium of photovoltaic panels”. The tender stipulated that the panels should remain in ownership of the contractor.

On conclusion of the tender process, the Council entered into a tripartite agreement with Mark Group Ltd and Our Generation Ltd in April 2012. An update report on progress was provided to Finance & Resources committee in October 2012.

Under the agreement Mark Group was responsible for the agency supply and installation of the PV panels, with Our Generation retaining title, the electricity sales and responsibility for the maintenance. Two

income streams were expected from the companies as a result of the agreement; the full benefit of the FITs available, and income from selling the electricity produced by the PVs to the Council. The Council expected to receive the benefit of cheaper electricity by purchasing the PV output, rather than through the usual electricity contracts available on the utilities markets. The Council was also obliged to provide and maintain the infrastructure necessary to host the panels i.e. appropriate sites with roofs in good order, and also to provide necessary access to the Mark Group for installation and maintenance of the PVs.

Subsequent to the installation of the PV Panels there were three thermal events that were classed as RIDDOR incidents (Reporting of Injuries, Diseases and Dangerous Occurrences) that required to be reported to the Health & Safety Executive. Following these incidents the Mark Group were instructed by the council having considered all risk factors to switch of all systems as a precautionary measure to ensure buildings and their inhabitants were safe. This was to allow the council to be satisfied that systems were safe and the cause of the 'thermal events' was clear. Fire Risk assessments of all the properties were carried out and a list of required actions was prepared to enable the systems to be re-commissioned and switched back on. Some of these works were a responsibility of the contractor and some were an additional requirement for the council. The majority of systems were however considered to carry no risk and were switched on following this review.

The remedial works that were required included works to upgrade fire alarm systems in some properties, installation of fire detectors and the re-location of some equipment in a limited number of properties.

Due to the actions of the council a number of sites did not generate income for the contractor which resulted in them being due payment for the loss of income under the terms of the contract. This was eventually agreed at £275,000.

6. IMPACT

**Improving Customer Experience –**

The building users which have the solar PV installations on the roof would be able to learn and understand more about the benefits of on-site renewable electricity generation.

**Improving Staff Experience –**

There staff involved in the process would benefit from the knowledge and understanding of how solar PV installations could reduce carbon emissions and promote renewable energy.

**Improving our use of Resources –**

The electricity generated from the solar PV panels will be renewable electricity which reduces carbon emissions helping to alleviate climate change. The Council will also benefit from the cost saving in electricity charges as the electricity generated from the solar PV is at a lower rate than the grid electricity rate.

**Corporate -**

The generation of renewable electricity through the installation of solar PV meets Aberdeen the Smarter City – Smarter Environment Objective.

**Public –**

The EHRIA form will be completed.

7. MANAGEMENT OF RISK

| **Risk** | **Risk level** | **Mitigation/Control** |
|---|---|---|
| The solar PV electrical equipment causing damage to the buildings electrical installations or introducing health and safety risks, in particular fire risks.. | High | Emergency shut down procedures, 24hour emergency call out service to be provided by the solar PV company. Council Health and Safety team to be informed of any incidents and any improvements from risk assessments are carried out. |
| The solar PV panels are not operating for unplanned reasons such as re-roofing and refurbishment projects in the future. | High | The Council need to be aware of the financial impact of these projects on the solar PV contract. |
| The solar PV company does not maintain the solar PV panels to ensure maximum efficiency. | Medium | Regular maintenance checks. |
| The solar PV panels causing damage to building roofs. | Medium | Any leaks or damage to roofs need to be reported to solar PV company as soon as possible to rectify the issues. |

| | | |
|---|---|---|
| The inflation rate increases significantly from current rate, adding cost to the electricity rates from the solar PVs. | Medium | Annual check on RPI inflation rates to ensure that there is a cost benefit from the contract arrangement. |
| The cost of electricity from the grid lower than the cost of electricity generated from solar PVs. | Low | Annual check on electricity prices to ensure that there is a cost benefit from the contract arrangement. |

## 8. BACKGROUND PAPERS

- Finances & Resources Committee report no: EP&I/11/129 dated 21st April 2011
- Finances & Resources Committee report no: EPI/12/205 dated 4th October 2012
- Audit, Risk & Scrutiny Committee Article 15 dated 27th June 2016
  *Compliance with Procurement related Legislation and Financial Regulations – Internal Audit Report*

## 9. REPORT AUTHOR DETAILS

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ABERDEEN CITY COUNCIL

| | |
|---|---|
| COMMITTEE | Audit, Risk and Scrutiny |
| DATE | 24 November 2016 |
| DIRECTOR | Richard Ellis |
| TITLE OF REPORT | Review of the System of Risk Management |
| REPORT NUMBER | CG/16/129 |
| CHECKLIST COMPLETED | Yes |

## 1. PURPOSE OF REPORT

To present the Committee with the output of the Good Governance Institute's (GGI) evaluation of the Council's risk management system and the next steps with regard to implementing the agreed actions arising from their report.

## 2. RECOMMENDATION

It is recommended that the Committee consider the attached report and Implementation Plan and agree:-

i. To receive updates on the implementation of actions to address the agreed recommendations arising from the review of the risk management system.

## 3. FINANCIAL IMPLICATIONS

There are no financial implications arising as a result of this report.

## 4. OTHER IMPLICATIONS

There are implications associated with the Council's approach to risk management in light of the changing economic and socio-demographic profile of Aberdeen. The attached report sets out how we need to manage our readiness to control risks within agreed tolerances and to embrace opportunities within a risk appetite to be determined. This impacts on our continuing delivery of effective essential services and the management of our core functions within the framework of the Aberdeen – the Smarter City priorities.

## 5. BACKGROUND / MAIN ISSUES

I. 2016 saw the inception of a wide-ranging Governance Review which is due to conclude May / June 2017. The review is structured around the CIPFA Principles of Good Governance, compliance with which will inform the Council's annual statement of governance. The review aims to deliver the following outcomes:

- A governance framework which supports the Council in implementing the Strategic Business Plan.
- Reassurance to Audit Scotland in respect of their Best Value Audit findings from July 2015.

II. One of the six CIPFA Principles is:

- Managing risks and performance through robust internal controls and strong public financial management.

III. The review of our risk management arrangements is therefore a key component of the Governance Review and in light of a number of issues which have arisen in recent months, a high priority for our governance improvement agenda.

IV. The GGI previously carried out work for the Aberdeen Health and Social Care Partnership around developing risk appetite and assurance. Due to this experience of local circumstances and their specialist knowledge of public sector risk management, the Council agreed to engage the GGI to conduct a detailed evaluation of our risk management system. This included a requirement to define a process whereby the Council's appetite for risk will ultimately be determined.

V. The GGI reviewed risk management documentation, carried out observations of CMT, committee meetings and meetings of the ALEO Governance Hub. They conducted interviews with a range of officers drawn from across the Council. The GGI reported their findings in September and the report was considered at an extended CMT workshop on 4 October. A project implementation plan is now in place to take forward the agreed recommendations of the report (Appendix 2).

VI. Early in the review, a specific requirement to consider assurance mapping in our risk management processes was added to the project brief. Assurance mapping is a technique which identifies internal and external sources of assurance that the effectiveness of our risk controls is robust. These assurances must be relevant, timely and offer an indication of their respective strengths. Assurance mapping allows us to identify gaps in required assurance and through clear linkages with the internal audit function, provides for an enhanced risk-based audit planning process. Taking forward the agreed actions on assurance mapping will be a high priority of the implementation plan.

## 6. IMPACT

**Improving Customer Experience –**

We aim to deliver services which better meet customer expectations and this requires an innovative approach to service design and delivery. Innovation comes with risk. A clearly defined set of risk tolerances within an established risk appetite, will permit a better informed approach to that process.

**Improving Staff Experience –**.
The redefined system of risk management will clearly establish delegated authority around risk tolerances. This will allow managers to take informed decisions which take account of the management of risk and present service committees with properly evaluated recommendations.

**Improving our use of Resources –**
Our resources will continue to be stretched over the next few years, whilst demands are forecast to continue to increase. Coupled with this, increasing policy changes and requirements imposed by Government and its agencies, mean that a consistent approach to resource management that takes account of the management of risk, is required.

**Corporate –** The actions taken in response to the GGI's review of the risk system are clearly corporately supportive of Aberdeen – the Smarter City vision, as well as our directorate and service planning processes.

**Public –** This report provides members with an opportunity to apply scrutiny to the development and improvement of our risk management arrangements No EHRIA or PIA are therefore required.

## 7. MANAGEMENT OF RISK

The report details planned improvements to the risk management system.

## 8. BACKGROUND PAPERS

None

## 9. REPORT AUTHOR DETAILS

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Good Governance Institute

ABERDEEN CITY COUNCIL

# Aberdeen City Council

## Assurance development programme: risk management system

A report from the Good Governance Institute (GGI)

September 2016

Good Governance Institute

## The Good Governance Institute

The Good Governance Institute exists to help create a fairer, better world. Our part in this is to support those who run the organisations that will affect how humanity uses resources, cares for the sick, educates future generations, develops our professionals, creates wealth, nurtures sporting excellence, inspires through the arts, communicates the news, ensures all have decent homes, transports people and goods, administers justice and the law, designs and introduces new technologies, produces and sells the food we eat - in short, all aspects of being human.

We work to make sure that organisations are run by the most talented, skilled and ethical leaders possible and work to build fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions.

Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole. It enables organisations to play their part in building a sustainable, better future for all.

Good Governance Institute

## Final Report

| | |
|---|---|
| Client: | **Aberdeen City Council** |
| Project name: | **Assurance development programme: risk management system Document name: Final report** |
| Reference: | **GGI_ACC_Final report_09Sept** |
| Version: | **Final version 1** |
| Date: | **September 2016** |
| Authors: | **Hilary Merrett, Senior Associate, Good Governance Institute, John Bullivant, Chairman, Good Governance Institute** |
| Reviewed by: | **Donal Sutton, Team Leader - Service Development, Good Governance Institute, Hannah Campbell, Senior Programme Delivery Officer, Good Governance Institute, David Cockayne, Managing Director, Good Governance Institute** |
| Designed by: | **Emiliano Rattin, Senior Communications Officer, Good Governance Institute** |

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## Contents

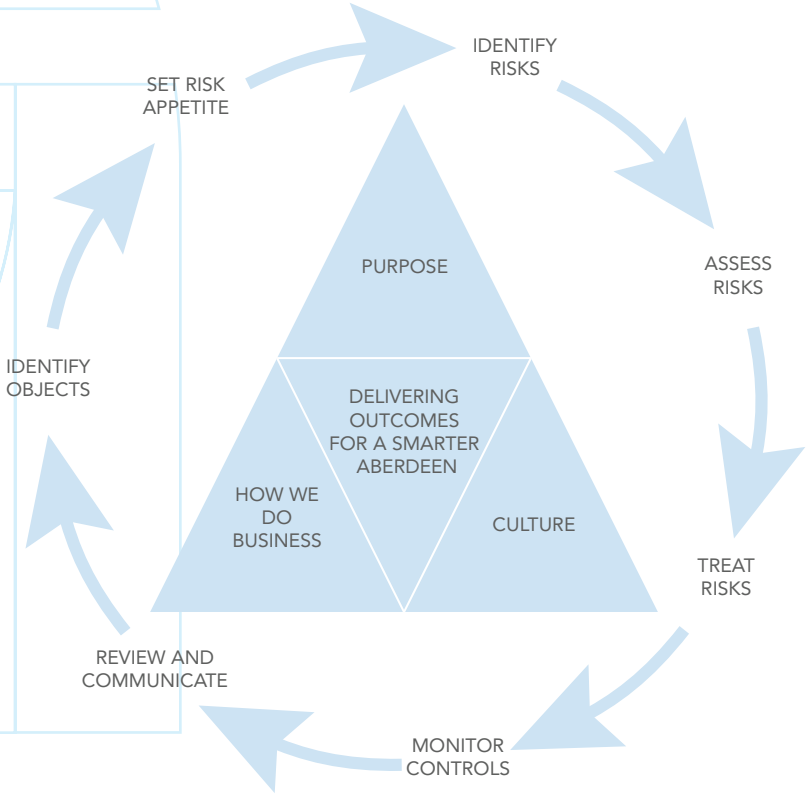
# 1.0 Introduction

## 1.1 Background

Aberdeen City Council (ACC) is committed to supporting communities, investing in the future of the city and working in partnership to deliver the vision originally set out in its long term plan, "Shaping Aberdeen"[1].

In order to ensure its refreshed strategy for a Smarter Aberdeen is supported by a reliable and coherent governance system, the Council has embarked on a wide-ranging review of governance, aimed at delivering a dynamic assurance framework and set of constitutional documents for March 2017. This review is being supported and facilitated by the Good Governance Institute (GGI) and by the Chartered Institute of Public Finance and Accountancy (CIPFA). As part of this assurance development programme, GGI has been commissioned to focus on the Council's risk management system.

The outputs of this review are thus intended to help to ensure that there are effective and comprehensive structures, processes and behaviours in place to identify, understand, monitor, and address the range of current and future risks faced by ACC. GGI understands that the governance system in general, and the risk management system in particular, must support the achievement of the six strategic priorities for Council services set out as a vision for a Smarter Aberdeen. These priorities, in turn, are supported by organisational plans which establish the purpose, culture and business approach to deliver the required outcomes.




The review has been informed by GGI's current status as the governance development partner with Aberdeen City Health and Social Care Partnership (ACHSCP), and our experience of developing the partnership's assurance framework.

1) Aberdeen City Council, Strategic Business Plan; Refresh 2016-2017, Aberdeen City Council, 2016

This report outlines the findings of our review and the associated recommendations for improvement. Our recommendations are aligned with the Society of Local Authority Chief Executives and Senior Managers, or "SOLACE", principles of good governance.[2]

The ultimate aim of the Council's corporate governance function is to construct and maintain a "golden thread" which runs through all its plans, policies and improvement activity and targets. This "golden thread" depends on clarity around strategic objectives and priorities and how these connect service, directorate and corporate governance and risk systems.

The scope of the review covered all operations of the Council, including the effectiveness of the developing accounting reporting process between the Council's Governance Hub and its Arm's-Length External Organisations (ALEOs) and with the Integration Joint Board (IJB) of the ACHSCP.

The outputs of the risk management review include:

- An assessment of ACC risk management strategy, structure and systems, and setting out recommendations for improvements and recommendations in relation to a revised risk management and assurance framework
- An assessment of risk appetite and risk tolerance in liaison with Council officers and members, and development of a risk appetite statement for ACC

This report outlines the GGI team's findings and recommendations with relation to the first of these outputs, and includes refined proposals for the achievement of the second.

### 1.2 Methodology

For this review GGI adopted a classic systems review approach, based on observations, interviews and document review, allowing for triangulation of findings.

Between June and August 2016, interviews were undertaken with selected members, directors and officers of the Council, key corporate governance personnel and the Managing Directors or Chief Executives of all Tier 1 and some Tier 2 ALEOs.

Relevant documentation was reviewed, including Council and committee minutes and papers, and governance and risk management related strategies, policies and procedures. Observations of the Corporate Management Team (CMT), the Audit, Risk and Scrutiny Committee (ARSC) and the Tier 1 Governance Hub / ALEO meetings were also undertaken.

The team's proposals have thus been developed in the context of the findings from interviews, observations, document review and in line with best practice[3], the SOLACE principles, Treasury[4] and Government[5] guidance, as well as Australia/New Zealand risk management standard.[6 7]

2) CIPFA SOLACE (2016) Delivering Good Governance in Local Government: Framework 2016, http://www.cipfa.org/policy-and-guidance/publications/d/delivering-good-governance-in-local-government-framework-2016-edition
3) Good Governance Institute, 2013, Countering the biggest risk of all: attempting to govern uncertainty in healthcare management, http://www.good-governance.org.uk/wp-content/uploads/2014/02/Countering-the-biggest-risk-of-all-attempting-to-govern-uncertainty-in-healthcare-management.pdf
4) HM Treasury, 2006, Thinking about risk: Managing your risk appetite – a practitioner's guide, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/191520/Managing_your_risk_appetite_a_practitioners_guide.pdf
5) Risk Management – public sector guidance, The Scottish Government, http://www.gov.scot/Topics/Government/Finance/spfm/risk
6) Institute of Risk Management, 2012, Risk Culture: Under the microscope guidance for boards, https://www.theirm.org/media/885907/Risk_Culture_A5_WEB15_Oct_2012.pdf
7)Standards New Zealand, 2009, AS/NZS ISO 31000:2009 Risk Management – Principles and guidelines, https://shop.standards.govt.nz/catalog/31000:2009(AS%7CNZS%20ISO)/scope?

The report identifies our high level findings and an outline view of how a revitalised risk management framework might contribute to the overall governance approach, setting out arrangements for assurance and escalation. A more detailed commentary follows on the risk management system and each of its key elements, setting out suggested recommendations for improvement or adjustment. There are also commentaries as requested on the approach to mapping of assurances, and on the governance processes between the Council and ACHSCP's IJB, and between the Council and its ALEOs.

### 1.3 Limitations

The review did not cover interviews with service managers, nor was it possible within the time frame to observe the Finance, Policy and Resources Committee. GGI is also aware that there are improvements and developments underway on an ongoing basis and that some of the issues described within this report may have been or are being addressed meanwhile.

### 1.4 Acknowledgements

GGI would like to thank everyone who participated, including all interviewees. In particular GGI would like to thank Vikki Cuthbert, (Programme Manager, Governance Review, ACC) for her support in the co-ordination of the project and our project sponsor Richard Ellis, (Interim Director of Corporate Governance, ACC).

## 2.0 High level findings

The GGI review team encountered a high degree of enthusiasm for improving governance amongst all interviewees, and an appreciation of the need for a "golden thread" of good governance connecting all parts of the Council and its operations. It was also clear from all aspects of the review that much good work has been done in recent weeks and months, particularly in relation to the development of performance reporting and the risk management reporting system. There was a widespread appreciation of the quality of leadership provided by the Chief Executive Officer (CEO) and of the work of the Corporate Governance Directorate (CGD). Risk is now a standing item on all agendas and communication of the importance of a risk management approach has been stepped up. The Council's vision for the city will be enhanced by its commitment to engage on governance and risk management with the newly formed ACHSCP, as well as with the full range of ALEOs.

The foundation of a functional risk management approach is a strong understanding of the strategic objectives of an organisation. This is key to the identification of risks to achieving those objectives and putting in place controls and assurances as needed. There are several sets of priorities in play across the Council, including the outcomes of the Single Outcome Agreement (SOA) and other area plans, the priorities of "Smarter Aberdeen" and the triple aims set out in "Shaping Aberdeen" and those shared with ACHSCP. While it is not GGI's intent to suggest any set of objectives take precedence, we strongly recommend that the same framework of priorities is used for the risk reporting and risk register system, as is now being adopted for the performance reporting framework.

The development of a risk appetite statement for the Council depends on clarity of the Council's strategic priorities and its ability to take a balanced approach to making decisions, where both risk and opportunity are considered, and outcomes rather than processes become the focus. It will also, importantly, support better horizon scanning processes and delegation within agreed tolerances across the council and for arm's length bodies. Once risk appetite and tolerance are agreed, Council should set out an annual delegation of roles to its committees, ALEOs, and officers, aligned to best practice and the agreed risk tolerances.

Council directors and officers are clear on the need to develop a risk management culture and to increase the level of risk awareness and tackle silo thinking about risk. There is an education and development programme required at all levels of Council operations, from Elected Members to Practitioners at service level, which must be supported by investment of time and resources.

In terms of the risk system itself, there were a few overarching issues for the review team. There remains a need to standardise risk register formats, if possible with project management and perhaps with Tier 1 ALEOs. These will need to be aligned to strategic priorities as stated above, and it is imperative that assurances (as distinct from controls) are also included in the strategic risk register and preferably other risk registers as well.

The assurance roles of committees and groups are currently not universally clear. The team has made recommendations about ensuring that the role of the ARSC remains focused on assurance of governance risk systems, rather than on their operational performance. There is also a need to refine the reporting, moderation (to ensure consistent scoring) and escalation of risks. This of itself has implications for the committee structure and this report sets out a role for an extended CMT and / or a revitalised Risk Management Committee.

Financial pressures are likely to increase over time and the Council has recognised the need to streamline its operations. This review aims to make suggestions which will support this need. There are issues of resilience, however, especially with regard to supporting the development and embedding of risk management across operations, and the CGD is heavily dependent on a small number of senior managers.

# 3.0 Detailed findings

## 3.1 The governance framework and risk: picking up the golden thread

### Strategic priority

There is a strong Council commitment to the concept of a "golden thread" running through all activities and reporting lines, which will allow the full Council and its management team to be assured of the quality and performance of its services.

The Council has oversight of a wide range of diverse operations and services, encompassing both direct and arm's-length management arrangements. In order to account properly to its stakeholders, the Council leadership must be able to rely on strong line of sight from operations upwards to assure itself of probity, performance against objectives and maintenance of high levels of quality and safety. Fundamental to any assurance system are that the organisation's strategic objectives are specific, measurable, actionable, realistic and time bound (SMART), in support of its vision.

ACC's refreshed Strategic Plan for 2016/17 clearly sets out the vision for a Smarter Aberdeen, in the context of area plans. There are six objectives associated with this vision. There are also a set of "Triple Aims" identified in "Shaping Aberdeen" which define the goals which should shape Council directorates and service plans.

Many of these objectives are interdependent and complementary, and directorate and service managers are expected to take account of both Smarter Aberdeen and "Shaping Aberdeen" in developing plans. It is notable that the strategic plan does not describe risk or risk management as an integral part of its strategic framework, nor is there any mention of the Council's approach to its risk appetite against objectives. Making risk management fundamental to an organisation's thinking and business approach is the cornerstone of robust governance.

The newly developed performance management framework is designed to allow directorates and services to report against objectives. It appears that the three directorates may be using different overall objectives according to their remits. While this is understandable, it is critical that the Council's strategic objectives or priorities are consistent across the board so that both performance reporting and risk reporting facilitate the golden thread, or "line of sight". Streamlining or standardising the top line objectives may thus be helpful to enhance overall accountability for service quality and performance, and to establish an overall framework for:

- development of decision-making criteria for service and project development, planning and delivery; resource and funding allocation
- the assurance and escalation system
- risk reporting across all providers
- individual performance and appraisals
- evaluation of achievement against objectives

**Recommendation 1**

Clarify top line strategic objectives for the Council and standardise which will be used for performance and risk reporting systems

### The assurance and escalation framework

This report presents proposals for improvement and development which the GGI team hopes will be helpful to, and consistent with, the outcomes of the wider governance review. Our suggestion at this point is that the Council should consider compiling a high-level governance framework as part of its constitution which describes the means by which it secures assurance on its activities. The framework should set out the governance structure, systems and performance and outcome indicators through which the Council receives assurance. It should also describe the process for the escalation of concerns or risks which could threaten delivery of the strategic priorities.

Our suggested framework would involve the population of a table as outlined in Figure 1. This broadly follows the approach developed for the ACHSCP.

| | ASSURANCE of COMPLIANCE | ASSURANCE of TRANSFORMATION – achieving the triple aims |
|---|---|---|
| FOCUS | Compliance with standards and regulation, communication and escalation of concerns and risks | Improving services, measuring and sustaining improvement Challenging existing behaviours and work patterns, innovation, redesign and transformation |
| KEY COMPONENTS | People and Groups: partners; roles; committee structures<br>Plans and Strategies : area plans, strategic plans, business and funding plans, transformation, workforce etc Risk Management strategy and audit plans etc<br>Feedback and Reporting processes: routes for routine reporting, raising concerns and escalation process | |
| MAP OF COMPONENTS AT EACH LEVEL | COUNCIL LEADERSHIP LEVEL | |
| | DIRECTORATE LEVEL | |
| | SERVICE LEVEL AND PROJECT LEVEL | |
| | ARMS LENGTH PROVIDERS / AHSC PARTNERSHIP | |
| | INDIVIDUAL LEVEL | |
| OUTCOMES | Council measures of success for stakeholders and assurances from internal and external sources | Council measures of success for the tax payer and its stakeholders and assurances from internal and external sources |

*Figure 1. Suggested high-level governance framework*



The recommendations and commentary in the body of this report are intended to inform the constituent parts of this framework.

**Recommendation 2**

Compile an assurance framework which describes components of assurance system for compliance and for transformation

### 3.2 The risk management system

**Risk management strategy**

The internal audit report into risk management of 2015 recommended the revision of the Council's risk management strategy. While the document itself has not yet been revised due to the reviews underway, there have been significant developments in terms of the risk management system.

We would advise the identification of specific objectives for the risk management system, in line with the achievement of strategic priorities as outlined above. The revised strategy and associated operational manual will provide the detail for key parts of the assurance framework as suggested above, especially in terms of role and responsibilities, risk processes and risk reporting flows. Any revised strategy should reflect the reality of the revised risk register system (see section 3.1).

The current strategy sets out in detail the theory of enterprise risk management – this is not yet apparent in risk registers observed and may be an important issue to include in training and to assess in terms of understanding when reviewing the quality and comprehensiveness of risk reporting.

There is some lack of clarity about the use of the terms "residual" and "current" and some inconsistency observed between risk registers. This issue is discussed in section 3.2.

The role of audit is critical to the provision of assurance and a vital tool for addressing risks and monitoring the implementation and success of mitigating actions. While the contribution of internal audit is clearly set out, the roles of Council committees and groups for assurance monitoring is less so. This is addressed further in this report in section 3.4, on roles and responsibilities. It is of concern that the internal audit plan uses different terminology and risk assessment methodology from the risk management strategy. However, there was a clear indication that it will be easier for audit colleagues to align their plans and programmes with the newly developed format for the Council's strategic risk register.

If the risk management requirements of provider organisations (ALEOs and ACHSCP) are to be incorporated into this strategy, there needs to be explicit description of how these are monitored i.e. through Governance Hub arrangements and reporting to the Council.

The Corporate Risk Management Group referred to in the document did not appear to be extant at the time of the review, nor was its original remit clear. Further proposals about this group and potential functions are discussed in section 3.4.

**Recommendation 3**

Ensure that the revised risk management strategy incorporates risk management objectives

**Risk appetite**

The CMT is clear that the achievement of strategic priorities may involve balancing different types of risk and that there may be a complex relationship between different risks and opportunities. There is widespread agreement between elected members and officers that discussion is needed about the level and nature of risk that the Council is prepared to take in pursuit of its aims. This should be beyond financial and short-term political criteria, to include the full range of capitals that underpin the triple aims outlined in Shaping Aberdeen.

The output from this discussion should be an agreed statement to be used to guide the Council in decision-making. It can be used to consider the risks to organisational goals and of not taking decisions as well as of taking them. It also valuable in communicating to stakeholders the criteria by which Council members can ensure that they exercise their duties in line with the Council's vision and values. Robust horizon scanning through proper scrutiny as defined by the Williams Commission[8] will also ensure that the public and stakeholders are involved appropriately.

All reports and information on activities that go to the Council should be assessed against the risk appetite. This will help to clarify the required role of the Council in report i.e. whether they are for decision and recommendation, endorsement, or for information and noting only.

The risk appetite statement will be an important milestone for demonstrating the maturity of the governance approach, not least for the Council's key external and other partners in service provision. The Council will benefit by ensuring a shift from developing an overall risk appetite 'mission statement', to the specific and practical use of the approach when tackling each objective or issues that arise. GGI's Risk Appetite Board Assurance Prompt developed with ACHSCP is attached in Appendix III and may serve as a useful reference for the Council.

8) Welsh Government, 2014, Commission on Public Service Governance and Delivery, http://gov.wales/topics/improvingservices/public-service-governance-and-delivery/report/?lang=en

The following is an extract from the type of risk appetite statement that other organisations have developed:

This organisation recognises that achievement of its priorities will involve balancing different types of risk and that there will be a complex relationship between different risks and opportunities. The risk appetite approach is intended to be helpful to the Council in decision-making and to enable members to consider the risks to organisational goals of not taking decisions as well as of taking them.

The board has identified several broad dimensions of risk which will affect the achievement of its strategic priorities. These are: financial risk; regulatory compliance risks; risks to transformation and innovation outcomes; risk of harm to members of the community, Council clients and to staff; reputational risk.

The organisation will set a level of appetite ranging from "none" up to "significant" for these different dimensions. It will have zero tolerance of instances of fraud. It will accept no or minimal risk in relation to breaches of regulatory and statutory compliance. Similarly, it will accept no or minimal risks of harm to service users or to staff. It will accept low to moderate risk in relation to financial loss and to transformation and innovation outcomes which predict clearly identifiable benefits and can be managed within statutory safeguards. It will accept moderate to high risks to reputation where the decision being proposed has significant benefits for the organisation's strategic priorities. Higher levels of all risk types may be accepted if specific and effective controls are demonstrably in place and there are clear advantages for our objectives.

The Council has an appetite from its inception to take decisions which may expose the organisation to additional scrutiny and interest where there is evidence of confidence by key stakeholders, especially the public, that difficult decisions are being made for the right reasons.

This risk appetite statement will be reviewed annually.

At this point, it is important to differentiate between risk appetite and risk tolerance. The Institute of Risk Management has produced clear guidance on this distinction, which can be summarised as: "risk appetite is about the pursuit of risk, risk tolerance is about what you can allow the organisation to deal with."[9] While the council will wish to discuss, develop and quantify as far as possible the extent of risk that it is willing to take in the context of its aspirations, it is likely that its risk tolerance will be wider e.g. the amount of financial risk that it could bear or the level of reputational damage that it could sustain. Risk tolerances should also be measured as far as possible to allow for delegated levels of decision-making to be set. This will allow Council business to be streamlined so that decisions bearing risk within certain tolerances may not have to come to full council. The risk scoring system described in sections 3.6 should inform both risk appetite and risk tolerances. The suggested application of a richer impact table (see section 3.6) would facilitate setting both risk appetite and delegating tolerances.

**Recommendation 4**

Hold workshops with Council to discuss and agree risk appetite. Develop an associated risk appetite statement, to underpin Council decision-making

**Risk register structure: strategic and corporate risk registers**

At a high level the risk management framework should be formed by the risk appetite statement, risk management strategic objectives, and strategic and corporate risk registers[10]. The CGD has worked with the CMT to agree a revised risk register matrix which identifies different tiers for risk registers aligned to different areas of Council business. This is designed to make clear the difference between strategic and corporate risks. Strategic risks are defined as those that pose significant threats to the Council's ability to do essential business and comply with statutory requirements. In theoretical terms, these issues are those which could have a serious impact on the ability of the organisation to deliver on its strategic objectives, hence the importance of articulating these and setting risk appetite levels against them. Corporate risks are defined as those which could impact adversely on key business dependencies including employee health and safety, business continuity planning, workforce planning, financial stewardship, IT systems and customer relations management.

9) The Institute of Risk Management, 2011, Risk Appetite and Tolerance, https://www.theirm.org/knowledge-and-resources/thought-leadership/risk-appetite-and-tolerance/
10) Good Governance Institute, 2013, Countering the biggest risk of all: attempting to govern uncertainty in healthcare management, http://www.good-governance.org.uk/wp-content/uploads/2014/02/Countering-the-biggest-risk-of-all-attempting-to-govern-uncertainty-in-healthcare-management.pdf

There has been historical confusion between a corporate risk register and the corporate governance directorate risk register. The new structure has a logical thread and will depend on effective communications and review of its operations to identify any adjustments needed and ensure it becomes embedded across the Council's business.

There is a need to describe and establish processes for:

- aligning all registers with strategic priorities
- escalating issues from other service and directorate, and project risk registers
- moderating risk measurements to improve consistency
- identifying cross-cutting risk issues and aggregating issues appropriately
- identifying the nature and strength of assurances on the strategic risk register
- standardising formats, and inclusion of target risk and risk appetite
- identifying monitoring mechanisms for mitigating actions on the corporate risk register
- ensuring council is sighted on the risk appetite and risk registers of arm's length bodies and has sought assurance of risk mitigation

Our suggestions for the points above appears in section 3.4.

**Recommendation 5**

Consider amendments to the risk register formats in line with the report suggestions, especially the inclusion of assurances on the strategic risk register

### 3.3 Ownership of risk

**Overall accountability for risk management**

The CEO holds overall accountability for risk and delegates responsibility to the corporate governance directorate.

All risks are assigned owners at director level or project manager level for projects.

The CEO is clear that directors are accountable for the performance and risk management within their services and reporting runs through the service and directorate committee structure, and from the Transformation Board to CMT. The escalation route is through to the CMT. It is important to ensure accountability for identifying and addressing shared risk across services e.g. with ACHSCP.

The role of the ARSC is to have oversight of the systems for risk management and audit.

The provision of assurance to the Council is described variously as resting with the CMT and the ARSC, and the system for risk register review does not reflect a clear distinction between review of the effectiveness of the system for control on the on the hand, and the review of the effectiveness of the controls themselves, on the other. Suggestions for how this might be clarified appear in the specific sections below.

**Culture and understanding of risk**

The review observed and was told of considerable confusion about the nature and scale of risks and a concomitant difficulty in pitching discussions at various committees and groups at the right level. This affects the strength of risk management by limiting the quality and thus value of constructive challenge at Council meetings and committees. The development of a mature approach to risk appetite and proactive communications and engagement plans with elected members, officers, and service managers, should help to improve this picture.

These plans must include clarification of the roles of certain individuals, committees and groups. Key points about some of these are highlighted below.

### 3.4 Roles and responsibilities in relation to risk

**Elected Members**

Council members' corporate responsibility for decision-making needs to be discharged with good access to information, subject matter expertise, and against a background of transparency and scrutiny. There are huge expectations of elected members, who tend to be bombarded with a wealth of information on a range of diverse issues. Committee papers are substantial and late submission is reportedly an issue.

There is a Code of Conduct for members and a Member Officer Protocol is under development. While these give sound guidance for elected members, there is little detailed guidance on procedures around conflict of interest etc.

There is a need to improve confidence and awareness about the appropriate level of challenge and discussion, whether at full Council or at committee level, and where local politics or operational minutiae may not be appropriate to the discussion in hand.

Currently, neither the strategic risk register nor the corporate risk register is discussed at full Council. It is important that all Council members have an overview of key risks to Council business and how well these are being managed. It may be that the Council Group reviews the top line registers and reports to full Council.

There does not appear to be an effective, accessible structured programme for the induction or development of elected members. The governance review should reinforce the importance of these issues with Council members and allow for the standardising of terms and processes.

**Recommendation 6**

Ensure there is supporting guidance or worked scenario sand advice on induction for elected members on procedures concerning conflict of interest and liability

**Directors and officers**

Interviewees felt that the confidence of Council officers and directors in challenging elected members or each other at meetings varies.

**Performance and Risk Manager**

This role is pivotal to the operation and promotion of the risk management system and reports appropriately into the CGD. Many interviewees reported working closely with the incumbent and valuing his input. The current workload is skewed towards risk rather than performance, and there are no team members supporting this role on the risk remit. The reporting arrangements for this role seem to be largely into the Director of Corporate Governance but theoretically into the CGD Business Manager. It would be helpful to consider the creation or designation of a role dedicated to risk, reporting into the Performance and Risk Manager, and to consider clarifying the Manager's reporting role and / or change this to a direct report into the Director of Corporate Governance. Guidance on the role should make it clear that the officer is not holding the risk, but rather advising on how to identify, mitigate and provide/seek assurance.

**Recommendation 7**

Consider support to the Performance and Risk Manager and communicate and promote this role and the team role across the Council

**Risk Management Team**

More clarity is needed within the Council, its committees, directorates and services, about the role of the Performance Risk Manager and his team, although this has reportedly improved significantly in recent times. Integrating the approach to performance and risk reporting will help to strengthen this understanding further.

### Corporate Management Team

The CMT alternates its fortnightly meetings between stewardship and strategic issues. It is charged with discussing risk and compiling both the strategic risk register and the corporate risk register. The CEO also discusses risk in her one to one meetings with directors and they, in turn, should have discussed these with their service managers.

While the overall agendas are clearly structured, there does not appear to be a structured approach to discussion of risk at CMT, especially where there is no obvious driver (e.g. legal requirement) for the risk issue. As a consequence, meeting time can be taken up with ad hoc identification of likely risks and requesting further information, rather than the identification of cross cutting issues and horizon scanning.

**Recommendation 8**

Develop CMT agenda structure to include review high level risks reported through the system, and risks to be escalated to strategic risk register.

### Extended CMT

The senior management team - or extended CMT – comprising all directors and heads of services was suspended at the time of the GGI review. This appears to be partly due to a lack of clarity about its role. There are important functions that need to be fulfilled in terms of risk identification and moderation: i.e. sense checking the nature and scale of the issues headlining risk registers. While these may be fulfilled by a revitalised extended CMT, it is equally possible that they would fall into the remit of the Corporate Risk Management Group (see below). At this stage, and in the knowledge that the governance review may make further proposals, the GGI team recommends the identification of a forum for the following with some urgency.

- moderation of risk scores escalated to the corporate risk register
- review of high level risks from directorate risk registers
- compilation and refresh of corporate risk register
- submission of issues for escalation to CMT for the strategic risk register
- horizon scanning discussion and escalation

### Corporate Risk Management Group

This group ran for 1.5 years but reportedly the membership was too junior to fulfil its remit. It is important that heads of service are engaged in the reality check of how risk is recorded, shared, aggregated and escalated. Please see the suggested remit for a group of this nature above.

**Recommendation 9**

Consider re-establishing the Corporate Risk Management Group with a remit as discussed in this report

### Audit, Risk and Scrutiny Committee

The review team found that many interviewees felt that the level of challenge at the ARSC has improved and there was also a reduction in the level of operational detail discussed, although this still remains a concern. The Internal Audit Team has reported to the committee on the strengths and weaknesses of the risk management system. There was no structured discussion of risk management systems and developments at the meeting observed and a more formalised structure for considering risk may be beneficial. The members seem more comfortable with the internal audit role than with the risk management one. There was no observed review of the quality of assurance against risk, or of any gaps in assurance and how these would be addressed.

The 2015 self evaluation of the committee document observed by the team showed high levels of comfort with the committee's operations. It is likely that a more objective and comprehensive system across all committees would allow for comparison over time and measurement against planned improvement.

As a general rule the Audit Committee is not a performance committee, but should ensure that the business is being run according to its stated policies, procedures and guidelines. The Terms of Reference (ToR) for the ARSC make its role to oversee the effectiveness of governance, audit and risk systems clear.

Some duties listed in the ToR do not sit comfortably with the role of the ARSC, but stray into operational territory. These activities may be focussed on the actions of directly managed or arm's length services and the achievement of their objectives or compliance with standards. There is a belief amongst some interviewees that the ARSC reviews strategic and operational risk: while it should receive the registers to ensure that the system is operating effectively, it can have no management responsibility for the effectiveness or otherwise of the management of risk itself.

Committees should not hold management roles such as whistleblowing, although they may seek assurance that the processes are working and that access to routes for raising concerns is good. The receipt of specific concerns should not be a role for the ARSC, unless this is aggregated information which the ARSC uses to commission audit work or recommend specific actions to Council.

It also does not seem appropriate for the ARSC to be developing health and safety policy as this is a specialised area. Approval of the policy and oversight of achievement of its implementation plan are legitimate roles.

**Recommendation 10**

Refocus the ARSC to include:

- discussion of assurances to the risk management system
- review of its role in relation to whistleblowing and policy development

**Finance, Policy and Resources Committee**

The ToR for this committee do not mention risk although the team was told that it reviews its risk register regularly and also discusses the financial risks from the directorates. As it is charged with reviewing performance against objectives, as well as developing resource polices and plans, it is essential that committee members understand the risks to achievement of objectives which may be presented by resource allocation decisions.

**Transformation Board**

The Transformation Board has oversight and stewardship of all programmes within the Shaping Aberdeen portfolio. It reports progress into the CMT, aligning reporting with the relevant strategic priorities. Again, it seems logical that the board should review risk registers from programme and projects in order to fulfil its function, but this is not explicit in its ToR. The team takes this as a further indication that a risk management culture is not yet embedded or fully understood across the Council.

**Governance Hub and ALEO board**

The Governance Hub is relatively new and establishing regular meetings with Tier 1 and Tier 2 ALEOs to provide assurance via the ARSC to the Council that ALEO business is moderated by robust risk management arrangements.

The ALEO board is a very new forum, hosted by the Director of Corporate Governance and it has been warmly welcomed by the ALEO personnel interviewed. It is widely believed that it should develop a more strategic role in enabling the Council to ensure that there is clarity about what ALEOs can contribute to the Council's vision and stated direction, and to build upon opportunity in the context of horizon scanning and partnership working. The ALEO Board should have a clear focus on forward trajectories of delivery and the risks that could compromise achievement of objectives. Where a capacity challenge arises in relation to delivering assurance against risks, this should be escalated to the ALEO Board for refocusing of resources and capacity, and to Council where a re-prioritisation of objectives in time and scale is required.

Further commentary and recommendations on ALEO / Council relationship in the context of risk is given in section 3.8.

**Integration Joint Board**

The IJB is the decision-making body of the ACSCP and has a joint reporting relationship to ACC and to NHS Grampian. It has developed a risk appetite statement and risk reporting system which will be enhanced by the agreement of joint objectives with the Council (please see diagram 2.0 and section 3.6).

Much work has already been undertaken to understand the role of elected Council members on this Board. This clarification of responsibilities to the Integration Joint Board rather than the Council is a useful model for ALEOs requiring processes other than councillor attendance to provide assurance of safe, joined up, cost effective service delivery.

**Recommendation 11**

Establish a rigorous and objective evaluation process for all committees, to be considered by full Council

### 3.5 Risk reporting structure

The current risk reporting diagram – "Risk Management and Reporting Roles" shows all information flowing up to the ARSC. For the reasons set out in the section above, this may not be helpful or conducive to sound scrutiny and the separation of operational or management roles from strategic or assurance roles. The diagram observed does not describe roles for the CGD, the Transformation Board or the IJB.

Reportedly, a "common sense" approach is applied to the need to escalate risk. Undoubtedly heads of service and directors and other risk owners are responsible and knowledgeable about risk in their areas. However, the emerging risk measurement system (section 3.2) should be used to determine risk tolerances and appropriate and timely escalation in most cases. It is also imperative that service committees and directorate committees include review of risk registers as a standing item on agendas.

There needs to be a clear route through from service level to the corporate risk register, and Council members must have regular access to the top level risks on this register as well as to the strategic risk register, as well as to assurance that these are being managed (see assurance section 3.9).

The diagram below is a suggested revision incorporating a Corporate Management Group and showing how assurance might flow through committees and groups operating across the Council and its services. It should be viewed as a point for further discussion in view of the findings of the wider governance review and it should be noted that this shows risk reporting information as it flows through committees and groups and is not a substitute for management ownership and responsibility for risk which should predate and inform discussion at the committees.

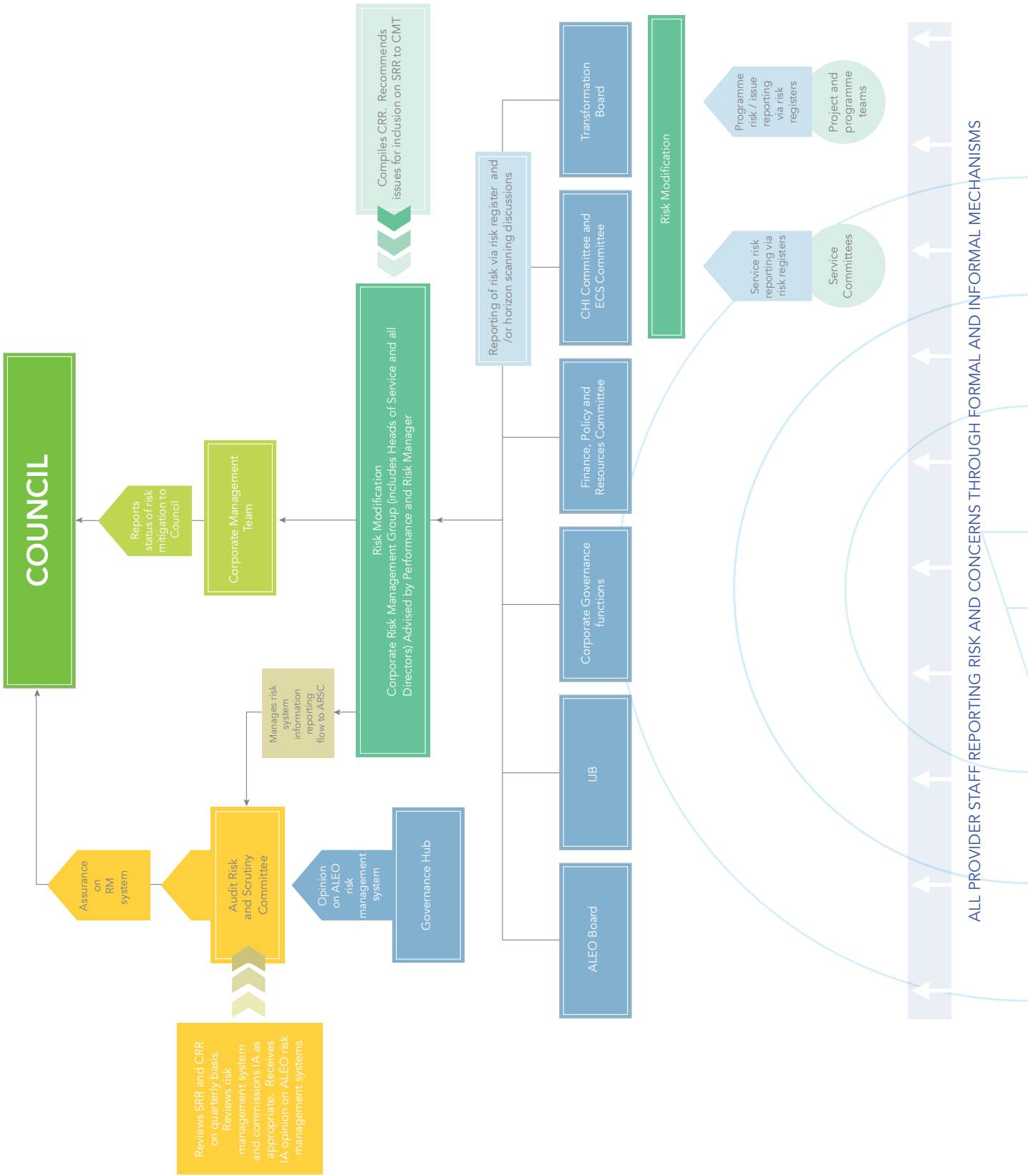



*Figure 2.0 Suggested risk reporting structure*

**Recommendation 12**

Consider streamlining risk reporting to include:

- clarity of delegation using risk tolerance levels
- escalation using risk scores
- service and directorate committees include review of their risk registers
- transformation board and IJB to report risk through to CMT via Corporate Risk Management Group
- Council to review strategic risk register and corporate risk register at agreed intervals

### 3.6 Risk processes

#### Identification

There is currently a lack of confidence at senior level at ACC about how and whether heads of service discuss forward risks, and whether risk registers reflect the true nature and scale of existing and future risk issues. The process is becoming more structured and embedded at directorate level but it is acknowledged that there is work to do at service level. Using a strategic priority framework for risk registers should aid this discussion, as will standardising committee agendas.

A fully formed picture of risk depends on a range of activities, amongst which are:

- understanding of risk, appetite, tolerance, assurance and accountability particularly where the objectives and risk are corporate or shared across service areas and responsibilities
- analysis of risk reporting and incident information from service level
- benchmarking with similar organisations and services
- review of national and local inquiries and their findings
- review of alerts, legislation etc.
- horizon scanning discussions
- consideration of risk implications for all reports to Council and its committees

While risk management training programmes will doubtless the formalised means of identifying risk, it is important to build in review of the external sources which may pose threats to Council objectives. These may emerge as part of horizon scanning discussions but there is evidence to suggest that relevant information may not always be recognised as an indication of potential risk. Developing and communicating the risk appetite approach with directors and officers can help to establish a more formalised approach to horizon scanning and the identification of forward risk, especially from external sources.

**Recommendation 13**

Support identification and discussion of risk by:

- formal training and induction
- standardising committee agendas
- use of risk appetite within risk system
- promotion of a range of risk identification methods

#### Risk assessment and the risk register system

The current risk measurement or scoring matrix operated six likelihood categories and four categories for impact. This is unusual in risk matrices generally used for public bodies, where a "5 by 5" matrix is often used. The review team perceives no problem with this per se, providing it can be standardised as far as possible across the Council, including preferably project and programme risk registers (which currently use different scoring matrices). The descriptors for likelihood categories move within only one category from "low" to "significant" and all descriptors are measured in terms of numbers of years (i.e. "low" is occurring once in 10 years and "significant" once every 5 years). The team remit did not include an evaluation of how consistently the scores are applied not whether the leap in scale from low to significant feels comfortable for scoring.

However, it would seem likely that this is a difficult scale to apply and may discourage people from scoring risks higher. Indeed, very few higher scoring risks were observed across risk registers. This results in a lot of green risks with the attendant risk that these are not regularly reviewed or interrogated to enable the Council to be proactive in prevention of emergent issues.

In terms of the impact scale, there are descriptors for each point on the scale. Many public bodies use a more complex impact table which separate out the different dimensions of impact. An example from NHS Scotland is shown below:

**NHS Scotland Core Risk Assessment Matrices**

**Table 1 - Impact/Consequence Definitions**

| Descriptor | Negligible | Minor | Moderate | Major | Extreme |
|---|---|---|---|---|---|
| **Patient Experience** | Reduced quality of patient experience/ clinical outcome not directly related to delivery of clinical care. | Unsatisfactory patient experience/clinical outcome directly related to care provision – readily resolvable. | Unsatisfactory patient experience/clinical outcome, short term effects – expect recovery <1wk. | Unsatisfactory patient experience/ clinical outcome, long term effects –expect recovery > 1wk. | Unsatisfactory patient experience/clinical outcome, continued ongoing long term effects. |
| **Objectives/ Project** | Barely noticeable reduction in scope, quality or schedule. | Minor reduction in scope, quality or schedule. | Reduction in scope or quality of project; project objectives or schedule. | Significant project over-run. | Inability to meet project objectives; reputation of the organisation seriously damaged. |
| **Injury (physical and psychological) to patient/ visitor/staff.** | Adverse event leading to minor injury not requiring first aid. | Minor injury or illness, first aid treatment required. | Agency reportable, e.g. Police (violent and aggressive acts). Significant injury requiring medical treatment and/or counselling. | Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling. | Incident leading to death or major permanent incapacity. |
| **Complaints/ Claims** | Locally resolved verbal complaint. | Justified written complaint peripheral to clinical care. | Below excess claim. Justified complaint involving lack of appropriate care. | Claim above excess level. Multiple justified complaints. | Multiple claims or single major claim. Complex justified complaint. |
| **Service/ Business Interruption** | Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service. | Short term disruption to service with minor impact on patient care. | Some disruption in service with unacceptable impact on patient care. Temporary loss of ability to provide service. | Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked. | Permanent loss of core service or facility. Disruption to facility leading to significant "knock on" effect. |
| **Staffing and Competence** | Short term low staffing level temporarily reduces service quality (< 1 day). Short term low staffing level (>1 day), where there is no disruption to patient care. | Ongoing low staffing level reduces service quality **Minor error** due to ineffective training/implementation of training. | Late delivery of key objective/ service due to lack of staff. **Moderate error** due to ineffective training/ implementation of training. Ongoing problems with staffing levels | Uncertain delivery of key objective /service due to lack of staff. **Major error** due to ineffective training/implementation of training. | Non-delivery of key objective/ service due to lack of staff. Loss of key staff. **Critical error** due to ineffective training / implementation of training. |
| **Financial (including damage/loss/ fraud)** | Negligible organisational/ personal financial loss (£< 1k). | Minor organisational/ personal financial loss (£1-10k). | Significant organisational/ personal financial loss (£10-100k). | Major organisational/personal financial loss (£100k-1m). | Severe organisational/ personal financial loss (£> 1m). |
| **Inspection/Audit** | Small number of recommendations which focus on minor quality improvement issues. | Recommendations made which can be addressed by low level of management action. | Challenging recommendations that can be addressed with appropriate action plan. | Enforcement action. Low rating. Critical report. | Prosecution. Zero rating. Severely critical report. |
| **Adverse Publicity/ Reputation** | Rumours, no media coverage. Little effect on staff morale. | Local media coverage – short term. Some public embarrassment. Minor effect on staff morale/ public attitudes. | Local media – long-term adverse publicity. Significant effect on staff morale and public perception of the organisation. | National media/adverse publicity, less than 3 days. Public confidence in the organisation undermined. Use of services affected. | National/International media/ adverse publicity, more than 3 days. MSP/MP concern (Questions in Parliament). Court Enforcement. Public Enquiry/FAI. |

**Table 2 - Likelihood Definitions**

| Descriptor | Rare | Unlikely | Possible | Likely | Almost Certain |
|---|---|---|---|---|---|
| **Probability** | • Can't believe this event would happen<br>• Will only happen in exceptional circumstances. | • Not expected to happen, but definite potential exists<br>• Unlikely to occur. | • May occur occasionally<br>• Has happened before on occasions<br>• Reasonable chance of occurring. | • Strong possibility that this could occur<br>• Likely to occur. | This is expected to occur frequently/in most circumstances more likely to occur than not. |

Version March 2013

**Table 3 - Risk Matrix**

| Likelihood | Consequences/Impact | | | | |
|---|---|---|---|---|---|
| | Negligible | Minor | Moderate | Major | Extreme |
| Almost Certain | Medium | High | High | V High | V High |
| Likely | Medium | Medium | High | High | V High |
| Possible | Low | Medium | Medium | High | High |
| Unlikely | Low | Medium | Medium | Medium | High |
| Rare | Low | Low | Low | Medium | Medium |

References: AS/NZS 4360:2004 'Making It Work' (2004)

**Table 4 - NHSG Response to Risk**

Describes what NHSG considers each level of risk to represent and spells out the extent of response expected for each.

| *Level of Risk* | Response to Risk |
|---|---|
| Low | Acceptable level of risk. No additional controls are required but any existing risk controls or contingency plans should be documented. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. |
| Medium | Acceptable level of risk exposure subject to regular active monitoring measures by Managers/Risk Owners. Where appropriate further action shall be taken to reduce the risk but the cost of control will probably be modest. Managers/Risk Owners shall document that the risk controls or contingency plans are effective. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Managers/Directors/Assurance Committees will periodically seek assurance that these continue to be effective. |
| High | Further action should be taken to mitigate/reduce/control the risk, possibly urgently and possibly requiring significant resources. Managers/Risk Owners must document that the risk controls or contingency plans are effective. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Managers/Directors/Executive and Assurance Committees will periodically seek assurance that these continue to be effective and confirm that it is not reasonably practicable to do more. The Board may wish to seek assurance that risks of this level are being effectively managed. However NHSG may wish to accept high risks that may result in reputation damage, financial loss or exposure, major breakdown in information system or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public. |
| Very High | Unacceptable level of risk exposure that requires urgent and potentially immediate corrective action to be taken. Relevant Managers/Directors/Executive and Assurance Committees should be informed explicitly by the relevant Managers/Risk Owners. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. The Board will seek assurance that risks of this level are being effectively managed. However NHSG may wish to accept opportunities that have an inherent very high risk that may result in reputation damage, financial loss or exposure, major breakdown in information system or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public. |

*Figure 3.0 NHS Scotland Core Risk Assessment Matrices (A more legible version is included in Appendix II)*

The advantage of this approach is that it enables managers and staff to consider a range of impacts, which may be present, but at different degrees or may appear to conflict e.g. a high risk to client safety may be mitigated by taking a decision that has a high financial cost. The decision-making involved is aided by the approach to setting risk appetite outlined in this report. The value of an impact table as suggested is that it can help to make decision-making around risk more consistent, transparent and realistic.

The newly revised risk management system aims to standardise the format for risk registers. It is understood that directorates and, the team assumes, services will move to this format. The new formats observed are an improvement in the following areas:

- tighter description of risk issue
- inclusion of consideration of potential impact
- closer attention to describing controls and effectiveness, leading to identification of mitigating actions required

However, there does not appear to be facility for:

- aligning risk with strategic priorities (see previous comments)
- source of risk – i.e. was it on a service or other risk register – how was it escalated / reported?
- recording the target risk score or any note of risk appetite
- metrics used for evaluating success of mitigating actions and explaining movement or closure of risks
- assurances – these are at times confused with controls or gaps in assurances

It was not clear to the team how "current" and "residual" risk terms are now being used. This was also not clear in previous versions. Presumably, current now refers to the actual risk score with controls in place and taking into account their effectiveness. Previously, this term was used to mean "inherent" in some cases. In the new format, it is unclear whether "residual" score means the target score or the current score.

The team appreciates the work and thought that has underpinned the new format, and suggests that this is supported over the next year, perhaps with the additions and amendments listed in our recommendations. The system and formats should be evaluated at the end of this period with particular regard to how accessible and useful they prove to be for service line managers and their teams, as embedding of a risk system depends on the involvement of those who are most likely to confront and manage risk on a daily basis. GGI believes that the nature of risk held on a strategic risk register – or a board assurance register - lends itself to a different format from the operational risk registers – whether at corporate, directorate or service level. We would be happy to discuss this further and provide examples, in the light of the wider governance and/or risk register review.

Multiple risk registers also lead to confusion on how to manage composite risk of risks, and it is important to clarify how cross-cutting and shared risks are managed. GGI believe a simple guide and extended scheme of delegation to include risk ownership will support clarity of role and the remit of different groups.

The importance of identifying where and how risk scores are moderated has been set out in the Roles and Responsibilities section above. The following diagram suggests how risk issues from risk registers might be escalated, based on the adoption of a standardised scoring system for projects and services. As it may not be possible to agree a standardised system with all ALEOs, an agreement about how they delegate risk tolerances and how they report triggers for escalation with these organisations should be reached and qualifying risk issues reported at Governance Hub meetings.

The effectiveness of using risk scores for escalation will depend on promotion of the system and a proactive risk management education and awareness support programme (see section 3.7). However, investment in this process will pay dividends in enabling a less subjective consideration of complex issues which may cut across organisational boundaries.

**Recommendation 14**

Standardise risk register and recording system and terminology as far as possible, to validate the use of risk scores for escalation. Issues to consider include:

- review of likelihood scores
- the use of a table allowing for different dimensions of impact
- alignment with strategic priorities
- risk target and risk appetite
- metrics for success of mitigating actions
- assurances and gaps in assurance

**Recommendation 15**

Agree delegated tolerances and triggers for escalation with all ALEOs within agreed risk appetite and tolerance

**Recommendation 16**

Evaluate the system for acceptability and consistency after year one of operation

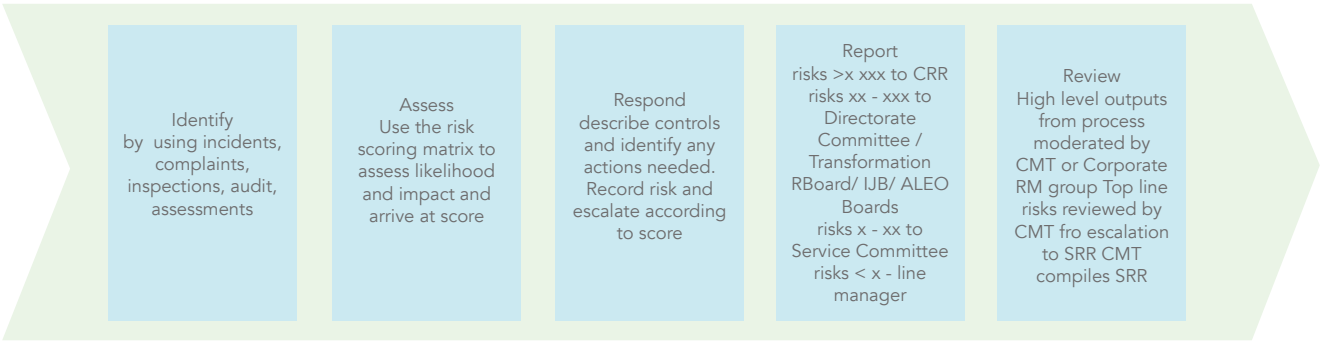



*Figure 4.0 Escalation of risks from risk register*

**Risk monitoring - closing the loop**

Mitigating actions must be monitored both to ensure they have been implemented and also to assess their effectiveness.

The CGD operates a robust system for monitoring and closing off actions. Directorate senior management teams undertake monthly monitoring of risk to assess the need for escalation. This should be undertaken in the light of risk scores as detailed in the previous section. This discipline should now be rolled out to service committees.

While the CMT monitors action plans at a high level, this does not seem to be a formalised process overall and a CMT action tracker would be helpful. Action plans reported to the CMT are standardised and there is a good discipline of clarifying the actions required of the CMT.

Most interviewees felt that learning was ad hoc across the Council's business and tended to be in reaction to events, rather than emanating from analysis of operations, horizon scanning or risk reporting.

The risk management strategy observed describes the role of service risk champions. While these have been identified, it is less clear whether they are currently fulfilling any specific role for identifying and sharing learning. There is plenty of scope emerging from this review to use these roles to engage with Council staff and partners and to spearhead the embedding of new processes.

**Recommendation 17**

An action tracker could assist the CMT in closure of actions

**Recommendation 18**

The potential contribution of service risk champions to learning within, between and beyond services should be defined

**Risk processes at service level**

Council officers and directors are conscious of the fact that risk management is not yet embedded at service level. It is encouraging to note that heads of service are working on populating risk registers which are, or will be, linked to service plans. The risk assessment methodology is better understood in some places than others and the CGD has a challenge in ensuring that services are supported in taking a risk-based approach to planning and performance reporting. The directorate has category managers in place whose role will be to take a business partner approach with the services. Services will need support in:

- recognising emergent risks
- liaising and sharing risks and opportunities with other services, across directorates and partners, including the implications of mitigating actions
- formalising and minuting discussions around risk

- completion of performance reporting and business case templates
- contributing to the planned annual review of the system

**Recommendation 19**

Support to services from the CGD in embedding risk management systems should be recognised, resourced and time-limited if appropriate

**Risk process issues – projects and programmes**

Systems and processes relevant to project management are described within the corporate project management toolkit. The Project Management Office (PMO) is developing dashboard reporting and strategic projects are all reported through the PMO to the Transformation Board, which reporters to the CMT. Services manage programmes, supported by the PMO.

As mentioned previously, the risk measurement matrix generally used in project risk registers differs from the main Council approach. There is very little monitoring or assurance information provided. The Council's Performance and Risk Manager works closely with the PMO and is committed to bringing the systems in line with each other. Lack of clear accountability for project risks was mentioned to the team as an issue, and the directorate or service senior management teams are expected to monitor risk identification and management across their projects and programmes.

The assurance route was variously described as running through ARSC and also to CMT – see previous commentary on risk reporting structure (section 3.5 for a suggested clarification that this should be primarily through directors and the CMT).

## 3.7 Risk supports

**Information**

The Council relies on the Covalent system for its risk information capability. There was some feeling that the system does not meet all directorate needs. There was also awareness that the analysis and transformation of data into intelligence was weak across the Council, and that the optimal level of detail in Council papers may not always be achieved. There is a need to develop a strategy aligned to priorities, which also identifies the strengths and weaknesses of current management information systems in relation to these goals.

**Recommendation 20**

Build risk management information needs and evaluation of the Covalent system into Information Communications Technology (ICT) strategy and plans

**Training and development**

Elected members and others interviewed identified a need for a programme which they can realistically access and that focuses on their roles in Council, and as committee convenors or members. Other staff and partners also spoke of emerging training needs.

There appear to be many different strands to an ideal programme but, in relation to risk management, the GGI team would very broadly suggest the following:

| | Elected members | Directors and officers | Head of service and managers | Directors in partner organisations |
|---|---|---|---|---|
| Risk appetite discussion | X | X | | X |
| Risk roles on council and committee – eg conflict of interest / code of conduct – scenario testing | X | X | | |
| Building confidence and skill in constructive challenge | X | X | | |
| Risk management awareness | X | X | X | X |
| Risk identification and assessment – using the system | | X | X | |
| Testing risk scores – moderation of assessment | | X | | X |
| Investigation and learning from events | | X | X | X |

**Recommendation 21**

Develop training and development programmes tailored to stakeholder groups with summaries to be incorporated into induction packs

### 3.8 Relationships with provider stakeholders

**Aberdeen City Health and Social Care Partnership**

Through the Integration Joint Board (IJB), the ACHSCP has set its risk appetite and approved its overall approach to assurance. Its strategic priorities are aligned with the Council's overall vision and values. While it has its own risk management methodology, there is clarity about how significant risks are measured and escalated. The IJB agenda and reports go to full Council, including statutory, financial and the Chief Social Worker's report, as part of its accounting relationship with ACC. There is currently a challenge in streamlining which reports go through the internal audit routes and which go to the Council. This is likely to become more pressing as the ACHSCP moves forward with its integration agenda, and it is critical to establish a succinct form of reporting relevant risks.

**Recommendation 22**

Using the risk appetite statement, agree with IJB reporting routes for specific papers and establish their place in cycle of business

## Arm's Length External Organisations

As part of the review of risk management, GGI was asked to consider the relationship between the Council's Governance Hub and the ALEOs, with particular reference to the level of assurance that is currently being provided. It is likely that many of our comments below will be more relevant to Tier 1 ALEOs than others.

## Role of the Governance Hub and accountabilities

There is a clear role described for the scrutiny of performance against objectives via the Governance Hub to the ARSC. However, the ALEO senior managers interviewed reported being unclear about how their organisational objectives aligned with those of the Council and a consequent lack of clarity about expectations. This impacts understandably on the efficiency and effectiveness of reporting, with many ALEOs reporting that they provide the Council with Key Performance Indicators (KPIs) that are not used within their organisations, nor deemed to be helpful to business. What became clear during the review was that the Governance Hub is not the appropriate forum for discussion of expectations and current or emerging objectives and targets: the recently convened ALEO board is much better placed. This has only recently started to meet and has been met with enthusiasm by many ALEO officers. The GGI team believes that there has been conflation of two different roles:

- the setting and agreement of aspirational goals and mutual planning and horizon scanning on the one hand, and
- the scrutiny of performance against agreed objectives, on the other

Several interviewees expressed concern that there was confusion about accountability at the Council for some ALEOs, depending on which directorate had originally commissioned services. While elected members and the full Council must be ultimately accountable for all services they commission, it would seem logical that the relevant service directorate has delegated responsibility for assessing performance, assisted by audit processes.

## Governance Hub meetings

Several issues emerged from our review of meetings:

- there is too much paperwork provided for meetings, running into 100s of pages of audit results – it is laudable that some ALEOs are open and transparent with their data but detailed reporting should be by exception i.e. where there are significant risk or performance issues and other wide dependent on reporting of the working of risk management and performance systems, rather than process measures
- the burden of attending 28 meetings annually (this includes pre meeting with convenors) will be unsupportable in future – the differentiation of business at the Governance Hub and at the ALEO board should help to address this, as will tighter management of reporting
- while questioning and challenge at meetings is informed and thorough, there is too much operational and process detail discussed, much of which could be addressed outside of, and prior to, meetings. This could also address concerns about accuracy of reports and discrepancies which can reportedly lead to confrontational exchanges at meetings
- the terminology around audit is used inconsistently: internal audit as a function should be differentiated from the range of audit methods and measures which all organisations will have to assess the quality and performance of their business
- in the absence of clear objectives and an agreed dataset to demonstrate achievement and progress against these, there is a tendency to rely on word of mouth e.g. "presumably you will....." which elicits a positive response but does not constitute proper scrutiny, or provide tracking or strong assurance of delivery

**Gaining assurance: requirements and reporting dataset**

The Governance Hub arrangements are still relatively new and tackling the challenge of finding the right level of assurance from ALEOs. The 2015 internal audit report into governance made several recommendations in relation to ALEOs which are being addressed.

The Director of Procurement is currently reviewing service level agreements with ALEOs and this should ensure that there is alignment with Council objectives, and thus a transparent means of demonstrating a return on investment. This presents an opportunity to reset KPIs which are meaningful to the ALEO itself as well as to the Council, and which support the achievement of ACC's vision for Aberdeen. The dataset template to be submitted to the Governance Hub and upon which questioning should be based might include the ALEO's top scoring risks and mitigation and assurance status.

The procurement team has recently produced a suggested template for reporting to the Governance Hub. This is an excellent initiative and should be refined and extended to cover finance, risk, quality, health and safety and other considerations.

Personnel from the education and children's directorate have participated in a performance review workshop with IJB members and are developing more meaningful KPIs as a result.

Many interviewees reported a wish to measure and discuss outcomes e.g. the effect of participation in sport on obesity and health. While this is desirable, it is challenging and would be better planned into the emerging ALEO board's agenda and / or to workshops operating outside of hub meetings themselves.

In terms of risk, there is scope to work with a group of ALEOs to consider standardisation of risk systems (see section 3.8) and to share approaches to measuring and managing risk. As a minimum, the Governance Hub should be receiving assurance that there is a risk register in place which covers:

- alignment with objectives
- delivery against trajectory milestones
- risk owners
- target risk
- assessment of current controls and planned mitigating actions
- reasons for movement of risk
- internal and assurance means and assessment if any gaps

They should also be assured that the ALEO has a functioning structure and board level review of risk, and a range of routes for raising concern and escalation of risks – both formal and informal.

In terms of other types of assurance, most ALEOs can demonstrate accreditation to voluntary and/or mandatory standards e.g. ISO 9000 and ISO12012, Investors in People, and other professional body accreditations or quality statements according to the nature of their business. ACC can take assurance from these accreditations providing renewals or changes are reported to them and they have access to any associated high level reports or action plans.

One of the internal audit report recommendations was that the Council members of Governance Hub meetings should articulate an opinion on the level of assurance they had gained from ALEO officers after each meeting. The hub convenor will then produce a summary statement of assurance, inform the AEO of the content of this summary statement, and pass this to internal audit for submission to the ARSC. In the meetings observed, Council officers seemed unsure of what level of assurance they had gained in some examples and unwilling to make a definitive statement in others. This is understandable as there is no clarity about what level of accountability is expected of them. While no one can guarantee that nothing can go wrong in an organisation, the hub should be receiving enough information – both before, during and outwith the meetings – to satisfy members that the structures and systems are in place and working as intended to deliver agreed outcomes or that issued and problems in the working of structures and systems have been identified and plans are in place to deal with these.

The use of templates as discussed above and other suggestions in this section and in the whole of this report should contribute to the hub's ability to have confidence that it can fulfil this requirement. The range of assurances discussed in this section could also be used to develop a method for deciding appropriate levels of scrutiny for different ALEOs, depending on which tier they belong to, the health of their financial performance and the degree of risk their operations may pose to the Council's objectives. This was another internal audit recommendation.

**Relationships in the future**

During the review, many suggestions were made to improve relationships between ALEOs and the Council. These include:

- developing the agenda for the ALEO board as illustrated below
- increasing the capacity in the Council for liaison between directorates and ALEOs
- encouraging ALEO board members or trustees to attend Council meetings
- encouraging elected members to attend ALEO board or committee meetings
- inviting elected members to visit ALEOs
- sharing risk management approaches

**Differentiating the roles of the Governance Hub and the ALEO board**

| Governance Hub – one to one with individual ALEO | ALEO board – involving members of all ALEOs (of all tiers) |
|---|---|
| • holding ALEO executives to account for achievement against goals agreed with ACC<br>• reviewing KPIs<br>• receiving and challenging information on the operation of the ALEO's structure and systems in term of governance , risk management and assurance of ALEO Board members<br>• forming an opinion based on information for onward submission to ARSC | • meeting with ALEOs to discuss objectives and strategy<br>• discussion of cross-cutting issues between ALEOs in terms of overall strategic direction<br>• discussion of governance systems and assurance approaches<br>• Discussion of how best to measure outcomes<br>• horizon scanning debates |

**Recommendation 23**

Differentiate the scrutiny and assurance role of Governance Hub from the strategic and horizon scanning role of the ALEO board

**Recommendation 24**

Agree objectives for each ALEO in line with the Council's vision and priorities, facilitating:

- revised KPIs
- streamlined reporting dataset templates

**Recommendation 25**

Locate accountability for ALEO performance with the relevant service directorate supported by the CGD, who oversee the operation of the governance process

**Recommendation 26**

Review opportunities to standardise or share risk management approaches

**Recommendation 27**

Clarify acceptable ALEO assurances to include quality audits and external accreditation schemes

**Recommendation 28**

Consider a range of initiatives to improve informal relationships between ALEOs and Council members and officers

### 3.9 Assurance mapping

The team has been asked to consider the assurance map exercise undertaken by PriceWaterhouseCoopers (PWC) in January 2015, in the light of how comprehensive it is and how valid its approach might be. Further to the report on the crematorium incident this summer, ACC has issued instruction for the development of a full assurance map and required Council directors to involve service committees in the process for checking the existence and adequacy of assurances emanating from ACC itself.

While CIPFA will wish to form an opinion and comment as a result of the wider governance review, our response can be summarised as follows:

- the PWC approach is theoretically sound, and maps assurances from three different sources – business, corporate and external or independent against the operations and services within remits of the three Council directorates
- the methodology involved discussion with directors and heads of service – if these are the individuals completing risk registers, performance reports and service plans, this is a sound approach to covering the right issues
- the assurances listed do not give a sense of the cycle of business and assurance that is needed to provide a true picture of assurance: rather they list the functions, reviews and audits in terms of the process or the resulting report without any reference to reporting periods
- such a map can only ever be a snapshot in time as the nature of services as well as the strength or other wise of assurances, will change over time
- many of the interviewees of the GGI review did not seem sighted on the exercise or aware of what it was for: this indicates a more important issue about assurance picked up elsewhere in this report
- before the assurance mapping exercise can be successfully completed, there is an awareness raising task to be undertaken with elected members, directors and heads of service covering:
    - the nature of assurances and the cycle of assurance
    - the difference between controls and assurances in relation to the risk management process and risk registers
- an assessment of assurances (business and corporate) should be built into the risk register system as a matter of urgency: gaps in assurances should be identified and actions for addressing these implemented

In addition to these comments, the team has picked up some service-specific concerns about the adequacy of assurances which we include here for information. It should be stressed that these issues have been reported by interviewees but have not been triangulated with other data:

- social care risk – child and adult protection
- security of social care records / IT
- insufficient horizon scanning of national inquiries and potential issues (eg crematorium incident)
- lack of process for holding police to account

- lack of assurances on fleet management
- lack of assurance that innovation and service redesign will still be within mandatory or legal requirements
- compromised ability to align workforce plans with strategy and service plans

**Recommendation 29**

Reinforce the assurance mapping task by:

- building review of assurances into Council business cycle
- define and communicate the distinction between controls and assurances
- engage heads of service in the recognition and analysis of assurances of good risk management
- build the identification and assessment of assurances as an integral part of the risk management system, reflected in risk registers

# Appendix I

## Recommendations

**Recommendation 1**

Clarify top line strategic objectives for the Council and standardise which will be used for performance and risk reporting systems

**Recommendation 2**

Compile an assurance framework which describes components of assurance system for compliance and for transformation

**Recommendation 3**

Ensure that the revised risk management strategy incorporates risk management objectives

**Recommendation 4**

Hold workshops with Council to discuss and agree risk appetite. Develop an associated risk appetite statement, to underpin Council decision-making

**Recommendation 5**

Consider amendments to the risk register formats in line with the report suggestions, especially the inclusion of assurances on the strategic risk register

**Recommendation 6**

Ensure there is supporting guidance or worked scenario sand advice on induction for elected members on procedures concerning conflict of interest and liability

**Recommendation 7**
Consider support to the Performance and Risk Manager and communicate and promote this role and the team role across the Council

**Recommendation 8**

Develop CMT agenda structure to include review high level risks reported through the system, and risks to be escalated to strategic risk register.

**Recommendation 9**

Consider re-establishing the Corporate Risk Management Group with a remit as discussed in this report.

**Recommendation 10**

Refocus the ARSC to include

- discussion of assurances to the risk management system
- review of its role in relation to whistleblowing and policy development

**Recommendation 11**

Establish a rigorous and objective evaluation process for all committees, to be considered by full Council

**Recommendation 12**

Consider streamlining risk reporting to include:

- clarity of delegation using risk tolerance levels
- escalation using risk scores
- service and directorate committees include review of their risk registers
- transformation board and IJB to report risk through to CMT via Corporate Risk Management Group
- Council to review strategic risk register and corporate risk register at agreed intervals

**Recommendation 13**

Support identification and discussion of risk by:

- formal training and induction
- standardising committee agendas
- use of risk appetite within risk system
- promotion of a range of risk identification methods

**Recommendation 14**

Standardise risk register and recording system and terminology as far as possible, to validate the use of risk scores for escalation. Issues to consider include:

- review of likelihood scores
- the use of a table allowing for different dimensions of impact
- alignment with strategic priorities
- risk target and risk appetite
- metrics for success of mitigating actions
- assurances and gaps in assurance

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- build the identification and assessment of assurances as an integral part of the risk management system, reflected in risk registers

# NHS Scotland Core Risk Assessment Matrices

## Table 1 - Impact/Consequence Definitions

| Descriptor | Negligible | Minor | Moderate | Major | Extreme |
|---|---|---|---|---|---|
| **Patient Experience** | Reduced quality of patient experience/ clinical outcome not directly related to delivery of clinical care. | Unsatisfactory patient experience/clinical outcome directly related to care provision – readily resolvable. | Unsatisfactory patient experience/clinical outcome, short term effects – expect recovery <1wk. | Unsatisfactory patient experience/ clinical outcome; long term effects –expect recovery >1wk. | Unsatisfactory patient experience/clinical outcome, continued ongoing long term effects. |
| **Objectives/ Project** | Barely noticeable reduction in scope, quality or schedule. | Minor reduction in scope, quality or schedule. | Reduction in scope or quality of project; project objectives or schedule. | Significant project over-run. | Inability to meet project objectives; reputation of the organisation seriously damaged. |
| **Injury (physical and psychological) to patient/ visitor/staff.** | Adverse event leading to minor injury not requiring first aid. | Minor injury or illness, first aid treatment required. | Agency reportable, e.g. Police (violent and aggressive acts). Significant injury requiring medical treatment and/or counselling. | Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling. | Incident leading to death or major permanent incapacity. |
| **Complaints/ Claims** | Locally resolved verbal complaint. | Justified written complaint peripheral to clinical care. | Below excess claim. Justified complaint involving lack of appropriate care. | Claim above excess level. Multiple justified complaints. | Multiple claims or single major claim. Complex justified complaint. |
| **Service/ Business Interruption** | Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service. | Short term disruption to service with minor impact on patient care. | Some disruption in service with unacceptable impact on patient care. Temporary loss of ability to provide service. | Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked. | Permanent loss of core service or facility. Disruption to facility leading to significant "knock on" effect. |
| **Staffing and Competence** | Short term low staffing level temporarily reduces service quality (< 1 day). Short term low staffing level (>1 day), where there is no disruption to patient care. | Ongoing low staffing level reduces service quality **Minor error** due to ineffective training/implementation of training. | Late delivery of key objective/ service due to lack of staff. **Moderate error** due to ineffective training/ implementation of training. Ongoing problems with staffing levels | Uncertain delivery of key objective /service due to lack of staff. **Major error** due to ineffective training/implementation of training. | Non-delivery of key objective/ service due to lack of staff. Loss of key staff. **Critical error** due to ineffective training / implementation of training. |
| **Financial (including damage/loss/ fraud)** | Negligible organisational/ personal financial loss (£<1k). | Minor organisational/ personal financial loss (£1-10k). | Significant organisational/ personal financial loss (£10-100k). | Major organisational/personal financial loss (£100k-1m). | Severe organisational/ personal financial loss (£>1m). |
| **Inspection/Audit** | Small number of recommendations which focus on minor quality improvement issues. | Recommendations made which can be addressed by low level of management action. | Challenging recommendations that can be addressed with appropriate action plan. | Enforcement action. Low rating. Critical report. | Prosecution. Zero rating. Severely critical report. |
| **Adverse Publicity/ Reputation** | Rumours, no media coverage. Little effect on staff morale. | Local media coverage – short term. Some public embarrassment. Minor effect on staff morale/ public attitudes. | Local media – long-term adverse publicity. Significant effect on staff morale and public perception of the organisation. | National media/adverse publicity, less than 3 days. Public confidence in the organisation undermined. Use of services affected. | National/International media/ adverse publicity, more than 3 days. MSP/MP concern (Questions in Parliament). Court Enforcement. Public Enquiry/FAI. |

## Table 2 - Likelihood Definitions

| Descriptor | Rare | Unlikely | Possible | Likely | Almost Certain |
|---|---|---|---|---|---|
| **Probability** | • Can't believe this event would happen<br>• Will only happen in exceptional circumstances. | • Not expected to happen, but definite potential exists<br>• Unlikely to occur. | • May occur occasionally<br>• Has happened before on occasions<br>• Reasonable chance of occurring. | • Strong possibility that this could occur<br>• Likely to occur. | This is expected to occur frequently/in most circumstances more likely to occur than not. |

Version March 2013

## Table 3 - Risk Matrix

| Likelihood | Consequences/Impact | | | | |
|---|---|---|---|---|---|
| | Negligible | Minor | Moderate | Major | Extreme |
| Almost Certain | Medium | High | High | V High | V High |
| Likely | Medium | Medium | High | High | V High |
| Possible | Low | Medium | Medium | High | High |
| Unlikely | Low | Medium | Medium | Medium | High |
| Rare | Low | Low | Low | Medium | Medium |

References: AS/NZS 4360:2004 'Making It Work' (2004)

## Table 4 - NHSG Response to Risk

Describes what NHSG considers each level of risk to represent and spells out the extent of response expected for each.

| *Level of Risk* | Response to Risk |
|---|---|
| **Low** | Acceptable level of risk. No additional controls are required but any existing risk controls or contingency plans should be documented.<br>Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. |
| **Medium** | Acceptable level of risk exposure subject to regular active monitoring measures by Managers/Risk Owners. Where appropriate further action shall be taken to reduce the risk but the cost of control will probably be modest. Managers/Risk Owners shall document that the risk controls or contingency plans are effective.<br>Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective.<br>Relevant Managers/Directors/Assurance Committees will periodically seek assurance that these continue to be effective. |
| **High** | Further action should be taken to mitigate/reduce/control the risk, possibly urgently and possibly requiring significant resources. Managers/Risk Owners must document that the risk controls or contingency plans are effective. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective.<br>Relevant Managers/Directors/Executive and Assurance Committees will periodically seek assurance that these continue to be effective and confirm that it is not reasonably practicable to do more. The Board may wish to seek assurance that risks of this level are being effectively managed.<br>However NHSG may wish to accept high risks that may result in reputation damage, financial loss or exposure, major breakdown in information system or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public. |
| **Very High** | Unacceptable level of risk exposure that requires urgent and potentially immediate corrective action to be taken. Relevant Managers/Directors/Executive and Assurance Committees should be informed explicitly by the relevant Managers/Risk Owners.<br>Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective.<br>The Board will seek assurance that risks of this level are being effectively managed.<br>However NHSG may wish to accept opportunities that have an inherent very high risk that may result in reputation damage, financial loss or exposure, major breakdown in information system or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public. |

Good Governance Institute

# Risk Appetite for Health & Social Care Partnerships
## A maturity matrix to support better use of risk in partnership decision taking

Aberdeen City Health & Social Care Partnership
A caring partnership

DEVELOPED WITH ABERDEEN CITY H&SCP
V 1.1 OCT 2015

| RISK LEVELS / KEY ELEMENTS | 0 AVOID<br>Avoidance of risk and uncertainty is a Key Organisational objective; No consensus by partners | 1 MINIMAL (ALARP)<br>(as little as reasonably possible) Partners have reference for ultra-safe delivery options that have a low degree of inherent risk and therefore potential for only limited reward | 2 CAUTIOUS<br>Partners have preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward | 3 OPEN<br>All parties willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM) | 4 SEEK<br>All parties eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk) | 5 MATURE<br>Partnership confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust |
|---|---|---|---|---|---|---|
| FINANCIAL /VFM | Avoidance of financial loss is a key objective. Only willing to accept the low cost option. VfM is the primary concern. | Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern. | Prepared to accept the possibility of some limited financial loss. VfM still the primary concern but willing to also consider other benefits or constraints. Resources generally restricted to existing commitments | Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on potential opportunities. | Prepared to invest for the best possible return and accept the possibility of financial loss (with controls and assurances in place). Resources allocated without firm guarantee of return – 'investment capital' type approach | Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself |
| COMPLIANCE / REGULATORY | Avoid anything which could be challenged, even unsuccessfully. Play safe | Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances | Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge | Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences. | Chances of losing any challenge are real and consequences would be significant. A win would be a great coup. | Consistently pushing back on regulatory burden. Front foot approach informs better regulation |
| INNOVATION/ QUALITY / OUTCOMES | Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems / technology developments | Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations | Tendency to stick to the status quo, innovations generally in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations. | Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved. | Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control. | Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice. |
| REPUTATION | No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern | Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management encouraged to distance themselves from any chance of exposure to attention | Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest | Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Proactive management of organisation's reputation | Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation | Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweigh the risks. New ideas pursued |
| APPETITE | NONE | LOW | MODERATE | HIGH | SIGNIFICANT | |

Based on the Risk Appetite Matrix developed initially by HMT, 2005 and subsequently by GGI and Southwark BSU, 2011


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Appendix 2

| Action | Priority (high, medium or low) | Timescale |
|---|---|---|
| Clearly align our strategic objectives with risk management and risk reporting systems. | High | December 2016 |
| Compile an assurance framework which describes components of assurance system for compliance and for transformation. Ensure risks are identified, evaluated, controlled and have appropriate assurance mapped out in order to inform internal audit planning for the 2017/18 financial year. (May require external resource). | High | March 2017 |
| Ensure that the revised risk management strategy incorporates risk management objectives. | High | February 2017 |
| Amend the risk register formats in line with the report suggestions, especially the inclusion of assurances on the strategic risk register | High | March 2017 |
| **Streamline risk reporting to include:** | | |
| • clarity of delegation using risk tolerance levels | Medium | June 2017 |
| • escalation using risk scores | High | February 2017 |
| • service and directorate committees include review of their risk registers | High | February 2017 |
| • Council to review strategic risk register and corporate risk register at agreed intervals | Medium | June 2017 - |
| Standardise risk register and recording system and terminology as far as possible, to validate the use of risk scores for escalation, metrics for success of mitigating actions and to incorporate different dimensions of impact. | High | March 2017 |
| Develop an action tracker to assist the CMT in closure of actions | High | March 2017 |
| Using the risk appetite statement, agree with IJB reporting routes for specific papers and establish their place in cycle of business | High | March 2017 |
| Reinforce the assurance mapping task by:<br>• Building review of assurances into Council business cycle<br>• Define and communicate the distinction between controls and assurances<br>• Engage heads of service in the recognition and analysis of assurances of good risk management. | Medium | June 2017 |
| Hold workshops with Council to discuss and agree risk appetite. Develop an associated risk appetite statement, to underpin Council decision-making. | Medium | June 2017 |

| | | |
|---|---|---|
| Ensure there is supporting guidance or worked scenarios and advice on induction for elected members on procedures concerning conflict of interest and liability. | Following May elections. | |
| Establish a risk identification and moderation role for the ECMT which encompasses:<br>• Horizon-scanning, discussion and identification of new risks.<br>• Compilation and refresh of corporate operational risk register.<br>• Review of high level risks from directorate risk registers.<br>• Submission of issues for escalation to the CMT for strategic risk register.<br>• Moderation of risk scores in the corporate operational risk register. | Medium | June 2017 |
| **Support identification and discussion of risk by:** | | |
| • Formal training and induction | Ongoing | |
| • Standardising committee agendas | Part of wider Governance Review | |
| • Use of risk appetite within risk system | Medium | June 2017 |
| • Promotion of a range of risk identification methods | Ongoing (part of training process) | |
| Build risk management information needs and evaluation of the covalent system into Information Communications Technology (ICT) strategy and plans | Medium | April – June 2017 |
| Develop training and development programmes tailored to stakeholder groups with summaries to be incorporated into induction packs. | Medium | April – September 2017 |
| Evaluate the system for acceptability and consistency after year one of operation | Low | October 2017 |
| Agree delegated tolerances and triggers for escalation with all ALEOs within agreed risk appetite and tolerance | As part of the Governance Review, the recommendations of the reports by both the GGI and CIPFA will be assimilated so that appropriate amendments to the ALEO governance process can be made which will ensure that the support of ALEOs is retained as we move forward | |
| Differentiate the scrutiny and assurance role of Governance Hub from the strategic and horizon scanning role of the ALEO board | | |
| Agree objectives for each ALEO in line with the Council's vision and priorities, facilitating:<br>• revised KPIs<br>• streamlined reporting dataset templates | | |
| Locate accountability for ALEO performance with the CGD, informed by Subject Matter Experts from the relevant service directorate | | |
| Review opportunities to standardise or share risk management approaches | | |
| Clarify acceptable ALEO assurances to include quality audits and external accreditation schemes | | |
| Consider a range of initiatives to improve informal relationships between ALEOs and Council members and officers | | |

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ABERDEEN
CITY COUNCIL

# Internal Audit Report

# Finance

# Budget Monitoring

**Issued to:**
Richard Ellis, Interim Director of Corporate Governance
Steven Whyte, Head of Finance
Sandra Buthlay, Accounting Manager
Carol Smith, Accounting Manager
Doris Wyness, Finance Projects Manager

**Date of Issue: November 2016** **Report No. AC1610**

## EXECUTIVE SUMMARY

The Council budgeted General Fund net revenue expenditure of £443,627,000 for 2015/16.

Budget holders across each Service have been assigned responsibility for specific elements of income and expenditure under their control. Finance supports Service budget holders by providing access to budget monitoring information including actual expenditure to date, committed funds and forecast outturns and through regular budget holder meetings. Finance then prepare reports to Service Management, and Service Committees, highlighting spending patterns and forecast variations from budget in order to demonstrate performance and advise on any areas of risk and corresponding management action.

The objective of this audit was to review procedures used for monitoring the Council's budget. Although there are timetables in place, and individual Finance teams have their own guidance notes, there is no comprehensive corporate procedure document for budget monitoring. Some variation in practice, and in the quality of supporting records and report narrative, was therefore identified, and improvements have been recommended. Finance will review and incorporate these into new written procedures.

Committees scrutinise financial performance through Finance budget monitoring reports on a regular basis, however it was noted that the Chief Executive's Service and Corporate Budgets are presented for scrutiny to the same level of detail. In comparison to other budgets, these are smaller sums (amounting to 7.5% of the total Council budget), however it remains important that expenditure in these areas is accounted for transparently, including providing opportunity for scrutiny by the appropriate Committee. Finance does not consider that this is a significant risk since the budgets are reported at an overall level. Any exceptional matters at any time in the cycle would be escalated to the Director, CMT and relevant Committee Convenor.

# 1. INTRODUCTION

1.1 The Council budgeted General Fund net revenue expenditure of £443,627,000 for 2015/16.

1.2 Budget holders across each Service have been assigned responsibility for specific elements of income and expenditure under their control. Finance supports Service budget holders by providing access to budget monitoring information including actual expenditure to date, committed funds and forecast outturns. Finance, in consultation with relevant budget holders then prepare reports to Service Management, and Service Committees, highlighting spending patterns and forecast variations from budget in order to demonstrate performance and advise on any areas of risk and corresponding management action.

1.3 The objective of this audit was to review procedures used for monitoring the Council's budget.

1.4 The factual accuracy of this report and action to be taken with regard to the recommendations made have been agreed with Steven Whyte, Head of Finance.

# 2. FINDINGS AND RECOMMENDATIONS

## 2.1 Written Procedures

2.1.1 Comprehensive written procedures which are easily accessible by all members of staff can reduce the risk of errors and inconsistency. They are beneficial for the training of current and new employees and provide management with assurance of correct and consistent practices being followed, especially in the event of an experienced employee being absent or leaving.

2.1.2 Documentation on the Zone shows the Finance and Service responsibilities in respect of budget monitoring but does not go into detail on how Finance should fulfil those requirements. Although the roles and responsibilities of Finance and Services are set out at a high level, there is limited information available to document responsibilities within Finance for producing, reviewing and reporting budget monitoring information. There are a number of procedures within Accounting teams setting out the process in more detail, but these have evolved over time and could benefit from being more accessible to budget holders.

2.1.3 There is a fixed timetable for production of budget monitoring data, and much of the process is driven by the financial system. Individual accounting teams have standing processes which are followed each monitoring period, however much of this relates to the detailed completion of specific tasks rather than setting out the principles and practices to be applied. Although there are similarities in the tasks performed, there is no 'corporate' comprehensive procedure for budget monitoring applied across Finance. Without this there is a risk of variation in practice which might lead to varying quality of budget monitoring information.

**Recommendation**
Finance should develop comprehensive budget monitoring procedures for Finance staff to follow, including documenting roles and responsibilities.

**Service Response / Action**
Agreed. The budget monitoring timetable sets out a clear, consistent method in practice to the significant processes of the budget monitoring approach. This includes budget reporting cycles and dates for reports to services, accruals and forecasting, reporting to SMT's, CMT and Committees, budget holder meetings. In addition, there are a number of procedures in place for specific elements of the process. It is recognised that there could be a corporate, comprehensive procedure document, and further that there could be a clearer document about roles and responsibilities. This will be put in place.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| April 2017 | Accounting Manager | Important within audited area |

2.1.4 There is no formal training for budget holders. Finance has stated it has recognised the need to instil ownership in Services, and is working on Councillors training. Budget holder training will be covered under phase two of the Finance Framework – which sets out a strategy for developing financial competency within the Council. Without clear guidance and training there is a risk that the requirements of their role will not have been communicated or understood by management, and budget monitoring information may be incomplete or inaccurate as a result.

**Recommendation**
Finance should develop and provide training for budget holders.

**Service Response / Action**
Agreed. There are a number of training programmes that have been developed for budget holders, and there was a formal training programme in 2013. It is recognised that this needs to be refreshed. Informal training is provided as part of the new budget holder induction and support is provided by their Finance contact through budget holder meetings. This allows training and support to be tailored to the budget holder's requirements.

The Reporting and Monitoring E&CS team are delivering a set of training sessions for Educational Establishment staff, which started in September 2016. Formal training and other resources are being developed as part of the Shaping Aberdeen Use of Resources Academy. This will start rolling out in November 2016. A dedicated training team is under consideration as part of the revised Accounting structure. Finance Framework training will be delivered to all budget holders by December 2017.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| December 2017 | Accounting Manager | Important within audited area |

## 2.2 Scheduling and Reporting

2.2.1 Budget monitoring is timetabled for presentation to Corporate Management Team (CMT). It is not specifically scheduled to meet individual Service and Policy Committee dates thereafter – it is a standing item on Committee agendas, and each will receive the most up to date figures available. Although each receives a report on an approximately quarterly basis, aligned with the Committee cycle, different Service Committees may therefore receive financial information for different periods. Committees may also not receive the same periods' monitoring reports in subsequent financial years.

| | Budget monitoring reported to: | | | |
|---|---|---|---|---|
| | **CH&I** | **E&CS** | **FP&R** | **IJB / E&CS** |
| **September 2015** | | June 2015 | July 2015 | |
| **October 2015** | July 2015 | | | |
| **November 2015** | | Cancelled | | |
| **December 2015** | | | October 2015 | |
| **January 2016** | October 2015 | November 2015 | | October 2015 |
| **February 2016** | | | | |
| **March 2016** | December 2015 | January 2016 | | January 2016 |
| **April 2016** | | | February 2016 | |
| **May 2016** | February 2016 | | | |
| **June 2016** | | March 2016 | March 2016 | |
| **July 2016** | | | | |
| **August 2016** | May 2016 | | | June 2016 |

2.2.2 Data is still produced in the intervening periods for CMT and management purposes, and therefore still informs management action. However, inconsistency in reporting periods could affect the ability of Committees to monitor trends in their Service's financial performance.

2.2.3 Although Committees are provided with information regularly, as can be seen in the above table, it is normally two months after the end of the period to which it relates. Depending on scheduling of Committee meetings, there may in some circumstances be limited opportunity to scrutinise financial performance, and direct appropriate action, in advance of the end of the financial year. However, Finance has stated that any exceptional important matters at any time in the cycle would be escalated to the Director, CMT and relevant Committee Convenor.

2.2.4 In contrast to other Service budgets, costs relating to the Chief Executive's Service budget (£3,241,000), and Corporate Budgets (£29,930,000), are not being reported to a Committee, except as a single line within quarterly overall Council General Fund monitoring reports to the Finance Policy and Resources Committee (FP&R).

2.2.5 The Chief Executive's Service budgets include expenses for the Chief Executive's Office, Civic Support, Media and Promotions. Corporate Budgets include Capital Financing Costs, Supplementary Pensions, Welfare Reform Grants, Councillors Expenses, Joint Boards, Contingencies, and Trading Operations.

2.2.6 According to the Council's Standing Orders, FP&R should monitor all Council budgets, but is specifically accountable for Corporate Governance and the Chief Executive's Service budgets and performance. No separate reports have been provided to FP&R regarding the latter, and these have not been included within the reports for Corporate Governance. It will be difficult for the Committee to manage the Chief Executive's Service budget and performance without separate budget monitoring detail.

**Recommendation**
Finance should ensure all budgets are monitored and reported to a standing Committee of the Council.

**Service Response / Action**
Not agreed. It is not considered that this is a significant risk since the budgets are reported at an overall level. Any exceptional matters at any time in the cycle would be escalated to the Director, CMT and relevant Committee Convenor. It is not felt that there is any risk to the financial performance as a result of this schedule.

**Audit Position**
Although in comparison to other budgets, these are smaller sums (amounting to 7.5% of the total Council budget), it remains important that expenditure in these areas is accounted for transparently, including providing opportunity for scrutiny by the appropriate Committee.

**Grading**
Major at a Service Level

2.2.7 CMT reports provide bottom line figures for Revenue and Capital budgets for the General Fund, Trading Services, Housing Revenue Account and Common Good. Trends and key risks are documented. There is minimal discussion of any individual Services or Directorates within the reports.

2.2.8 There is also limited evidence of discussion of performance and figures in CMT meeting minutes. Whilst there is general discussion of finance related issues, this does not often involve detailed review of the budget monitoring figures. However, as the monitoring is largely by exception and the periods reviewed were in surplus, and within 10% variance overall (which CMT includes as 'green' within a traffic light system), it is unlikely that much discussion would have been necessary. Finance has stated that new savings, cost pressure, and earmarked reserve, trackers are being presented regularly to CMT for the 2016/17 financial year: which will provide additional information regarding areas identified as at risk during the budget setting process.

2.2.9 Although there is a link between the CMT and Service Committee budget monitoring papers, the extent to which the data is summarised means that it is difficult to identify a clear link between items highlighted in individual Service papers, the Corporate General Fund monitoring paper presented to FP&R, and the CMT report.

2.2.10 Most of the Committee papers reviewed as part of this audit did not clearly state on the cover which period the monitoring figures apply to. Although in most cases this detail was included in the accompanying tables / appendices, it should be clear from the cover of the report. Not clearly identifying which period monitoring reports refer to could cause difficulty in interpreting the data – since spend to date, and accuracy of forecasts, will increase the further through the financial year they progress.

2.2.11 The majority of the figures presented in Committee papers are 'bottom line' only for each Service. Within Corporate Governance budget monitoring the bottom line figures for Finance are separately reported to those for HR, Legal and others, in a single table. In a separate table, the combined costs for all of these are then split by expenditure category. As a result, variations (e.g. underspends on Staffing and overspends on Transport costs) are not clearly attributable to any particular Service within Corporate Governance. Although significant variations at an individual Service level are discussed in the narrative section of the Committee report, there is no clear connection between the figures in the tables and the variances described in the narrative. Combining budgets at a summary level could mask variations between Services which may be of interest to Committees. As it is not possible to reconcile variance notes with the narrative, Committees will not have assurance that all variances have been appropriately explained.

2.2.12 This is not the case with CH&I and E&CS, which present both a summary and a separate analysis into account categories for each Head of Service. Variance notes are then provided, and separately calculated, for each Head of Service area. Although this is clearer, the headings do not clearly demonstrate which services fall under which Head of Service. For example it is not immediately clear what services come under 'Public Infrastructure and Environment' within CH&I, or 'Lead Service Manager 2' within Social Care. Providing clarity regarding which budgets are under the control of which Heads of Service would aid interpretation of the budget monitoring figures by putting them in context, and improve readers' ability to match these with the accompanying notes. However, Finance does not consider that this would add value to the reports.

2.2.13 There is a standard format of Committee report, which is also used for presenting budget monitoring information. Sections on 'Impact' and 'Management of Risk' do not appear to be well used: in most cases these include generic statements about the usefulness of budget monitoring information rather than explaining the risks and impact on delivery of services resulting from variations in actual and forecast spend compared with the budget applying to that particular Service. Explanation of the risks and how they are being managed would provide additional assurance to Committees. Finance has stated that more recent reports do include additional detail, as they continue to develop through a process of continuous improvement.

2.2.14 Whilst it would not be appropriate to provide excessive detail on all operational issues, it is vital that the Committees are able to understand the nature of budget variances and have assurance over management's actions. Committee papers could be improved to provide further assurance to Councillors that Service budgets are being managed appropriately.

**Recommendation**
Finance should review the content and format of budget monitoring Committee reports to ensure an adequate and consistent level of detail is presented to each Committee, with a clear link between each level of reporting.

**Service Response / Action**
Not Agreed. The Council has a strong recent history of financial management as evidenced through our external audit reports. There is a thorough approach to presenting reports to appropriate levels of management. There is a consistent source of data in the ledger that aligns to our statutory reporting information. The style of reports has been tailored to specific needs of our customers. Whilst it is recognised there are some minor inconsistencies in our reporting this is not perceived as a control risk for the organisation. It is recognised that it is important to consider the fitness for purpose of reports, particularly in light of the new challenges facing the City and Public Sector but this is something incorporated in our ongoing processes.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| N/A | N/A | Significant within audited area |

2.2.15 Committee papers should contain enough detail to describe the circumstances surrounding budget variances, i.e. why they have occurred and what the implications are, as well as describing the actions being taken by management to address and mitigate these variations. In carrying out the audit, a number of committee reports were reviewed with varying detail found.

2.2.16 For example:

- "the underspend (£x) reflects lower than budget spending on staffing";
- "the adverse movement since the previous period is due to additional spend";
- "the adverse variance reflects shortfalls in recoveries";

2.2.17 There is currently no set standard for budget variance notes, and as a result notes can be inconsistent. Other than those included in a high level summary which is presented quarterly to FP&R on the overall position, which provides more detail but only on major variances, the majority of notes simply state in which service or budget line the variance has occurred. Variance notes should do more than highlight that there has been a variance between budget and actual or forecast outturn. They should explain why there has been a variance, and provide assurance that action is being taken to resolve it.

2.2.18 The way in which reports are set out might also cause confusion, as often multiple variances are discussed within the same sentence, paragraph or bullet point. Prior and detailed knowledge of the Service and its functions are also assumed, as in addition to the points discussed at 2.2.12 above there is extensive use of acronyms and jargon.

2.2.19 Applying a standard which includes the following would improve the quality of budget monitoring variance information and provide additional assurance to management and Councillors:

- Requirement to provide information to management / Councillors on why a specific budget is under or overspent;
- Sufficient detail to allow the reader to grasp the reason without having to ask further questions; explaining rather than noting the variance;
- Whether or not it is recurring;
- Whether the forecast has changed substantially from previous periods;
- Whether it affects service delivery;

- How is it being dealt with;
- Avoiding jargon, unexplained abbreviations, and acronyms

2.2.20 For example:

- "the underspend (£x) reflects lower than budget spending on staffing. This is due to a combination of recruitment difficulties in area y, and vacancies in area z being held open pending completion of a service structure review. Management anticipates the review will be complete by the end of the financial year and has engaged with HR to develop new recruitment initiatives. In the interim agency staff are being utilised where necessary."

**Recommendation**
Finance should develop a standard for budget variance notes, including the requirement for clear reference to why a variance has occurred and what action is being taken in response.

**Service Response / Action**
Agreed. It is recognised that the quality of explanations is variable in written documents and it is agreed that a standard guidance should be introduced.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| April 2017 | Accounting Manager | Significant within audited area |

2.2.21 Budget holders at all levels are provided with BOXI reports – summarised data available live or downloaded from the financial system. There is no narrative in these reports, but there is a traffic light system to indicate variances in excess of £10,000. Further detail is available to recipients who may use the reports to access the details of individual transactions which make up the summary balances.

2.2.22 Finance engages with budget holders through regular meetings, at which more relevant information is discussed, and used to review forecast outturns and prepare Highlights and Committee reports. Although minutes are typically retained, there is no formal reporting at this level. More formal analysis at a Head of Service or Manager level might yield benefits in terms of explaining to operational managers what they are spending and why, and allowing them to take relevant action as appropriate.

2.2.23 Service Management Teams are provided with Highlights reports on a monthly basis. These are in a similar format to the Committee reports, but contain additional detail which is more relevant to management. As with Committee reports, only larger variances are reported, and costs are typically grouped across different services or cost types, making it difficult to verify them back to the ledger directly.

**Recommendation**
Finance should consider whether management needs are being met by the existing complement of reports.

**Service Response / Action**
Not Agreed. The Service considers that management needs are being met effectively. Budget holders can review data at any point using BOXI reports, and will meet regularly with Finance through budget holder meetings and Finance Partner attendance at management team meetings. Highlights reports allow Service Management Teams to focus attention on high risk areas. Budget holders were consulted extensively on the reports and feedback is always welcome on the content of the reports.

| Audit Comment | Grading |
|---|---|
| Service position noted. | Important within audited area |

**2.3 Data Processing and Output**

2.3.1 Transaction data is held within the financial ledger system: e-financials. The system is regularly updated with new transactions, for example: invoices, payroll, and journal entries (financial adjustments). At the end of each month checks are carried out and the current period is closed for new transactions, balances are rolled forward, and all new transactions will be posted to the next period.

2.3.2 As noted at 2.1.3 above much of the work completed by Finance is driven by the need to process information through the financial system:

- Budgets and profiles are uploaded to the ledger.
- Figures are downloaded each period to check actual costs and provide a baseline for adjustments.
- BOXI reports are sent out to budget holders at various levels.
- Journals are prepared and uploaded to update budgets.
- Journals are prepared and uploaded to update accruals.
- Journals are prepared and uploaded to update forecasts.
- Figures are downloaded again, and reviewed to prepare Highlights reports.
- Updated BOXI reports are sent out to budget holders at various levels.
- Highlights reports are sent to / discussed with budget holders.
- Figures are downloaded again, and reviewed to prepare Committee reports.
- Committee reports are published.

2.3.3 Data can be extracted directly, via BOXI reports, or from Collaborative Planning – a system designed to provide access to financial data for budget holders, and to facilitate them updating forecasts and narrative explanations directly, without direct access to the financial system. It appears to have been the intention to use Collaborative Planning for all services and budget holders, in order to reinforce the role of services in monitoring their budgets, however use of this system varies.

2.3.4 In order to demonstrate the accuracy of budget monitoring data provided to Committee and CMT, Internal Audit sought to reconcile the figures presented in reports to data downloaded from the financial system. Although the majority of figures matched, there remained unreconciled differences. These have subsequently been explained as manual adjustments to the reported figures, which had not been applied to the ledger in the period concerned. Whilst there may be good reasons for doing so: in order to report a more accurate position; the audit trail becomes less clear.

2.3.5 Although Finance collates data in a spreadsheet, which could be used to reconcile ledger and reported figures, and explain the differences, it is not currently being populated with sufficient information to do so.

**Recommendation**
Finance should ensure it can demonstrate that all figures included in reports for management and committees can be reconciled to ledger data.

**Service Response / Action**
Not Agreed. There are a number of control checks in place to reconcile corporate level data to service data. The source of all financial information is the ledger system. If recent and significant changes need to be reported that supersedes the ledger information this may be adjusted.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| N/A | N/A | Significant within audited area |

2.3.6 Variations were also evident between the budget, year to date variance, and forecast outturn figures depending on the point at which reports from the financial system were run. Further investigation revealed that changes had been made retrospectively to budgets at the end of the financial year, including: transfers from Capital to Revenue expenditure, adjustments for internal charges, and changes to reporting lines for staff costs. This meant that the reported results for prior periods could not be replicated at a later date. Adjustments should not have a backdated effect on prior periods' data, as it reduces the transparency of the audit trail.

**Recommendation**
Finance should ensure that journals do not have a backdated effect on prior ledger periods.

**Service Response / Action**
Not Agreed. There are a number of situations where retrospective adjustments are appropriate.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| N/A | N/A | Significant within audited area |

2.3.7 An 'accrual' is an accounting term for including transactions completed to date but not yet recorded in the financial system, within the current period's results. Accruals may be processed for items which have been purchased and received, but not yet invoiced – in order to reflect the current level of expenditure. Similarly spend committed via Purchase Order may be accrued for in advance in order to demonstrate that the remaining budget has been reduced. It may also be appropriate in some instances to process a negative accrual (a prepayment) where expenditure has been incurred but the value is still to be received.

2.3.8 Finance regularly processes accruals to reflect such adjustments. In many cases it is apparent that accruals are being processed to make up the difference between actual year to date spend and the anticipated spend based on the number of months progressed into the financial year. This process is recommended in many of the Finance teams' guidance notes and is replicated across the majority of budget lines reviewed. However, this smooths the actual spend data and may mask the fact that expenditure is variable throughout the year, or whether it has or has not occurred in line with expectations.

2.3.9 Neither Highlights reports (for management) nor Committee reports contain details of the original actuals or the accruals – these are combined into a single 'revised actual' figure, though it is not declared as such: it is called "Actual Expenditure". This could be misleading, as readers are likely to assume that these are actual costs incurred to date.

2.3.10 Although there is a record of the net value of accruals in the ledger system, there is generally only a limited audit trail supporting their calculation. Some accounting teams and individuals keep more records and notes than others.

2.3.11 Whilst it is appropriate that professional judgement is applied, which may not always be based on a specific detailed calculation, there is a risk that incorrect or unsupported revisions may be made and not identified, resulting in adjusted actual spend figures which are not reflective of service expenditure to date. If these figures are used to determine ongoing spending priorities, decisions may be made on the basis of inaccurate information. This is partly mitigated by the segregation of duties and review stages through which each set of monitoring figures passes, however these checks are at a summary level, and may miss smaller variations – which could have a cumulative effect or affect individual lower level budget holders' actions.

**Recommendation**
Finance should ensure it can demonstrate that accruals have been appropriately calculated, and applied only where necessary.

**Service Response / Action**
Agreed. The current accruals methodology has been in place for a number of years and it is recognised that it needs to be reviewed for consistency and materiality across the service areas. The main focus of financial control in year is forecast outturn rather than the accrued in-year position. There should be a greater focus on looking at a high level of spending profiles as a predictor of forecast outturn rather than detailed focus on minor accruals. This will be incorporated in the new procedures in 2.1.3.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| April 2017 | Accounting Manager | Significant within audited area |

2.3.12 Accruals are entered into the financial system as a journal entry. However, journal line descriptions are not self-evident, therefore there is a reduced audit trail. For example:

- "Accrual P9 Dec Agency Staff";

2.3.13 As accruals are applied only to one particular field in the financial system, a user will already know a journal to this part of the financial system is an accrual. The period and account code and their names are already in the system and linked to this record – therefore do not need to be duplicated in the line description. Re-stating these elements is not efficient and does not provide additional value. It would provide more valuable information if the need for the accrual was provided instead. This would also help demonstrate that accruals were for legitimate value received or obligations entered into but not yet paid, rather than adjusting the actual cost to date figures. For example:

- "Charges for agency provided at x location between y & z dates not yet invoiced."

**Recommendation**
Finance should ensure that journal line descriptions are clear and meaningful.

**Service Response / Action**
Agreed. It is recognised that the quality of explanations is variable in written documents and it is agreed that a standard guidance should be introduced.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| April 2017 | Accounting Manager | Significant within audited area |

**2.4 Forecasting**

2.4.1 An important part of the budget monitoring process is determining the forecast year end outturn for each budget. This can only ever be a best estimate, based on professional judgement and knowledge of the service, and consultation with budget holders, however it is key to ensuring that the Council's budget is met. Management may need to take action in response to forecast budget variances, in order to resolve them before the end of the financial year.

2.4.2 The accuracy of the forecast should increase with each successive period of budget monitoring as new information on income and expenditure patterns is received. At a Council and Directorate level the final year-end outturns for 2015/16 were all within a small percentage variance of each Directorate's budget (-5% to +3%), and differences between forecasts and final outturn were also very small in percentage terms (-4% to +2%). This level of accuracy was generally maintained between periods.

2.4.3 For a sample of budgets at a Head of Service level there was more variation in the level and accuracy of forecasts (-15% to +27%), and the outturn from budget (-11% to +39%). The level of accuracy was maintained in some areas, and deteriorated marginally in others, between periods. At a detailed cost centre level variations were more marked, but not all forecasts are entered, or regularly updated, at this level of detail. This may be as a result of focusing on higher risk and more material budget variances.

2.4.4 Although there is a record of the net value of forecast changes in the ledger system, there is generally only a limited audit trail supporting their calculation. Forecasts are being updated by Finance teams based on their own judgement or figures provided by budget holders – directly or via Collaborative Planning. As with accruals there are limited records of how forecasts have been calculated or arrived at. Whilst there are records of budget holder meetings, these do not all clearly demonstrate or match the changes to individual forecasts.

2.4.5 Whilst it is appropriate that professional judgement is applied, which may not always be based on a specific detailed calculation, there is a risk that incorrect or unsupported revisions may be made and not identified, resulting in adjusted forecast figures which are not as accurate as they could be. If these figures are used to determine ongoing spending priorities, decisions may be made on the basis of inaccurate information. This is partly mitigated by the segregation of duties and review stages through which each set of monitoring figures passes, however these checks are at a summary level, and may miss smaller variations – which could have a cumulative effect or affect individual lower level budget holders' actions.

2.4.6 Forecasts at a detailed level are often not changed to demonstrate an anticipated variance from the budget until later in the financial year, particularly where spend has been less than expected in the year to date. As a result, in combination with the accrual of expected spend as discussed at 2.3.8 above, it can look as though budgets will be fully spent, even though they have not been thus far. This is prudent – as there may still be expenditure later in the year, and Services will want to avoid an over-spend. However, as there is a delay between the end of the period and publication of management and Committee reports the following month/s, this may not leave much time to take action to resolve under-spends by virement or spending.

2.4.7 If forecasts are not updated regularly there is a risk that expenditure variations will not be corrected promptly. Where spend is less than profiled there may be a temptation to leave the forecast at the budgeted level, as the service may still spend the full budget, and the perceived risk is lower than those areas at risk of over-spending. However, under-spending and over-forecasting risks tying up resources unnecessarily.

**Recommendation**
Finance should ensure it can demonstrate that forecasts have been appropriately calculated, and are updated regularly – including where spend is less than profiled.

**Service Response / Action**
Not Agreed. Forecasts are agreed in consultation with budget holders at budget holder meetings. It is not evident that these findings materially compromise the forecast process. This would be picked up by training identified in 2.1.4

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| N/A | N/A | Significant within audited area |

## 2.5 Variance Identification and Commentary

2.5.1 Forecast variances from budget indicate a need for management action. However, not all variances will be material in size or nature. Finance has set a variance threshold of £50,000, at which point a variance note must be produced and included within relevant reports to management and Committees.

2.5.2 The threshold applies regardless of the size of the budget line affected: i.e. this is £50,000 whether the budget is £50,000 or £50,000,000. Although straightforward to apply, a variance of £50,000 may be insignificant in percentage terms for larger budgets, and would not cover smaller variances which whilst less material in the context of a Service or Council budget, may represent a significant impact on specific aspects of service delivery.

2.5.3 Applying a mixed threshold, or more than one threshold, including both a percentage and an absolute value may provide more useful information. E.g. variances exceeding 5% of the relevant budget and £10,000, and those exceeding £50,000.

**Recommendation**
Finance should regularly review the variance threshold and tolerances.

**Service Response / Action**
Agreed. The current agreed method was decided after consultation in order to provide a simple to understand method. It is recognised that the needs of the organisation may change in more challenging economic times. The revised procedures in 2.1.3 will consider the approach to materiality and ensure financial risk is appropriately reported and managed through the use of thresholds.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| April 2017 | Accounting Manager | Important within audited area |

2.5.4 Application of the materiality level varies according to how the budget monitoring figures are combined – for example in the Committee and Highlight reports there are often divisions or combinations of costs across a directorate. For example staff costs across Finance, Procurement and Legal might collectively vary by over £50,000 but individually by less than £50,000. If presented by Service, there would be no variance note required, but if presented by category there would. Presentation varies between the Directorates.

Standardising this would promote consistency in variance reporting, but might be considered unnecessary if the Committees / management are satisfied with existing reports.

**Recommendation**
Finance should review the consistency of presentation of budget monitoring reports across services to ensure variances are consistently identified and reported.

**Service Response / Action**
Agreed. This will be incorporated in procedures in 2.1.3.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| April 2017 | Head of Finance | Important within audited area |

2.5.5 As with accruals and forecasts there is limited supporting evidence to demonstrate that variances have been assessed and discussed with management. Variances are typically identified and highlighted but there is limited information on their nature and action being taken to resolve them.

**Recommendation**
Finance should ensure there are clear records of discussion of variances with management, including their extent, nature and actions being taken to resolve them.

**Service Response / Action**
Agreed. Variances are discussed and highlighted at budget holder meetings, SMTs, CMT and Committee. It is recognised that there could be clearer documentation of the nature and discussions undertaken and this will be incorporated in the revised procedures highlighted in 2.1.3.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| April 2017 | Accounting Manager | Important within audited area |

2.5.6 The Financial Regulations set out a scheme of virement – which sets out the rules for moving budgets between different headings and services after they have been set by Full Council for the year. Approval must be sought from Service Committees for specific types and values of virement, and they must be advised of others approved by management.

2.5.7 Whilst it is evident that approval for some virements is being sought from Service Committees, not all virements are being clearly documented in order to explain their necessity and impact before they are processed and changes are made to budgets. It is not apparent that virements selected from the financial system for review by Internal Audit were included within a Committee report (though they may have formed part of a larger whole) as the relevant budgets and / or values have not been clearly disclosed in the Committee reports. In other cases there does not appear to have been any reference in Committee reports to virements within the areas audited, yet budgets have been vired. Although the ledger system holds an audit trail of virements processed against the budget, as with other journal entries there is limited narrative detail to explain them.

2.5.8 As with budget monitoring reporting, Office of the Chief Executive and Corporate Budget virements are not reported to a Committee. This could provide significantly more opportunity to make budget changes within these areas without seeking Committee approval.

**Recommendation**
Finance should ensure adherence to the scheme of virement is clearly documented and adhered to.

**Service Response / Action**
All virements are processed by the budgeting team, and have to be signed off by a Finance Business Partner. The budget tracker records all cases of virement. OCE and Corporate budget virements would be reported through FP&R Committee. The importance of recording virements to an appropriate level of detail will be incorporated in the revised procedures highlighted in 2.1.3. This is not seen as a significant risk to budgetary control.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| April 2017 | Accounting Manager | Significant within audited area |

**AUDITORS:** D Hughes
C Harvey

**Appendix 1 – Grading of Recommendations**

| GRADE | DEFINITION |
|---|---|
| **Major at a Corporate Level** | The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss, or loss of reputation, to the Council. |
| **Major at a Service Level** | The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss to the Service/area audited.<br><br>Financial Regulations have been consistently breached. |
| **Significant within audited area** | Addressing this issue will enhance internal controls.<br><br>An element of control is missing or only partial in nature.<br><br>The existence of the weakness identified has an impact on a system's adequacy and effectiveness.<br><br>Financial Regulations have been breached. |
| **Important within audited area** | Although the element of internal control is satisfactory, a control weakness was identified, the existence of the weakness, taken independently or with other findings does not impair the overall system of internal control. |

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ABERDEEN
CITY COUNCIL

# Internal Audit Report

# Finance

# Bank Reconciliations

**Issued to:**
Richard Ellis, Interim Director of Corporate Governance
Steven Whyte, Head of Finance
Carol Smith, Accounting Manager

**Date of issue: November 2016** **Report No. AC1616**

# EXECUTIVE SUMMARY

Bank Reconciliations explain differences at a particular point in time between the balances shown in the Council's bank statements, as supplied by the bank, and the bank balances as shown in the Financial Ledger.

The objective of this audit was to ensure that the Council's main bank accounts are reconciled on a regular and timely basis and that the methodology used is robust. The results of testing, supplemented by discussions with appropriate officers involved in the process confirmed that this was the case.

# 1 INTRODUCTION

1.1 Bank Reconciliations explain differences at a particular point in time between the balances shown in the Council's bank statements, as supplied by the bank, and the bank balances as shown in the Financial Ledger.

1.2 The Bank Reconciliations team within Finance, comprising the Income Support Officer and three Income Assistants, is responsible for the timeous and accurate reconciliation of all the Council's bank accounts and the ledger control accounts for payroll, creditors and debtors.

1.3 The objective of this audit was to ensure that all bank accounts are reconciled on a regular and timely basis and that the methodology used is robust. The scope of the audit covered the Council's main bank accounts.

1.4 The factual accuracy of this report and action to be taken with regard to the recommendations made has been agreed with Carol Smith, Accounting Manager.

# 2. FINDINGS AND RECOMMENDATIONS

## 2.1 General

2.1.1 The Bank Reconciliations team is responsible for the timeous and accurate reconciliation of 13 of the Council's 15 grouped bank accounts. The other 2 are reconciled by Treasury Management. Production of the consolidated bank reconciliation rests primarily with the Income Support Officer who reports to the Finance Controls Manager.

2.1.2 The Service has used the Civica Icon Bank Reconciliation module, which is attached to the Cash Receipting System, since 2008. The system was reconfigured to be fully automated in 2013 and the current process is based on that configuration. The reconciliation module allows for the automatic posting of payments made directly to the Council's bank accounts to the financial ledger, using electronic files received from the bank.

2.1.3 Currently files received from the bank have to be edited into a useable format by the reconciliations team before being uploaded to Civica. The Service advised this is a process that takes around 5 minutes per day. There is a minimal risk of error with one or two occurring per year. In this situation such errors would prevent the file from being uploaded to Civica or be identified later in the reconciliation process.

**Recommendation**
The Service should investigate the possibility of the bank providing the bank statement information in an uploadable format.

**Service Response / Action**
The Service will investigate the provision of information in an uploadable format in consultation with IT colleagues. New impex reports will be required to be developed by the IT team.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| April 2017 | Income Support Officer | Important within audited area. |

2.1.4 The bank reconciliation module has been configured to automatically process transactions in different ways depending on the fund to which they relate and the method of payment (MOP). The fund type determines whether a transaction is posted to the ledger while the MOP type determines whether a transaction is posted to the cashbook. The Management module within Civica shows whether the transactions by fund will be exported to the ledger or the transactions by MOP will be posted to the cashbook. However the rationale behind the system configuration for fund and MOP types is not currently documented which would be beneficial for staff unfamiliar with the system.

**Recommendation**
The Service should document the way in which the fund types and MOPs are configured detailing how each impacts on the Bank Reconciliation module and reconciliation process.

**Service Response / Action**
Agreed. The Service will document an explanation of how the MOP and fund types apply.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| February 2017 | Income Support Officer | Important within audited area. |

2.1.5 During the audit the Service demonstrated how to create new fund types with reference to the system help manuals. The Income Support Team has advised that the IT team are also familiar with setting up MOPs and these have been set up for new payment methods on a regular basis.

2.2 **Written Procedures**

2.2.1 Comprehensive written procedures which are easily accessible by all members of staff can reduce the risk of errors and inconsistency. They are beneficial for the training of current and new employees and provide management with assurance of correct and consistent practices being followed, especially in the event of an experienced employee being absent or leaving.

2.2.2 Detailed written procedures have been established which describe the processes for uploading each bank statement to the bank reconciliation module, generating the required reports and the matching process that has to be completed to allow for the identification of unmatched items. These are entries that are either in the bank account but not reflected in the financial ledger or vice-versa, which require investigation by a member of the reconciliation team. The treatment of mis-matches is dealt with by reference to a file that records all previous actions. Since there are a variety of actions, it is not thought effective to record the different potential situations in the procedures.

2.2.3 A walkthrough of the process was undertaken and compared to that detailed in the procedures. Current practise reflects that set out in the written procedures. The Income Support Officer is currently trialling improvements to streamline the process and has advised the procedures will be updated as required.

2.3 **Format of Reconciliations**

2.3.1 The bank reconciliation statements were reviewed to ensure they were in a format that would provide meaningful information to allow for the detection of discrepancies between the accounting entries and the bank transactions as well as supporting the accuracy of the bank account figures reflected in the annual accounts.

2.3.2 The daily bank reconciliation is a two stage process. The first stage involves the use of the Civica Icon Bank Reconciliation module to reconcile the bank statement to the Civica Icon cashbook. Reconciling differences are shown which include the balance of transactions included in the bank statement but not included in the ledger as well as the balance of cashbook transactions not included in the bank statements. Further detail is available of the transactions making up each reconciling difference.

2.3.3 The second stage involves the reconciliation of the Civica Icon cashbook to the ledger using the combined analysis by fund daily bank reconciliation. This has been established with advice from the system supplier and is used widely in other organisations. The reconciliation has been configured to take account of the complex timing system for the various types of automated transaction that enter the system at different times in the day. This daily bank reconciliation is the main control for the system.

2.3.4 The combined analysis by fund daily bank reconciliation lists the imported bank

statement transactions for the day and then, through the use of an Excel spreadsheet with VLOOKUP formulae, allocates transactions to those expected to be posted to the ledger based on fund and those expected to be posted to the cashbook based on MOP. The spreadsheet is difficult to follow and could benefit from being simplified with a summary reconciliation position that shows the actual ledger movement compared to the actual cashbook movement, with a list of the transactions making up the reconciling difference including reasons.

2.3.5 The ledger to cashbook reconciliation is summarised at a higher level in the main reconciliation. This includes a 'GL Export' column of differences between the ledger and cashbook however a breakdown of the transactions making up these reconciling differences was absent.

**Recommendation**
The Service should simplify the combined analysis by fund daily bank reconciliation and provide reasons for reconciling differences between the cashbook and ledger.

**Service Response / Action**
The Service recognises the value of continuing to improve the format of the reconciliations, bearing in mind that with the significant number of bank accounts and payment methods involved and due to timing differences it is a complex and multiple stage process.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| April 2017 | Income Support Officer | Important within audited area. |

2.3.6 In addition to the daily reconciliation, a monthly reconciliation is undertaken using cumulative data. There are specific timing differences between this reconciliation and the daily reconciliation due to the way the reports operate that mean that certain fund types have to be identified and balanced between the two reconciliations. Both reconciliations are used for ensuring that year-end adjustments are correct.

2.3.7 During the course of the audit the Service visited another local authority which uses the same bank reconciliation module to share best practice. The service recognised that there were some format improvements that could be made that are being considered for implementation.

## 2.4 Transactions posted to Suspense

2.4.1 The Bank Reconciliations team identify unmatched transactions per the bank statement or conversely identify instances whereby there is a general ledger entry for which there is no income received into the bank (this can arise as a result of income returns processed and reflected within the ledger before the income has been lodged within the bank account) and aims to ensure that a matching entry is identified or processed as soon as possible and at least within 2 months. A high proportion of unmatched transactions are identified in the first day with it being rare for any transaction to remain outstanding for 2 months.

2.4.2 Many tasks are undertaken to identify income, such as talking to bank, sending out letters to the bank to pass to customers, speaking with accountancy, phoning companies, checking for past payments with same references/amounts.

2.4.3 The Income Support Officer monitors unmatched items every day. Typically there would be about 100 unmatched items at any one time. If, after 2 months, an income entry on the bank statement cannot be matched to an outstanding ledger entry the

team will process an entry to recognise the income in the appropriate Service's revenue account.

2.4.4 The income is recognised as revenue and, as it cannot be allocated to a specific outstanding debt, will be posted to a Service system suspense account. This eliminates the outstanding entry from the bank reconciliation statement. It is then incumbent on the Service to investigate the income source. Should it be found that the income relates to another Service a transfer within the cash receipting system as well as a general ledger journal entry will be processed. Finance has stated that such items are exceptional and that this is felt to be the most appropriate way to deal with the timely resolution of issues. Services regularly review their Service system suspense accounts in order to ensure balances are cleared to the appropriate account. Any remaining outstanding items are reviewed as part of the year end process.

2.5 **Contingency Planning - Staffing**

2.5.1 Relevant training has been provided to the Income Support Officer involved in producing the bank reconciliations by way of the handover arrangements from the previous Head of the Bank Reconciliations team, written procedures and previous Finance experience. Tasks relating to the reconciliation of transactions impacting the various bank accounts are rotated amongst the Income Assistants to vary the workload and provide contingency in the event of staff absence.

2.5.2 In the event of the Income Support Officer being unavailable to complete the consolidated reconciliation, the task would fall to the Finance Controls Manager or an Income Assistant to complete. The Income Assistants have been trained in undertaking the consolidated reconciliation. The Finance Controls Manager has a good knowledge of the process and the support of the system supplier.

2.6 **Evidence of Production and Review**

2.6.1 To confirm that bank reconciliations were being routinely produced two, 2 week periods were reviewed. Testing confirmed that reconciliations as laid down in the procedures (Appendix 1 and Appendix 2) were successfully produced. Consolidated bank reconciliations (Combined Analysis by Fund) for the same periods, were also produced.

2.6.2 On a weekly basis the Income Support Officer who has prepared the Combined Analysis by Fund reconciliations sends an email to the Finance Controls Manager attaching a link to the previous weeks saved files. The Finance Controls Manager reviews these files and emails back to the Income Support Officer confirming the accuracy. The separate reconciliations produced by the Income Support Officer defined in Appendix 1 and Appendix 2 of the Procedure governing Bank Reconciliations are not reviewed. The details of the check undertaken by the Finance Controls Manager are included within the bank reconciliation procedures.

2.6.3 From discussions with the Income Support Officer and the Finance Controls Manager, Accountancy review the bank reconciliation that is completed at the year end. The Finance Controls Manager reports to the Accounting Manager and any issues relating to the reconciliation would be escalated as soon as they are identified. The Accounting Manager has been involved in developing the controls process around the bank reconciliation over the previous 4 years.

**AUDITORS**: D Hughes, M Beattie, A Johnston and D Lawson

**Appendix 1 – Grading of Recommendations**

| GRADE | DEFINITION |
|---|---|
| **Major at a Corporate Level** | The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss, or loss of reputation, to the Council. |
| **Major at a Service Level** | The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss to the Service/area audited.<br><br>Financial Regulations have been consistently breached. |
| **Significant within audited area** | Addressing this issue will enhance internal controls.<br><br>An element of control is missing or only partial in nature.<br><br>The existence of the weakness identified has an impact on a system's adequacy and effectiveness.<br><br>Financial Regulations have been breached. |
| **Important within audited area** | Although the element of internal control is satisfactory, a control weakness was identified, the existence of the weakness, taken independently or with other findings does not impair the overall system of internal control. |

ABERDEEN
CITY COUNCIL

# Internal Audit Report

# Following the Public Pound

**Issued to:**

Richard Ellis, Interim Director of Corporate Governance
Steven Whyte, Head of Finance
Ciaran Monaghan, Head of Service, Office of the Chief Executive
Neil Carnegie, Acting Head of Communities and Housing
Euan Couperwhite, E&CS Head of Policy Performance and Resources
Roderick MacBeath, Senior Democratic Services Manager

**Date of Issue: November 2016** **Report No. AC1704**

# EXECUTIVE SUMMARY

It is a statutory requirement to adhere to the Convention of Scottish Local Authorities (COSLA) "Code of Guidance on Funding External Public Bodies and Following the Public Pound" when dealing with external organisations which receive grants from public funds. The Council's Local Code of Practice for Funding External Bodies and 'Following the Public Pound' was revised and approved by the Finance, Policy and Resources Committee on 15 September 2015.

The objective of this audit was to review arrangements in place to ensure that public funds are awarded against set criteria which complies with the following the public pound principles and procedures. Although no particular problems have been identified where records were on file, quality and retention of evidence to demonstrate that the procedures are being applied is mixed. This includes updating the grants database, receipt and review of monitoring reports, and completion of risk assessments. In order to address this Finance is developing training and will carry out quarterly quality checks.

For the funding streams reviewed, where there were multiple applications for a finite budget, it was not always apparent how the value of individual awards had been determined, which may lead to a risk of challenge. With reducing resources it will become more important to be able to justify distribution of funds. In delivering training to budget holders, Finance will take the opportunity to obtain details of existing processes for awarding funding and use this to inform the next review of the Code

# 1. INTRODUCTION

1.1 In 1996 the Accounts Commission and Convention of Scottish Local Authorities (COSLA) published a "Code of Guidance on Funding External Public Bodies and Following the Public Pound". In June 2005, the Scottish Government issued a "Direction on the Code of Guidance on Funding External Bodies and Following the Public Pound" requiring all Scottish Local Authorities to comply with the 1996 Code. Given this statutory requirement, it is imperative that all Services within the Council comply with the Code when dealing with external organisations which receive grants from public funds.

1.2 The Council compiled a Local Code of Practice for Funding External Bodies and 'Following the Public Pound' which was approved by Council on 6 October 2011. The Code of Practice was revised following an Internal Audit review of Tier 2 ALEOs in February 2015 in which it was noted that governance arrangements applied per the 2011 Code of Practice were determined only by the value of the funding awarded. This exposed the Council to the risk of being unable to manage or mitigate any further potential risks inherent with its association with funded organisations.

1.3 The funding tiers incorporated into the Code of Practice were revised, and officers are now required to identify, grade and categorise each risk with reference to the assessed level of control assurance. Application of the revised Code should, therefore, ensure that there are suitable and proportionate governance arrangements for all funding agreements. The revised Code was approved by the Finance, Policy and Resources Committee on 15 September 2015.

1.4 The objective of this audit was to review arrangements in place to ensure that public funds are awarded against set criteria which comply with the principles of following the public pound requirements. As ALEO governance arrangements have recently been reviewed in Internal Audit Report AC1621 (February 2016) and Service management of ALEO performance and payments will be reviewed as part of a further planned audit in 2016/17, this audit has focused on grant funding arrangements: a sample of documentation and payments for which has been selected and reviewed.

1.5 The factual accuracy of this report and action to be taken with regard to the recommendations made have been agreed with Steven Whyte, Head of Finance.

## 2. FINDINGS AND RECOMMENDATIONS

### 2.1 Code of Practice

2.1.1 The Council has a duty to ensure proper accountability for public funds used in delivering services, irrespective of the means of service delivery. It discharges this responsibility by ensuring that there is adequate guidance in place to guide officers through the process.

2.1.2 The revised Code of Practice was approved by the Finance, Policy and Resources Committee in September 2015, and sets out principles of best practice to ensure that governance arrangements are suitable and proportionate. The level of scrutiny applied varies depending on risk, control and funding value: four Tiers are used, with Tier 1 requiring the highest level of scrutiny.

2.1.3 In order to ensure that the principles are adopted, and that best practice is followed, all officers responsible for considering applications for funds, for reviewing the applications and recommending awards, and for monitoring agreements must be fully aware of their responsibilities. Whilst each of the officers consulted during the course of the audit acknowledged their awareness of the Code, none had been specifically trained on the application of the principles and best practice.

2.1.4 The provision of formal training would provide assurance that relevant staff have been properly briefed on their responsibilities and that they know what is expected of them. If officers are not trained in the application of the procedures, there is a risk that either they will not be applied correctly and consistently, or that they will not be applied at all due to a lack of awareness of their existence and importance.

2.1.5 There are some elements of the Code of Practice which require specialist skills. For example, the organisations' policies and procedures governing the way their finances are handled should be reviewed every two years. How these reviews should be carried out is not included in the guidance. As a result, the checks are not always being done, or are not being appropriately evidenced.

2.1.6 Under the revised Code of Practice, there is no requirement for the Code to be applied for awards under £15,000. However, procedures for Tier 4 (funding between £15,000 and £75,000) may be followed if warranted by the level of associated risk. There is no guidance on how the level of risk should be assessed, therefore, the procedure may not be followed for funding under this threshold.

**Recommendation**
Finance should ensure guidance, training and support is available for officers responsible for applying the Code of Practice, including: application of the Code, reviewing organisations financial policies, and risk assessing low value grants.

**Service Response / Action**
Agreed. Training is currently planned for Services Accounting staff during October/November 2016, and will thereafter be rolled out to budget-holders.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| March 2017 | Senior Accountant | Significant within audited area |

### 2.2 Grants Database

2.2.1 Organisations may apply for funding from various sources within the Council. A central register of funding awards is currently maintained by Finance. This is in spreadsheet

format and is populated using information received from budget holders. In order to create a more efficient process, a database is being created in the Covalent system which it is intended will be populated directly by budget holders with the details all grants awarded. Finance will have an overarching responsibility for the database, and will undertake quarterly reviews of the data.

2.2.2 Whilst it is currently possible for budget holders to obtain information from the central register this new database will make it much easier for them to consult the database to gain an accurate overview of funding awarded to each organisation by the Council before making a decision on further funding. Development of the database is ongoing and it has been noted that data protection and information security issues must be addressed prior to it going live for budget holders.

2.2.3 There is currently no explicit requirement for officers to check for existing funding prior to recommending or approving a new grant. If the data is current, carrying out such a check would avoid the risk of duplicate funding. Without such a check there is also a risk that total funding to an organisation might exceed the current funding Tier, and the checks applied may fall short of those required under the Code of Practice – which requires cumulative annual funding to be taken into account.

2.2.4 Appendix C of the revised Code of Practice identifies a list of the data required to be held in the register. The majority of this is being recorded, with some minor exceptions. Finance is continuing to develop the list of requirements alongside development of the database.

**Recommendation**

Services should ensure the information is passed to Finance in order for the central register to be populated, and thereafter ensure the grants database is populated with existing grants, and maintained up to date, including all of the details required under the revised Code.

Services should check existing funding relationships prior to recommending or approving new grants.

**Service Response / Action**

Agreed.

This requirement will be included in the training for budget-holders and there will be quarterly checks undertaken by Finance in conjunction with budget-holders to ensure the database is populated correctly.

The checklist will be amended to include the check for existing funding relationships prior to approval of new grants.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| March 2017 | Senior Accountant | Significant within audited area |

**2.3 Compliance with the Code of Practice**

2.3.1 A review of applications and awards from a cross-section of Council funds revealed inconsistencies in levels of compliance with the Code of Practice. Without the required information, applications may not have been fairly assessed: meaning that the Council would not be able to demonstrate that funds had been distributed fairly and equitably; and necessary checks may not have been completed thus increasing the risk to the Council.

2.3.2 All awards are authorised at the correct level, however not all Services are able to demonstrate how each bid has been assessed against the Council's (or specific Funds') strategic priorities and outcomes, and there is no pre-determined standard or process to guide selection between organisations applying for the same funding stream. Nor is there any means of determining how the value of funding to be awarded has been reached. Submitting applications in a standard format would aid the assessment of their alignment with the Council's objectives, and scoring to enable and demonstrate equitable distribution of funds.

2.3.3 Applications or similar supporting documents are not submitted for some funding from the Community Learning and Development (CLD) budget, or for funding which is allocated to the applicant directly from the Common Good Fund. Awards are often made based on the amount awarded in previous years, and this is approved by the Communities, Housing and Infrastructure Team for CLD grants; and either by full Council at the annual budget setting meeting, or by the Finance, Policy and Resources Committee if requests for funding are received during the course of the year, for the Common Good Fund. In respect of CLD the Service has noted that it intends to develop new processes including closer alignment between projects and locality plans, following a recent restructuring exercise.

2.3.4 In the absence of applications and consistent supporting information there is a risk of funds being provided and used for purposes which are not clearly aligned with the Council or the Funds' objectives. The Council would be at risk of reputational damage, but may have no recourse to recover funds for which the use was not specified in advance.

**Recommendation**
Finance should update the Code of Practice to require Services to be able to demonstrate alignment of funded organisations plans with the Council's objectives, fair comparison of applications, and equitable distribution of funds

**Service Response / Action**
The requirement to demonstrate alignment of objectives will be included in the training for budget-holders and there will be quarterly checks undertaken by Finance in conjunction with budget-holders to ensure this is being done.

Training for budget-holders will provide an opportunity to obtain details of the processes for awarding funding which will be used as fact-finding to inform the next review of the Code.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| March 2017 | Senior Accountant | Significant within audited area |

2.3.5 Aberdeen City Council has funded activities in relation to its twin cities of Bulawayo (since 1986 – currently £45,000 per annum) and Gomel (since 1990 – currently £22,000 per annum) from the Common Good Fund. The Council has a high degree of control over both trusts with councillors chairing both, and trustees of each comprising councillors and Council appointees in addition to appointees of local organisations. The treasurer of both trusts is the Council's Head of Finance, and the secretary of both is the Head of Legal and Democratic Services. Both trusts are deficit funded by the Council. The Service is not applying the requirements of the Following the Public Pound Code of Practice to these grants from the Common Good Fund. The Head of Service, Office of Chief Executive has advised Internal Audit that the Council has instructed the undertaking of a review of expenditure from the Common Good Fund.

2.3.6 Under the 2011 Code of Practice, there were specific requirements for funding between £2,500 and £15,000. Twelve awards in this category were tested. All of the awards

checked had been properly authorised. However, evidence was not held on file to demonstrate that the requirements of the Code of Practice had been entirely fulfilled.

2.3.7 An annual income and expenditure account and approved statement of cash balance was required to enable the organisation's financial position to be assessed, and to ensure it was likely to be able to continue as a going concern in the near future. Without this information it will be difficult to assess the need for the funding requested, and there is a risk that the money will be lost if the organisation is unable to continue as a going concern. In 6 of 12 cases this had not been obtained, or had not been retained on file. This is no longer required for grants of this value under the revised Code of Practice, unless the Service considers the risk sufficient to apply the Tier 4 requirements.

2.3.8 In order to confirm that the relevant information has been received, and that the required checks have been completed, the Budget Holder should complete and file a copy of the checklist at Appendix A to the Code of Practice. This covers: criteria of the grant or funding; information required from applicants; approval; payments; the funding agreement; consideration for inclusion in the group accounts; and updating the central register. If the checklist is not completed, there is a risk that some of the information or checks required will be omitted. Checklists had not been completed for any of the grant awards reviewed. This is no longer required for grants of this value under the revised Code of Practice, unless the Service considers the risk sufficient to apply the Tier 4 requirements.

2.3.9 A funding letter sets out the terms and conditions associated with an award. Without this, it is difficult to enforce them which in turn increases the risk of funds being used inappropriately. The revised Code of Practice therefore includes this as part of the minimum requirements for all grants regardless of value. However, funding letters were only on file for 7 of 12 grants reviewed below £15,000.

**Recommendation**
Services should ensure that they are completing funding agreements and checklists for all funding awarded.

**Service Response / Action**
Agreed. This requirement will be included in the training for budget-holders and there will be quarterly checks undertaken by Finance in conjunction with budget-holders to ensure this is being done.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| March 2017 | Senior Accountant | Significant within audited area |

2.3.10 Under the 2011 Code of Practice, an annual statement from the funded organisation was required to be submitted to the Head of Service. As this check would have been done at the end of the financial year, the Code of Practice which was approved in 2015 was in operation. Under the revised Code, there is no requirement for it to be followed for funding of less than £15,000 unless deemed prudent when the level of risk associated with the arrangement is assessed. However, organisations which applied or were granted funding under the 2011 Code should still have been required to provide this information in 2015/16 as this will have formed part of the terms and conditions in place at the point their funding was agreed.

2.3.11 No formal agreement was drawn up with any of the four organisations reviewed that were awarded funding up to £15,000 from the Common Good Fund, and none submitted monitoring reports. An organisation which was awarded funding from the Twinning budget should have submitted a report, but none was received, and this was not followed up.

Without monitoring reports, the Council has no assurance whether and how the funding has been used, and could result in an organisation which has spent funds inappropriately being funded again in future and repeating the practice.

**Recommendation**
Services should ensure that they are obtaining monitoring reports where required under the Code of Practice and that further grant payments and award decisions are withheld pending receipt.

**Service Response / Action**
Agreed. This requirement will be included in the training for budget-holders and there will be quarterly checks undertaken by Finance in conjunction with budget-holders to ensure this is being done.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| March 2017 | Senior Accountant | Important within audited area |

2.3.12 Two awards between £15,000 and £75,000 were reviewed. Both were paid from the Fairer Aberdeen Fund. The Fairer Aberdeen Fund Co-ordinator has good processes in place for ensuring that all of the information required per the Code of Practice is obtained, that the necessary checks are done, that applications are assessed fairly, and that approval is granted by the Fairer Aberdeen Fund Board. However, operational risk assessments were not completed.

2.3.13 Each of the officers consulted during the course of this audit (for all levels of grant funding under both Codes of Practice) confirmed that annual financial checks are completed by Finance colleagues, and that the results of these are discussed at budget holders meetings. However, these results are not held on file with the rest of the supporting evidence for grant funding to demonstrate that these checks had been completed and that Finance was satisfied with the results.

2.3.14 In addition, although the Service confirmed the checklist at Appendix A of the Code of Practice is followed, the checklist itself is not completed and retained. These elements are still required under the 2015 Code of Practice.

**Recommendation**
Services should ensure that they are completing operational risk assessments, Finance checks, and the Appendix A checklist and that evidence is held on file for all relevant grants.

**Service Response / Action**
Agreed. This requirement will be included in the training for budget-holders and there will be quarterly checks undertaken by Finance in conjunction with budget-holders to ensure this is being done.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| March 2017 | Senior Accountant | Important within audited area |

2.3.15 Three awards over £75,000 were tested: one from the Fairer Aberdeen Fund, and two from the CLD General Services Fund.

2.3.16 Although the majority of the requirements for this level of funding were met, there is limited evidence to demonstrate that proper consideration was given to the financial position and governance arrangements of the organisations, or to the risk to which the Council would

be exposed by entering into arrangements with the organisations, before funding was approved. The recommendation at 2.3.14 above applies.

2.3.17 Under the 2011 Code of Practice annual monitoring reports from the organisations demonstrating the outcomes they had achieved should have been reported to the appropriate Service Committees. Although annual reports were received from each of the organisations, they were not presented to Service Committees. Under the 2015 Code of Practice, this has been relaxed: reports relating to grants under £7,000,000 are reviewed by Service Management Teams, and under £300,000 should be signed off by the Head of Service, however this has not been evidenced for the three grants reviewed.

**Recommendation**
Services should ensure that grant funding monitoring reports are approved by the Service Committee, Service Management Team, or Head of Service as applicable under the Code of Practice.

**Service Response / Action**
Agreed. This requirement will be included in the training for budget-holders and there will be quarterly checks undertaken by Finance in conjunction with budget-holders to ensure this is being done.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| March 2017 | Senior Accountant | Important within audited area |

**AUDITORS:** D Hughes
C Harvey
A Taylor

**Appendix One – Grading of Recommendations**

| GRADE | DEFINITION |
|---|---|
| **Major at a Corporate Level** | The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss, or loss of reputation, to the Council. |
| **Major at a Service Level** | The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss to the Service/area audited.<br><br>Financial Regulations have been consistently breached. |
| **Significant within audited area** | Addressing this issue will enhance internal controls.<br><br>An element of control is missing or only partial in nature.<br><br>The existence of the weakness identified has an impact on a system's adequacy and effectiveness.<br><br>Financial Regulations have been breached. |
| **Important within audited area** | Although the element of internal control is satisfactory, a control weakness was identified, the existence of the weakness, taken independently or with other findings does not impair the overall system of internal control. |

ABERDEEN
CITY COUNCIL

# Internal Audit Report

# Finance

# Business Rates

**Issued to:**
Richard Ellis, Interim Director of Corporate Governance
Steven Whyte, Head of Finance
Wayne Connell, Revenues and Benefits Manager
Ewan Wallace, Revenues Support Manager
Anne MacDonald, Audit Scotland

**Date of Issue: October 2016** **Report No. AC1713**

## EXECUTIVE SUMMARY

Business Rates are levied in respect of all non-exempt commercial properties. The amount to be paid by the liable party is based on the rateable value (as determined by the Assessor) and the poundage rate set by the Scottish Government each year. The Council is responsible for the billing, collection and enforcement of Business Rates, with its main area of discretion being the award of various types of relief.

The objective of this audit was to ensure that Business Rates billing and collection arrangements are robust and adequately applied and that reliefs awarded are adequately supported. This involved reviewing written procedures, interviewing staff and accessing the system.

In general, Business Rates billing and collection arrangements were found to be robust, well managed and adhered to. Reliefs were also adequately supported.

# 1. INTRODUCTION

1.1 Business Rates are levied in respect of all non-exempt commercial properties. The amount to be paid by the liable party is based on the rateable value (as determined by the Assessor) and the poundage rate set by the Scottish Government each year. The Council is responsible for the billing, collection and enforcement of Business Rates, with its main area of discretion being the award of various types of relief.

1.2 All Business Rates collected by local authorities are paid into the national non domestic rating pool, maintained by the Scottish Government. This is then redistributed to local authorities according to population.

1.3 The Council uses the Northgate System to manage Business Rates. The scanning and workflow system, Unified Revenues & Benefits (URB) is used to store all documents and correspondence.

1.4 The poundage rate set for 2016/17 was 48.4p, with a supplement of 2.6p for rateable values in excess of £35,000. The public health supplement concluded at the end of 2014/15. Therefore there is no longer an additional supplement for large properties selling both alcohol and tobacco.

1.5 The current net amount collectable by Aberdeen City Council for Business Rates for 2016/17 is approximately £217.7 million, after the granting of various forms of exemption and relief totalling £33.6 million. As at August 2017, Business Rates applied to 8,612 rateable subjects, with 4,099 qualifying for some type of exemption or relief.

1.6 The objective of this audit was to ensure that Business Rates billing and collection arrangements are robust and adequately applied and that reliefs awarded are adequately supported.

1.7 The factual accuracy of this report and action to be taken with regard to the recommendations made has been agreed with Ewan Wallace, Revenues Support Manager.

# 2. FINDINGS AND RECOMMENDATIONS

## 2.1 Written Procedures

2.1.1 Written procedures and their effective communication are an essential element in any system of control. The Business Rates Team have access to an intranet site which contains relevant legislation and guidance on Business Rates. However, it was noted that the site has not been updated for the changes introduced by the The Non-Domestic Rates (Levying) (Scotland) Regulations 2016 (2016 Regulations) in relation to empty relief for industrial and non-industrial properties and the new rateable values for Small Business Bonus Scheme (SBBS) relief.

2.1.2 While guidance is available on Business Rates write offs and the acceptable reasons, authorised signatories and limits for writing off debts is not included within this guidance.

**Recommendation**
Written procedures should be updated to reflect the changes introduced by the 2016 Regulations.

Written procedures on writing off of debts should be updated to include authorised signatories and authorisation limits.

**Service Response / Action**
Agreed. The updates to the on-line Procedure Guide have been finalised to reflect the changes to empty property relief from 2016, the amended SBBS thresholds and write-off authorisations and limits. The external provider of the on-line Procedure Guide will apply these updates.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| November 2016 | Revenues Support Manager | Important within audited area. |

## 2.2 Annual Billing

2.2.1 As per the 2016/17 Business Rates Annual Billing Timetable, annual billing was complete by 8 April 2016. Billing information is sent electronically to the Print and Design section at Woodhill House via a batch job in the Northgate NDR system. The bills are printed and enveloped and then returned to the Business Rates Team at Marischal College for issue. For customer enquiries, the system has an enhanced display screen which gives all the information included in the relevant document issued.

## 2.3 Assessor's Reconciliation

2.3.1 At annual billing, the Business Rates team obtain information, by email, from Northgate regarding the total number of accounts on the system for the year, the total number of accounts billed for the year (as at a defined issue date), breakdown by pay type and any variations between the total number of accounts on the system and total billed. The Business Rates team use this information to verify that the number of bills being issued is complete.

2.3.2 A full extract of the Assessor's database is reconciled to Northgate every week. The most recent reconciliation showed that the total number of properties in Northgate was higher than the Assessor's database by one property. The additional property was a business destroyed by a fire which is no longer liable to Business Rates as a result. While the number of properties differed the total rateable value was the same in both systems.

| | | |
|---|---|---|
| **Recommendation**<br>Northgate should be updated to remove the property no longer subject to Non-Domestic Rates.<br><br>**Service Response / Action**<br>Agreed. Instances of property mis-matches between the Assessor Valuation Roll and the NDR system are reported via the Assessor Valuation Roll Audit Report. This highlights cases where action is required and these are resolved in conjunction with either the Assessor or Northgate. Such action has been taken with regard to this noted case and Northgate will remove the property destroyed by fire from the NDR system as a result. | | |
| **Implementation Date** | **Responsible Officer** | **Grading** |
| Implemented | Revenues Support Manager | Important within audited area. |

**2.4 Calculation of Rates**

2.4.1 A sample of thirty accounts was reviewed and it was confirmed that that the rateable value reflected on Northgate matched the rateable value shown on an extract from the Assessors database.

2.4.2 A sample of ten accounts was reviewed and it was confirmed that the correct poundage rate had been applied and the additional supplement had been applied to those with a rateable value of over £35,000).

**2.5 Changes in Liability**

2.5.1 On a weekly basis the Assessors send reports to the Business Rates team advising them of changes to the valuation roll. These can be changes to rateable value, liable parties, or property status and are applied to the Northgate system which will recalculate the rate payer's liability and print a revised bill. Many changes relate to previous periods and therefore this can affect previous year's bills that may have already been fully paid.

2.5.2 A sample of ten accounts with liability changes was reviewed and all were supported with appropriate documentation and had liabilities correctly recalculated.

**2.6 Exemptions**

2.6.1 Statutory exemptions apply to properties which are exempted from the valuation roll (e.g. agricultural lands and heritages) or included on the valuation roll but fully exempt from payment of rates (e.g. churches and other places of worship).

2.6.2 A sample of ten accounts with exemptions was selected. Data in Northgate was checked as well as the documentation held in the Unified Revenues and Benefits (URB) system (e.g. application forms, photos of empty properties, refund forms and correspondence). Each of the sampled accounts fell into one of the exemption categories set out in the legislation.

2.6.3 Churches / buildings being used for religious purposes are not visited. While initial application forms are completed and review forms are sent every two years, no visits are made unless the review form suggests the property is being used for business purposes. There is a risk that a church / building used for religious purposes may also be being used for business purposes. However, as there is no legislative requirement for Billing Authorities to review Statutory Exemptions, and the use of premises for religious purposes is usually on Sundays or evenings, the Service considers that visits would be impractical.

## 2.7 Empty Property Relief

2.7.1 Since 1 April 2016, there are three tiers of Empty Property Relief. Empty industrial properties are eligible for 100% relief for the six months after becoming empty and then 10% relief thereafter. Empty non-industrial properties are eligible to 50% relief for the first three months and then 10% relief thereafter. There are also limited exceptions which qualify for indefinite 100% relief whilst vacant. These include listed buildings, insolvency, bankruptcy or administration, and properties with a rateable value of less than £1,700.

2.7.2 Empty property relief must be claimed on an application form or in writing and should detail the vacant nature of the property and be supported by suitable evidence. Evidence includes photographs, stock manifests, removal fees, as well as utility and water bills showing no or reduced consumption.

2.7.3 The Business Rates Team spot check 10% of empty properties (usually 50 – 70 properties). A sample of fifteen accounts with empty property relief were tested. Thirteen of the accounts were adequately supported with application forms and photographs / other evidence such as bills. One property has been receiving empty relief since before 2011 when there was no requirement to visit / photograph properties. The other property lacking evidence is owned by the Council and was visited recently but no photographs were taken to demonstrate it was empty.

2.7.4 Review forms are completed on an annual basis. Where properties have a rateable value of £50,000 or over, they are visited every time a Review Form is received. In view of the number of empty properties (around 600 at any given time), the Service does not consider that it is viable to undertake any further visits, particularly due to the changing nature of the properties concerned.

2.7.5 There are emails within the URB system for one of the accounts reviewed (00001057), which suggest that the property rating has been altered from Business to Residential (and therefore subject to Council Tax instead of Business Rates). The Business Rates Team are waiting for information from the Assessor before removing the property from Northgate. The emails from the property owner advise that the property was empty between 23 March and 30 April 2016, when the new tenant moved in. The email dated 20 May 2016 confirms that the new tenant has been in the property for three weeks. Empty Property Relief has been awarded starting 20 March 2016 until 31 March 2017 to avoid Business Rates being charged in the absence of information from the Assessor.

2.7.6 When a property is empty, the Business Rates Team select one of the 'empty' categories from a drop down list within Northgate. The system then automatically tracks when an exemption should end. The empty categories do not appear to have been updated following the most recent update to legislation in April 2016. The empty exempt category options within Northgate are Empty Exempt, Empty Short Term (s24a 1966 Act), Empty 50/90% Charge (Non-Exempt) and Empty New Build.

2.7.7 The empty exempt category in Northgate is currently selected for different types of empty property relief. Account 00003417 has been empty exempt since 2005. As per Northgate, since 1 April 2016, this is 'empty exempt' due to being industrial property. Empty industrial property is eligible to 100% relief for 6 months followed by 10% relief thereafter.

2.7.8 Account 00001255 has also been 'empty exempt' in Northgate since February 2016. This is empty exempt due to being vacant land (no buildings). Business rates do not apply to vacant land with no actual buildings or infrastructure.

2.7.9 If the empty exempt categories in Northgate are not clear, the wrong category could be selected, resulting in incorrect rates being billed. However, the Service has stated that it

is conversant with the terminology used and are clear on the relevant system / processing requirements. To effect any change would require the agreement of all system users.

### 2.8 Mandatory & Discretionary Reliefs

2.8.1 All reliefs, mandatory and discretionary, must be applied for. Mandatory relief is prescribed by legislation and discretionary relief is decided at Council level.

2.8.2 Mandatory and discretionary relief are both considered on receipt of an application for charitable rates relief. Mandatory charitable relief is available for all organisations registered with the Office of the Scottish Charity Regulator (OSCR). A determination is made based on the application as to whether only 80% mandatory relief is available in the case of a registered charity or whether additional discretionary relief is also available depending on the use of the property, e.g. where the property is not used for education, training, research, administrative function.

2.8.3 Both mandatory and discretionary relief are reviewed annually. 'Review of charitable rates relief' letters are issued to check the property is still occupied, being used for charitable activities, a description of activities undertaken and the charity's OSCR registration number. If the information is not returned or the circumstances have changed, mandatory and / or discretionary relief will be cancelled if appropriate.

2.8.4 A sample of 10 accounts with mandatory and / or discretionary relief was selected for testing. Two of these accounts have been receiving discretionary relief since 1989 although there are no authorisation forms within the URB system for this relief. Despite this both organisations have returned 'Review of charitable rates relief' forms enabling an assessment of eligibility to be made.

2.8.5 The sample of ten accounts in receipt of mandatory and / or discretionary relief was tested to ensure that the reliefs had been correctly calculated and that the correct documentation had been received to substantiate the application and satisfy the required criteria.

2.8.6 One account (00001149) was identified where Small Business Bonus Scheme Relief has been awarded to an account without evidence that the relief still applies. The relief should be cancelled unless the 'Review of charitable rates relief' letter is returned, confirming that the relief should still be awarded. A review letter was sent to account 00001149 but it has not been returned. The Service was advised that this relief should therefore be cancelled and they have done so.

### 2.9 Payments

2.9.1 Customers have a number of payment options available to them. Their annual Business Rates Bill will indicate their current method of payment, the amount of each instalment and the due date by which each payment must reach the Council. The Bill also details other payment methods available.

2.9.2 'Advice of unpaid Direct Debits' BACS reports are received by the Payments Control Team on a daily basis. These list direct debits which have failed, detailing name, sort code, account number, amount and reason for the rejection. The report is reviewed and "failed direct debit" letters are issued as appropriate to tenants and the rejected direct debit transactions are manually posted to the Business Rates system.

2.9.3 There have been 324 failed direct debits so far for 2016/17, totalling approximately £1.3 million. A copy of the latest daily 'Advice of unpaid Direct Debits' BACS report was provided which showed evidence of review.

## 2.10 Suspense

2.10.1 As at September 2016, the Suspense Account balance relating to Business Rates was approximately £114,000.

2.10.2 Where a payment is received and has an incorrect, or no Business Rates account number recorded it is accepted and banked, but initially recorded in a Northgate suspense account. Until recently the Business Rates Team ran a suspense account report on a monthly basis. Three teams had access to the suspense account – Business Rates, Payment Control and the Bank Reconciliation team. Personnel within each of these departments reviewed and cleared the account.

2.10.3 The responsibility for reviewing and clearing the Business Rates suspense account report has recently been transferred from the Business Rates Team to the Payment Control Team.

## 2.11 Arrears Recovery

2.11.1 The Business Rates Team use a spreadsheet to track recovery status and the Northgate Top Debts Report records the recovery status of every account. As at August 2016, there were no accounts at final notice stage but there were accounts at first reminder stage. These are highlighted in the Top Debts Report. First reminders were sent to accounts in arrears at the end of August 2016 and will be followed by a Final Notice, if required.

## 2.12 Write Offs

2.12.1 The Business Rates team run Write Offs Reports on a weekly basis. This Report was obtained and a sample of eight Write Offs was requested to verify that they were adequately supported.

2.12.2 Although not written as a procedure as indicated in paragraph 2.1.2, the Team Leader (Non Domestic Rates) can authorise write offs up to £10,000. An authorisation sheet must be completed. Write offs with a value higher than £10,000 are approved by either the Revenues Support Manager or the Head of Finance.

2.12.3 Each of the Write Offs tested were supported by signed authorisation sheets.

2.12.4 Write Offs are now only authorised when one of the following categories applies: Insolvency, Authorised Charge Adjustment, Sheriff Officer Recommendation, Ceased Trading or Small Balance Uncollectable.

## 2.13 Refunds

2.13.1 Overpayments by rate payers can occur for a number of reasons, the most common being the award and application of back dated relief or the retrospective decrease of rateable value of a property. Where this occurs, the Business Rates Team will notify the rate payer by letter and arrange for a BACS payment to be made for the refund. Prior to this being done checks are made for any outstanding debts due by the rate payer against which the refund could be offset. Overpaid Accounts Reports are run on a regular basis to identify refunds due.

2.13.2 The most recent Refunds Report was obtained and a sample of ten refunds were selected for testing. All refunds were correctly calculated and authorised with supporting documentation held in the URB system.

## 2.14 Performance Measurement & Reporting

2.14.1 The Business Rates Team has set internal performance targets for the processing of reliefs which are measured on a monthly basis and reported to the Revenues Support Manager and Finance SMT. These reports show the progress against the performance indicators, including the collection target for 2016/17 of 98%. As at 31 March 2016, the Council had collected 97.3% of the 2015/16 liability. The actual collection rate to date for 2016/17 is 54.39% which compares to 54.49% for the same period in 2015/16.

2.14.2 Should there be an issue with regard to performance, this would be escalated to the Corporate Governance SMT or, if a significant issue, as an exceptional item in the Service's performance reporting to Committee.

**AUDITORS:** D Hughes
A Johnston
A Mitchell

**Appendix 1 – Grading of Recommendations**

| GRADE | DEFINITION |
|---|---|
| **Major at a Corporate Level** | The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss, or loss of reputation, to the Council. |
| **Major at a Service Level** | The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss to the Service/area audited.<br><br>Financial Regulations have been consistently breached. |
| **Significant within audited area** | Addressing this issue will enhance internal controls.<br><br>An element of control is missing or only partial in nature.<br><br>The existence of the weakness identified has an impact on a system's adequacy and effectiveness.<br><br>Financial Regulations have been breached. |
| **Important within audited area** | Although the element of internal control is satisfactory, a control weakness was identified, the existence of the weakness, taken independently or with other findings does not impair the overall system of internal control. |

ABERDEEN
CITY COUNCIL

# Internal Audit Report

# Adult Social Work / Integration Joint Board

# Purchasing & Creditors

**Issued to:**
Judith Proctor, Chief Officer – Aberdeen City Health & Social Care Partnership
Richard Ellis, Interim Director of Business Services
Tom Cowan, Head of Operations – Aberdeen City Health & Social Care Partnership
Steven Whyte, Head of Finance
Alex Stephen, Chief Finance Officer – Aberdeen City Health & Social Care Partnership
Craig Innes, Head of Procurement

**Date of Issue: November 2016** **Report No. AC1701**

# EXECUTIVE SUMMARY

Aberdeen City Adult Social Work, now part of the Aberdeen City Health and Social Care Partnership following delegation of activities to the Integration Joint Board on 1 April 2016, is comprised of a number of teams operating from various locations.

In 2015/16, Adult Social Work made over 11,000 payment transactions totalling over £1.8 million. The objective of this audit was to consider whether robust documented procedures are in place relating to purchasing, and are satisfactorily complied with throughout the Service; and to consider whether value for money is being achieved.

Whilst in general this is the case, variations in and from procedure have been identified and raised with the Service, and a number of recommendations have been made and actions agreed to reinforce and improve controls over expenditure.

The Service, under the direction and approval of the IJB, has procured consultancy services in excess of the EU public tendering threshold, without competitive tendering. This is a breach of procurement regulations and internal financial regulations. There is a risk that Best Value may not have been demonstrated through this arrangement.

Although typically low in value, transactions carried out by the Service in cash or cash equivalent vouchers are not always supported by sufficiently evidenced authorisation and records. Finance will review and refresh corporate procedures, and the Service will ensure these are adhered to.

# 1. INTRODUCTION

1.1 Aberdeen City Adult Social Work, now part of the Aberdeen City Health and Social Care Partnership following delegation of activities to the Integration Joint Board on 1 April 2016, is comprised of a number of teams operating from various locations.

1.2 Excluding commissioned care, between 01 April 2015 and 29 March 2016, Adult Social Work made 11,157 payment transactions totalling just over £1.8 million.

1.3 The objective of this audit was to consider whether robust documented procedures are in place, and are satisfactorily complied with throughout the Service; and to consider whether value for money is being achieved. This involved reviewing written procedures and analysing a sample of expenditure charged to Adult Social Care budgets. Commissioned care has not been reviewed as this has recently been covered under Internal Audit report AC1619 – Social Work Tendering.

1.4 Transactions relating to the following sections were reviewed as part of a random sample:

- Business Management
- Duty Team
- Care Management
- Learning Disabilities
- Mental Health
- Criminal Justice
- Domestic Abuse
- Addiction
- Womens' Services

1.5 The factual accuracy of this report and action to be taken with regard to the recommendations made have been agreed with Tom Cowan - Head of Operations (Aberdeen City Health and Social Care Partnership), Steven Whyte - Head of Finance, Alex Stephen – Chief Finance Officer (Aberdeen City Health and Social Care Partnership), and Craig Innes – Head of Commercial and Procurement Services.

# 2. FINDINGS AND RECOMMENDATIONS

## 2.1 Written Procedures

2.1.1 Written procedures are essential in any system, in order that staff take a consistent approach towards administration. Where they are robust they promote good internal control and if reviewed regularly and approved by management they ensure that staff are aware of management's expectations of how tasks should be performed.

2.1.2 Adult Social Care do have extensive procedures on the use of eFinancials, PECOS and Infosmart. However individual offices have their own procedures reflecting local practices, and in some instances these were out of date, or incomplete. Without corporate or Service-wide procedures and training covering key financial processes there is a risk of inconsistent administration, and reduced control over spending.

**Recommendation**
The Service should ensure clear and consistent written procedures are developed and rolled out to all establishments covering financial administration processes.

**Service Response / Action**
Agreed. There are corporate procedures already in place. The Service will ensure these are applied in all establishments.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| January 2017 | Chief Finance Officer | Significant within audited area |

## 2.2 Contracts / Tendering

2.2.1 The Council's Standing Orders relating to Contracts and Procurement require Services to demonstrate Best Value in contracts and purchasing. When a contract for supplies and services exceeds £10,000 but is less than £50,000 (formerly £60,000), at least four quotations are required to be gathered. When costs are anticipated to exceed £50,000 a full tender exercise must be carried out, and approved by Committee. Contracts within 10% of the EU tender threshold of £164,176 (£172,514 up to 1 January 2016) are required to meet additional EU tendering requirements.

2.2.2 Payments amounting to £208,000 (plus additional expenses) have been agreed to a Consultancy firm specialising in Governance for development of the Integration Joint Board's governance arrangements. At a meeting of the shadow IJB on 26 May 2015, it was minuted that the Chief Officer would continue to develop a programme of work to support the development of a Governance and Assurance Framework and that she would engage with appropriate governance around its procurement. The Chief Officer sought agreement from the Board that funding for the proposed developmental sessions would be taken from the Care Fund and that she had received procurement advice from both parent bodies on commissioning services for the shadow IJB.

2.2.3 Although the Shadow IJB was given regular information on meetings and progress with this project, this was not subject to an EU tendering exercise and a signed contract. A schedule of payments was only developed after four months and over £142,000 had been paid. Without clear agreement on terms in advance there is a risk of payments exceeding the anticipated cost and budget. The Service has stated that the services received however have not exceeded costs or budget having met the costs agreed at the outset.

At the time of the appointment the IJB was not formally constituted or 'live' and the complexity was one of managing transactions across the two parent organisations.

**Recommendation**
The Service should ensure that contracts and schedules of contract payments are prepared and agreed prior to payments being made.

**Service Response / Action**
Agreed.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| January 2017 | Chief Finance Officer | Significant within audited area |

2.2.4 The minute of the above meeting shows that the Legal Manager advised that the Board's standing orders allowed them to directly appoint contractors and that a mechanism could be put in place to transfer funds. The minute also shows that there were questions on the challenges of appointing a single provider and particular reference was made to the constraints in the Single Tender Guidance. The Legal Manager reiterated that Legal Services and colleagues from Commercial and Procurement Services would continue to advise and support the Chief Officer with these matters. There is however no record of the advice provided.

2.2.5 Directly awarding a contract of this value without competitive tender is a breach of the Council's Financial Regulations and EU procurement rules. Best Value may not be achieved, and the Council and IJB may be at risk of challenge over contract awards.

**Recommendation**
The Service should ensure that all Services in excess of EU thresholds are tendered appropriately.

**Service Response / Action**
The Service considers that Procurement and Legal advice was taken before this course of action was agreed, and that the IJB were made aware of the appointment. The Service is also of the view that sole source was applicable in this instance given the highly complex and specialist nature of the work. Work is currently taking place to clarify governance arrangements around procurement and directions issued by the IJB to the Council.

| Internal Audit Position | Grading |
|---|---|
| The Heads of Procurement, and Legal and Democratic Services, can provide advice but cannot approve contravention of EU regulations. There is a risk of challenge from other interested parties, and Best Value cannot be clearly evidenced. | Major at a Service Level |

2.2.6 In one instance £17,270 has been paid in rent by the Service to the Land and Property Assets Service on behalf of a charitable organisation occupying offices at Aberdeen Business Centre. This is approximately 4 years of rental payments at £360 per month. The organisation had moved location from a Council office in which they paid no rent, into the business centre at which they already paid rent for another office, on the understanding that Adult Social Care would either increase their grant funding or pay the rent for the additional office on their behalf. This arrangement was never formally agreed, however a Service Manager in discussion with the then Head of Service instructed the Accountancy Team to clear the debt by transferring funds internally. As this is a write-off

of payments due to the Council, Financial Regulations require formal approval from the Head of Finance, but this was not sought in advance. The issue has subsequently been resolved through re-commissioning the services.

**Recommendation**
The Service should ensure formal approval for the write off of rental payments to date is sought from the Head of Finance.

**Service Response / Action**
Not agreed. The Service considers that this was not a write off, it was additional grant funding to the organisation to cover the increased rental cost. In order to minimise risk the funding was paid directly to Land and Property Assets rather than to the organisation.

| Internal Audit Position | Grading |
|---|---|
| The Service has breached Financial Regulations. | Significant within audited area |

## 2.3 Purchasing

2.3.1 Financial Regulation 5.11.2 states that "orders must be issued for all work, goods or services, or such other expenditure as the Head of Finance may approve".

2.3.2 A sample of 31 transactions between July 2015 and March 2016 was selected, covering 19 different cost centres and 24 different account codes. In four instances payments had been authorised without a purchase order being raised. In another case a purchase order was not raised until after the goods were received. In another example, although a purchase order had been raised, this had not been recorded on the Infosmart system to demonstrate that the correct procedure had been followed.

2.3.3 As part of actions arising under Internal Audit report AC1623, Compliance with Procurement Related Legislation and Financial Regulations, in June 2016 the Head of Joint Operations instructed all officers to ensure purchase orders are raised in advance.

2.3.4 HR facilitates applications and payments for Disclosure Scotland checks and PVG registration for applicants and employees in designated posts across the Council. These are then recharged to individual Services. Purchase orders are not raised due to the volume of requests. Whilst HR has noted that there are alternative controls in place to ensure that only applications which have been applied for and received by the Council are paid, there is no dispensation from the requirement to raise a purchase order set out in Financial Regulation 5.11.2. As agreed in Internal Audit report AC1623 Commercial & Procurement Services and the Head of Finance are progressing with actions to clarify the raising of Purchase Orders and any exceptions. Finance has stated that disclosure checks will be considered within this review.

2.3.5 Financial Regulation 5.11.3 states "all supplier invoices will be directed to the Accounts Payable Team for processing through the Council's workflow systems to enable a comprehensive audit trail to be maintained and electronic access to such records". Invoices not being sent directly to the Accounts Payable Team can cause delays in payments. However, in some cases invoices are still being sent to Social Care offices and establishments.

2.3.6 Whilst invoices received by Accounts Payable are scanned on to Infosmart on the day of receipt, and this date is recorded on the system, processing of invoices received by the Service at individual establishments may be delayed. In 14 instances the invoice had not

been date stamped when received. Having a clear record of the date of receipt provides useful information in the event of any dispute, and allows the Service to prioritise payment of overdue debts. It is also important in the calculation of the Council's Statutory Performance Indicator in respect of prompt payment of debts.

**Recommendation**
The Service should ensure that suppliers are aware of the requirement for invoices to be sent directly to the Accounts Payables Team.

If invoices continue to be received at individual establishments, the Service should ensure these are date stamped and Accounts Payable should ensure the first received date is recorded on Infosmart.

**Service Response / Action**
Agreed. The Service will ensure suppliers are aware of the correct address details for invoicing, and that documents are date stamped if received at local establishments.

Accounts payable cannot physically separate out invoices received at different locations from those received directly from suppliers, therefore the system will always include the scanned rather than received date in these instances. Accounts Payable will remind relevant services of the requirement for invoices to be sent direct.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| January 2017 | Chief Finance Officer | Important within audited area |

2.3.7 Failure to make a payment within 30 days of receipt of the invoice can result in the Council having to pay late payment interest and potentially having to reimburse the recovery costs of the creditor in accordance with the Late Payments of Commercial Debts (Interest) Act 1988 as amended. Regular late payment could impact not only on the Council's Statutory Performance Indicators but also on the Council's business relationships with the suppliers. In general the Council does not have an issue with ensuring prompt payment: figures provided to Finance, Policy & Resources Committee in June 2016 show 98.93% of invoices were paid within 30 days.

2.3.8 However, in 5 of 32 instances reviewed invoices had not been paid promptly: 42 days, 49 days, 62 days, 136 days and 226 days. Where it is not appropriate to pay invoices they can be held pending resolution of disputes or conclusion of the contract. For example in one case (62 days) there is evidence to suggest that payment was withheld until goods had been delivered or a credit note issued. In two instances authorisation was delayed, though there is insufficient information to explain the delay. In the other two the process has been delayed pending a new supplier being set up on the system, and purchase orders being raised and corrected.

**Recommendation**
The Service should ensure that all invoices are paid timeously, where it is appropriate to do so. Where it is not appropriate to do so, records of the reasons should be retained.

**Service Response / Action**
Agreed. These are not considered to be representative of the generally high compliance rate for prompt invoice payment as shown in the Statutory Performance Indicator.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| January 2017 | Chief Finance Officer | Important within audited area |

2.3.9 The Accounts Payable Team considers there is sufficient evidence where staff are marking on PECOS or Infosmart that the goods or services have been received. Whilst in each case reviewed the relevant system had been updated to reflect goods receipt, in six cases there was no documentary evidence held on file substantiating that the goods or services had been provided and received.

2.3.10 Practice for retaining documentary evidence of receipt is mixed: some staff stated that delivery notes are sent to Accounts Payable, whilst others hold these on file at individual establishments, or dispose of them after recording receipt. Currently delivery notes are not retained or scanned on to Infosmart by Accounts Payable. Doing so would reduce physical storage requirements and provide a clearer and more accessible audit trail of documentary evidence.

**Recommendation**
The Accounts Payable Team should review options for corporate retention of evidence of receipt of goods and services.

**Service Response / Action**
Agreed. The Accounts Payable Team will explore options and advise services of the appropriate process for retention of goods receipt notes.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| December 2016 | Business & Procurement Improvement Manager | Important within audited area |

2.3.11 Services may delegate the authority for officers to approve orders and / or payments within a specified financial authorisation limit. Where a purchase order is being raised, this limit is enforced by PECOS, through which orders must be approved in advance by an authorised signatory with an appropriate limit.

2.3.12 Where there is no purchase order, the authorisation limits are recorded on Infosmart, and approval must be obtained prior to paying the invoice. In one such instance a Social Care Administration Officer's authorisation limit of £2,000 on Infosmart was exceeded by £350 for payment of musicians' fees.

**Recommendation**
The Service should ensure its authorisation limits are not exceeded.

**Service Response / Action**
Agreed. Staff will be reminded about complying with their authorisation limits.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| January 2017 | Chief Finance Officer | Significant within audited area |

2.3.13 In another case a cross-service invoice for fuel cards (included here as part of the cost was charged to Social Care) was authorised on Infosmart for just over £113,000, whilst the authorised limit recorded on the system for the member of staff (Finance, Accountancy) was only £30,000. If controls are not being enforced by the system there is a risk of inappropriately authorised payments. There are currently no reports being run to determine whether and how often authorised limits are being exceeded.

**Recommendation**
Accounts Payable should implement controls to ensure authorisation limits are being applied.

**Service Response / Action**
Agreed. Processing Officers will be reminded of the requirement to check authorised signatory limits prior to assigning invoices to authorised officers' workflow via InfoSmart. Enforcement of the No Purchase Order No Pay policy within the Financial Regulations should reduce the volume of invoices returned to officers via Infosmart.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| December 2016 | Team Leader, Accounts Payable | Major at a Corporate Level |

## 2.4 Petty Cash

2.4.1 Petty Cash is made available for small cash transactions, where raising a purchase order is not possible or appropriate. As noted in section 2.1 above practice and procedures vary across the Service. A sample of transactions from a selection of establishments was reviewed.

2.4.2 In order to demonstrate effective control over cash, it should be signed for at the point it is distributed or passed between officers, and there should be receipts or other evidence supporting its final use. None of the transactions reviewed had been authorised prior to the purchases being made. There is also no evidence being obtained showing that Petty Cash was handed over to the member of staff using it. Without these key controls there is limited accountability in the event of cash going missing or being misused.

2.4.3 Petty Cash may be used to provide assistance to service users either in cash or through purchase of necessary supplies or services. Prior to distribution of cash or equivalent assistance, a Financial Assistance Form should be completed and authorised.

2.4.4 There were two instances identified where Financial Assistance Forms had not been used prior to money being handed out from Petty Cash. In addition five forms were not signed by the client substantiating that the payment was handed over to them. Two had been noted as being received by the Social Worker on behalf of the client.

2.4.5 In 15 instances Financial Assistance Forms used for purchases from Petty Cash had not been fully completed or appropriately signed by the Social Worker and Line Manager. Section 18 of the form (financial code) is no longer used, and other sections had not always been completed including: Social Workers and authorised signatories names and signatures, contact details, the correct category of the request and authoriser, the service user's address and the method of payment.

**Recommendation**
Adult Social Work should ensure that Financial Assistance Forms are fully completed and authorised prior to making payments (or equivalent assistance) to service users.

**Service Response / Action**
Agreed. Staff will be reminded of this requirement.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| January 2017 | Chief Finance Officer | Significant within audited area |

2.4.6 Petty cash is generally subject to a limit of £20, though declared and evidenced practice varies between establishments. In two instances this limit had been exceeded: £24.00 was paid out for items for volunteers, and £64.51 was paid out for items for a staff event including cleaning and catering supplies. In two further cases petty cash was reimbursed for items which are available via alternative preferred routes: batteries (which are available through corporate contracts), and staff bus fares (which can be obtained via travel and subsistence claims or provision of cards / vouchers).

2.4.7 In 2 instances VAT was not claimed for recovery. In addition there were 8 instances where receipts were not produced and or retained, and therefore VAT could not be claimed. If recoverable VAT is not supported by receipts, or recorded in the system, there is an additional cost to providing the Service which could have been avoided.

2.4.8 Financial Regulations state that "Petty Cash Imprests are to be reconciled at regular intervals (no less than quarterly) to the Service's own records and to the financial ledger". This ensures that funds are available and expenditure has been appropriately accounted for. However, in one establishment Petty Cash purchases made in August and September 2014 were not reconciled and the imprest reimbursed until July 2015.

2.4.9 The Women's Connections Team within Criminal Justice had been advised by Accounts Payable to split their Petty Cash between VAT and Non VAT items. Accordingly two separate spreadsheets are produced for each reconciliation. This additional step adds limited value, impacts on traceability between receipts and summary records, and has presented some difficulties: particularly in cases where staff have produced receipts for items bought for work and themselves on the same receipt.

2.4.10 Where staff are purchasing items for their own benefit and for work purposes at the same time there is a risk of error – i.e. the wrong items being reimbursed for. This also suggests that Petty Cash is being used to reimburse payments made by staff from their own funds. Petty Cash would be better controlled through prior authorisation and distribution.

**Recommendation**

Corporate Petty Cash procedures should be reviewed and reinforced to ensure adequate controls are in place, including the following:

- measures to evidence advance authorisation and distribution of Petty Cash
- a standard Petty Cash limit and ensuring it is not exceeded
- reinforcing that Petty Cash is not used where alternative procurement methods are available
- a requirement to have separate receipts for personal and work expenses
- ensuring the VAT element of Petty Cash purchases is evidenced and correctly recorded
- regular reconciliations of Petty Cash in a simple consistent manner

**Service Response / Action**

Agreed. There are corporate petty cash procedures already in place, however these will be reviewed to ensure they adequately cover the points highlighted in the Internal Audit report. Finance will work with services to ensure their requirements are incorporated or service policies cross-referenced. Thereafter the Service will ensure these are rolled out to and applied in all establishments.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| June 2017 | Finance Controls Manager | Important within audited area |

## 2.5 Pre-Paid Store Cards

2.5.1 A variety of establishments use pre-paid retailer cards for purchases and financial assistance for service users. Establishments including those administering Criminal Justice Services, Royal Cornhill Hospital and a Women's Connection Centre were contacted regarding their use of these cards.

2.5.2 Used appropriately the cards can provide a useful method of assisting service users to e.g. obtain food or other essential supplies. However, as these are essentially 'cash' it is important that their distribution and use is adequately controlled.

2.5.3 Cards can only be purchased in batches of £1,000 or more, though the denominations purchased typically vary between £5 and £20. Only £3,650 of cards have been purchased by the Service during 2015/16, though across all services over £89,000 of vouchers have been purchased.

2.5.4 The administrative centres were not always keeping a running total of what was used and left when each new batch of cards was purchased. In the cases reviewed there was not always evidence substantiating the need for the cards provided; there was no authorisation given prior to their use, and there was no evidence retained at the point cards were handed over for use. Cards are distributed on request, and if returned the balances are recorded. In addition there was very little evidence obtained in way of receipts substantiating that the cards had been used appropriately. VAT is also not being recovered on purchases made via these cards, resulting in additional cost.

2.5.5 The cards could be used to circumvent approved procurement routes, or to obtain personal benefit for staff. For example where records had been retained by the Service these demonstrated that items including: food, a camera, and a microwave had been purchased. Without appropriate records there is a risk of misuse of these funds not being identified and addressed.

**Recommendation**
The Service should ensure they implement controls and monitoring over the use of Pre-Paid Store Cards.

**Service Response / Action**
Agreed. There are circumstances where it is appropriate to provide cards to service users or use them on their behalf, however adequate records need to be kept.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| January 2017 | Chief Finance Officer | Significant within audited area |

2.5.6 On two occasions cards had been issued at Royal Cornhill Hospital for Section 12 loans. These are issued on the basis that the service users had agreed to pay the loans back. The Service advised that they do not keep a log of outstanding monies to be paid back and the recovery of loans is not controlled or monitored.

2.5.7 If the loan is repaid then this is recorded on a Petty cash reimbursement form. This is contrary to Financial Regulation 5.2.11 which states that "Income received on behalf of the Council cannot be paid into an imprest account, instead must be deposited in the Authority's main bank account(s), or paid over to the Authority in a form as provided elsewhere in these Regulations".

**Recommendation**
The Service should implement controls and monitoring of Section 12 loans and repayments.

The Service should ensure repayment of Section 12 loans is correctly accounted for.

**Service Response / Action**
Agreed. If loans are provided there will need to be records maintained. The Service will review the value of loans issued and determine whether this remains the best way of dealing with service users' needs.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| January 2017 | Business Manager | Significant within audited area |

**2.6 Bus Cards / Bus Carnets**

2.6.1 A variety of establishments hold stocks of pre-paid bus vouchers. Until recently £20 fare cards were available and could be used in place of cash, however following a change to bus company procedures these can no longer be used and have been replaced with 10 journey 'Carnet' tickets costing £21. In 2015/16 the Service spent over £11,000 on these tickets / cards, and in total the Council spent over £60,000.

2.6.2 These tickets are being used by staff for travel within the City. Whilst the face value is similar it has been suggested by staff that they are not value for money as before the change £20.00 fare cards could be used to purchase a £4.00 daily ticket allowing staff to conduct multiple visits to various locations within the same day. However now every time they access the bus; each journey is costing £2.10 and amounting to more than a £4.00 daily ticket. Although the difference for a single return journey is insignificant, where more than two trips are completed in the same day this will now be at additional cost.

2.6.3 Day tickets are still available for cash purchase. It may therefore be appropriate to ask staff to pay for their own tickets and reimburse them through a travel and subsistence claim – as other staff do for business related journeys. Alternatively the Service may wish to consider using petty cash where multiple bus journeys are required. Both options require the retention of appropriate receipts / bus tickets.

2.6.4 There was no evidence substantiating the need for the cards provided; there was no authorisation given prior to their use, and there was no proof obtained that the Bus Cards were handed over or signed out. The Carnet tickets also have no audit trail of their use as each journey is recorded as a punched section of the Carnet rather than as a separate ticket.

**Recommendation**
The Service should review options for control over bus tickets for business use.

**Service Response / Action**
Agreed. The original decision to utilise fare cards was intended to reduce administration costs, and there is a risk of additional administration being required to e.g. review and process additional travel and subsistence claims, however if additional costs are being incurred this may have to be revisited. This does not just affect social care, therefore bus ticket purchasing will be reviewed as part of the review of corporate petty cash procedures agreed at 2.4.10 above.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| June 2017 | Finance Controls Manager | Significant within audited area |

**AUDITORS:** D Hughes,
C Harvey,
J Galloway

**Appendix 1 – Grading of Recommendations**

| GRADE | DEFINITION |
|---|---|
| **Major at a Corporate Level** | The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss, or loss of reputation, to the Council. |
| **Major at a Service Level** | The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss to the Service/area audited.<br><br>Financial Regulations have been consistently breached. |
| **Significant within audited area** | Addressing this issue will enhance internal controls.<br><br>An element of control is missing or only partial in nature.<br><br>The existence of the weakness identified has an impact on a system's adequacy and effectiveness.<br><br>Financial Regulations have been breached. |
| **Important within audited area** | Although the element of internal control is satisfactory, a control weakness was identified, the existence of the weakness, taken independently or with other findings does not impair the overall system of internal control. |

ABERDEEN
CITY COUNCIL

# Internal Audit Report

# Self-Directed Support

**Issued to:**
Judith Proctor, Chief Officer, Aberdeen City Health and Social Care Partnership
Tom Cowan, Head of Joint Operations, Aberdeen City Health and Social Care Partnership
Alex Stephen, Chief Finance Officer, Aberdeen City Health and Social Care Partnership
Kevin Toshney, Interim Head of Strategy and Transformation, Aberdeen City Health and Social Care Partnership

Richard Ellis, Interim Director of Corporate Governance
Gayle Gorman, Director of Education & Children's Services
Euan Couperwhite, Head of Policy, Performance and Resources
Bernadette Oxley, Head of Children's Social Work
Steven Whyte, Head of Finance

**Date of Issue: October 2016** **Report No. AC1617**

# EXECUTIVE SUMMARY

Under the Social Care (Self-Directed Support) Scotland Act 2013, Self-Directed Support (SDS) options must be offered to all Social Work service users. The provisions of the Act came into force on 1 April 2014, placing a duty on local authorities to provide people with four options in respect of how their support is designed and delivered. These options include Direct Payment of funds to service users to purchase their own care, service user direction over the use of funds held by a third party, Council selection of and payment for services, or a mix of all three.

In 2014/15 just over £3.7 million of Direct Payments were made to service users in Aberdeen City; allowing them to purchase their own care. As at February 2016 the Service identified 331 service users managing or directing their own support funds.

The objective of this audit was to ensure that adequate control is exercised over SDS and Direct Payments made in advance to service users. At the time of the audit, a number of processes were still in development as the Service continues to progress with implementation of new SDS arrangements.

Improvements to procedures have been recommended and actions agreed by the Service in respect of retaining evidence of the SDS options offered, scanning paperwork, and ensuring the consistency and accuracy of system records. New forms, checks and automation of processes through CareFirst are being introduced.

Some delays were identified in following up financial monitoring returns to ensure that funds are being used to meet service users' agreed care needs. The Service will implement changes to the process to highlight and escalate potential problems more quickly. Additional guidance has also been developed to clarify the types of expenditure which are appropriate, and the Service intends that Practitioners and Finance colleagues will work together more closely in future to monitor use of funds and delivery of care within the agreed financial package.

# 1. INTRODUCTION

1.1 In November 2010 the Scottish Government set out a 10 year strategy for Self-Directed Support. Under the Social Care (Self-Directed Support) Scotland Act 2013, Self-Directed Support options must be offered to all eligible Social Work service users. The provisions of the Act came into force on 1 April 2014, placing a duty on local authorities to provide people with four options in respect of how their support is designed and delivered.

1.2 The four options are:

- Option 1 – Direct Payment (a cash payment) where the service user chooses how the budget is used and the service user manages the money.
- Option 2 – The service user directs how the budget is used, but the money is managed by someone else.
- Option 3 – The service user asks the council to choose and arrange services for them.
- Option 4 – A mix of the above.

1.3 Self-Directed Support extends and replaces an existing system which included 'Direct Payments' offered by Practitioners to selected service users to utilise within specified limits and criteria. Under the 2013 Act eligible service users have more direct influence over the selection of the appropriate option and arrangement of elements to meet their agreed care needs. The Social Worker will still hold responsibility for ensuring that the decisions and choices made by the individual achieve their assessed outcomes and personal budgets are being spent according to need.

1.4 In 2014/15 approximately £3.7 million of Direct Payments were made to service users in Aberdeen City; allowing them to purchase their own care. As at February 2016 the Service identified that 326 service users are in receipt of Option 1 payments and a further 5 are receiving Option 2.

1.5 The objective of this audit was to ensure that adequate control is exercised over Self-Directed Support Payments made in advance to service users. This involved reviewing written procedures and analysing a sample of Self-Directed Support records selected from Service and Finance systems.

1.6 Although the Service has provided summary and detailed information and explanations on request, the scope of the audit has been restricted to a degree as the auditor was not granted access to CareFirst or the full detail of Support Plans and other records, due to concerns within the Service over compliance with data protection legislation. Whilst partial assurance has been obtained from the data and redacted documentation provided, there is a risk that omitted or redacted records could have contained information to confirm, add, or contradict findings raised within this report. The Service has stated that information redacted was third party and personal information relating to service users families only, however Internal Audit cannot verify this without access to the original documentation.

1.7 The factual accuracy of this report and action to be taken with regard to the recommendations made have been agreed with Alex Stephen, Chief Finance Officer, Aberdeen City Health and Social Care Partnership; Gaynor Clarke, SDS Project Manager, and Carol Ann Smith, Accounting Manager.

# 2. FINDINGS AND RECOMMENDATIONS

## 2.1 Implementation of Self Directed Support

2.1.1 Under the Social Care (Self-Directed Support) Scotland Act the Council has a duty to offer the four Options detailed in paragraph 1.2, above. Although the Service has provided a timetable for 2015-2016 review and implementation, and has developed procedures, guidelines, leaflets and forms, these are still in the process of being rolled out.

2.1.2 In the last audit report relating to this area in June 2014 the Service stated that Full Council would be provided with a briefing on progress in July 2014. However, no matching Council or Committee reports were identified. If the plans are not published there is an increased risk of project slippage not being identified and addressed timeously.

**Recommendation**
The Service should ensure the appropriate Committees are provided with updates on progress with implementing the timetable for Self Directed Support.

**Service Response / Action**
Agreed. Six monthly committee updates will be provided to the IJB and Education Culture and Sport.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| October 2016 | SDS Project Manager | Significant within audited area |

2.1.3 The Service is currently unable to demonstrate that the 331 service users identified in CareFirst as in receipt of Option 1 and 2 have been offered each of the four Options.

2.1.4 A number of the arrangements included within that number and reviewed as part of this audit remain governed by former 'Direct Payments' agreements which have not yet been reviewed in line with current SDS Legislation. The four options being offered cannot be evidenced: therefore it cannot be demonstrated that they comply with the 2013 SDS legislation until a review has taken place and the Four Options have been offered.

2.1.5 Current procedures also suggest that other service users: for example in Substance Misuse or Mental Health may not be offered all of the options. However, this is not an exception included within the Act. The Service has stated that no blanket policy is in place, and individual risk assessments are carried out in line with statutory guidance.

**Recommendation**
The Service should ensure it can demonstrate that appropriate options have been offered to all eligible service users.

**Service Response / Action**
Agreed. The Board will be asked to consider a timeline to ensure all reviews are completed and all four options are offered where it is appropriate. New paperwork, applications, and six week reviews will begin to capture this data for supported people. Workshops to support implementation will commence in August 2016. Where it is not deemed appropriate to offer all options to a supported person this will be evidenced in their assessment, support plan and/or risk assessment and management plan.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| January 2017 | Interim Head of Strategy and Transformation; SDS Project Manager | Significant within audited area |

## 2.2 Written Procedures

2.2.1 Written procedures are essential in any system, in order that staff take a consistent approach towards administration. Where they are robust they promote good internal control and if reviewed regularly and approved by management they ensure that staff are aware of management's expectations of how tasks should be performed.

2.2.2 There are procedures and guidance provided by the Service for Self-Directed Support which cover most eventualities, and are under review in 2016. These documents have been reviewed, and a sample of documentation relating to service users currently in receipt of Direct Payments (which included cases set up prior to implementation of new procedures under the 2013 Act) was reviewed in line with the procedures in place at the point each had been set up or last reviewed. Some variations from documented practice were identified during the course of the audit as discussed in the following sections of this report.

2.2.3 Finance's Direct Payments procedure states that processed documents are archived in either Whitemyres or Marischal College. The procedure does not reflect the process from January 2015 in which records are scanned onto a shared drive. This could result in this part of the process being missed if not included. In addition the Service has stated that Direct Payments documentation is not stored at Whitemyres.

**Recommendation**
Finance should update its Direct Payments procedure to reflect the current scanning and storage processes.

**Service Response / Action**
Agreed. Finance procedures will be updated to reflect the process for scanning all monitoring paperwork.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| October 2016 | Finance Support Officer | Important within audited area |

2.2.4 It was identified that documents relating to 12 of the 20 service users selected had not been fully scanned onto the shared drive. The majority of documents are double-sided, yet many had only been scanned on one side. Other documents including: Setup checklists, Application Forms, Alteration Forms, Startup and Variation Letters, Letters of Agreement, and Creditors data forms, were missing or had been corrupted and could not be opened.

2.2.5 Finance was also unable to produce some service user award letters issued between 2011 and January 2015 as they were lost during the transition between paper and scanned records.

2.2.6 Finance verified that data was missing, and advised that it could take some time to obtain all of it from archives. Whilst in most cases there was sufficient evidence to demonstrate existence of the relevant forms and signatures, and therefore Internal Audit did not request sight of the original documents, the missing pages are important to the Service and should be recovered if possible. Without these there is an increased risk of relevant information being missed from the audit trail of records. This could impact on accuracy when reviewing audit returns (see below), or risk delays whilst awaiting the information being retrieved from archives. Given that the majority of records pertaining to this small sample are incomplete, it is likely that further records are affected. It is important that the total number affected is identified and corrected.

| **Recommendation** | | |
|---|---|---|
| Finance should ensure that all relevant documents are scanned onto the shared drive correctly, including review of existing scanned documents to ensure they are complete. | | |
| **Service Response / Action** | | |
| Agreed. A review of existing scanned documents will take place. | | |
| **Implementation Date** | **Responsible Officer** | **Grading** |
| October 2016 | Finance Support Officer | Significant within audited area |

2.2.7 Two procedures were provided by Finance in which the process for auditing service users' direct payments income and expenditure records are described. Neither exactly matches current practice in respect of following up overdue returns:

2.2.8 The Finance Direct Payments Procedures (v3 2015-16) document states that where returns are 'late' (undefined) a letter should be sent allowing 2 weeks to return the required paperwork. If there is no response within this time, a further letter will be sent allowing another 2 weeks. At this point the Care Manager should be contacted and advised that the final step will allow a further 8 weeks to return the audit or payments could be suspended. (Total of 12 weeks.)

2.2.9 The Aberdeen City Health & Social Care Partnership Non Return of Direct Payment Paperwork Escalation procedure states that on discovery of a failure to return the required information (within an undefined period), a reminder letter will be sent asking that they return the paperwork within 30 days. If nothing is received another reminder is sent allowing another 30 days, and the Practitioner will be contacted. This is then escalated to Social Work Management if not resolved within the 30 days. (Total of 8-9 weeks.)

2.2.10 Documenting the process in more than one place could result in confusion over the correct practice, leading to discrepancies in its application. Reviews may not take place timeously. Irrespective of these procedures Finance advised that reminder letters are sent allowing 30 days, 14 days and then a further 30 days. (Total of 10-11 weeks.)

2.2.11 Whichever process is applied it is likely that at least two, and probably three further payments will have been made to service users without having obtained assurance that the funds are being spent appropriately, before the Service will consider suspending payments. It may provide more incentive to service users to submit returns if payments are suspended, after an appropriate period and following reminders, pending receipt of evidence. This would need to be publicised and included within the signed agreements between the Service and service users.

2.2.12 The Non Return of Direct Payment Paperwork Escalation procedure also states that Finance will record observations regarding the non-return of the audits in the service users CareFirst record. The Service has noted that this should state 'Finance will record activities on CareFirst' to this effect, however this facility is not currently available to Finance, which maintains a spreadsheet of events instead. The ability to record an activity would assist Finance in maintaining consistent records, and these would be accessible to the Service.

2.2.13 In the previous Internal Audit report on this area, reported to Audit, Risk and Scrutiny Committee in September 2014, the Service agreed to: *"Continue to work with the CareFirst system provider, to eliminate restrictions on flexibility and enable SDS. In particular, to develop a facility for proportionate financial monitoring requirements to be input on an individual basis."* The Service agreed to implement this action by December 2014,

however it does not appear to have developed a proportionate risk based monitoring process to date.

2.2.14 It should be possible to set up records of financial monitoring as activities in CareFirst, which could be flagged for completion at specific points and updated or closed as the monitoring takes place. This could improve consistency of approach, and adherence to the review procedure. The period between review dates could also be adjusted based on a risk assessment of the service user's ability to manage the funds, as demonstrated by evidence obtained through previous reviews. A proportionate approach could reduce the administrative burden for staff administering the review process, and service users.

**Recommendation**

The Service should reduce the number of days allowed for late returns before suspending payments.

The Service should ensure all users are aware of and are consistently following the correct Direct Payments monitoring and escalation procedures.

The Service should review whether the audit return process can be managed through CareFirst, then ensure all relevant parties have appropriate access to do so.

The Service should consider whether the financial monitoring process can be made more proportionate to the level of risk involved in each instance.

**Service Response / Action**

Agreed.

A new 24 Day escalation process has been developed to supersede the current process. This will ensure limited payments are made where non return is evident.

New audit letters and the escalation process (using activities) will be developed on CareFirst. Letters and e-mails will be sent to supported people as part of the new process, all letters will sit in CareFirst.

Upskilling and engagement with practitioners and supported people is required to ensure they are all familiar with the new process. The 'My life' portal will be updated and an individual communication with each supported person in receipt of a DP will be completed.

Escalation data will be pulled from CareFirst and presented to the SDS Board by Finance on a monthly basis.

A timeline will be developed for the introduction of proportionate monitoring. Supported people who are recognised as requiring support at assessment will provide monthly monitoring statements. This will be reduced where audits are satisfactory. Where they are not, consideration will be given as to whether extra support is required i.e. payroll, i-connect or op2 is more suitable. Payroll support will be offered to all in the first instance. All supported people in receipt of a personal budget may be asked for paperwork at any given time as an aspect of quality assurance.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| March 2017 | SDS Project Manager; CareFirst Team Manager; Finance Support Officer | Significant within audited area |

## 2.3 Self-Directed Support / Direct Payments

2.3.1 At the point of first contact with the Service, or during the course of a care review, Social Work Practitioners will assess the needs of each service user, and develop a support plan identifying how those needs can be met. This may or may not include paid support packages.

2.3.2 Reports were obtained from CareFirst and Finance showing payments made to service users. From these, 20 cases were randomly selected: 17 Direct Payments / 'Option 1' and 3 'Option 2' cases.

2.3.3 In order to set up a Direct Payment certain paperwork must be prepared and authorised, including a Direct Payment Application Form, a Service User Plan, and a Letter of Agreement. Forms should be being signed in all cases giving a clear audit trail of events and substantiating that the package has been authorised for payment. However, in 4 cases the Service had not signed these forms, but Finance had processed them on CareFirst. If forms are accepted without signatures, there is a risk of unauthorised payments being made.

2.3.4 The Service has stated that final authorisation, before a service agreement is commenced and any payments made, is always via CareFirst: therefore signed forms are effectively redundant. The system however has no facility to enforce limits on delegated authority e.g. limits by value or package type. It also cannot enforce segregation of duties. Whilst directive management controls are in place, and Practitioners are not supposed to enter Direct Payment agreements themselves, the system itself does not prevent officers with approval rights from authorising service packages they have set up themselves. This presents an increased risk of fraud or error. Where the correct process is followed, and Finance input service packages which are subsequently approved by an authorised signatory, this risk is mitigated against.

2.3.5 If the Service does not intend to apply alternative preventative controls e.g. signed forms entered by independent officers, then it should ensure sufficient controls are in place to identify any instances where segregation of duties has not been applied or authorisation limits exceeded so that these can be reviewed at an appropriate level.

**Recommendation**
The Service should ensure processes are in place to demonstrate that appropriate segregation of duties and delegated authority levels have been applied to all new or revised care packages.

**Service Response / Action**
The Service considers that sufficient checks and processes are already in place. It is established practice that Social Workers and other Practitioners have a delegated authorisation level up to which they may create and approve service agreements. There are six weekly professional supervision meetings, and quality assessment checks of 10% of case files are completed by line management.

| **Audit Comment** | **Grading** |
|---|---|
| Service position noted. In the absence of segregation of duties there remains a risk of fraud or error, however this is partly mitigated by the review activities described. The Service has accepted the risk. | Significant within audited area |

2.3.6 In 9 cases, Direct Payment Application forms were incomplete or had insufficient information to describe the planned support for the service user. A new version of the form has been introduced, which more clearly documents the required content, however in the majority of cases reviewed this was not yet in place. Introducing the new form to cover all service users would improve the audit trail and demonstrate that all service users were aware of and had signed up to the current terms and conditions as discussed at 2.1.4 above. This could be progressed at each Service User's next review point.

**Recommendation**
The Service should complete new style application forms for all service users following a change or review.

**Service Response / Action**
Agreed. Actions as noted above at 2.1.5 will address this point.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| October 2016 | SDS Project Manager | Important within audited area |

2.3.7 Elements of support provided or paid for are set up in CareFirst as 'Service Agreements'. These are given a monetary value and a start date in each instance. There are also fields for notes in which a description of the service being paid for can be recorded.

2.3.8 In 11 instances the Service Agreement notes were either left blank or were not sufficient to describe the service being paid for. Although in most cases the monetary values imply a certain type of service, this is insufficient for more complex examples. A user would have to access other records to determine whether or not the current Service Agreement was correctly calculated and matched care being provided. As this is not regularly checked, there is a risk of incorrect payments not being identified.

2.3.9 In one case the calculations on a Direct Payments Alteration form had not been correctly recorded. On further review Finance agreed that the total on the alteration form had been miscalculated, however Finance does not regularly check or query calculations – a Service Agreement is set up on CareFirst for payment based on the total as declared by the practitioner on the form. Without calculations being checked there is an increased risk of incorrect payments.

2.3.10 In another case a service user was paid a one off payment in January 2015 covering school holidays for 2015. This was reflected in the Service Agreement, however evidence showed that the service user left school in July 2015, resulting in an overpayment of £1,776. The Service has stated that this will be recovered from the audited account, however this could have been avoided by ensuring that separate Service Agreements were set up for discrete packages of care covering specific time periods, rather than a lump sum.

**Recommendation**
The Service should ensure calculations and service agreements are completed and entered correctly and consistently.

**Service Response / Action**
Agreed. There is a need for consistency in recording, although it should be noted that the notes field is limited to 250 characters. A consistent method of recording information and better understanding of the process and system will lead to better quality data and reduce the risk of error. New Direct Payment forms, and changes to forms on CareFirst, have made the requirements clearer. Finance role is to input data as provided by the

Service, however further information or clarification will be sought from practitioners where appropriate.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| Implemented | CareFirst Team Manager; Finance Support Officer | Important within audited area |

2.3.11 In one instance (out of the 17 agreements reviewed as referenced at 2.3.2) the audit letter sent to the service user had the wrong year noted for the return. In another, a service user's award letter had the wrong total amount noted, albeit the correct amount was paid. These documents are prepared and sent by Finance. If the information sent to service users is incorrect there is a risk of misunderstanding which may cause difficulties if the Service needs to change services provided or recover funds in the future.

**Recommendation**
The Service should ensure information for service users is reviewed for accuracy before it is sent.

**Service Response / Action**
Agreed. New forms have been developed on CareFirst to automate the process, reducing the scope for error.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| Implemented | CareFirst Team Manager | Important within audited area |

2.3.12 In 5 instances, Finance's payments spreadsheets had not been updated with the Creditors Number, which is obtained from another team within Finance. In another case the weekly amount on the service user's paperwork did not match the spreadsheet, as the wrong formula had been added to the spreadsheet.

2.3.13 The spreadsheets are not used directly for processing payments to service users, as this is completed via CareFirst, however it is used to confirm that payments are correct before they are made. If the data is incorrect or incomplete, and has not been updated, there is a risk that these checks are not being completed effectively and incorrect payments may result.

**Recommendation**
Finance should ensure that the payments spreadsheets are complete and correct.

Payments should not be made until discrepancies or omissions have been corrected.

**Service Response / Action**
Creditor numbers on the spreadsheet are for information only and are not a key control in the payment process. Spreadsheets are not the primary control to compare CareFirst records with payment runs: checks are in place prior to this stage within CareFirst. Spreadsheets are however still used as an additional check.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| Implemented | Finance Support Officer | Significant within audited area |

2.3.14 In each of the 3 'Option 2' cases reviewed, the Council is managing a small amount of funds on behalf of the service user. Cash is withdrawn following submission of a payment request form, and is held by the Social Worker. Funds are then made available to the service user as and when required to pay for agreed items and activities.

2.3.15 The Option 2 cash payment request form in place at the time of the audit has nowhere to record a signature authorising the payment. The Service advised that authorisation via CareFirst, or other electronic approval is currently being considered. Without some form of authorisation control in place there is a risk of unauthorised or inappropriate payments being made. There are however few payments currently being made in this way.

**Recommendation**
The Service should ensure an authorisation process is put in place for cash payments.

**Service Response / Action**
Agreed. The most recent form has authorisation by service manager written into the process.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| Implemented | SDS Project Manager | Significant within audited area |

## 2.4 Service User Contributions

2.4.1 Where chargeable elements of paid support are made available, service users may be asked to contribute towards a proportion of the cost of their care. A Financial Assessment will be offered, to determine the maximum amount of available income after allowances and disregards have been applied. If a service user has capital in excess of specified thresholds, or does not want to provide information to complete an Assessment, a maximum charge level applies.

2.4.2 Although a review of the charging policy, and the key elements which were planned to be changed, were agreed by the Education and Children's Services Committee in June 2015, the 'Contributing to Your Care and Support Policy' has not yet been implemented.

**Recommendation**
The Service should finalise and implement the Contributing to Your Care and Support Policy and guidance.

**Service Response / Action**
Agreed. The relevant committee report was approved, but has not been developed into a policy/guidance document. This will be completed and implemented.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| March 2017 | Interim Head of Strategy and Transformation | Significant within audited area |

2.4.3 The Financial Assessments part of the process could not be tested as staff were absent due to illness. Finance stated that this work was not being done while the staff are absent, and records were not accessible through other means. In one instance, it was identified that a service user had not received a new Financial Assessment since 2012. If Financial Assessments are not processed timeously, service users may be incorrectly charged. This could have financial and reputational impacts for the Council.

**Recommendation**
Finance should ensure Financial Assessments are carried out annually for all service users and that sufficient staff have been trained and have access to complete Financial Assessment work timeously in the event of absences.

**Service Response / Action**
Agreed. This activity was transferred to the Finance team shortly before the audit commenced, and Residential care assessments had been prioritised. Cover is now in place, and CareFirst reports have been set up to highlight upcoming reviews and assist in scheduling.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| Implemented | Finance Support Officer | Significant within audited area |

## 2.5 Monitoring and Review

2.5.1 Service users in receipt of a direct payment are required to provide audit monitoring returns at least every 6 months to demonstrate that funds provided have been spent appropriately.

2.5.2 In 16 of the 20 cases selected for review, the most recently due audit returns were not recorded as received. Whilst Finance had records of overdue returns, this was not updated to record returns received but not yet processed. As at 22 January 2016 Finance records indicated that 266 returns were due. Of these, 27 related to monitoring periods between December 2014 and November 2015. Finance plans to review returns within 60 days of their due date, however at the point of the audit visit the returns had not been date stamped, or recorded as received. Finance cannot chase up any overdue audit returns until they have updated records of those received to date. As discussed at 2.2.11 above, further payments will be made in the interim.

2.5.3 A sample of 15 returns which had been processed was reviewed. In one instance the first audit was not pursued following discussion with the service user; resulting in the audit being written off until the next audit due date. This next audit has been overdue since 30 September 2015. On 12 April 2016, Finance confirmed that 50 returns from January monitoring periods had still to be reviewed.

2.5.4 Until returns and evidence are received and reviewed, the Service has no assurance that the payments have been used appropriately. Delays in obtaining this assurance could result in further payments being made and used inappropriately, and could impact on the ability of the Service to effect recovery. If funds are not being used, or are being put to another purpose not aligned with the support plan, there is a risk that service users might not be receiving the level of care planned and paid for. Timely monitoring should identify these risks and assist the Service in planning and paying for appropriate levels of care.

2.5.5 There were four instances where the audit checklist was not fully completed or signed. This makes it harder to substantiate the audit trail of events, and ensure that checks have been completed appropriately.

**Recommendation**
Finance should log the receipt of all monitoring returns, and ensure audit returns are reviewed promptly, and overdue returns followed up timeously.

**Service Response / Action**
Agreed. Returns are now being logged on a spreadsheet. Going forward the stage of completion of reviews will be recorded on CareFirst, and will be monitored.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| October 2016 | Finance Support Officer; CareFirst Team Manager | Significant within audited area |

2.5.6 Service users are permitted to build up a contingency fund of up to 8 weeks payments, beyond which the Service will seek to recover any excess. Although one audit identified 12 months' worth of payments in the account, this was not recovered promptly. Finance has stated that this has been picked up in the next audit.

**Recommendation**
Finance should ensure that excess funds are recovered promptly following their identification.

**Service Response / Action**
Agreed. Following conclusion of the escalation process (see actions at 2.2.14) recovery will be progressed by raising invoices via efinancials, which can then be followed up through the corporate recovery process.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| January 2017 | Finance Support Officer | Important within audited area |

2.5.7 The Service has explained that Scottish Government guidance provides that any legal expenditure can be considered if it meets a supported person's assessed and agreed outcomes. The Service does not want guidance on the use of funds to be overly prescriptive, since they are to be directed by the service user in support of their identified needs. However, unless the Service documents what is and is not appropriate to fund via Self Directed Support there is a risk of challenge from service users, Finance in their monitoring role, and potentially from the public / media, in unusual cases. Potentially inappropriate activity may be implicitly accepted, or time may be spent exploring its legitimacy at a later date. Clear boundaries, approved by the appropriate Committee, would provide justification and support for Practitioners and Managers decision making.

2.5.8 In one case reviewed, receipts provided in support of a service user's spending indicated top ups to a bingo hall account. Although there is an argument that this specific use of funds could be viewed as a contribution towards social interaction, which aids the service user in meeting their needs, this could be perceived as an inappropriate use of public funds. The Service has stated that this was identified and challenged and is not considered appropriate. Any funds spent on gambling will be recovered.

2.5.9 Service users are regularly using payments to take part in activities. For example in one case: a service user's meal in addition to their carer's, in another: a football season ticket, and in another: holiday accommodation and travel for the service user and their parent. Although service users may have specific needs which the Service has agreed should be met, the purpose of Self Directed Support is to support them to engage in activities to meet their outcomes – not necessarily to pay for them to take part. For example a personal assistant might be employed to escort a service user to an activity and payments for that assistant to partake in the activity would be appropriate, since they are being employed to do so. It may however not be necessary for the service user's participation to be paid for directly.

2.5.10 Assessed and agreed outcomes and how they will be met are documented in individuals' assessments and subsequent reviews. The examples given above contribute towards developing social skills, and provide alternatives to day care and respite care respectively. Although this is correct there remains a risk that without clarity of guidance on what is and is not appropriate, this could be perceived as inappropriate use of public funds – since unsupported members of the public would have to pay to take part in these activities. Supported people not receiving these provisions may also perceive this as inequitable, however the Service has a finite budget and must prioritise its resources.

**Recommendation**
The Service should develop guidance in respect of activities and spending Direct Payments funds.

**Service Response / Action**
Agreed. Guidance has been developed and made available in 'My Life' and within 'My Life' link to the SDS area on The Zone for practitioners.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| Implemented | SDS Project Manager | Significant within audited area |

2.5.11 In order to protect officers there may be a need for a consistent approach to the consideration of high value or unusual requests to be delivered under Self Directed Support. For example some other Local Authorities have resource panels or boards which consider applications in excess of a particular level of funding requirement.

**Recommendation**
The Service should consider whether a further layer of approval is necessary for unusual or high value cases.

**Service Response / Action**
Agreed. Consideration will be given to a board/resource panel that covers and represents all service areas, including Finance, NHS, Adult and Children's Social Care. Consideration needs to be taken to the needs of the LD and MH current panels to ensure the support of the senior practitioner is not lost. If agreed supported activities which are unusual, high cost, unique, negotiable as per can/cannot spend guidance (see 2.5.10) would be taken to the panel.

The development of a 'board' to ensure consistency of approach; eligibility criteria, negotiated spend and so on will benefit the Service. This may require a change in culture, and difficult conversations to be had with supported people where the new legislation does not support historical spend.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| November 2016 | SDS Project Manager | Important within audited area |

2.5.12 The Service has noted that it is not always clear in some existing assessments in Adult and Children's Social Work what the Direct Payment is specifically for, and that this needs to be improved. Unless acceptable expenditure under the agreement is documented in advance it will be difficult for the Service and Finance to monitor use of the funds appropriately. Without access to further information Finance may not be best placed to carry out this monitoring effectively. Incorrect assumptions may be made, or a response to correct and recover funds spent inappropriately may be delayed. However, it remains important that an independent review of expenditure is undertaken regularly.

**Recommendation**
The Service should ensure sufficient information is available to those carrying out monitoring reviews to determine whether service user expenditure included within monitoring returns is appropriate.

**Service Response / Action**
Agreed. The Service is working with Practitioners, Finance and the CareFirst team to improve communication and embed a consistent approach across service areas.

Changes are being considered to develop and better coordinate the current separate financial monitoring (Finance) and care needs (Practitioners) reviews.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| March 2017 | SDS Project Manager | Significant within audited area |

2.5.13 In one instance Finance established that since 2012 a service user had not been paying their own contributions into their Direct Payments account. The Service instructed Finance not to seek recovery of contributions prior to May 2015 as it was considered to be the Council's error. Although the Service may waive charges under specific circumstances, these did not apply in this case.

2.5.14 As a chargeable service has been provided during the period Internal Audit considers that a debt has effectively accrued. Financial Regulations require approval from the Head of Finance to write off debts, however this has not been sought.

**Recommendation**
Approval from the Head of Finance should be sought to write off the debt or the funds should be recovered.

**Service Response / Action**
Not Agreed. Finance and the Service do not consider that a debt has accrued in this case. If the servicer user did not contribute to their direct payment account, they cannot have purchased services with that money, and therefore no chargeable service has been provided. The service user's contribution towards their care is not available to be recovered by the Council – it is only possible to recover excess funds paid by the Council.

| Internal Audit Position | Grading |
|---|---|
| The service user committed to paying a proportion of their care costs and has not done so. Had the Service identified this at an earlier stage it could have reviewed and adjusted the care plan and payments as appropriate (see 2.5.15). In the interim the Service has provided more funds than necessary to meet its share of the care being purchased. However, actions agreed as part of this Internal Audit report should ensure that such cases are identified and addressed at an earlier stage. | Significant within audited area |

2.5.15 Where agreed contributions towards the cost of care is not evident at financial audit, consideration must be given at review as to whether or not the supported person's outcomes and care needs are being met.

**Recommendation**
The Service should ensure that in cases where contributions are not being paid, or care not being purchased to the level anticipated, the service users' needs and outcomes are reviewed timeously.

**Service Response / Action**
Agreed. This is a collaborative approach based on the financial audit, which may evidence that contributions are not being made. This will then require to be flagged with the relevant practitioner to ensure at review this can be discussed and considered, as to whether the supported persons needs and outcomes are being met and their SDS arrangement reviewed.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| Implemented | Lead Service Manager | Significant within audited area |

**AUDITORS:** D Hughes
C Harvey
J Galloway

**Appendix 1 – Grading of Recommendations**

| GRADE | DEFINITION |
|---|---|
| **Major at a Corporate Level** | The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss, or loss of reputation, to the Council. |
| **Major at a Service Level** | The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss to the Service/area audited.<br><br>Financial Regulations have been consistently breached. |
| **Significant within audited area** | Addressing this issue will enhance internal controls.<br><br>An element of control is missing or only partial in nature.<br><br>The existence of the weakness identified has an impact on a system's adequacy and effectiveness.<br><br>Financial Regulations have been breached. |
| **Important within audited area** | Although the element of internal control is satisfactory, a control weakness was identified, the existence of the weakness, taken independently or with other findings does not impair the overall system of internal control. |

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# Internal Audit Report

# Education & Children's Services and Aberdeen City Health & Social Care Partnership

# CareFirst System

**Issued to:**
Judith Proctor, Chief Officer – Aberdeen City Health & Social Care Partnership
Tom Cowan, Head of Joint Operations – Aberdeen City Health & Social Care Partnership
Kevin Toshney, Interim Head of Strategy & Transformation – Aberdeen City Health & Social Care Partnership
Alex Stephen, Chief Finance Officer – Aberdeen City Health & Social Care Partnership

Richard Ellis, Interim Director of Corporate Governance
Gayle Gorman, Director of Education & Children's Services
Euan Couperwhite, Head of Policy, Performance & Resources
Bernadette Oxley, Head of Children's Social Work
Steven Whyte, Head of Finance
Craig Innes, Head of Commercial & Procurement Services
Simon Haston, Head of Information Technology & Transformation

**Date of Issue: November 2016** **Report No. AC1709**

# EXECUTIVE SUMMARY

CareFirst is a web based, multi modular Case Management system commonly used by local authorities for recording care arrangements, statutory interventions and related events pertaining to Social Care Service Users. In addition to case recording, CareFirst has functionalities which enable the Council to control payments to external care providers and the delivery of Services to meet assessed needs. It also holds financial assessment data to determine whether and to what extent Service Users contribute towards their care.

The objective of this audit was to consider whether appropriate control is being exercised over the CareFirst system, including contingency planning and disaster recovery, and its data input, and, in addition, that interfaces to and from other systems are accurate and properly controlled. In general this is the case, and minor improvements have been recommended and agreed with the Service in respect of routine maintenance activities and checks. Further enhancements to security will be added as part of a planned upgrade from the supplier.

Disaster recovery has still to be tested following a change in Data Centre provider, and Children's Social Work and the Health & Social Care Partnership Business Continuity Plans are still in development.

Annual expenditure on the system is in excess of EU tendering thresholds and the system has not been market tested to determine whether Best Value is being delivered. The Service will work with Commercial & Procurement Services to determine an appropriate action plan in respect of the system.

Whilst the charging policy was under review it was agreed that Non-Residential financial re-assessments would not be carried out, resulting in assessments not having been done since 2013. This may mean that incorrect contributions have been paid in the interim. Since the new policy was agreed in August 2016, plans have been put in place to bring all assessments up to date.

# 1. INTRODUCTION

1.1 CareFirst is a web based, multi modular Case Management system commonly used by local authorities for recording care arrangements, statutory interventions and related events pertaining to Social Care Service Users. The system has been utilised by Aberdeen City Council since 1999.

1.2 CareFirst Users are generally front line Practitioners involved in either Children's or Adult Social Work, some Housing staff and staff who provide finance and administrative support to the Social Work teams. These users access the system from within the Council's network. Users from external agencies, including Bon Accord Care and the NHS, can access CareFirst data via a Multi-Agency View.

1.3 In addition to case recording, CareFirst has functionalities which enable the Council to control payments to external care providers and the delivery of Services to meet the Service Users' Assessed needs. It also holds financial assessment data to determine whether and to what extent Service Users contribute towards their care.

1.4 CareFirst has reporting functionalities which can make management information available to the CareFirst Team, Social Work Staff and Service Accountants which, amongst other things, enables them to monitor care arrangements and costs, system data quality, budget forecasting, and assists in completing statutory returns and responding to Freedom of Information and Subject Access requests.

1.5 The objective of this audit was to consider whether appropriate control is being exercised over the CareFirst system, including contingency planning and disaster recovery, and its data input, and, in addition, that interfaces to and from other systems are accurate and properly controlled.

1.6 As reported in previous Internal Audit reports the Service has not granted direct access to the live CareFirst system due to concerns over compliance with data protection legislation. Internal Audit has instead obtained assurance through examination of the processes and systems in place, discussion with key officers, redacted records provided by the CareFirst Team, and viewing data from the anonymised Test version of the system. Although the Service has stated that the Test and Live systems are directly comparable, restrictions on access to live data could have had an effect on the findings and the level of assurance obtained through the audit process.

1.7 The factual accuracy of this report and action to be taken with regard to the recommendations made have been agreed with Euan Couperwhite - Head of Policy, Performance & Resources, Sally Wilkins - Lead Service Manager (Adult Social Work), Sandra Massey - ICT Technology Services Manager, Kate MacKay - Business Manager, and Trevor Gillespie - Team Manager (Performance Management).

# 2. FINDINGS AND RECOMMENDATIONS

## 2.1 CareFirst System Procurement

2.1.1 The system has been utilised by the Council since 1999, and although subsequent extensions and additional services have been obtained the contract with the supplier dates back to this point. Commercial and Procurement Services (C&PS) has been unable to locate a copy of the original terms and conditions of the contract.

2.1.2 Between April 2014 and June 2016 the Service paid £755,400 in respect of annual CareFirst software support fees, system enhancements and additional ad hoc support. Since the system was purchased there have been a number of upgrades and system developments and additional licence purchases, negotiated by the CareFirst Team with limited input from C&PS. Although it might be considered that purchases of enhancements are separate procurement activities, these affect the overall cost of the whole system, and typically commit the Service to additional ongoing expenditure.

2.1.3 Currently a three year support deal is in place and although the Service has no contract document which indicates the agreed costs and terms and conditions, there is a Service Level Agreement. Annual expenditure on support fees is £176,000, which is in excess of EU tender thresholds (currently £164,176 over the life of a contract) and the Council's thresholds for tendering (£50,000) as set out in the standing orders relating to contracts and procurement. Although the Service has negotiated discounts in exchange for a three year contract extension (expiring in 2017) and purchase of additional modules, it cannot demonstrate that the system provides Best Value since tendering, market testing or benchmarking have not been undertaken. There is therefore a risk of challenge from suppliers of similar systems.

2.1.4 Although there has been discussion between C&PS and the Service regarding the need to ensure that the Service is compliant with standing orders and procurement legislation, no progress has been made to date.

**Recommendation**
The CareFirst Team should ensure that it complies with Standing Orders and procurement regulations in terms of the Service's Case Recording System for Social Care Clients.

**Service Response / Action**
Agreed. The Service will work with C&PS to determine an appropriate action plan in respect of the system. This is an essential core business system which is embedded in the services' business processes, though due to changes in the way services are being delivered future systems requirements have not yet been established. Any action will need to take into account the need to minimise any potential service disruption and adverse impact on service users.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| April 2017 | Team Manager, Performance Management | Significant within audited area |

2.1.5 Due to the incremental development of the system and addition of different modules at different times, nine different invoices are received each April in respect of support fees. The invoice detail could be clearer, as although the supported parts of the system are listed there is no breakdown of costs between them. There is currently no schedule of

anticipated payments held by the Service therefore there is a risk of overlap or duplication of payments.

**Recommendation**
The CareFirst Team should consider requesting the system provider to issue one invoice for annual support in order to prevent any duplicate payments.

**Service Response / Action**
Agreed. The Service has considered this and determined that it is not appropriate to action this at this point in time for the following reasons:

- Some invoices are paid for by other services (e.g. Communities Housing and Infrastructure) and a single invoice for that component ensures correct coding. Without this, Finance would be required to make a virement to ensure appropriate budget movement.
- Discussions are ongoing within Education and Children's Services and the H&SCP with regard to the future of the CareFirst system. At the moment, it is possible to track spend by each service on the system. It would not be proposed that we move to one invoice until the future of the CareFirst system is agreed.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| Implemented | Team Manager, Performance Management | Important within audited area |

## 2.2 Software Licences

2.2.1 There are over 1,300 registered CareFirst Users, however as these users will not all require access concurrently only 310 user licences are currently required. In addition there is an 'enterprise' (or unlimited) licence for the Multi Agency View where other authorised agencies can access CareFirst when necessary. The cost of these is included in annual support fees which also cover 15 Business Objects licences for data analysis and reporting tools.

2.2.2 The CareFirst system does not prevent the number of concurrent user licences held being exceeded, and although OLM has provided scripts which can be run to determine whether actual user numbers exceed the concurrent licence holding, these are not routinely run.

2.2.3 While a sample check indicates that the Service is operating well within the current licence holding, not monitoring concurrent user numbers routinely increases the risk of breaching licence conditions.

**Recommendation**
The CareFirst Team should perform regular monitoring of concurrent CareFirst system usage to demonstrate compliance with software licence terms and conditions.

**Service Response / Action**
Agreed. IT has run the concurrent user script as requested by the CareFirst Team and will continue to do so on a quarterly basis.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| Implemented | Team Manager, Performance Management | Important within audited area |

## 2.3 System Support

2.3.1 The CareFirst Team, managed by the Team Manager (Performance Management), consists of 5.7 FTE staff which includes two designated trainers who provide specific and refresher training for CareFirst Users. Staff receive training prior to being given their user name and password, and the basic Care Base training is scheduled weekly, with ad hoc and refresher training provided as needs are identified. CareFirst User manuals are accessible by front end users on the intranet and these appear to meet staff's needs. In addition to this, the CareFirst Team provides a helpdesk facility to help users with matters such as password changes and navigation through system menus and screens.

2.3.2 Technical detail and instructions relating to areas such as implementing upgrades, screen and report configurations, and database relationships are available to back office users in the CareFirst Team and can be accessed from the supplier's website.

2.3.3 In addition to the CareFirst Team, an IT Account Manager is in place to ensure smooth running of the system on the Council's network and implementation of upgrades and enhancements. Several significant developments and other system modifications are being planned. For example, the current standalone Foster Carer payment system is being replaced with the Care Pay Module and is due for implementation in October 2016. Development of Service User billing functionality is planned but is on hold pending finalisation of policy and procedure relating to Self-Directed Support.

## 2.4 System Access Controls

2.4.1 Adequate controls must be in place to ensure that personal and sensitive data is maintained within the CareFirst system in accordance with the Council's Data Protection responsibilities. Access to CareFirst is restricted so that only appropriate staff see Service User and provider information which is relevant to them and their job role.

2.4.2 New system users are required to complete a New User Form, with signed approval from their line manager, before they can access CareFirst. Checks on a sample of users showed that in each case forms had been completed and signed.

2.4.3 Leavers' access rights need to be amended or revoked promptly. Leavers' reports are provided by HR monthly and the CareFirst Team will update records accordingly. Although generally this was found to be operating well, the report for March 2016 had not been received as normal and was overlooked until July 2016, resulting in some leavers not having their CareFirst access withdrawn timeously. Where the leavers had left the Council, they would not have been able to access CareFirst as it requires access to the Council's network.

2.4.4 There is currently no schedule or checklist of regular tasks which need to be completed in maintaining the CareFirst system. Reliance is being placed on external processes (e.g. HR providing a list) and individual team members' knowledge and experience. In the event of staff changes or absence, there may be reduced assurance that these tasks are being completed timeously.

**Recommendation**
The CareFirst Team should put in place a checklist of daily, weekly, monthly, quarterly and annual tasks which are necessary to maintain control of the CareFirst System. Those responsible for these tasks should indicate that they have been performed.

**Service Response / Action**
Agreed. The CareFirst Team will establish checklists of tasks which are routinely required in CareFirst.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| April 2017 | Team Manager, Performance Management | Significant within audited area |

2.4.5 Awareness of responsibilities and therefore accountability as a CareFirst system user is adequate. All employees logging into the Council network are reminded that they are required to comply with the Council's acceptable use policy relating to its IT facilities. Acceptance of conditions specific to the use of CareFirst is also necessary in the application's login screen, and this also applies to third parties who access the system using the Multi Agency View facility. Staff are also required to undertake the Council's routine data protection training.

2.4.6 From time to time the supplier needs access to assist in the maintenance of the system. Access is arranged via the Council's IT helpdesk, subject to authorisation from the CareFirst Team, which monitors access thereafter.

2.4.7 The Council's Information Security Good Practice Guidelines and the ICT Acceptable use policy detail the expected parameters in relation to the expiry, reuse and complexity of passwords. Passwords should be alphanumeric, at least 8 characters long, and include at least one special character. Whilst users are expected to adhere to these requirements, CareFirst does not currently enforce any password complexity standards.

2.4.8 This functionality is available as part of a recent update, and the CareFirst Team has been testing with a view to applying it in the near future. To ensure that control over password strength is increased, a recommendation has been made to track progress of this proposed system enhancement.

**Recommendation**
The CareFirst Team should ensure that current password complexity requirements are enforced in the CareFirst system.

**Service Response / Action**
Agreed. The system has been reconfigured to ensure alphanumeric passwords with a minimum of 8 characters including a special character are enforced.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| Implemented | Team Manager, Performance Management | Significant within audited area |

2.4.9 Repeated failed access attempts could indicate attempts to gain access to a system by guessing a user's password. Typically systems are configured so that the user is referred to the system administrator after a specified number of incorrect password entries. The CareFirst system is not set to lock down a user account after a set number of failed log in attempts, and staff were unclear as to whether the system has this functionality. This increases the risk of inappropriate access to data, particularly in combination with the absence of password complexity requirements as discussed above.

**Recommendation**
The CareFirst Team should determine whether CareFirst has the functionality to lock down user accounts where repeated failed attempts to access the system are made, and apply this security control.

**Service Response / Action**
Agreed. A call was raised (15/09/2016) with OLM to determine if this functionality is available. OLM has agreed to include this as an enhancement in a future release.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| Implemented | Team Manager, Performance Management | Significant within audited area |

2.4.10 User access rights are set in CareFirst on the basis of the user's job title, the care area involved (e.g. Children's, Learning Disability, etc.), and the type of work to which the job relates (e.g. Administration, Worker, Invoice Processing, etc). There are individual privileges within 'Privilege Sets' which dictate which screens a user can view and what actions they can perform in terms of the input, amendment, authorisation or deletion of information. Standard roles are set within the System which also has the flexibility to assign individual privilege sets and/or individual privileges. Testing found that access rights are being appropriately allocated.

2.4.11 The Helpdesk staff have the authority to assist users to rectify errors which they have made during input. Where information is amended or deleted, the system retains a record of this. The records are effectively hidden from view but can be extracted using CareFirst's Audit module. Although approval is requested from a Team Manager where a Practitioner requests to delete the input of another worker, there is no protocol which gives Helpdesk staff guidance on other instances where it may be prudent to seek further authorisation where amendments are requested.

**Recommendation**
The Service should establish a written protocol to demonstrate where amendments and deletions requested in the CareFirst system require authorisation or supporting detail.

**Service Response / Action**
Agreed. Instructions for CareFirst staff and practitioners relating to the authorisation requirements for amendments and deletions of information in client records in CareFirst will be determined and incorporated in the Social Work Case Recording Procedure which is currently being revised. In the meantime an interim instruction will be issued to the CareFirst Team and practitioners.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| April 2017 | Business Manager – Children's Services | Important within audited area |

## 2.5 Data Quality and Retention

2.5.1 The Council has a responsibility to ensure that the data maintained within the CareFirst system is accurate, up to date and safeguarded from loss. In order to be useful it must be recorded consistently and be retained in a manner which lends itself to review and reporting.

2.5.2 Electronic forms are in place within the CareFirst system which help to standardise input. These contain field masks, and data validation controls which prevent obvious errors or

omissions. The system is still dependent however on the consistency of the user to ensure that some fields and free text areas are completed as and when they should be.

2.5.3 The system maintains an audit trail of system activity relating to users' access to records and their input, amendment and deletion. Reports can be run by the CareFirst team to monitor this activity for individual users.

2.5.4 Update of some parts of the system are solely the responsibility of the CareFirst Team – e.g. Care Provider framework rate revisions and charging policy client contribution rates. The Non Residential Charging Policy which was revised in 2015 has not been applied to the system as yet since it is not yet clear how a Service User's 'overall budget' will be identified for Self-Directed Support. This has already been highlighted to the Service in Internal Audit Report AC1617.

2.5.5 Reassessments of the financial position of most Service Users should be performed annually by the Finance Team and input to CareFirst. This has been done for Residential Clients annually at the point at which benefit rates are revised by the Government. However, Non-Residential financial re-assessments have not been completed since 2013. Finance has stated that changes in staffing and responsibilities caused this situation to arise, meaning that non-residential clients may have been charged incorrect contribution rates.

2.5.6 The CareFirst team might have picked this up and taken further action to highlight the omission had the need been included in a checklist as recommended at paragraph 2.4.4. Going forward, Finance needs to reinstate the annual reassessment regime for Non-Residential Service Users and determine the extent to which they have been under / over charged.

**Recommendation**

Finance should ensure that all Service Users are subject to the financial reassessment process on an annual basis.

Finance should review the instances where service users have not been reassessed and charged correctly.

**Service Response / Action**

A new charging policy has been under consideration for some years and it was agreed in 2013 to stop calculating assessments until a new charging policy was in place. The new policy was authorised in August 2016 and the Finance team have plans in place to bring all assessments up to date. Members, Finance and Services established that no elderly/vulnerable people should receive large back dated bills. This decision was seen as an effective balance between ensuring appropriate charges were made and balancing the needs of vulnerable people. Since the integration of the Assessments team in November 2015 with the Social Care Finance team in Accounting there is wider resource available to share tasks and new procedures have been implemented.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| March 2017 | Finance Controls Manager | Significant within audited area |

2.5.7 System data is backed up incrementally on a daily basis. A full back up is done weekly and 30 days of backups are retained in a data centre in Aberdeen which is provided under a contract with the Council's Data Centre provider. A full backup of the data is transferred once a month to a further offsite location where it is kept for 90 days.

2.5.8 Disaster Recovery is tested annually, and was last done in 2014 with the previous Data Centre provider. These tests established some weaknesses in relation to the reinstatement of CareFirst, the Multi Agency View and Business Objects. Revisions to the arrangements in place are being made with the new provider. Until these are completed and tested there is a risk that in the event of a major ICT incident affecting the Data Centre, that reinstatement of the CareFirst system may be incomplete or delayed.

2.5.9 The Service is currently in dialogue with IT as part of Digital Transformation activities to design a model so that assurance can be given and that system reinstatement testing is adequate to ensure continuity of the availability of CareFirst Data in the event of disaster.

**Recommendation**
IT should ensure that disaster recovery is tested with the new supplier.

**Service Response / Action**
Agreed.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| December 2016 | IT Technology Services Manager | Significant within audited area |

## 2.6 System Interfaces

2.6.1 The CareFirst system interfaces with e-financials, the Home Care system (CM2000) and the Child protection register, and there are designated individuals who have responsibility for monitoring the transfer of data – some of which is automatically transferred (e-financials and the Child Protection Register) and others where it is done manually (CM2000).

2.6.2 The Interface between CareFirst and e-financials was checked and found to be working satisfactorily.

2.6.3 It would be beneficial for the Service to document details of who is responsible for ensuring each interface is run and is operating correctly, and how this is checked and evidenced. This will help to preserve knowledge which could be lost or become unavailable due to staff changes or absence.

**Recommendation**
The CareFirst Team, in conjunction with IT, should document the interfaces to other systems from CareFirst and ensure these are available for staff as and when necessary.

**Service Response / Action**
Agreed.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| March 2017 | IT Technology Services Manager;<br>Team Manager, Performance Management. | Significant within audited area |

## 2.7 Business Continuity Planning

2.7.1 A Business Continuity Plan (BCP) sets out how services will operate following an incident and how they expect to return to 'business as usual' afterwards. Key Services are required to have Business Continuity Plans (BCP's) to limit the impact on vital service provision.

2.7.2 Whilst there is a BCP for the CareFirst system itself, there are currently no overarching BCP's for Children's Social Work or Aberdeen City Health and Social Care Partnership. There are however 48 individual service BCP's in place, and an NHS contingency plan.

2.7.3 The BCP's for Mental Health, Children with Disabilities, and Criminal Justice Services were reviewed to ensure that there are adequate measures in place to maintain continuity of service provision in the event of a loss of key systems – specifically CareFirst. Whilst there is a section in each regarding Loss of Systems these do not all include proper definitions of 'systems', a strategy statement, or specific actions to be taken by responsible officers in the event of the loss of CareFirst access.

2.7.4 Education and Children's Services and the Health and Social Care Partnership have stated that these individual plans are currently being reviewed and updates are to be requested from Team Managers. In order to ensure that adequate Business Continuity measures are in place, a recommendation has been made to track progress with the development of the plans.

**Recommendation**
The Service should ensure that Business Continuity Plans adequately reference how activities will continue to operate in the event of loss of CareFirst access.

**Service Response / Action**
Agreed. Business Continuity Plans are being reviewed and updated.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| April 2017 | Business Manager – Children's Services; Interim Head of Strategy & Transformation | Significant within audited area |

## 2.8 System Reporting

2.8.1 Numerous 'Actuate' reports are available within CareFirst itself for Front End Users. In addition the CareFirst Team use, and can run, 'Business Objects' reports for managers to provide them with management information.

2.8.2 The CareFirst Team uses Business Objects for producing Statutory Returns and responding to Freedom of Information requests and in the course of this often pick up issues with data quality which need to be addressed with individual users or team managers. For example, where a care agreement has been superseded but not closed off - which results in the data available for budget forecasting being impaired. Whilst there are regular reports for commitments and other potential errors, there is no regular monitoring to highlight trends and areas where additional training or process adjustments are required. Additional exception reporting could provide Team Managers with information with which they could encourage better input practice.

2.8.3 The CareFirst Team has also suggested that Team Managers may not be getting the full benefit of the reporting tools which are available to them. More standard reports or

dashboards which are relevant to the everyday and overall control of the Service could be created to provide Managers and their staff with a broader overview of their workload and activity. Increased engagement between the CareFirst Team and the Service may be required to ensure that they get best value from the system resources available to them.

**Recommendation**
In conjunction with the Services, the CareFirst Team should review the suite of reports made available for improving data quality and management information.

**Service Response / Action**
Agreed. Work has already commenced to provide dashboard information in both Children's (Reclaiming Social Work) and Adults (Health & Social Care Partnership) Services. Data quality and exception reporting will be progressed under the Council's Master Data Management Programme, agreed by Finance Policy & Resources Committee in December 2015. Regular reporting will be added to the checklists agreed at 2.4.4.

| Implementation Date | Responsible Officer | Grading |
|---|---|---|
| Implemented | Team Manager, Performance Management. | Important within audited area |

**AUDITORS:** D Hughes
C Harvey
P Smith

**Appendix 1 – Grading of Recommendations**

| GRADE | DEFINITION |
|---|---|
| **Major at a Corporate Level** | The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss, or loss of reputation, to the Council. |
| **Major at a Service Level** | The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss to the Service/area audited.<br><br>Financial Regulations have been consistently breached. |
| **Significant within audited area** | Addressing this issue will enhance internal controls.<br><br>An element of control is missing or only partial in nature.<br><br>The existence of the weakness identified has an impact on a system's adequacy and effectiveness.<br><br>Financial Regulations have been breached. |
| **Important within audited area** | Although the element of internal control is satisfactory, a control weakness was identified, the existence of the weakness, taken independently or with other findings does not impair the overall system of internal control. |

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**ABERDEEN CITY COUNCIL**

| | |
|---|---|
| COMMITTEE | Audit, Risk & Scrutiny Committee |
| DATE | 24 November 2016 |
| DIRECTOR | N/A |
| TITLE OF REPORT | Outstanding Internal Audit Recommendations Pre 2015/16 |
| REPORT NUMBER | N/A |
| CHECKLIST COMPLETED | Yes |

## 1. PURPOSE OF REPORT

1.1 This report advises the Committee of progress Services have made with implementing recommendations agreed in Internal Audit reports issued by PWC.

## 2. RECOMMENDATIONS

2.1 The Committee is requested to review, discuss and comment on the issues raised within this report and the attached appendix.

## 3. FINANCIAL IMPLICATIONS

3.1 There are no financial implications arising as a result of this report.

## 4. FOLLOW UP OF RECOMMENDATIONS

4.1 On 27 September 2016, the Committee was advised that there were 10 recommendations, made previously by PWC, which had not been implemented by their due date of before the end of July 2016.

4.2 There are currently 8 agreed Internal Audit recommendations, which were due to be implemented by the end of September 2016, that have not yet been implemented. The detail relating to these is shown in the attached appendix.

## 5. REPORT AUTHOR DETAILS

David Hughes, Chief Internal Auditor
David.Hughes@aberdeenshire.gov.uk
(01224) 664184

**Outstanding Internal Audit Recommendations** **Appendix A**

| Report Title | Date Issued | Recommendation and Risk Rating | Update | Responsible Officer | Original Due Date | Revised date |
|---|---|---|---|---|---|---|
| Carefirst | Feb-15 | Risk Rating – Medium<br>1. Management should assign responsibility for reviewing and actioning the unmatched transactions report. Management may consider creating a dedicated role for this task as it would benefit from a technical understanding of CareFirst, knowledge of the Council's financial arrangements with suppliers and all client groups.<br>2.· Agreement will be reached on the criteria/ parameters to be used for deciding whether transactions should be investigated or not. The unmatched transaction report will be modified by the CareFirst Team to ensure it only includes the transactions for assessment before it is issued to the individual responsible for reviewing and actioning.<br>3.· Dummy invoices will be processed in CareFirst to remove illegitimate transactions. This will not impact actuals (which are reported through e-Financials) and will allow for accurate commitment reporting. | Update for March 2016 Committee: Progress has been further delayed by the long term absence of a service manager resulting in the lead for the project having to cover operational services<br><br>Update for April 2016 Committee:<br>1. An officer has been assigned to review the unmatched transactions report, and has recently commenced work on the review. Early findings suggest that carefirst entries are correct, so it is not presently understood why these entries appear on the unmatched report. A meeting will be set up in the near future with finance and carefirst colleagues to investigate why these items appear on the unmatched transaction report.<br><br>2. As for 1<br><br>3. As for 1 | Head of Joint Operations<br><br>Update for March 2016 Committee: This work stream will sit with the Integrated Social Care Partnership Responsible Officer will be Lead Service Manager (Older People). | 30-Jun-15 | 31-Mar-16<br><br>Update provided to April 2016 Committee Meeting:<br><br>Now 30-Sep-16<br><br>Update for November 2016 Meeting:<br><br>Recs 1 – 5 will be complete by the end of November 2016 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | The individual responsible for the unmatched transaction report should also be responsible for this task.<br>4.· To ensure temporarily suspended care packages do not accrue costs, the person responsible for reviewing and actioning the unmatched transactions report should enter variances to offset the amount. A list of users who are not closing care packages as per the guidelines should be issued to Service Managers for appropriate action.<br>5.· The completed unmatched transaction report should be reviewed and signed off by the responsible person's line manager on a monthly basis.<br>6.· Consideration will be given to separating the roles of those who assess and manage frontline client needs and those who are sourcing the supply of care and subsequently recording the care on the system. | 4. As for 1<br><br>5. As for 1<br><br>6. Discussions are taking place to include this in the role of the 'care bureau' which is in the process of being set up within care management. | | | |

<u>Update for November 2016 Committee:</u>

Recommendations 1, 2, 4, 5 – A report will be developed by the careFirst team which will highlight service users where there has been no invoicing activity for more than 12 weeks. Individual emails will be sent to the named worker on careFirst, or the relevant team, for action. The email will also contain guidance on the action required. Where action is not taken, initial escalation is to the Administrative Officer. A weekly overview report will be sent to the Admin Officer and Team Managers. This process to be in place by 30.11.16 and first reports to be run and distributed on 01.12.16. Process will be monitored and reviewed via the existing 8 weekly meeting between finance and business management staff.

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|---|---|---|---|---|---|---|
| | | Recommendation 3 – A dummy invoice process will be developed by Finance Control Team for 30.11.16.<br><br>Recommendation 6 – The Resource Co-ordinator post has been developed and the recruitment process has commenced. This post will respond to the recommendation of separating the assessment of care needs from the sourcing of care. The initial recording of the need for a care package onto the system will be carried out by the Resource Co-ordinator, however, once the package of care has commenced the ongoing maintenance of the client's care records will remain the responsibility of the front line worker. | | | | |
| Corporate Landlord Responsibilities | Apr-15 | <u>Risk Rating – High</u><br>(3) For each property type, standard indicators of utilisation should be agreed to allow for benchmarking and evaluation of value for money.<br><br>(4) Schedules of reporting on the | (3) This work is still in progress. A Property Strategy has been drafted which incorporates an Action Plan highlighting that utilisation is an area for further development. Some elements of the portfolio have been considered on a project by project basis across the estate, in particular reviews of community assets. There are long standing utilisation assessments in place for corporate offices and schools. Potential methods for assessing properties in the wider estate have been devised and will be discussed with Services when resources are made available. The Service is currently looking to recruit to vacancies with appointments in place early next year. Associated work will be prioritised between then and the beginning of the next financial year.<br><br>(4) Within the draft Property Strategy | Director of Communities, Housing and Infrastructure | 31-May-16 | 31-Mar-17<br><br>As reported to Committee in September 2016 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | agreed asset utilisation information should be arranged with the different service areas. | a Property Performance Report has been proposed which will be submitted to Committee. It is currently under development and will include utilisation indicators. | | 31-May-16 | 31-Mar-17<br><br>As reported to Committee in September 2016 |

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**ABERDEEN CITY COUNCIL**

| | |
|---|---|
| COMMITTEE | Audit, Risk and Scrutiny Committee |
| DATE | 24 November 2016 |
| DIRECTOR | N/A |
| TITLE OF REPORT | Internal Audit Reports – Follow-up of Agreed Recommendations |
| REPORT NUMBER | N/A |
| CHECKLIST COMPLETED | Yes |

## 1. PURPOSE OF REPORT

1.1 This report advises the Committee of progress made by Services with implementing recommendations that were agreed in Internal Audit reports issued since April 2015.

## 2. RECOMMENDATION

2.1 The Committee is requested to review, discuss and comment on the issues raised within this report and the attached appendices.

## 3. FINANCIAL IMPLICATIONS

3.1 There are no financial implications arising as a result of this report.

## 4. PROGRESS WITH IMPLEMENTING AGREED RECOMMENDATIONS

4.1 Appendices A and B show progress made by Services with completing agreed Internal Audit recommendations, based on assurances received from officers tasked with their implementation and independent checks where appropriate. Where all recommendations contained in individual reports issued before 1 April 2016 have been completed, these are no longer shown in the appendices.

4.2 Where recommendations have not been completed by their original due date, reasons are provided along with the grading applied to the recommendation in the original Internal Audit report. An explanation of the gradings used is shown at appendix C.

## 5. REPORT AUTHOR DETAILS

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**APPENDIX A**

# POSITION WITH AGREED RECOMMENDATIONS AS AT 11 NOVEMBER 2016

## SUMMARY

The following table provides a summary of progress being made by Services with completing agreed recommendations. On 27 September 2016, the Committee was advised that, as at 14 September 2016, there were 38 recommendations which were due to have been completed by 31 July 2016 which were not fully complete. This has reduced to 31. The total not fully complete, which had an original due date of before 30 September 2016, is 50. Full details relating to progress, on a report by report basis, are shown in appendix B.

| | **Recommendations** | | | | | | **Grading of Overdue Recommendations** | | |
|---|---|---|---|---|---|---|---|---|---|
| SERVICE | Agreed in reports shown in Appendix B | Due for completion by 31.07.16 | Confirmed complete by Service | New in August to September 2016 | Confirmed complete by Service | **Not fully complete by original due date of 30.09.16** | Major | Significant | Important |
| **Cross Service** | 100 | 83 | 72 | 7 | 1 | **17** | 0 | 10 | 7 |
| **Communities, Housing and Infrastructure** | 119 | 59 | 47 | 24 | 19 | **17** | 2 | 11 | 4 |
| **Corporate Governance** | 45 | 26 | 19 | 6 (i) | 5 (i) | **8** | 2 | 4 | 2 |
| **Education and Children's Services** | 51 | 19 | 18 | 27 | 20 | **8** | 0 | 6 | 2 |
| **Health and Social Care Partnership** | 5 | 4 | 4 | 0 | 0 | **0** | 0 | 0 | 0 |
| **Total** | 323 | 191 | 160 | 64 | 45 | **50** | 4 | 31 | 15 |

(i) Includes 1 recommendation due and implemented in reports issued before April 2016 which are no longer shown in Appendix B.

**APPENDIX B**

| POSITION WITH AGREED RECOMMENDATIONS AS AT 11 NOVEMBER 2016 |
|---|

| Report Number | Report Title | Date Issued | Number of Recommendations | | | | |
|---|---|---|---|---|---|---|---|
| | | | Agreed in Report | Due for implementation by 30.09.16 | Confirmed Implemented by Service | **Not implemented by original due date** | Grading of overdue recommendations |

**CROSS SERVICE**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AC1601 | Recruitment Procedures | February 2016 | 35 | 35 | 29 | **6** | 6 Important |

The 6 recommendations that are overdue were due to be implemented by the end of March 2016. Progress with these is detailed below.

| Recommendation | Position |
|---|---|
| 2.1.3 – HR should review and, where applicable, update information in the Managing Recruitment and Selection document, and should consider how often and by whom this document is reviewed in the future ***(graded "important within audited area")***. | As reported previously, HR has advised that it has taken longer than anticipated to undertake the necessary review of guidance. The agreed recommendations have been reflected in a draft of the guidance, however, other updates were required which are being made at the same time but are delaying the process. This was due to be complete by the end of July 2016 but will now be finalised by the end of November 2016. |
| 2.1.4 – Documents being published for use should be dated with an author's name or post, and the next proposed review date. HR should ensure consistency when classifying documents as policies, procedures, protocols ***(graded "important within audited area")***. | As 2.1.3, above. |

| Report Number | Report Title | Date Issued | Number of Recommendations | | | | |
|---|---|---|---|---|---|---|---|
| | | | Agreed in Report | Due for implementation by 30.09.16 | Confirmed Implemented by Service | **Not implemented by original due date** | Grading of overdue recommendations |

**CROSS SERVICE (continued)**

| Recommendation | Position |
|---|---|
| *(AC1601 – Recruitment Procedures – Continued)* | |
| 2.1.6 – A staff procedure manual should be created and issued to staff. An agreed document, filing and naming convention should be agreed and followed ***(graded "important within audited area")***. | As reported previously, HR has just merged the Recruitment and ELC Teams with effect from 03/05/16 so they will be doing end to end process from appointment through to termination. Members from each former team have been paired together in a new HR Support Team (which there will be 3 of) and each pairing will be training up their 'partner' in tasks they do. As part of this they will be expected to draw up guides for use by the new teams. Initial areas to be covered will be those that are not scheduled for YourHR developments in the next few months. The YourHR ones have workflow behind them when developed.<br><br>Guides were to be provided to Internal Audit once created to close this off by the end of August 2016. However, although progress has been made, these will not now be complete until the end of September 2016.<br><br>Some of the guides have been provided to Internal Audit. The absence and leave guides have still to be completed. |
| 2.3.12 – HR should provide guidance on completion of candidate assessment forms ***(graded "important within audited area")***. | As 2.1.3, above. |
| 2.6.2 – HR should review and, where appropriate, update the Managing and Recruitment Selection document (graded "important within audited area"). | As 2.1.3, above. |
| 2.6.3 – HR should consider whether to enforce the panel composition for primary school teachers or amend it to reflect current practice (graded "important within audited area"). | As 2.1.3, above. |

| Report Number | Report Title | Date Issued | Number of Recommendations | | | | |
|---|---|---|---|---|---|---|---|
| | | | Agreed in Report | Due for implementation by 30.09.16 | Confirmed Implemented by Service | **Not implemented by original due date** | Grading of overdue recommendations |

**CROSS SERVICE (continued)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AC1604 | Corporate Policies and Procedures | March 2016 | 2 | 0 | 0 | **0** | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AC1615 | Timesheets | January 2016 | 25 | 25 | 21 | **4** | 4 Significant |

Progress with the 6 recommendations that are overdue is detailed below.

| Recommendation | Position |
|---|---|
| 2.4.6 (1c) was due to be implemented in July 2016 – On-line timesheet to be implemented which will have built in rules that will help ensure that payments are made in accordance with the rules and conditions of service ***(graded "significant within audited area")***. | As reported previously, this has been delayed due to competing priorities and because testing identified issues with the formulas. It is anticipated that a pilot will begin in October 2016 with full implementation in January or February 2017. |
| 2.4.6 (2) was due to be implemented in July 2016 – Spot checks will be put in place on an ongoing basis to ensure the correct application of guidance in relation to payment for non-standard hours ***(graded "significant within audited area")***. | As reported previously, this is now going to be addressed through the on-line timesheet in Your HR. In view of this, and the issues detailed at 2.4.6 (1c) above, this will now be implemented in January or February 2017 |
| 2.4.6 (3) was due to be implemented in August 2016 – Steps should be taken to recover overpayments / pay underpayments made to staff in relation to overtime paid at the wrong rate of pay (2.4) and in relation to additional holiday pay (2.2) ***(graded "significant within audited area")***. | In view of the fact that Financial Regulations require the Head of HR to take all reasonable steps to recover any identified overpayments, it was agreed that Directorates would analyse the findings from the Internal Audit report, relating to specific pay elements, and notify HR / Payroll of any overpayments to be recovered or underpayments due to be paid. HR has advised that none of the Services will be recovering any overpayments or paying any underpayments. Internal Audit is awaiting details of the analysis undertaken by each Service. |

| Report Number | Report Title | Date Issued | Number of Recommendations | | | | |
|---|---|---|---|---|---|---|---|
| | | | Agreed in Report | Due for implementation by 30.09.16 | Confirmed Implemented by Service | **Not implemented by original due date** | Grading of overdue recommendations |

**CROSS SERVICE (continued)**

| Recommendation | Position |
|---|---|
| *(AC1615 – Timesheets – Continued)* | |
| 2.6.4 was due to be implemented in June 2016 – HR should ensure that the draft Working Time Regulation Exclusions and Modifications adequately cover working practice in the Roads Service and ensure that they are finalised through a Collective Agreement process ***(graded "significant within audited area")***. | As reported previously, the revised Working Time Collective Agreement has been prepared and discussed, and is in the process of being signed off by various parties. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AC1621 | ALEOs | February 2016 | 10 | 4 | 4 | **0** | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AC1623 | Compliance with Procurement Legislation | June 2016 | 28 | 27 | 20 | **7** | 6 Significant 1 Important |

Progress with the 6 recommendations that are overdue is detailed below.

| Recommendation | Position |
|---|---|
| 2.1.6 was due to be implemented in August 2016 – C&PS should clarify and combine relevant procedures to ensure procurement requirements are correct, and straightforward to understand and use ***(graded "significant within audited area").*** | The Service is finalising and reviewing procedures prior to publication by the end of October 2016. |
| 2.1.10 was due to be implemented in August 2016 – C&PS should review the approval process for Quotation Exemption Forms ***(graded "significant within audited area").*** | The Service is reviewing the final format of the forms prior to them being published by the end of October 2016. |

| Report Number | Report Title | Date Issued | Number of Recommendations | | | | |
|---|---|---|---|---|---|---|---|
| | | | Agreed in Report | Due for implementation by 30.09.16 | Confirmed Implemented by Service | **Not implemented by original due date** | Grading of overdue recommendations |

**CROSS SERVICE (continued)**

| Recommendation | Position |
|---|---|
| *(AC1623 – Compliance with Procurement Legislation – Continued)* | |
| 2.1.12 was due to be implemented in June 2016 – C&PS in conjunction with Finance should review Financial Regulations to clarify whether and what exceptions to the requirement to raise a Purchase Order are allowed ***(graded "significant within audited area").*** | As reported previously, Commercial and Procurement Services has advised that a draft list of exceptions has been prepared and requires to be finalised with Finance colleagues. Reference to the list of exceptions will be included in the next update to the Financial Regulations which is currently being prepared. A revised completion date of 31 March 2017 would fit with this review. |
| 2.2.14 was due to be implemented in September 2016 – The Service should ensure that the Scheme of Delegated Powers references the need to adhere to Financial Regulations, Procurement SO's and other relevant procedures, whilst exercising those delegated powers ***(graded "important within audited area").*** | The Governance Review is still in progress, and CPS is still working with Finance and Committee Services in relation to changes in Scheme of Delegation and Financial Regulations. Amendments to Financial Regulations is due to be approved in December 2016. |
| 2.4.7 was due to be implemented in September 2016 – The Service should ensure that spend on supplies which are likely to be used by more than one school is forecast so that appropriate Committee approval and tendering can be completed for aggregate spend. | The Service is in the process of identifying expenditure across the schools. It is anticipated that this will be completed by March 2017 and that expenditure across other Directorates will have to be considered. |
| 2.6.4 was due to be implemented in June 2016 – C&PS in conjunction with Finance should review whether revision and re-authorisation of Purchase Orders is necessary for minor changes to content and value ***(graded "significant within audited area").*** | As 2.1.12 above. |
| 2.6.6 was due to be implemented in June 2016 – C&PS will issue guidance clarifying the raising of purchase orders and any exceptions ***(graded "significant within audited area").*** | As 2.1.12 above. |

| Report Number | Report Title | Date Issued | Number of Recommendations | | | | |
|---|---|---|---|---|---|---|---|
| | | | Agreed in Report | Due for implementation by 30.09.16 | Confirmed Implemented by Service | **Not implemented by original due date** | Grading of overdue recommendations |

**COMMUNITIES, HOUSING AND INFRASTRUCTURE**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AC1602 AW | Craft Workers Terms and Conditions | October 2015 | 9 | 9 | 0 | **9** | 2 Major 7 Significant |
| As reported previously, all of the recommendations in this report were due to be implemented by the end of June 2016. The Service has advised that they are being progressed through discussion and negotiation, and that it is anticipated that they will all be resolved by December 2016. | | | | | | | |
| AC1605 AW | Building Services Recharges | July 2016 | 11 | 7 | 4 | **3** | 1 Important |
| The overdue recommendation **(2.1.4, *graded "important within audited area"*)** was due to be implemented in September 2016 and relates to the Service ensuring that, where increases in job costs are identified, revised estimates (where appropriate) are issued to an owner / tenant prior to the work going ahead. The Service has advised that discussions are ongoing regarding this issue and it will be fully resolved by December 2016. | | | | | | | |
| AC1607 | Rent Collection and Arrears Management | April 2016 | 8 | 6 | 6 | **0** | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AC1608 | Trade Waste | January 2016 | 14 | 14 | 10 | **4** | 2 Significant 2 Important |
| Progress with the 4 recommendations that are overdue is detailed below. | | | | | | | |

| Report Number | Report Title | Date Issued | Number of Recommendations | | | | |
|---|---|---|---|---|---|---|---|
| | | | Agreed in Report | Due for implementation by 30.09.16 | Confirmed Implemented by Service | **Not implemented by original due date** | Grading of overdue recommendations |

**COMMUNITIES, HOUSING AND INFRASTRUCTURE (continued)**

| Recommendation | Position |
|---|---|
| *(AC1608 – Trade Waste – Continued)* | |
| 2.1.9 was due to be implemented in June 2016 – The Service in conjunction with Finance should review the charging system for extraordinary uplifts ***(graded "important within audited area").*** | As reported previously, the Service has advised that it has developed a revised process management system for extraordinary uplifts and is working with Finance on integrating this with other systems. However, the proposed introduction of a Council-wide Digital Platform is limiting completion of this work although the Waste and Recycling Service will be one of the first areas for integration with the Digital Platform. The completion of this action cannot be determined until the Digital Platform provider is appointed and its project plan delivered although it is anticipate that it will be complete by June 2017. |
| 2.1.10 was due to be implemented in September 2016 – The Service should implement reconciliations between records of work completed, work invoiced, and income received, to ensure that income has been received for the provision of all goods and services ***(graded "significant within audited area").*** | The Service has advised that the Bartec system being introduced which is designed to resolve the issues. However, delays to the introduction of the system mean this will now not be done until April 2017 |
| 2.1.12 was due to be implemented in September 2016 – The Service should introduce checks to ensure the accuracy and completeness of all invoices raised ***(graded "significant within audited area").*** | As 2.1.10, above |
| 2.1.13 (a) was due to be implemented in June 2016 – The Service should review the cost of uplifts against charge rates, and determine whether or not it is appropriate for reduced charges to be offered to either attract or retain customers ***(graded "important within audited area").*** | As reported previously, the Service has advised that a review of costs of uplifts cannot be completed until data derived from the Bartec Collective System have been gathered and validated. Use of a non-standard charging rate is rare at this time and therefore the Service considers that the impact of deferring this action until confidence in its outcome can be gained is low. The recommendation will be implemented by the end of March 2017. |

| Report Number | Report Title | Date Issued | Number of Recommendations | | | | |
|---|---|---|---|---|---|---|---|
| | | | Agreed in Report | Due for implementation by 30.09.16 | Confirmed Implemented by Service | **Not implemented by original due date** | Grading of overdue recommendations |

**COMMUNITIES, HOUSING AND INFRASTRUCTURE (continued)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AC1611 | Sheltered Housing | February 2016 | 10 | 10 | 9 | **1** | 1 Significant |
| As reported previously, the overdue recommendation ***(2.2.3 graded "significant within audited area")*** was due to be implemented in May 2016 and relates to the Service ensuring that a detailed prediction of staffing levels is undertaken and any forecasts from this are used in future planning for budgeting, staffing levels and negotiations with Bon Accord Care. The Service has advised that the Communities, Housing and Infrastructure Committee has approved that officers develop a method of delivering the Services required and after that an assessment of staffing levels. The Service anticipates that this will be complete by the end of October 2016. | | | | | | | |
| AC1618 | Vehicle and Driver Records | April 2016 | 22 | 15 | 14 | **1** | 1 Important |
| The overdue recommendation ***(2.5.7 graded "important within audited area")*** was due to be implemented in August 2016 and relates to Fleet, in conjunction with HR and User Services, should maintain a list of Posts with driving duties, and the relevant licence categories required. HR has advised that the list is almost complete and an action plan detailing driving checks should be complete by the end of November 2016. | | | | | | | |
| AC1702 | Building Services Procurement | June 2016 | 9 | 0 | 0 | **0** | 0 |
| AC1703 | Cleaning Payroll | June 2016 | 14 | 9 | 8 | **1** | 1 Significant |
| The overdue recommendation ***(2.3.13 graded "significant within audited area")*** was due to be implemented in September 2016 and relates to HR reviewing a sample of new starts / leavers where the non-standard working week allowance is paid to determine if there are other errors that have been made, correcting any errors identified and identifying the root cause of the issues. To date, a sample of rotas held by HR have been checked to payments being made and are in the process of being checked with Service management. It is anticipated that this will be complete by the end of November. | | | | | | | |

| Report Number | Report Title | Date Issued | Number of Recommendations | | | | |
|---|---|---|---|---|---|---|---|
| | | | Agreed in Report | Due for implementation by 30.09.16 | Confirmed Implemented by Service | **Not implemented by original due date** | Grading of overdue recommendations |
| **COMMUNITIES, HOUSING AND INFRASTRUCTURE (continued)** | | | | | | | |
| AC1705 | Roads Payroll | August 2016 | 22 | 13 | 13 | **0** | 0 |
| **CORPORATE GOVERNANCE** | | | | | | | |
| AC1602 | Payroll System | October 2015 | 3 | 1 | 1 | **0** | 0 |
| AC1606 | Creditors System | November 2015 | 5 | 5 | 4 | **1** | 1 Significant |
| As reported previously, the overdue recommendation ***(2.3.1 graded "significant within audited area")*** was due to be implemented by the end of June 2016 and relates to IT and Transformation ensuring that remote access agreements are in place for all systems that require one. The Service has advised that this is taking longer than anticipated. A system is now in place for any new suppliers requiring access and it is anticipated that existing suppliers will be completed by the end of September 2016. Internal Audit is awaiting an update on progress. | | | | | | | |

| Report Number | Report Title | Date Issued | Number of Recommendations | | | | |
|---|---|---|---|---|---|---|---|
| | | | Agreed in Report | Due for implementation by 30.09.16 | Confirmed Implemented by Service | **Not implemented by original due date** | Grading of overdue recommendations |

**CORPORATE GOVERNANCE (continued)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AC1614 | Risk Management | November 2015 | 10 | 9 | 5 | **4** | 2 Significant<br>2 Important |

Three of the overdue recommendations were due to be implemented by the end of March 2016. The position with each of these is as follows:

| Recommendation | Position |
|---|---|
| 2.1.6 – The Strategic Risk Register should be updated, approved and reported to the Audit, Risk and Scrutiny Committee ***(graded "significant within audited area")*** | As reported previously, there will now be a strategic risk register (SRR) and a corporate operational risk register. The operational one will be drawn from those risks with corporate impact which are recorded in the service risk registers. The corporate operational risk register was to be reported to the Audit, Risk and Scrutiny Committee in June 2016 and the SRR would follow (no timescale yet).<br><br>The latest update is that the corporate operational and strategic risk registers were reported to CMT on 25 August 2016, but there is no firm timeline for reporting these to Committee. |
| 2.1.7 – Performance Dashboards held on The Zone should be populated with the required data ***(graded "important within audited area").*** | As reported previously, all risk registers will be uploaded to the relevant dashboards once agreed. The Corporate Governance register was uploaded to the Corporate Governance Dashboard after the Audit, Risk and Scrutiny Committee on 28 April 2016. The Corporate Dashboard, where the SRR and Corporate Operational Registers will be housed, has yet to be approved by CMT. |

| Report Number | Report Title | Date Issued | Number of Recommendations | | | | |
|---|---|---|---|---|---|---|---|
| | | | Agreed in Report | Due for implementation by 30.09.16 | Confirmed Implemented by Service | **Not implemented by original due date** | Grading of overdue recommendations |

**CORPORATE GOVERNANCE (continued)**

| Recommendation | Position |
|---|---|
| *(AC1614 – Risk Management – Continued)* | |
| 2.1.13 – The Risk Management Manual should be reviewed and updated where appropriate ***(graded "important within audited area").*** | As reported previously, the strategy will be revised through work with consultants on the governance review and the manual will then need to be revised after that. The strategy was due to be reported to the Audit, Risk and Scrutiny Committee in September 2016 and the manual revision would be complete by September 2016. The revised strategy was to be reported to Committee in November with the manual being revised in 2017.<br><br>The latest update from the Service is that the risk system review has concluded and the associated implementation plan is being reported to the Audit, Risk and Scrutiny Committee in November 2016. Work on the revised strategy and manual are about to start and it is expected that the strategy will be reported in the first half of 2017. |
| As reported previously, a further recommendation ***(2.1.19 graded "significant within audited area")*** was due to be implemented by the end of April 2016 and relates to a risk management annual report being prepared and presented to the Audit, Risk and Scrutiny Committee. This had been delayed to the September 2016 meeting of the Committee to allow for inclusion of a benchmarking exercise. At that time, the benchmarking exercise has not commenced and it was intended to report to the November 2016 meeting of the Audit, Risk and Scrutiny Committee.<br><br>The latest update from the Service is that the benchmarking data has been received in draft form only and, as a result of having not received final data, the exercise has been delayed further. | |

| Report Number | Report Title | Date Issued | Number of Recommendations | | | | |
|---|---|---|---|---|---|---|---|
| | | | Agreed in Report | Due for implementation by 30.09.16 | Confirmed Implemented by Service | **Not implemented by original due date** | Grading of overdue recommendations |

**CORPORATE GOVERNANCE (continued)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AC1619 | Social Work Tendering | April 2016 | 14 | 11 | 8 | **3** | 2 Major<br>1 Significant |

Progress with the three overdue recommendations is as follows:

| Recommendation | Position |
|---|---|
| 2.3.6 (i) was due to be implemented in September 2016 – Social Care and Children's Social Work should ensure that there is an adequate audit trail between the values of contracts in the contracts register and the budget from which they come ***(graded "significant within audited area")***. | Arrangements for the future have been established, however, it will take until the end of December 2016 to address current contracts. |
| 2.5.4 (i) was due to be implemented in June 2016 – The contract management procedure will be reviewed in light of the shared service and a risk based approach adopted. A recharge protocol is also being prepared to manage the use of block funded services by other local authorities. Where double funding has been identified, Services will work together to identify the extent of this , secure repayment where appropriate, and put systems in place to ensure it does not happen again ***(graded "major at a service level").*** | As reported previously, the Service has advised that the contract management framework was rolled out in June 2016, staff have completed training and new procedures have been implemented. The recharge protocol issue has been agreed in principle by the two Councils. The value of the necessary adjustment has to be agreed following which work can begin on a recharging protocol to identify and recover double funding, although this is being held up with complications over resource transfer issues at present. |
| 2.5.4 (iii) was due to be implemented in June 2016 – Social Work should consider the risks and value for money associated with block-funded care arrangements and report to Committee the number of providers that have been double funded by other local authorities ***(graded "major at a service level")*** | As 2.5.4 (i), above. |

| Report Number | Report Title | Date Issued | Number of Recommendations | | | | |
|---|---|---|---|---|---|---|---|
| | | | Agreed in Report | Due for implementation by 30.09.16 | Confirmed Implemented by Service | **Not implemented by original due date** | Grading of overdue recommendations |
| **CORPORATE GOVERNANCE (continued)** | | | | | | | |
| AC1626 | Council Tax Reduction | April 2016 | 1 | 1 | 1 | **0** | 0 |
| AC1706 | Scottish Welfare Fund | August 2016 | 3 | 3 | 3 | **0** | 0 |
| AC1708 | Infosmart System | August 2016 | 7 | 1 | 1 | **0** | 0 |
| AC1710 | Public Records (Scotland) Act | August 2017 | 2 | 0 | 0 | **0** | 0 |
| **EDUCATION AND CHILDREN'S SERVICES** | | | | | | | |
| AC1604 AW | Payment Controls in Children's Social Work | February 2016 | 19 | 14 | 10 | **4** | 3 Significant 1 Important |

Progress with the four overdue recommendations is as follows:

| Recommendation | Position |
|---|---|
| 2.2.14 (i) was due to be implemented in September 2016 – The Service, in conjunction with Finance, should review the interface from CareFirst to ensure full invoice numbers are transferred to the financial system ***(graded "significant within audited area")***. | The Carefirst system supplier has confirmed that they will be increasing the field length for invoice numbers in the first quarter of 2017 as part of the release of the next version of the system. This will, therefore, be implemented by June 2017. |

| Report Number | Report Title | Date Issued | Number of Recommendations | | | | |
|---|---|---|---|---|---|---|---|
| | | | Agreed in Report | Due for implementation by 30.09.16 | Confirmed Implemented by Service | **Not implemented by original due date** | Grading of overdue recommendations |

**EDUCATION AND CHILDREN'S SERVICES (continued)**

| Recommendation | Position |
|---|---|
| *(AC1604AW – Payment Controls in Children's Social Work – Continued)* | |
| 2.2.15was due to be implemented in June 2016 – relates to Financial Services reviewing and rationalising supplier numbers to ensure that there are no duplicates ***(graded "important within audited area")***. | As reported previously, implementation of the enhanced reporting tool that would have enabled this recommendation to be completed has been delayed. The Service is working with the provider, Finance and ICT colleagues to resolve the issues and expect that this will be achieved by the end of November 2016. |
| 2.2.27 (i) was due to be implemented in August 2016 – The Service should review whether block-funded arrangements are necessary and appropriate. Where there are alternative spot purchase arrangements, these should be explored ***(graded "significant within audited area")***. | The Service is in the process of reviewing arrangements and this will be complete by April 2017. |
| 2.2.27 (ii) was due to be implemented in August 2016 – The Service should review controls over payments for block-funded care ***(graded "significant within audited area")***. | As 2.2.27 (i), above. |

| Report Number | Report Title | Date Issued | Number of Recommendations | | | | |
|---|---|---|---|---|---|---|---|
| | | | Agreed in Report | Due for implementation by 30.09.16 | Confirmed Implemented by Service | **Not implemented by original due date** | Grading of overdue recommendations |

**EDUCATION AND CHILDREN'S SERVICES (continued)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AC1605 | Secondary Schools | April 2016 | 17 | 17 | 13 | **4** | 3 Significant<br>1 Important |

Progress with the other overdue recommendations is detailed below:

| Recommendation | Position |
|---|---|
| 2.1.2 (b) was due to be implemented in August 2016 – The Service should consider preparing a financial administrative procedure manual for all schools to have access to (Training) ***(graded "important within audited area")***. | The Service has stated that training will be provided to all schools between September 2016 and January 2017 incorporating Internal Audit's recommendations, financial and procurement procedures. |
| 2.6.7 was due to be implemented in August 2016 – The service should ensure class contributions, and waived charges are consistent across all schools, that calculations supporting the values are retained, and all monies collected are receipted and paid directly into the council bank account timeously ***(graded "significant within audited area")***. | The Service is currently investigating practice in schools and returns received to date suggest that there is diversity in practice. It may require a working group to determine a common approach and this will be resolved by March 2017. |
| 2.10.10 (a) was due to be implemented in August 2016 – The Service should ensure that school funds are supported by a constitution, accurate records, regular school management reviews, and an annual audit review ***(graded "significant within audited area")***. | This was to be addressed through the issue of a circular to schools which was scheduled to be issued in the week commencing 19 September 2016. This was delayed and was then to be issued on 4 November 2016. Internal Audit is awaiting confirmation that the circular has been issued. |
| 2.10.10 (b) was due to be implemented in August 2016 – The Service should ensure that school funds are operated for the benefit of pupils, and where appropriate should undertake a cost benefit analysis of retaining school fund charitable status ***(graded "significant within audited area")***. | As for 2.10.10 (a). |

| Report Number | Report Title | Date Issued | Number of Recommendations | | | | |
|---|---|---|---|---|---|---|---|
| | | | Agreed in Report | Due for implementation by 30.09.16 | Confirmed Implemented by Service | **Not implemented by original due date** | Grading of overdue recommendations |
| **EDUCATION AND CHILDREN'S SERVICES (continued)** | | | | | | | |
| AC1624 | Family Centres | July 2016 | 6 | 6 | 6 | **0** | 0 |
| AC1625 | Teachers Payroll | April 2016 | 9 | 9 | 9 | **0** | 0 |
| **HEALTH AND SOCIAL CARE PARTNERSHIP** | | | | | | | |
| AC1609 | Pre-Integration Financial Assurance | January 2016 | 5 | 4 | 4 | **0** | 0 |

**APPENDIX C**

**Grading of Recommendations**

| GRADE | DEFINITION |
|---|---|
| **Major at a Corporate Level** | The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss, or loss of reputation, to the Council. |
| **Major at a Service Level / within audited area** | The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss to the Service/area audited.<br><br>Financial Regulations have been consistently breached. |
| **Significant within audited area** | Addressing this issue will enhance internal controls.<br><br>An element of control is missing or only partial in nature.<br><br>The existence of the weakness identified has an impact on a system's adequacy and effectiveness.<br><br>Financial Regulations have been breached. |
| **Important within audited area** | Although the element of internal control is satisfactory, a control weakness was identified, the existence of the weakness, taken independently or with other findings does not impair the overall system of internal control. |

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ABERDEEN CITY COUNCIL

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| COMMITTEE | Audit, Risk & Scrutiny |
| DATE | 24th November 2016 |
| DIRECTOR | Angela Scott |
| TITLE OF REPORT | Audit Scotland National Reports |
| REPORT NUMBER: | OCE/16/144 |
| CHECKLIST COMPLETED | Yes |

1. PURPOSE OF REPORT

The purpose of this report is to present a summary of Audit Scotland national studies published in the last cycle together with any actions taken or agreed to be taken by the Council in response to these.

2. RECOMMENDATION(S)

that the Committee:-

(a) note the detail of the reports:-

- "Maintaining Scotland's Roads"
- "Social Work in Scotland"

(b) consider officers' comments.

3. FINANCIAL IMPLICATIONS

There are no direct financial implications arising from this report.

4. OTHER IMPLICATIONS

Every national Audit Scotland review is likely to have implications for this Council. The nature of the implications will vary depending on the subject matter. Officers are required to assess these and report to committees.

5. BACKGROUND/MAIN ISSUES

Audit Scotland has an annual programme of national reviews it undertakes. Some of these are specific to individual councils and Community Panning Partnerships, others are intended for local government and other public sector bodies more broadly.

Since the last time this was reported to Committee there have been 2 reports with direct significance for Aberdeen City Council.

- “Maintaining Scotland’s Roads”
- “Social Work in Scotland”

A summary of each report is set out below.

## A. Maintaining Scotland's Roads

This audit follows up previous audit reports in 2011 and 2013. It reviews:

- changes in road condition and spending on roads maintenance since the 2011 report
- progress made against previous audit recommendations
- progress in implementing the actions set out in the NRMR, in particular Option 30.

Summary

Roads authorities, locally and nationally, urgently need to demonstrate a much greater commitment to innovation, comparing relative efficiency and being clearer with the public about the impact on road condition of agreed spending levels. It is clear that the status quo is no longer an option if there is to be any improvement in road condition. A longer term view is required, one that takes into account both the need for new roads and the maintenance of the existing road network.

Independent survey results indicate that the condition of council maintained roads has remained stable at around 63 per cent in acceptable condition over the period 2011/12 to 2014/15. There is significant variation in road condition among councils. There is also concern that the survey approach does not always pick up the full extent of failures in the structural integrity of lower road layers. Fifty-seven per cent of users report that road condition is a major concern. While 13 authorities increased their spending, overall council expenditure on roads maintenance continues to decrease, from £302 million in 2011/12 to £259 million in 2014/15 (14 per cent). Overall, councils spent £33 million (13 per cent) less on planned and routine maintenance in 2014/15 than the Society of Chief Officers of Transportation Scotland considers was necessary to maintain the current condition of local roads.

The condition of trunk roads declined from 90 per cent in acceptable condition in 2011/12 to 87 per cent in 2014/15. Most of this decline is associated with the condition of motorways. Transport Scotland attributes this to more resurfacing work, instead of more expensive reconstruction which would also improve the condition of the lower road layers. Transport Scotland's expenditure on trunk roads maintenance fell from £168 million in 2011/12 to £162 million in 2014/15 (four per cent). It spent £24 million (38 per cent) less on structural maintenance in 2014/15 than it considers was necessary to maintain trunk road condition at its current levels.

In the current context of reduced public spending, the competing priorities of some services, such as education, health and social care mean that roads maintenance budgets may be put under further pressure. There is evidence that roads authorities are better prioritising and targeting roads maintenance, and using cheaper treatment options. This has helped available budgets go further but carries risks. Increasing the use of surface dressing might help to

maintain the condition of the surface of the road network in the short term, but this may not deliver value for money in the longer term. It is important that 6 | proper scrutiny and challenge includes taking account of all options and users' views when considering spending on roads.

Progress with introducing a shared services approach to roads maintenance, a central theme of the 2012 National Roads Maintenance Review, has been disappointingly slow. Councils are in the process of establishing regional governance bodies for local roads maintenance but there is still no clear plan and timetable for determining the extent of shared services at an operational level. Scottish ministers want to see councils make more progress, and be able to demonstrate the efficiency savings and other benefits arising, before trunk roads could be considered for inclusion in such regional arrangements.

The report's recommendations are shown below together with Council officers' comments:-

| ***Recommendation*** | ***Officer Comments*** |
|---|---|
| ***The Strategic Action Group should:*** | |
| *i. Ensure that the Roads Collaboration Board works with regional group partners to determine a clear plan and timetable for:*<br><br>– *supporting the development of regional arrangements for roads services to secure the benefits arising, such as efficiencies, increased service resilience and professional skills, while also preserving local accountability*<br>– *making decisions on the extent of shared services at an operational level*<br>– *learning lessons from existing shared service models such as the Ayrshire Roads Alliance, Tayside Contracts and further afield*<br>– *establishing a baseline position, so that roads authorities can measure the expected benefits from collaboration over time*<br>– *develop outcome measures which demonstrate the contribution of well-maintained roads to Scotland's economy* | Noted |
| ***Councils should:-*** | |
| *i. Ensure that they work closely with the Roads Collaboration Programme and regional group partners to determine* | The Northern Roads Collaboration Forum has met three times in 2016 with a general agreement to move forward to a Joint |

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| *the extent of shared service models for roads maintenance operations* | Committee to deliver collaborative working |
| *ii. Ensure that they implement the findings of the consultant's review of Roads Asset Management Plans (RAMPs) where relevant* | Project 2 RAMP went to Committee in January 2016, a further update will go to Committee January 2017. An Action Plan has been implemented to take forward the exp. consultants visit of October 2016 |
| *iii. Implement methods for assessing and comparing councils' roads maintenance efficiency with the aim of identifying and learning from councils delivering services more efficiently* | A new costing system has been proposed that will allow a greater scrutiny of productivity and unit costs |
| *iv. Use the National Highways & Transport (NHT) Network Survey, or similar, to obtain user views and perceptions of roads services consistently* | ACC carry out a customer survey via questionnaires sent out to local residents after work has been completed to obtain their views on the completed work. |
| *v. Use the results of user surveys to develop more proactive ways of engaging with the public over roads maintenance issues, and to help inform scrutiny and challenge of roads maintenance budgetary proposals.* | Results of the survey are discussed and presented to Committee as a satisfaction figure |
| ***Councils and Transport Scotland should:*** | |
| *i. Ensure that they use their RAMPs to inform elected members and Scottish ministers of long-term investment plans for maintaining roads that take into account the whole-life costing of treatment options* | Ramp with options for spend are presented to council on an annual basis |
| *ii. Ensure that the consequences of spending less than that necessary to maintain current road condition adequately features in budget setting processes to allow elected members and Scottish ministers make informed choices which take account of competing demands and priorities.* | This is highlighted within the Ramp report. Road Condition is presented as part of the annual Capital Budget proposed spend, from there it becomes part of the available information on the web site. This may need to be more prominent within the web |
| ***Transport Scotland should:*** | |
| *i. Make road condition information publicly available for the geographical areas of the trunk road network: North West, North East, South East and South West Scotland.* | Noted |
| *ii. Identify unit cost or other efficiency measures to evaluate the value for money provided by operating companies.* | Noted |

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| *iii. Consider the overall trend in performance of operating companies and ensure it has appropriate mechanisms in place for addressing areas of poorer performance.* | Noted |
| *iv. Fully take account of the needs of the existing trunk road network when considering the affordability of large-scale transport investments taken forward within the Scottish Government's Infrastructure Investment Plan.* | Noted |
| *v. Consider its future strategy for maintaining the trunk road network. The strategy should fully reflect the progress made by council regional groupings in determining the extent of shared service models for roads maintenance operations. If Transport Scotland decides to renew its existing operating contracts, it should seek to maximise opportunities for greater collaboration with councils through contract conditions.* | Noted |
| ***The Society of Chief Officers of Transportation Scotland (SCOTS) should:*** | |
| i. Work with councils to implement the findings of the consultant's review of RAMPs, and promote good practice where it is identified. | Noted |
| ii. Continue, as a matter of priority, to work with consultants to develop methods for assessing and comparing how efficient councils are at roads maintenance. | Noted |
| iii. Focus the work of the Scottish Roads Research Board so that it identifies a programme of research projects aimed at maximising innovation and sharing current good practice in delivering roads maintenance services. | Noted |

## B. Social Work in Scotland

The overall aim of the audit was to examine how effectively councils are planning to address the financial and demographic pressures facing social work. The objectives were to assess:

- the scale of the financial and demand pressures facing social work;
- the strategies councils are adopting to meet these challenges;
- the effectiveness of governance arrangements, including how elected members lead and oversee social work services;
- the impact of financial and demand pressures on people who use services and on carers, and how councils involve them in planning how services are provided.

Key Messages

Current approaches to delivering social work services will not be sustainable in the long term. There are risks that reducing costs further could affect the quality of services. Councils and Integration Joint Boards (IJBs) need to work with the Scottish Government, which sets the overall strategy for social work across Scotland, to make fundamental decisions about how they provide services in the future. They need to work more closely with service providers, people who use social work services and carers to commission services in a way that makes best use of the resources and expertise available locally. They also need to build communities' capacity to better support vulnerable local people to live independently in their own homes and communities.

Councils' social work departments are facing significant challenges because of a combination of financial pressures caused by a real-terms reduction in overall council spending, demographic change, and the cost of implementing new legislation and policies. If councils and IJBs continue to provide services in the same way, we have estimated that these changes require councils' social work spending to increase by between £510 and £667 million by 2020 (16–21 per cent increase).

The integration of health and social care has made governance arrangements more complex, but regardless of integration, councils retain statutory responsibilities in relation to social work services. Elected members have important leadership and scrutiny roles in councils. It is essential that elected members assure themselves that service quality is maintained and that risks are managed effectively. Elected members have a key role to play in a wider conversation with the public about service priorities and managing people's expectations of social work and social care services that councils can afford to provide in the future. The Scottish Government also has an important role to play in setting the overall context of the debate.

With integration and other changes over recent years, the key role of the chief social work officer (CSWO) has become more complex and challenging. Councils need to ensure that CSWOs have the status and capacity to enable them to fulfil their statutory responsibilities effectively.

The report's recommendations are shown below:-

| **Social work strategy and service planning** |
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| ***Councils and IJBs should:*** |
| *instigate a frank and wide-ranging debate with their communities about the long-term future for social work and social care in their area to meet statutory responsibilities, given the funding available and the future challenges* |
| *work with the Scottish Government, their representative organisation (COSLA or the Scottish Local Government Partnership (SLGP)), Social Work Scotland and other stakeholders to review how to provide social work services for the future and future funding arrangements* |
| *i. develop long-term strategies for the services funded by social work by:*<br>*– carrying out a detailed analysis of demographic change and the contribution preventative approaches can make to reduce demand for services*<br>*– developing long-term financial and workforce plans*<br>*– working with people who use services, carers and service providers to design and provide services around the needs of individuals*<br>*– working more closely with local communities to build their capacity so they can better support local people who may be at risk of needing to use services*<br>*– considering examples of innovative practice from across Scotland and beyond*<br>*– working with the NHS and Scottish Government to review how to better synchronise partners' budget-setting arrangements to support these strategies* |
| **Governance and scrutiny arrangements** |
| ***Councils and IJBs should:*** |
| *ensure that the governance and scrutiny of social work services are appropriate and comprehensive across the whole of social work services, and review these arrangements regularly as partnerships develop and services change* |
| *improve accountability by having processes in place to:*<br>- *measure the outcomes of services, for example in criminal justice services, and their success rates in supporting individuals' efforts to desist from offending through their social inclusion;*<br>- *monitor the efficiency and effectiveness of services*<br>- *allow elected members to assure themselves that the quality of social work services is being maintained and that councils are managing risks effectively;*<br>- *measure people's satisfaction with those services;*<br>- *report the findings to elected members and the IJB.* |
| ***Councils should:*** |
| *demonstrate clear access for, and reporting to, the council by the CSWO, in line with guidance* |
| *ensure the CSWO has sufficient time and authority to enable them to fulfil the role effectively* |
| *ensure that CSWO annual reports provide an annual summary of the performance of the social work service, highlighting achievements and weaker areas of service delivery, setting out the council's response and plans to improve weaker areas and that these are actively scrutinised by elected members* |

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| **Workforce** |
| ***Councils should:*** |
| *work with their representative organisation (COSLA or the SLGP), the Scottish Government and private and third sector employers to put in place a coordinated approach to resolve workforce issues in social care* |
| *as part of their contract monitoring arrangements, ensure that providers who use zero hours contracts allow staff to accept or turn down work without being penalised* |
| **Service efficiency and effectiveness** |
| **Councils and IJBs should:** |
| *when planning an initiative, include evaluation criteria and extend or halt initiatives depending on the success of new approaches in improving outcomes and value for money* |
| *work with COSLA to review the eligibility framework to ensure that it is still fit for purpose in the light of recent policy and legislative changes* |
| **Councils should:** |
| *benchmark their services against those provided by other councils and providers within the UK and overseas to encourage innovation and improve services* |

**Officer Comment:-**

The recommendations from this report are to be considered by the Aberdeen City Health and Social Care Partnership Integration Joint Board and, for the Committee's information, a copy of a proposed IJB Action Plan is attached as Appendix A.

The Council's Education and Children's Services Committee received a Bulletin Report on 17th November which advised members of the key messages of the report.

6. IMPACT

**Improving Customer Experience** –
The actions which flow from national reports will have varying impact on customers. From an internal customer perspective, these reports allow the members of the Audit, Risk and Scrutiny Committee to undertake their role on behalf of the Council.

**Improving Staff Experience** –
The impact of governance in local authorities is a key determinant of its effectiveness. The regular and consistent reporting of national level reports with implications for Aberdeen City Council strengthen governance. Depending on the subject matter of national reports the potential impact can be relevant for staff, customers and use of resources. In this case, the national report relates to workforce planning which has a very direct impact on staff and, by association, customers. The specific impact of any proposals relating to Workforce Planning will be fully set out when proposed.

**Improving our use of Resources** –
The actions which flow from national reports will have varying impact on resources. These will be stated depending on the subject matter.

**Corporate -**
With regards to the national report referred to in this report, workforce planning is an integral part of corporate and service planning, underpinning the Council's to deliver quality services.

**Public –**
Whilst no direct implications arise from this "scrutiny" report, the Council's workforce planning arrangements must take account of the equality duty.

7. MANAGEMENT OF RISK

There are no identified material risks which would result from the approval of the recommendations in this report. The actions and recommendations contained in the report are a response to identified risks and are designed to mitigate these.

8. BACKGROUND PAPERS

Audit Scotland report
- "Maintaining Scotland's Roads"
- "Social Work in Scotland"

9. REPORT AUTHOR DETAILS

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mmurchie@aberdeencity.gov.uk
(01224) 522008

**APPENDIX A**

## Aberdeen Health & Social Care Partnership

| SOCIAL WORK STRATEGY AND SERVICE PLANNING | |
|---|---|
| **Recommendation** | **Response** |
| Community involvement about the long-term future for social work and care to meet statutory responsibilities. | • This will form part of the work we will do in relation to community engagement and participation in strategic and locality planning<br>• Our workforce planning approach will take cognisance of this |
| **Recommendation** | **Response** |
| Work with Scottish Government, Social Work Scotland and other stakeholders to review how to provide social work services for future and future funding arrangements | • We will continue to engage with relevant Scottish Government and SWS work streams.<br>• There are twice yearly meetings with Scottish Government Officials, the Chief Officer and Chief Executives.<br>• Senior Managers and CSWO are members of SWS and engage in relevant standing committees of that organisation. |
| **Recommendation** | **Response** |
| Develop long term strategies for the services funded by social work by:<br><br>**1.** Carrying out a detailed analysis of demographic change and the contribution. preventative approaches can make to reduce demand for services.<br>**2.** Developing long-term financial and workforce plans. | • Demographic analysis is a key element of the strategic planning process and a focus on prevention and sustainability underpins the structure of the Strategic Transformation Programme as well as our Strategic Commissioning aims<br>• Financial Strategy and workforce planning both underway and will be presented to the IJB. |

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| **3.** Working with service users, carers and service providers to design and provide services around the needs of individuals.<br>**4.** Working more closely with local communities to build community capacity to support people.<br>**5.** Consider examples of innovative practice.<br>**6.** Working with NHS and SG to review how to better synchronise partners' budgeting-setting arrangement to support these strategies. | • This is key to our locality team development as well as our approach to Self-Directed Support.<br>• Our locality approach sets out to lead this capacity building and we are recruiting via the 3rd sector community builders to enhance this approach.<br>• We believe our transformation programme to be innovative and also participate in national discussion and forums where best practice is shared and consider if new models can be adapted for the Aberdeen City context.<br>• Aberdeen City Council and NHS Grampian have already synchronised budget setting arrangements in support of the Integration Joint Board. |
| **GOVERNANCE AND SCRUTINY ARRANGEMENTS** | |
| **Recommendation** | **Response** |
| Ensure that governance and scrutiny of social work services are appropriate and comprehensive across the whole of social work services and review these arrangements regularly as partnerships develop and services change | • The CSWO is an advisory member of the IJB<br>• CSWO is a member of the Clinical and Care Governance Committee and has an open invitation to attend the Clinical and Care Governance Group<br>• The Clinical and Care Governance Structure sits within a wider Board Assurance Framework and is developing its governance and scrutiny processes – for social work purposes using the information routinely and regularly reported previously to the Service Committee<br>• Clinical and Care Governance processes are in place for ACC and NHS Grampian to get assurance from the processes being in place and for social work and statutory purposes the CSWO and Chief Exec of ACC also report to Full Council – the CSWO in her report and the CE in relation to 'matters of interest to the Council in regard to the IJB<br>• The Good Governance Institute have been commissioned to review the governance processes of the IJB and its Committees over the course of |

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| | its first 'live' year and this will be reported to the IJB |
| **Recommendation** | **Response** |
| Improve accountability by having processes in place to:<br>• Measure the outcomes of services and their success rates<br>• Monitor the efficiency and effectiveness of services<br>• Allow elected members to assure themselves that the quality of social work services is being maintained and that councils are managing risks effectively<br>• Measure people's satisfaction with services<br>Report the findings to elected members and the IJB. | • Clinical and Care Governance framework includes measurement of outcomes<br>• Performance framework in development for the IJB measures against the 9 national outcome measures and includes a suite of local and national measure of service quality and user experience<br>• We are also developing and refining approaches to measure outcomes across services commissioned for adult social care by the ACC as directed by the IJB<br>• We will seek to strengthen our approaches to people's satisfaction with services<br>• Regular performance reports are presented and the IJB is responsible for delivering an annual report to the Council and NHS also |
| **WORKFORCE (councils should)** | |
| **Recommendation** | **Response** |
| Work with representative organisation, Scottish Government and third/private sector employers to put in place a coordinated approach to resolve workforce issues in social care. | • A market facilitation plan is being developed in conjunction with our partners in the third and independent sectors showing the agreed principles and interventions that will provide individual support to providers and stabilise the local market.<br>• The UNISON ethical care charter is in the process of being adopted by the Council and IJB.<br>• Regular meetings are held with the third and private sector employers. |

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| | • Resolving the workforce issues in social care will cost more money at a time when budgets are already stretched due to the increasing complexity of client needs and demographics. |
| **Recommendation** | **Response** |
| As part of contract monitoring arrangements, ensure that providers who use zero hours contracts allow staff to accept or turn down work without being penalised. | • There are currently no monitoring arrangements in respect of the relationship between employees on zero hours contracts and their employer.<br><br>• However the IJB supports the principles of the Ethical Care Charter and has directed that a working group be established to consider the implementation of the Charter and to provide the IJB with an update before the end of the financial year. |
| **SERVICE EFFECIENCY AND EFFECTIVENESS** | |
| **Recommendation** | **Response** |
| When planning an initiative, include evaluation criteria and extend or halt initiatives depending on the success of new approaches in improving outcomes and value for money. | • The Programme Office Approach to the Transformation Programme sets out a clear, proportionate approach to evaluation. |
| **Recommendation** | **Response** |
| Work with COSLA to review the eligibility framework to ensure that it is still fit for purpose in the light of recent policy and legislative changes. | • ACC are members of the Scottish Local Government Partnership and not CoSLA however currently apply the agreed national eligibility criteria guidance in respect of Social Work assessments. |

Exempt information as described in paragraph(s) 8 of Schedule 7A
of the Local Government (Scotland) Act 1973.

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of the Local Government (Scotland) Act 1973.

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