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ABERDEEN
CITY COUNCIL

To: Councillor Flynn, Convener; Councillor Yuill, Vice Convener; and Councillors Allard, Duncan, Graham, Lumsden, Avril MacKenzie, Reynolds and Townson.

Town House,
ABERDEEN 30 April 2018

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 TUESDAY, 8 MAY 2018 at 2.00 pm.**

FRASER BELL
CHIEF OFFICER - GOVERNANCE

B U S I N E S S

DETERMINATION OF URGENT BUSINESS

1.1 There are no items of urgent business at this time

DETERMINATION OF EXEMPT BUSINESS

2.1 Members are Requested to Determine that any Exempt Business be Considered with the Press and Public Excluded

DECLARATIONS OF INTEREST

3.1 Members are requested to intimate any declarations of interest (Pages 5 - 6)

BUSINESS PLANNER

4.1 Committee Business Planner (Pages 7 - 14)

REQUESTS FOR DEPUTATION

5.1 There are no requests at this time

MINUTE OF PREVIOUS MEETING

6.1 Minute of Meeting of 22 February 2018 (Pages 15 - 34)

FINANCE, PERFORMANCE RISK AND SERVICE WIDE ISSUES

Financial Reporting

7.1 Unaudited Annual Accounts 2017/18 - to follow

Performance and Improvement

7.2 Internal Audit Progress Report - IA/18/006 (Pages 35 - 44)

7.3 Format of Internal Audit Reports - IA/18/008 (Pages 45 - 50)

7.4 ALEO Assurance Hub - GOV/18/004 (Pages 51 - 88)

7.5 Protective Monitoring - CUS/18/007 (Pages 89 - 132)

7.6 SPSO Decisions and Inspector of Crematoria Complaint Decisions - CUS/18/006 (Pages 133 - 140)

7.7 Inspection Report of Aberdeen Crematorium by the Inspector of Crematoria - OPE/18/012 (Pages 141 - 150)

Control Environment and Assurance - Internal

7.8 Integration Joint Board - Integration and Change Funding - IA/AC/18/07 (Pages 151 - 154)

7.9 Financial Ledger System - IA/AC/18/12 (Pages 155 - 170)

7.10 PECOS - IA/AC/18/20 (Pages 171 - 184)

7.11 Out of Authority Placements - IA/AC/18/26 (Pages 185 - 198)

7.12 Capital Plan - IA/AC/1818 (Pages 199 - 210)

7.13 Homeless Person - Housing Support Budget - IA/AC/18/25 (Pages 211 - 224)

7.14 Care Management - IA/AC/18/28 (Pages 225 - 238)

Control Environment and Assurance - External

7.15 External Audit, Interim Management Report (Pages 239 - 248)

Control Environment and Assurance – Audit Follow Up

7.16 Internal Audit Follow Up on Agreed Recommendations - IA/18/007 (Pages 249 - 290)

EXEMPT/CONFIDENTIAL BUSINESS

8.1 Garthdee Alpine Sports (Pages 291 - 296)

EHRIA's related to reports on this agenda can be viewed at
Equality and Human Rights Impact Assessments

To access the Service Updates for this Committee please use the following link:
https://committees.aberdeencity.gov.uk/ecCatDisplayClassic.aspx?sch=doc&cat=13450&path=0

Website Address: www.aberdeencity.gov.uk

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

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You must consider at the earliest stage possible whether you have an interest to declare in relation to any matter which is to be considered. You should consider whether reports for meetings raise any issue of declaration of interest. Your declaration of interest must be made under the standing item on the agenda, however if you do identify the need for a declaration of interest only when a particular matter is being discussed then you must declare the interest as soon as you realise it is necessary. The following wording may be helpful for you in making your declaration.

I declare an interest in item (x) for the following reasons ……
For example, I know the applicant / I am a member of the Board of X / I am employed by…
and I will therefore withdraw from the meeting room during any discussion and voting on that item.

OR

I have considered whether I require to declare an interest in item (x) for the following reasons …… however, having applied the objective test, I consider that my interest is so remote / insignificant that it does not require me to remove myself from consideration of the item.

OR

I declare an interest in item (x) for the following reasons …… however I consider that a specific exclusion applies as my interest is as a member of xxxx, which is

(a) a devolved public body as defined in Schedule 3 to the Act;

(b) a public body established by enactment or in pursuance of statutory powers or by the authority of statute or a statutory scheme;

(c) a body with whom there is in force an agreement which has been made in pursuance of Section 19 of the Enterprise and New Towns (Scotland) Act 1990 by Scottish Enterprise or Highlands and Islands Enterprise for the discharge by that body of any of the functions of Scottish Enterprise or, as the case may be, Highlands and Islands Enterprise; or

(d) a body being a company:-

i. established wholly or mainly for the purpose of providing services to the Councillor's local authority; and

ii. which has entered into a contractual arrangement with that local authority for the supply of goods and/or services to that local authority.

OR

I declare an interest in item (x) for the following reasons……and although the body is covered by a specific exclusion, the matter before the Committee is one that is quasi-judicial / regulatory in nature where the body I am a member of:

- is applying for a licence, a consent or an approval
- is making an objection or representation
- has a material interest concerning a licence consent or approval
- is the subject of a statutory order of a regulatory nature made or proposed to be made by the local authority…. and I will therefore withdraw from the meeting room during any discussion and voting on that item.

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	A	B	C	D	E	F	G	H	I
1	**AUDIT, RISK & SCRUTINY COMMITTEE BUSINESS PLANNER** The Business Planner details the reports which have been instructed by the Committee as well as reports which the Functions expect to be submitting for the calendar year.								
2	**Report Title**	**Minute Reference/Committee Decision or Purpose of Report**	**Update**	**Report Author**	**Chief Officer**	**Directorate**	**Terms of Reference**	**If delayed, removed, transferred or withdrawn, enter either D, R, T or W**	**Explanation if removed, delayed or withdrawn**
3	**08 May 2018**								
4	Internal Audit Progress and Performance	To provide an update on progress for the 2017/18 and 2018/19 audit	on agenda	David Hughes	Governance	Governance	2.2 and 2.4		
5	Out of Authority Placements	Review progress with implementing the Inclusion Review and consider whether the system used to make and review on-going out of authority placements is robust and that alternatives are considered before decisions are made which commit expenditure.	on agenda	David Hughes	Governance	Governance	2.2		
6	Stores Purchasing	Ensure appropriate arrangements are in place regarding procurement of stock		David Hughes	Governance	Governance	2.2	D	Internal Audit have not managed to progress the audit report as quickly as they had hoped. Delayed until June Meeting.
7	Homeless Person - Housing Support Budget	Consider whether adequate control is being exercised over income and expenditure and that best value is being obtained	on agenda	David Hughes	Governance	Governance	2.2		
8	Internal Audit Follow Up on Recommendations	To provide an update on where Services are with implementing agreed recommendations	on agenda	David Hughes	Governance	Governance	2.3		
9	Internal Transport Tendering Procedures	Consider whether robust tendering procedures are in place and are operating satisfactorily		David Hughes	Governance	Governance	2.2	D	Proposal from the Service to defer the audit to 2019/20. Details have been included in the Internal Audit Progress Report.
10	Capital Plan	Consider whether robust mechanisms are in place for setting, progressing and monitoring the capital plan.	on agenda	David Hughes	Governance	Governance	2.2		
11	Integration Joint Board - Integration and Change Funding	Ensure appropriate governance is in place to manage delivery of funded projects and use of the funds	on agenda	David Hughes	Governance	Governance	2.2		
12	Financial Ledger System	Consider whether appropriate control is being exercised over the system and that interfaces to and from other systems are accurate and properly controlled.	on agenda	David Hughes	Governance	Governance	2.2		
13	Care Management	To obtain assurance that care needs are being identified, planned and recorded accurately and that costs charged are appropriate and adequately controlled.	on agenda	David Hughes	Governance	Governance	2.2		

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14	PECOS	Consider whether appropriate contreol is being exercised over the system and that interfaces to and from other systems are accurate and properly controlled	on agenda	David Hughes	Governance	Governance	2.2		
15	Fixed Asset Register	Consider whther procedures for ensuring timely recording of the acquisition/disposal of assets are adequate and that relevaluations are undertaken in accordance with recognised best practice.		David Hughes	Governance	Governance	2.2	D	The Internal Audit report has been delayed due to Finance not completing work which was subject to testing as part of the audit. Delayed until June.
16	Internal Audit Reports	To discuss the format of the Internal Audit Reports	on agenda	David Hughes	Governance	Governance	2.2		
17	ALEO Assurance Hub	To provide assurance to the Committee on the risk management, financial management and governance arrangements of the ALEOs within the remit of the Assurance Hub.	on agenda	Iain Robertson	Governance	Governance	1.2		
18	Garthdee Alpine Sports	to provide an update on the progress made with implementing the internal audit recommendations.	on agenda	Craig Innes	Commercial and Procurement	Commissioning	2.3		
19	Unaudited Annual Accounts 2017/18	To present the unaudited annual accounts		Lesley Fullerton	Finance	Resources	4.1		
20	Protective Monitoring	Finance, Policy and Resources on 1/2/18 - The Committee agreed:- (i) to defer deliberation of the report until a future meeting of the Committee; (ii) to instruct officers to include further details within the report regarding the governance process for officers and elected members; (iii) that officers circulate further details in relation to Airwatch regarding due process; and (iv) that members contact the Head of IT and Transformation with any additional governance and assurance issues that they would like to be addressed and included within the report.	on agenda	Norman Hogg	Digital and Technology	Customer	1.4		
21	Local Scrutiny Plan	To present, for approval, the Local Scrutiny Plan 2018/19 from the Local Area Network	The External Auditor has advised that further work was required on the Plan.	Andy Shaw	Governance	Governance	3.1	D	The Local Scrutiny Plan has not yet been finalised by the Local Area Network and will be presented to the meeting in June.
22	Interim Management Report	To present an interim report in relation to the external audit work.	on agenda	Andy Shaw	Governance	Governance	3.1		

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23	SPSO Decisions, Inspector of Crematoria Complaint Decisions	In order to provide assurance to Committee that complaints and Scottish Welfare Fund applications are being handled appropriately, this report provides information on all Scottish Public Services Ombudsman (SPSO) and Inspector of Crematoria decisions made in relation to Aberdeen City Council since the last reporting cycle.	on agenda	Lucy Mackenzie	Customer Experience	Customer	6.9		
24	Fleet and Transport MOT Issues	The report provides members with information regarding Aberdeen City Council operating six vehicles without valid MOT certificates.	on agenda	William Whyte	Operations and Protective Services	Operations	6.2		
25	Inspection Report of Aberdeen Crematorium by the Inspector of Crematoria	At its meeting on 1 November 2016, the Communities, Housing and Infrastructure Committee resolved to present resulting reports of audits of Aberdeen Crematorium to the Audit, Risk and Scrutiny Committee for assurance purposes. This report provides the Committee with the attached inspection report carried out by the Inspector of Crematoria on 31 January 2018.	on agenda	Graham Keith	Operations and Protective Services	Operations	6.9		
26			**27 June 2018**						
27	Audited Annual Accounts 2017/18	To present the audited annual accounts		Lesley Fullerton	Finance	Resources	4.1		
28	Timetable for Preparation of Internal Audit Plans for 2019/20 and 2020/21	To advise the Committee of the process and timetable for developing the Internal Audit Plan for 2019/20 and 2020/21		David Hughes	Governance	Governance	2.1		
29	Internal Audit Charter	To advise the Committee of the annual review of the Council's Internal Audit Charter		David Hughes	Governance	Governance	2.2		
30	Internal Audit Annual Report	To present Internal Audit's annual report to Committee		David Hughes	Governance	Governance	2.1		
31	Internal Audit Progress and Performance	To provide an update on progress for the 2017/18 and 2018/19 audit		David Hughes	Governance	Governance	2.4		
32	Creditors Payments	To provide assurance that there are adequate controls around the interface of payment data from named systems to the Creditors System (supporting documentation for and authorisation controls over input data, segregation of duties, accuracy and reconciliation of interfaced data sent and received) and that any associated balance sheet / suspense codes are reconciled on a regular basis.		David Hughes	Governance	Governance	2.2		

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33	Internal Audit Follow Up on Recommendations	To provide an update on where Services are with implementing agreed recommendations		David Hughes	Governance	Governance	2.3		
34	Interim Audit Report & ISA 260 Report to Those Charged with Governance	to present External Audit's interim position on the annual accounts		Andy Shaw	Governance	Governance	1.4		
35	RIPSA Activity	Audit, Risk and Scrutiny Committee's decision 26/9/17 the Committee requested quarterly updates on policy/compliance. The update includes an update on training delivered, the number of applications “live” and extant, and any new procedural requirements.		Jess Anderson	Governance	Governance	5.2		
36	Corporate Investigation Team - Annual Fraud Report	To consider the annual fraud report		Brian Muldoon	Governance	Governance	5.2		
37	SPSO Decisions, Inspector of Crematoria Complaint Decisions	In order to provide assurance to Committee that complaints and Scottish Welfare Fund applications are being handled appropriately, this report provides information on all Scottish Public Services Ombudsman (SPSO) and Inspector of Crematoria decisions made in relation to Aberdeen City Council since the last reporting cycle.		Lucy Mackenzie	Customer Experience	Customer	6.9		
38			**03 October 2018**						
39	Internal Audit Progress and Performance	To provide an update on progress for the 2017/18 and 2018/19 audit		David Hughes	Governance	Governance	2.4		
40	Internal Audit Follow Up on Recommendations	To provide an update on where Services are with implementing agreed recommendations		David Hughes	Governance	Governance	2.3		
41	Transformation	To provide assurance that the Council has appropriate arrangements in place to ensure the success of its transformational aspirations.		David Hughes	Governance	Governance	2.2		
42	Timesheets and Allowances	To provide assurance that payments are accurate and justified, and that improvements recommended in previous reviews have been fully implemented.		David Hughes	Governance	Governance	2.2		
43	General Data Protection Regulations	To provide assurance that the Council has adequate arrangements in place, that are understood throughout the organisation, to protect the Council’s information.		David Hughes	Governance	Governance	2.2		
44	Devolved Education Management	To provide assurance that the scheme in place is adequate and that the decision making process is appropriate based on delegations in place.		David Hughes	Governance	Governance	2.2		
45	Housing Rent	To provide assurance that appropriate arrangements have been put in place to manage the impact of Universal Credit on rent collection including intervention relating to identified vulnerable cases.		David Hughes	Governance	Governance	2.2		

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46	Debtors System	To provide assurance over system controls, documentation supporting invoices raised and debt recovery process.		David Hughes	Governance	Governance	2.2		
47	VAT	To provide assurance over arrangements in place to maximise the recovery of VAT and ensure that VAT recovered is adequately supported.		David Hughes	Governance	Governance	2.2		
48	Digital Strategy	To provide assurance that there are appropriate plans in place to manage the Council's digital strategy including reporting of progress against established milestones.		David Hughes	Governance	Governance	2.2		
49	Charging Policy	To provide assurance that there is a clear charging policy in place and that it is being complied with.		David Hughes	Governance	Governance	2.2		
50	Annual Information Governance Statement	To provide Committee with an annual report on the Council's information governance performance.		Caroline Anderson	Governance	Governance	1.4		
51	Council's RIPSA Policy and the statistical information on RIPSA activity	As per the Committee's decision 26/9/17 the report presented the annual report on the Council's RIPSA policy and the statistical information on RIPSA activity.		Jess Anderson	Governance	Governance	5.2		
52	External Audit Annual Report	to present External Audit's annual report on the accounts		Andy Shaw	Governance	Governance	3.1		
53	Money Laundering	To present the reviewed Money Laundering policy for approval.		Brian Muldoon	Governance	Governance	GD7.1		
54	ALEO Assurance Hub	To provide assurance to the Committee on the risk management, financial management and governance arrangements of the ALEOs within the remit of the Assurance Hub.		Iain Robertson	Governance	Governance	1.2		
55	Development of Models for Civic Leadership and Engagement	To consider models for Civic Leadership and Engagement		Derek McGowan	Early Intervention and Community Empowerment	Customer			
56	SPSO Decisions, Inspector of Crematoria Complaint Decisions	In order to provide assurance to Committee that complaints and Scottish Welfare Fund applications are being handled appropriately, this report provides information on all Scottish Public Services Ombudsman (SPSO) and Inspector of Crematoria decisions made in relation to Aberdeen City Council since the last reporting cycle.		Lucy Mackenzie	Customer Experience	Customer	6.9		
57			**04 December 2018**						
58	Internal Audit Progress and Performance	To provide an update on progress for the 2017/18 and 2018/19 audit		David Hughes	Governance	Governance	2.4		
59	Voluntary Severance / Early Retirement (VSER) Scheme	To provide assurance that the terms of the VSER Scheme are complied with and that payments made / enhancements to pensions are accurate.		David Hughes	Governance	Governance	2.2		

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60	Compliance with Procurement Legislation and Council Regulations	To provide assurance that the Council has appropriate arrangements in place that are being complied with, to ensure compliance with procurement legislation and internal regulations.		David Hughes	Governance	Governance	2.2		
61	Business Rates	To provide assurance over the accuracy of Business Rates billing and robustness of collection arrangements.		David Hughes	Governance	Governance	2.2		
62	Data security in a cloud based environment	To provide assurance over the Council's arrangements to ensure data security where business is transacted through the Cloud.		David Hughes	Governance	Governance	2.2		
63	National Care Home Contract	To provide assurance that risk to supply is controlled through adequate monitoring of supply and suppliers and related business continuity plans. (Ref Kingsmead Nursing Home.)		David Hughes	Governance	Governance	2.2		
64	ALEO Assurance Hub Annual Review	To review the ALEO Assurance Hub terms of reference and oversight of ALEOs over the previous 12 months		Iain Robertson	Governance	Governance	1.2		
65	Internal Audit Follow Up on Recommendations	To provide an update on where Services are with implementing agreed recommendations		David Hughes	Governance	Governance	2.3		
66			**14 February 2019**						
67	Internal Audit Progress and Performance	To provide an update on progress for the 2018/19 audit		David Hughes	Governance	Governance	2.4		
68	Internal Audit Follow Up on Recommendations	To provide an update on where Services are with implementing agreed recommendations		David Hughes	Governance	Governance	2.3		
69	Health and Safety	To provide assurance that appropriate arrangements to manage Health and Safety have been implemented across the Council.		David Hughes	Governance	Governance	2.2		
70	Prevention of Fraud, Bribery and Corruption	To provide assurance that the Council's arrangements for the prevention of fraud, bribery and corruption are adequate and proportionate.		David Hughes	Governance	Governance	2.2		
71	Pupil Equity Fund	To provide assurance that schools are spending in accordance with their plans, and that these were developed as required, to close the poverty related attainment gap.		David Hughes	Governance	Governance	2.2		
72	i-World	To provide assurance that appropriate control is being exercised over the i-World system and that interfaces to and from other systems are accurate and properly controlled.		David Hughes	Governance	Governance	2.2		
73	Craft Workers' Terms and Conditions	To provide assurance that new Terms and Conditions have been implemented and are being complied with.		David Hughes	Governance	Governance	2.2		
74	Bond Governance	To provide assurance that the requirements of the Bond Trust Deed are complied with.		David Hughes	Governance	Governance	2.2		

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75	SPSO Decisions, Inspector of Crematoria Complaint Decisions	In order to provide assurance to Committee that complaints and Scottish Welfare Fund applications are being handled appropriately, this report provides information on all Scottish Public Services Ombudsman (SPSO) and Inspector of Crematoria decisions made in relation to Aberdeen City Council since the last reporting cycle.		Lucy Mackenzie	Customer Experience	Customer	6.9		
76	RIPSA Activity	Audit, Risk and Scrutiny Committee's decision 26/9/17 the Committee requested quarterly updates on policy/compliance. The update includes an update on training delivered, the number of applications "live" and extant, and any new procedural requirements.		Jess Anderson	Governance	Governance	5.2		
77			**30 April 2019**						
78	Digital Booking, Fees and Charges	To provide assurance over the controls around on-line booking and collection of fees and charges		David Hughes	Governance	Governance	2.2		
79	Music Centre	To provide assurance that procedures have been improved following completion of work undertaken by Corporate Investigation Team.		David Hughes	Governance	Governance	2.2		
80	Contract Management	To focus on recent identified issues - 3rd Don Crossing - Photovoltaic Panels To include data/intelligence used for monitoring escalation of risk		David Hughes	Governance	Governance	2.2		
81	Criminal Justice	To provide assurance that adequate control is exercised over income and expenditure, that system data is accurate and adequately supported, and that reporting arrangements between the Council and IJB are appropriate.		David Hughes	Governance	Governance	2.2		
82	Annual Committee Effectiveness Report	To present the annual effectiveness report for the Committee.	May-19		Governance	Governance	GD 7.4		
83	SPSO Decisions, Inspector of Crematoria Complaint Decisions	In order to provide assurance to Committee that complaints and Scottish Welfare Fund applications are being handled appropriately, this report provides information on all Scottish Public Services Ombudsman (SPSO) and Inspector of Crematoria decisions made in relation to Aberdeen City Council since the last reporting cycle.		Lucy Mackenzie	Customer Experience	Customer	6.9		
84			**Other Items**						

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85	Marchburn Park	Operational Delivery Committee 19 April 2018 that in regards to Marchburn Park, "to instruct the Chief Officer (Early Intervention and Community Empowerment) to bring a report to Audit following conclusion of all matters detailed within this report."	A report has been instructed to be discussed at Operational Delivery Committee within 6 months. Following conclusion of all matters a report will be submitted to this Committee. No date has been scheduled as yet.		Early Intervention and Community Empowerment	Customer			

AUDIT, RISK AND SCRUTINY COMMITTEE

ABERDEEN, 22 February 2018. Minute of Meeting of the AUDIT, RISK AND SCRUTINY COMMITTEE. Present:- Councillor Flynn, Convener; Councillor Yuill, Vice-Convener; and Councillors Councillor Donnelly, the Depute Provost, Allard, Bell, Cooke, Jackie Dunbar, Duncan, Graham, Lumsden, Macdonald (as substitute for Councillor Councillor Crockett, the Lord Provost), Avril MacKenzie, McLellan, Samarai, Sellar, Townson and Wheeler (as substitute for Councillor Reynolds).

The agenda and reports associated with this minute can be found at:- https://committees.aberdeencity.gov.uk/ieListDocuments.aspx?CId=507&MId=5859

Please note that if any changes are made to this minute at the point of approval, these will be outlined in the subsequent minute and this document will not be retrospectively altered.

CONVENER ANNOUNCEMENT

1. The Convener advised that in relation to Marchburn Park, that a report would be submitted to the first scheduled meeting of the Operations Committee.

The Committee resolved:-
to note the information.

MINUTE OF PREVIOUS MEETING OF 23 NOVEMBER 2017

2. The Committee had before it the minute of its previous meeting of 23 November 2017.

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

MINUTE OF MEETING OF THE CORPORATE HEALTH AND SAFETY COMMITTEE OF 25 AUGUST 2017

3. The Committee had before it the minute of meeting of the Corporate Health and Safety Committee of 25 August 2017.

The Committee resolved:-
to note the minute.

AUDIT, RISK AND SCRUTINY COMMITTEE
22 February 2018

MINUTE OF MEETING OF THE CORPORATE HEALTH AND SAFETY COMMITTEE OF 17 NOVEMBER 2017

4. The Committee had before it the minute of meeting of the Corporate Health and Safety Committee of 17 November.

The Committee resolved:-
to note the minute.

COMMITTEE BUSINESS STATEMENT

5. The Committee had before it the Committee Business Statement as prepared by the clerk.

The Committee resolved:-
(i) subject to the decisions later on the agenda, to delete items 2 (Information Governance Report – Governance Standards); 3 (Information Governance Report – Release of Information to the Public); and 4 (Wellington Brae – Planning and Sustainable Development Service Review).
(ii) to otherwise note the content of the business statement.

COMMITTEE TRACKER

6. The Committee had before it the Committee Tracker which presented a list of reports to be discussed at today's meeting.

Councillor Samarai asked when the internal report on Care Management would be submitted to the Committee, wherein the Chief Internal Auditor advised that the draft report would be issued to management in the next week, with the report being submitted to the May meeting.

The Committee resolved:-
to note the content of the tracker.

ANNUAL ACCOUNTS 2017/18 - ACTION PLAN AND KEY DATES - CG/18/002

7. The Committee had before it a report by the Director of Resources which provided high level information and key dates in relation to the 2017/18 Annual Accounts including linkages to the plans and timescales of the Council's External Auditors.

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

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

INTERNAL AUDIT PROGRESS REPORT - IA/18/001

8. The Committee had before it a report by the Chief Internal Auditor which advised on progress against the 2017/18 Internal Audit Plan.

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 approve the recommendation contained in the report.

INTERNAL AUDIT PLAN 2018/19 - IA/18/003

9. The Committee had before it a report by the Chief Internal Auditor which sought approval of the Internal Audit Plan for 2018/19.

The report recommended:
that the Committee approve the Internal Audit Plan for 2018/19.

Councillor Duncan sought information relating to what would be achieved by having linked internal audit plans with Aberdeenshire Council on a three year rolling plan and why had these not been possible to implement to date.

The Chief Internal Auditor advised that having a linked plan would achieve efficiency in terms of the work of the Internal Audit Team however at present the priorities, strategic plans and risks were different so it had not been possible to link the plans together. He further advised that a report would be submitted to the June meeting providing information on the planning for the 2019/20 to 2021/22 audit plans.

The Committee resolved:-
to approve the Internal Audit Plan for 2018/19.

EXTERNAL AUDIT STRATEGY

10. The Committee had before it a report by the External Auditor which presented the planned external audit work for 2017/18.

Councillor Townson sought information relating to the level of management referred to in the report, wherein the External Auditor advised that any officer who could make adjustments to the journal and those charged with governance and that this would be amended in the report to make it clearer.

The Committee resolved:-
to note the content of the report and the information provided.

INFORMATION GOVERNANCE - DATA GOVERNANCE STANDARDS - CG/18/007

11. The Committee had before it a report by the Chief Officer, Governance which provided an update on the development of Data Governance Standards in support of compliance with the General Data Protection Regulation.

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

Councillor Cooke sought assurance that staff would read and understand the information contained in the lengthy appendices, wherein the Information Manager Advised that there was a programme or work to ensure that officers were trained using a variety of methods.

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

SUSTAINABLE DEVELOPMENT SERVICE REVIEW - WELLINGTON BRAE UPDATE CHI/18/006

12. The Committee had before it a report by the Interim Director of Communities, Housing and Infrastructure which provided an update in relation to how the wider Service Review of the Planning and Sustainable Development Service was taking full account of the need to implement additional safeguards to ensure that any debatable land ownership and contract procurement issues were appropriately escalated, resolved and recorded.

The report recommended:
That the Committee notes –
(a) the Planning Service Review had taken account of the requirement previously instructed by the Committee;
(b) the progress on the Investigation Report's recommendations in respect of the project at Wellington Brae; and
(c) that Audit Scotland would not be taking any further action in respect of the Wellington Brae project.

Councillor Donnelly sought guidance as to whether Councillors would be informed of projects in their areas in the future, wherein the Interim Director advised that all Councillors would receive training and would be informed of projects in their areas.

Councillor Duncan sought information in relation to the governance arrangements for all projects to gain assurance that they were being managed without the Project Management Software which was still to be sourced. The Interim Director advised that all projects should be managed and reporting arrangements in place. She further advised that an internal audit report would be submitted to this Committee in May which would highlight any areas requiring additional management.

Councillor Graham sought approval to add an additional recommendation "to agree that there was no misuse of public funds by former Councillor Willie Young" which was agreed by the Committee.

The Committee resolved:-
(i) to agree that there was no misuse of public funds by former Councillor Willie Young; and
(ii) to otherwise approve the recommendations contained in the report.

RESPONSE TO GRENFELL TOWER FIRE - BUILDING SAFETY - CHI/18/007

13. The Committee had before it a report by the Interim Director of Communities, Housing and Infrastructure which provided assurance on the Council's response to the Grenfell Tower fire and the approach taken to maintain fire safety in high rise domestic buildings.

The report recommended:
That the Committee notes –
(a) the report and the actions taken by Aberdeen City Council and its partners to review fire safety in high rise domestic buildings; and
(b) the Council's work programme, which is aligned with the Scottish Government Programme, as provided at appendix 6 of the report.

The Convener expressed his thanks to officers for the information that was provided to Councillors and the work undertaken following the Grenfell Tower Incident.

Councillor Townson sought clarification relating to the use of Aluminium Composite Material (ACM) as exterior cladding to buildings in Scotland, wherein the Building Standards Manager advised that there were three grades of ACM and that and that it was not permitted to use that cladding in some buildings. He further advised that there were two buildings which had been identified as having ACM cladding however they did comply with the regulations.

Councillor McLellan sought information relating to the cost of issuing letters to all residents and whether other communication methods had been considered, wherein the Interim Director advised that she would determine the cost for issuing the letters and advise the Committee, and that it was important to get the information out to residents as quickly as possible and that digital methods could be explored for the future.

The Vice Convener sought information as to the total cost per building over a five year period for the remedial works carried out, specifically relating to fire remedial works, wherein the Chief Officer – Corporate Landlord advised that he would look at all of the work orders for the properties and provide a cost to the Committee.

Councillors Cooke and Macdonald sought information relating to whether behaviours of tenants had improved with regards to communal areas, specifically in high rise buildings, with leaving objects lying around, wherein the Interim Director advised that a reminder letter would be issued to residents in June.

The Committee resolved:-

(i) in relation to a question from Councillor McLellan, to note that the Interim Director for Communities, Housing and Infrastructure would determine the cost of issuing letters to all residents and circulate the information to the Committee;

(ii) in relation to a question from the Vice Convener, to note that the Chief Officer - Corporate Landlord would provide the Committee with information relating to the number of work orders per building over the last five years including the costs of those orders;

(iii) to congratulate staff and partners for the high level management and response following the Grenfell Tower incident; and

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

SCOTTISH PUBLIC SERVICES OMBUDSMAN AND INSPECTOR OF CREMATORIA COMPLAINT DECISIONS - CG/18/003

14. The Committee had before it a report by the Chief Officer, Governance which provided information on all Scottish Public Services Ombudsman (SPSO), Inspector of Crematoria decisions and Regulation of Investigatory Powers (Scotland) Act 2000 (RIPSA) authorisations made in relation to Aberdeen City Council since the last reporting cycle to provide assurance to the Committee that the handling of complaints, Scottish Welfare Fund applications and surveillance was being undertaken appropriately.

The report recommended:
that the Committee notes the details of the report.

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

AUDIT OF ABERDEEN CREMATORIUM BY THE FEDERATION OF BURIAL AND CREMATION AUTHORITIES - CHI/18/001

15. The Committee had before it a report by the Chief Officer, Governance which (1) advised that the Communities Housing and Infrastructure Committee at its meeting of 1 November 2016, commissioned a Critical Friend Audit by an external crematoria industry body; and (2) presented the critical friend audit carried out by the Federation of Burial and Cremation Authorities (FBCA) on 27 November 2017.

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

Councillor Lumsden asked when the administration would transfer to staff at the Crematorium, wherein the Environment Manager advised that he would liaise with colleagues and provide a response to the Committee.

The Vice Convener sought an update relating to teams working in isolation and the work being undertaken to ensure they were managed appropriately, wherein the Chief Executive advised that an assurance mapping exercise was being undertaken and that once this had been completed a response would be provided to the Committee.

The Committee resolved:-
(i) in relation to a question from Councillor Lumsden, to note that the Environment Manager would provide the Committee with details relating to the timescales for transferring the administration to the crematorium;
(ii) in relation to a question from the Vice Convener regarding staff working in isolation which may impact working practices, to note that the Chief Executive would provide the Committee with information following the completion of the assurance mapping exercise; and
(iii) to otherwise approve the recommendation contained in the report.

DECLARATION OF INTEREST

Councillor Duncan declared an interest as an employee of UNISON, however did not consider that the nature of her interest required her to leave the meeting during consideration of the item.

AUDIT, RISK AND SCRUTINY COMMITTEE
22 February 2018

BOND GOVERNANCE PROTOCOL - CG/18/004

16. The Committee had before it a report by the Chief Officer, Governance which presented the Bond Protocol which had been developed to provide guidance on how Aberdeen City Council complied with the legislative and regulatory requirements resulting from the Council having issued Bonds on the London Stock Exchange.

The report recommended:
that the Committee note the Bond Governance Insider Protocol appended to the report.

Councillor Cooke requested that acronyms were explained and that the titles of posts be amended in the Protocol to reflect the Target Operating Model structure.

Councillor Duncan sought guidance on how Trade Union representatives would access information and be consulted, wherein Mrs Nicolson, Solicitor, advised that a session was held for Trade Unions to explain the Bond process and that the Bond process was still new with some areas requiring further discussions on how to move forward.

The Committee resolved:-
(i) to note that Officer titles would be updated with the Protocol to reflect the Target Operating Model and
(ii) to otherwise approve the recommendation contained in the report.

CORPORATE FRAMEWORK FOR MANAGEMENT OF RISK - CG/18/006

17. The Committee had before it a report by the Chief Officer – Governance which presented the Risk Management Framework.

The report recommended:
That the Committee -
(a) approve the Risk Management Framework; and
(b) agree that the appropriate Chief Officer report back to the Committee in February 2019 with an updated Framework reflecting the Target Operating Model.

Councillor Townson sought guidance relating to the nature of internal and external audit involvement and whether there would be a vertical check against all risk registers. The Performance and Risk Manager advised that internal and external audit would be reviewing the arrangements to give assurance that the processes in place for risk were robust. He also advised that there was a clear structure for the management of risk and all risks could escalate to the next tier of management.

Councillor Duncan sought assurance that staff would be trained on the importance of managing risk, wherein the Performance and Risk Manager advised that sessions had

been undertaken with staff and covered risk management, the systems in place and risk assessments.

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

FRAUD, BRIBERY AND CORRUPTION POLICY - CG/17/154

18. The Committee had before it a report by the Director of Resources which sought approval of the Fraud, Bribery and Corruption Policy.

The report recommended:
that the Committee approve the updated Fraud, Bribery and Corruption Policy as appended to the report.

Councillor Townson sought guidance relating to when Police Scotland would get involved with any cases, wherein the Corporate Investigation Manager advised that the Monitoring Officer would be involved in the first instance and they would make the final decision on which other agencies may need to be involved.

Councillor Donnelly sought guidance in relation to Council Tax Benefit and how these cases were dealt with as it wasn't always the tenants' fault that payments had not been calculated appropriately. The Corporate Investigation Manager advised that a balanced approach was taken and each case was dealt with individually.

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

VEHICLE MAINTENANCE AUDIT - AC/18/08 UPDATE - CHI/18/008

19. The Committee had before it a report by the Interim Director of Communities, Housing and Infrastructure which provided an update in relation to recommendation 2.7 Expenditure in the audit report on Vehicle Maintenance AC1808.

The report recommended:
that the Committee note the progress made in advancing compliance with recommendation 2.7, expenditure in the audit report on Vehicle Maintenance AC1808.

Councillor Duncan thanked officers for the report and sought assurance that all of the issues would be dealt with, wherein the Chief Officer – Operation and Protective Services advised that the team were working with the Corporate Procurement Service to ensure that all issues were dealt with and that an action plan was in place to address the outstanding issues.

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

MAJOR IT BUSINESS SYSTEMS - IA/AC/1810

20. The Committee had before it a report by the Internal Auditor which presented an audit in relation to Major IT Business Systems which was undertaken to ensure that the risk of Major IT business systems failure was adequately managed.

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

Members raised concerns relating to the implementation dates for some of the recommendations and sought assurance that all of the recommendations would be implemented by the due dates. Officers advised on the status on the recommendations within the audit report.

Councillor Dunbar sought guidance as to whether the Committee could do anything to support Officers to receive the information when it was requested, wherein the Chief Officer – Governance advised that the Committee were already assisting by scrutinising the reports and that work had been undertaken to identify the outstanding audit recommendations and that these were presented in the outstanding audit recommendations report under each Directorate to highlight the stage the recommendations were at.

The Committee resolved:-
(i) to note the comments from members relating to recommendations not being completed by the implementation date and to request that Services provide realistic dates for completion for all Internal Audit recommendations;
(ii) to otherwise note the content of the report and endorse the recommendations for improvement as agreed by the Service.

POST ELECTION TRAINING FOR NEW COUNCIL - IA/AC/1816

21. The Committee had before it a report by the Internal Auditor which presented an audit in relation to Post Election Training for Councillors which was undertaken to ensure that appropriate arrangements were made for induction and training of Councillors following the May 2017 Local Government Elections and that the training delivered was effective.

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

The Committee resolved:-
to note the content of the report and endorse the recommendations for improvement as agreed by the Service.

NURSERY EDUCATION - PRE-SCHOOL COMMISSIONED PLACES - IA/AC/1815

22. The Committee had before it a report by the Internal Auditor which presented an audit in relation to Pre-School Nursery Places which considered whether statutory obligations were being delivered and that adequate control was exercised over expenditure and to consider if plans were in place to deliver the Scottish Government's expansion of early learning and childcare which would come into force in August 2020.

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

Councillor Cooke sought information relating to how the Council were performing compared to other Local authorities in relation to the percentage of children accessing the early learning and childcare services, wherein the Head of Policy, Performance and Resources advised that he would liaise with colleagues and provide a response to the Committee.

Councillors Duncan and Graham sought information relating to the Council paying childcare places in advance of the school term and the discussions with external providers for changing the payment times, wherein the Head of Policy, Performance and Resources advised that he would provide the Committee with an update to advise on where the Council were with those discussions and the impact changes may have on providers.

Councillor Dunbar asked whether the recommendation at 2.2.4 had been completed, wherein the Head of Policy, Performance and Resources advised that he would liaise with colleagues and provide a response to the Committee.

The Committee resolved:-
(i) in relation to a question from Councillor Cooke regarding the comparison between other local authorities and the Council for the take up of Early Learning and Childcare, to note that the Head of Policy, Performance and Resources would liaise with colleagues and provide a response to the Committee;
(ii) in relation to questions from members regarding the paying of childcare places in advance of the school term and the discussions with external providers for

changing the payment times, to note that the Head of Policy, Performance and Resources would provide the Committee with an update to advise on where the Council were with those discussions and the impact changes may have on providers;

(iii) in relation to a question from Councillor Dunbar regarding whether the recommendation at 2.24 of the audit report had been completed, to note that the Head of Policy, Performance and Resources would liaise with colleagues and provide a response to the Committee; and

(iv) to otherwise note the content of the report and endorse the recommendations for improvement as agreed by the Service.

INTEGRATED JOINT BOARD - INTEGRATION REVIEW - IA/AC/1724

23. The Committee had before it a report by the Internal Auditor which presented an audit in relation to the Integration Joint Board – Post Integration Review which was undertaken to provide assurance over whether integration objectives were on line to be achieved which included that there had been an evaluation of actual risk and financial performance against pre-integration assumptions, performance on relevant integration milestones, lessons learnt and that the Partnership were on course to deliver the planned long term benefits.

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

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

VEHICLE USAGE - IA/AC/1817

24. The Committee had before it a report by the Internal Auditor which presented an audit in relation to Vehicle Usage which was undertaken to ensure that adequate procedures are in place to ensure that vehicles were being used effectively for business purposes and any non-business use was appropriately reported.

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

The Committee resolved:-
to note the content of the report and endorse the recommendations for improvement as agreed by the Service.

YOUR HR - IA/AC/1822

25. The Committee had before it a report by the Internal Auditor which presented an audit in relation to YourHR which considered whether appropriate control was being exercised over the system and that interfaces to and from other systems were accurate and properly controlled.

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

The Chief Internal Auditor advised that the YourHR would be replaced within the next 18 months with a new Human Capital Management System which would be part of the new integrated payroll and HR system.

The Committee resolved:-
to note the content of the report and endorse the recommendations for improvement as agreed by the Service.

CHILDREN'S SOCIAL WORK PAYMENTS - IA/AC/1809

26. The Committee had before it a report by the Internal Auditor which presented an audit in relation to Children's Social Work Payments which was undertaken to obtain assurance that care needs are being identified, planned and recorded accurately and that costs charged were appropriate and adequately controlled.

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

The Committee resolved:-
to note the content of the report and endorse the recommendations for improvement as agreed by the Service.

ADULT SOCIAL WORK PAYROLL - IA/AC/1821

27. The Committee had before it a report by the Internal Auditor which presented a report in relation to Adult Social Work Payroll which considered whether all aspects of payroll administration were adequately controlled.

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

Councillors Lumsden and Samarai sought assurance as to whether the information at section 2.3.16 leading to the recommendation at section 2.3.17 would be completed on time, wherein the Chief Officer for the Health and Social Care Partnership advised that she would liaise with colleagues and provide a response to the Committee.

The Committee resolved:-
(i) in relation to a question from Councillor Samarai and Councillor Lumsden regarding whether the information at section 2.3.16 leading to the recommendation at section 2.3.17 would be completed on time, to note that the Chief Officer for the Health and Social Care Partnership would liaise with colleagues and provide a response to the Committee;
(ii) to otherwise note the content of the report and endorse the recommendations for improvement as agreed by the Service.

CAPITAL CONTRACTS - IA/AC/1819

28. The Committee had before it a report by the Internal Auditor which presented an audit in relation to Capital Contracts which was undertaken to ensure that adequate control was exercised over Property Capital Projects in respect of project planning, contract tendering, committee reporting, project spend and project monitoring.

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

Councillor Duncan and the Convener sought guidance as to whether the estimating and scheduling recommendation implementation date of April 2019 at 2.4.12 could be escalated, wherein the Head of Land and Property Assets advised that he would discuss the recommendation with colleagues to determine if the date could be escalated.

The Vice Convener sought clarification in relation to the recommendation at 2.3.2 specifically that there was no actual implementation date provided. The Head of Land and Property Assets advised that he would discuss the recommendation with colleagues in the Programme Management Office to determine an actual implementation date.

The Committee resolved:-
(i) in relation to questions from Councillor Duncan and the Convener regarding estimating and scheduling and the recommendation implementation date of April 2019 at 2.4.12, to note that the Head of Land and Property Assets would discuss the recommendation with colleagues to determine if the date could be escalated;
(ii) in relation to a question from the Vice Convener, to note that the Head of Land and Property Assets would discuss the recommendation at 2.3.2 with colleagues

in the Programme Management Office to determine an actual implementation date;

(iii) to otherwise note the content of the report and endorse the recommendations for improvement as agreed by the Service.

SOCIAL WORK FINANCIAL ASSESSMENTS - IA/AC/1813

29. The Committee had before it a report by the Internal Auditor which presented an audit in relation to Social Care Financial Assessments which considered whether adequate arrangements were in place across the Service to undertake financial assessments in an accurate and efficient manner.

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

Councillor Samarai sought assurance that the concerns and recommendations would be implemented, wherein the Finance Partner advised that he was confident that all of the recommendations would be completed by the implementation date.

Councillor Duncan sought information as to whether a whole system and process review had been undertaken, wherein the Finance Partner advised that all systems and processes were reviewed on a regular basis and any improvements were implemented.

Councillor Cooke sought clarification in relation to whose signature was missing form some of the paperwork and whether the paperwork would be adapted for digital use, wherein the Finance Partner advised that it was the service user signature that was missing and that the forms were being redesigned for digital submission.

The Committee resolved:-
to note the content of the report and endorse the recommendations for improvement as agreed by the Service.

BOND GOVERNANCE - IA/AC/1824

30. The Committee had before it a report by the Internal Auditor which presented an audit in relation to Bond Governance which considered whether arrangements have been put in place to ensure compliance with the London Stock Exchange requirements and to safeguard the Council's credit rating.

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

The Committee resolved:-
to note the content of the report and endorse the recommendations for improvement as agreed by the Service.

RELEASING INFORMATION TO THE PUBLIC - IA/18/004

31. The Committee had before it a report by the Internal Auditor which advised members of the outcome from the work that the Committee requested Internal Audit undertake relating to Freedom of Information processes in place for determining what information can be released to the public.

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

Councillor Townson sought guidance as to the process if an individual was not satisfied with the information released to them under an FOI request, and whether they could apply directly to the Information Commissioners Office. The Chief Officer – Governance advised that the first stage would be to request a Review Panel and then after that stage they could still appeal to the Information Commissioner's Office.

The Vice Convener referred to the percentage of appeals where the initial response was either partially upheld or overturned and whether this was because the Council were being too robust and not releasing information. The Chief Internal Auditor advised that some of the appeals related to a failure to respond within the required timescales and not that the Council were too robust in decision making for releasing information.

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

INTERNAL AUDIT FOLLOW-UP ON RECOMMENDATIONS SINCE APRIL 15/16 - IA/18/002

32. The Committee had before it a report by the internal Auditor which provided an update on the progress made by Services with implementing recommendations that has been agreed in Internal Audit reports.

The report recommended:
That the Committee –
(a) agree that the five payroll related recommendations that were currently dependent on further development of the YourHR system being closed off and the relevant functionality being tested by Internal Audit when the new Human Capital Management System was implemented; and

(b) review, discuss and comment on the issues raised within the report and the attached appendices.

Councillor Dunbar sought clarification regarding why the date for reviewing the status of implied contracts, agreeing actions with the Services and reporting to Committee kept changing, wherein the Director of Resources advised that he would liaise with the Head or Commercial and Procurement Services and provide a response to the Committee.

Councillor Dunbar sought information relating to the Agency Staff audit and why Internal Audit had not received an update on the progress being made, wherein the Director of Resources advised that he would liaise with the Head of Commercial and Procurement Services and provide a response to the Committee.

Councillor Dunbar sought information relating to the ALEOs Management by Services audit and why Internal Audit had not received an update on the progress being made, wherein the Head of Policy, Performance and Resources advised that he would provide a response to Internal Audit and advise the Committee.

In relation to the outstanding recommendations, the Chief Executive advised that she would meet with the Chief Officer – Governance and the Chief Internal Auditor to discuss a way forward and that she would discuss the outstanding recommendations at her monthly management team meetings to ensure that work was being progressed.

The Committee resolved:-

(i) in relation to a question from Councillor Dunbar regarding why the date for reviewing the status of implied contracts, agreeing actions with the Services and reporting to Committee kept changing, to note that the Director of Resources would liaise with the Head or Commercial and Procurement Services and provide a response to the Committee;

(ii) in relation to a question from Councillor Dunbar regarding Agency Staff audit and why Internal Audit had not received an update on the progress being made, to note that the Director of Resources would liaise with the Head of Commercial and Procurement Services and provide a response to the Committee;

(iii) in relation to a question from Councillor Dunbar regarding the ALEOs Management by Services audit and why Internal Audit had not received an update on the progress being made, to note that the Head of Policy, Performance and Resources would provide a response to Internal Audit and advise the Committee;

(iv) to note that the Chief Executive, Chief Officer - Governance and the Chief Internal Auditor would meet to discuss each of the outstanding audit recommendations so that a response can be provided to the Committee;

(v) to note that the Chief Executive would include the list of outstanding recommendations in her monthly meetings until there was a sustained improvement;

(vi) to approve the recommendations contained with the report; and

(vii) to otherwise instruct officers to undertake the actions required to complete the internal audit recommendations.

- **COUNCILLOR STEPHEN FLYNN, Convener**

AUDIT, RISK AND SCRUTINY COMMITTEE
22 February 2018

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ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	8 May 2018
REPORT TITLE	Internal Audit Progress
REPORT NUMBER	IA/18/006
DIRECTOR	N/A
REPORT AUTHOR	David Hughes
TERMS OF REFERENCE	2.2 and 2.4

1. PURPOSE OF REPORT

1.1 This report advises the Committee of Internal Audit's progress against the approved 2017/18 Internal Audit plan.

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. BACKGROUND / MAIN ISSUES

3.1 The Internal Audit plan for 2017/18 was approved by this Committee on 23 February 2017. The plan included an indicative Committee date by when it was planned to report each audit. Progress against the plan has been reported to each subsequent meeting of the Committee, although the Committee was advised that some dates of reporting may change in order to ensure that External Audit could place reliance on specific work. On 26 September 2017, the Committee approved the rescheduling of two audits (PECOS and Fixed Asset Register) from September and November respectively to February 2018 to facilitate this.

3.2 On 23 November 2017, the Committee approved the rescheduling of the planned audit of the Craft Workers Payroll to 2018/19 in view of delays in the renegotiation of the Craft Workers Terms and Conditions.

3.3 Appendix A to this report shows progress with the audits contained in the plan and a summary is shown in the following table (which incorporates the changes detailed in paragraphs 3.1 and 3.2 above).

Planned Audit Status	As at 25 April 2018 by Original Target Committee Date						%age
	Jun 17	Sep 17	Nov 17	Feb 18	May 18	Total	
Complete	3	5	5	9	3	25	86.0
Draft Report Issued	0	0	0	0	1	1	3.5
Work in Progress	0	0	0	1	0	1	3.5
To Start	0	0	0	0	1	1	3.5
Rescheduled to 2018/19	0	0	0	0	1	1	3.5
Total	3	5	5	10	6	29	100.0

3.4 In September and November 2017, the Committee was advised of staffing issues in Internal Audit and the impact that this had had on the availability of completed audits for those meetings of Committee. Internal Audit is now operating at full establishment and progress is being made with recovering the lost time. Progress had been further impacted by delays in Services responding to requests for data and providing responses to draft reports, and the requirement to undertake additional work in relation to European Interreg project grant claims. The on-going work on these claims has now been incorporated into the agreed Internal Audit Plan.

4. FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from the recommendations of this report.

5. LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from the recommendations of this report.

6. MANAGEMENT OF RISK

6.1 The Internal Audit process considers risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are detailed in the resultant Internal Audit reports. Recommendations are made to address the identified risks and Internal Audit follows up progress with implementing those that are agreed with management. Where planned progress is not maintained, there is a risk that sufficient work will not have been completed by the end of the financial year for Internal Audit to complete its annual opinion on the Council's control environment.

7. OUTCOMES

7.1 There are no direct impacts, as a result of this report, in relation to the Local Outcome Improvement Plan Themes of Prosperous Economy, People or Place, or Enabling Technology, or on the Design Principles of the Target Operating Module.

7.2 However, Internal Audit plays a key role in providing assurance over, and helping to improve, the Council's framework of governance, risk management and control. These arrangements, put in place by the Council, help ensure that the Council achieves its strategic objectives in a well-managed and controlled environment.

8. IMPACT ASSESSMENTS

Assessment	Outcome
Equality & Human Rights Impact Assessment	An assessment is not required because the reason for this report is for Committee to review, discuss and comment on the outcome of an internal audit. As a result, there will be no differential impact, as a result of the proposals in this report, on people with protected characteristics.
Privacy Impact Assessment	Not required
Duty of Due Regard / Fairer Scotland Duty	Not applicable

9. APPENDICES

9.1 Appendix A – Progress with 2017/18 Internal Audit Plan.

10. REPORT AUTHOR DETAILS

David Hughes, Chief Internal Auditor
David.Hughes@aberdeenshire.gov.uk
(01467) 537861

APPENDIX A

PROGRESS WITH 2017/18 INTERNAL AUDIT PLAN – BASED ON 2017/18 COUNCIL STRUCTURE
(Note – text in italics represents updates provided to Committee previously)

SUBJECT / SCOPE	OBJECTIVE	Progress as at 25 April 2018		Red Amber Green	Comment where applicable
CROSS SERVICE					
Capital Plan	Consider whether robust mechanisms are in place for setting, progressing and monitoring the capital plan. It is understood that Council officers are undertaking a review of this area and the outcome of this will help inform Internal Audit's opinion.	Draft report due to be issued Draft report issued	14.03.18 08.03.18	 Green	
		Management response due Management response received	23.03.18 13.03.18	 Green	
		Updated draft issued to Service Final draft agreed	14.03.18 11.04.18	 Amber	
		Final Report Issued	11.04.18	Green	
		Original target Committee date Actual submission to Committee	08.05.18 08.05.18	 Green	
CORPORATE GOVERNANCE					
PECOS System	Consider whether appropriate control is being exercised over the system and that interfaces to and from other systems are accurate and properly controlled.	Draft report due to be issued Draft report issued	21.02.18 09.02.18	 Green	*Delayed due to previously reported staffing issues although this is now well progressed*
		Management response due Management response received	02.03.18 02.03.18	 Green	
		Updated draft issued to Service Final draft agreed	06.03.18 15.03.18	Green	
		Final Report Issued	15.03.18	Green	
		Original target Committee date Amended target date Actual submission to Committee	22.02.18 08.05.18 08.05.18	Amber Green	

SUBJECT / SCOPE	OBJECTIVE	Progress as at 25 April 2018		Red Amber Green	Comment where applicable

CORPORATE GOVERNANCE (continued)

Fixed Asset Register	Consider whether procedures for ensuring timely recording of the acquisition / disposal of assets are adequate and that revaluations are undertaken in accordance with recognised best practice. Ensure that a sample of recorded assets exist and those that should be recorded are.	Draft report due to be issued Draft report issued	TBC	Amber	*See below:*
		Original target Committee date Amended target date Revised amended target	22.02.18 08.05.18 26.06.18	Amber Red	
Following commencement of the audit, Internal Audit was advised that one area due to be tested is undertaken as an annual exercise by the end January each year. As at 8 February 2018, this work had not been completed. As this is one of the audits that External Audit planned to take assurance from Internal Audit's work, the testing requires to be undertaken on 2017/18 work. Therefore, completion of the audit has been delayed and the outcome will be reported to Committee in May 2018. Finance has not yet completed the work that Internal Audit planned to include in testing. Although External Audit has confirmed to Finance that they will not now be placing reliance on Internal Audit's work in this area, Internal Audit still intends to review the most recently completed work once it is done.					

Financial Ledger System	Consider whether appropriate control is being exercised over the system and that interfaces to and from other systems are accurate and properly controlled.	Draft report due to be issued Draft report issued	26.01.18 26.01.18	 Green	*Delayed due to previously reported staffing issues in Internal Audit and availability of Finance staff to deal with provision of information, although this is now well progressed*
		Management response due Management response received	09.02.18 09.02.18	 Green	
		Updated draft issued to Service Final draft agreed	20.02.18 15.03.18	Green	
		Final Report Issued	15.03.18	Green	
		Original target Committee date Amended target date Actual submission to Committee	22.02.18 08.05.18 08.05.18	Amber Green	

SUBJECT / SCOPE	OBJECTIVE	Progress as at 25 April 2018		Red Amber Green	Comment where applicable
EDUCATION AND CHILDREN'S SERVICES					
Out of Authority Placements	Review progress with implementing the Inclusion Review and consider whether system used to make and review on-going out of authority placements is robust and that alternatives are considered before decisions are made which commit expenditure.	Draft report due to be issued Draft report issued	23.02.18 22.02.18	Green	Meeting held to discuss response on 27.03.18
		Management response due Management response received	22.03.18 19.03.18	Green	
		Updated draft issued to Service Final draft agreed	03.04.18 10.04.18	Green	
		Final Report Issued	11.04.18	Green	
		Original target Committee date Actual submission to Committee	08.05.18 08.05.18	Green	
COMMUNITIES, HOUSING AND INFRASTRUCTURE					
Stores Purchasing	Ensure that appropriate arrangements are in place regarding procurement of stock.	Draft report due to be issued Draft report issued	27.04.18 25.04.18	Green	Delays in Internal Audit caused by staff sickness
		Management response due Management response received	23.05.18 N/A	N/A	
		Original target Committee date Revised target Committee date	08.05.18 26.06.18	Amber	

SUBJECT / SCOPE	OBJECTIVE	Progress as at 25 April 2018		Red Amber Green	Comment where applicable

COMMUNITIES, HOUSING AND INFRASTRUCTURE

Homeless Persons – Housing Support budget	Consider whether adequate control is being exercised over income and expenditure, and that best value is being obtained.	Draft report due to be issued Draft report issued	28.02.18 28.02.18	Green	
		Management response due Management response received	28.03.18 23.03.18	Green	
		Updated draft issued to Service Final draft agreed	03.04.18 17.04.18	Green	
		Final Report Issued	18.04.18	Green	
		Original target Committee date Actual submission to Committee	08.05.18 08.05.18	Green	

Internal Transport Tendering Procedures	Consider whether robust tendering procedures are in place and are operating satisfactorily.	Original target Committee date Revised target Committee date	08.05.18 25.09.18	Red	See below:
When Internal Audit contacted the Service to commence this audit, the Service, whilst accepting that the audit should proceed, requested that it be delayed for a short period of time to allow current work demands to be prioritised. As a result, Internal Audit plans to commence the audit on 14 May 2018, which would mean reporting the outcome from the review to the September 2018 meeting of the Audit, Risk and Scrutiny Committee.					

SUBJECT / SCOPE	OBJECTIVE	Progress as at 25 April 2018		Red Amber Green	Comment where applicable
ADULT SOCIAL CARE					
Care Management	To obtain assurance that care needs are being identified, planned, and recorded accurately, and that costs charged are appropriate and adequately controlled.	Draft report due to be issued Draft report issued	28.02.18 27.02.18	Green	*Commencement delayed due to staffing issues in Internal Audit as advised to Committee on 26.09.17*
		Management response due Management response received	27.03.18 23.03.18	Green	
		Updated draft issued to Service Final draft agreed	26.03.18 20.04.18	Amber	
		Final Report Issued	23.04.18	Green	
		Original target Committee date Amended target date Actual submission to Committee	22.02.18 08.05.18 08.05.18	Amber Green	
GENERAL					
Contingency - Investigations and additional works.	To undertake investigations and additional works as they arise and to provide a contingency should systems subject to audit not be adequately documented by Services prior to audit.	Additional works being undertaken are detailed in the following tables.			
First Level Control work in relation to Interreg Projects	Certify six-monthly grant claims made in relation to the following Interreg Projects as required by Interreg Programme Secretariat: • HyTrEc2 (Partner) • HyTrEc2 (Lead Partner) • ACE Retrofitting (Partner) • Heat Net (Partner) • BEGIN (Partner)	*First six-monthly grant claim for ACE Retrofitting certified – August 2017* *First six-monthly grant claim for Heat Net certified – August 2017* *First six-monthly grant claim for HyTrEc2 (Lead Partner) January and February 2018* Second six-monthly grant claim for ACE Retrofitting certified – March 2018 Second six-monthly grant claim for Heat Net certified – March 2018			

SUBJECT / SCOPE	OBJECTIVE	Progress as at 25 April 2018

INTEGRATION JOINT BOARD

The following audit was 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.

Integration and Change Funding	Ensure appropriate governance is in place to manage delivery of funded projects and use of the funds.	The report arising from this work was presented to the ACC IJB Audit and Performance Systems Committee on 13 February 2018 before presentation to the Audit, Risk and Scrutiny Committee on 8 May 2018.

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ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	8 May 2018
REPORT TITLE	Internal Audit Reports
REPORT NUMBER	IA/18/008
DIRECTOR	N/A
REPORT AUTHOR	David Hughes
TERMS OF REFERENCE	2.2

1. PURPOSE OF REPORT

1.1 To discuss the format of Internal Audit reports resulting from planned activity.

2. RECOMMENDATIONS

2.1 To consider whether the format of Internal Audit reports meets the requirements of the Audit Risk and Scrutiny Committee and determine whether any changes are required.

3. BACKGROUND / MAIN ISSUES

3.1 During 2017, the Council's external auditor, KPMG, completed a review of the Council's Internal Audit arrangements. The review was commissioned by Council management to satisfy the Public Sector Internal Audit Standards requirement of having an external assessment at least once every five years as well as to make comparisons to best practice for an entity listed on the London Stock Exchange. This replaced the Aberdeen City Council element of a planned review of the Shared Internal Audit Service that was to be completed through arrangements put in place by the Scottish Local Authorities Chief Internal Auditors' Group.

3.2 One of the findings / recommendations that came out of the KPMG review was as follows:

> **Finding**
>
> The format used to report findings to management and the ARSC has no measure of materiality and in some cases can contain detail on relatively minor points. We note that the reports do not include an executive summary which would concisely outline the number, nature and detail of the key findings for the ARSC.

Equally the gradings used for individual findings have not been agreed with ACC and have not been defined in the charter. There is no overall grading given to a report, only the individual findings which means it is difficult for stakeholders to make comparisons of the risk areas across service lines. We do however note that there is reference to the importance of a finding relative to the service area being reviewed and to the Council at a corporate level.

Risk

Stakeholders could find it difficult to focus on the key risk areas of a report where there is no executive summary of clearly defined grading of findings.

Recommendation

It is recommended that the format of IA reports is reviewed to ensure that it meets the requirements of the ARSC and the key senior stakeholders of the Council. Key points for review should include:

i. A clear measure of materiality and classification of findings which are defined in the charter.

ii. Potential introduction of an overall report grading.

iii. Introduction of an executive summary.

3.3 The above recommendation was reported to the Audit Risk and Scrutiny Committee on 23 November 2017 with an implementation date of April 2018. To implement the recommendation, it was agreed that, in view of the substantially changed membership of the Committee following the May 2017 local government elections, management would engage with the Audit, Risk and Scrutiny Committee regarding the nature and level of reporting required.

3.4 When the Shared Internal Audit Service was implemented in 2015, it was agreed that the work done and reporting thereof would be based on the methodology used in Aberdeenshire Council. Keeping the same methodology between the two Councils helps promote efficiency within the Internal Audit team as different styles are not required dependant on the client.

3.5 Aberdeenshire Council's Internal Audit reports contain all the detail of testing undertaken, whether this covers significant risk areas or areas that could be improved, either in relation to the control environment or efficiency. Whilst some of these areas will be minor in nature, they are included to show the level of coverage, the consideration given to the area under review and, where they relate to governance issues, because they have to be included as required by the Public Sector Internal Audit Standards.

3.6 Recommendations are graded and an explanation of the gradings used is attached as an appendix to each report. The gradings are not included in the Council's Internal Audit Charter as there is no requirement, under the Public Sector Internal Audit Standards, for them to be included. The

Standards are quite specific about what has to be included and to expand the document further could, in Internal Audit's view, make the document more unwieldy.

3.7 The wording in the main body of the reports generally follows the system from beginning to end, showing that the whole system has been considered during testing rather than grouping more material findings at the start of the report. Aberdeenshire Council reports include a detailed executive summary (as appropriate to the findings in the audit), stating either in detail or summary the areas where recommendations for improvement have been made. The more significant areas are highlighted with agreed corrective action, with the less material areas listed.

3.8 The Aberdeenshire Council Audit Committee receives the executive summary from each report. The Chair of the Aberdeen City IJB Audit and Performance Systems Committee recently requested that Internal Audit adopt this approach for reporting to that Committee to ensure that the Committee receives a more proportionate summarised report to allow it to focus on any material matters arising, rather than having, what is effectively, a report for management detailing all the areas examined and issues arising.

3.9 Following the February 2015 meeting of the Audit, Risk and Scrutiny Committee, prior to the shared service commencing, members were asked whether they wished to receive full Internal Audit reports or would be content to receive a detailed executive summary following the Aberdeenshire model. The consensus was that full reports would be desirable in terms of openness. In view of this, a less detailed summary is provided in these reports.

3.10 During the last three years, Internal Audit has received comments from recipients of reports relating to the number of recommendations being made, the grading of those recommendations, and relatively minor issues being included. In response, Internal Audit has attempted to group recommendations where appropriate to reduce the numbers, have discussed the grading applied to recommendations (but not the gradings used), and stated that, although some issues are considered less material by management, there is a requirement to include them, both under the Public Sector Internal Audit Standards and to ensure openness.

3.11 Consultation has been undertaken with other Scottish Councils to determine those that do use an overall grading for each report, what gradings are used, and how they are determined. There was a fairly even split between those that do give an overall grading and those that don't.

3.12 For those that do there were a variety of options ranging from complex to simple, with some using scoring mechanisms based on the relative significance of the area under review and the significance within that area of issues identified resulting in a score, which was then matched to a specific grading. Whilst these appeared to be "scientific" in their approach, others were based on a narrative description of the level of assurance being provided. It could be argued that some were cumbersome, time consuming to apply, could be subject to additional debate during the report clearance

phase of the audit, and added little additional assurance or clarity for those charged with governance. Any grading arrived at would have to be caveated based on the sample of documentation / transactions tested and there may be issues regarding the level of assurance that could be placed on the overall grading in terms of statistical significance. However, having each report graded could assist in the production of Internal Audit's annual report, providing explicit evidence supporting the annual opinion, and might help direct those charged with governance towards a more detailed examination of reports with a poor grading.

3.13 For those that did not apply a grading there was a general consensus that an overall grading would add little value, with some commenting that an audit report with a lot of significant findings and errors would provide the reader with little or no doubt as to the low level of assurance being provided, whilst a review with minor house-keeping issues may well suggest the opposite (whilst showing the level of consideration having been given to the subject area).

3.14 Internal Audit believes that the wording used in more recent Internal Audit report executive summaries is more explicit and, whilst not referring specifically to the word "assurance", it is clear whether Internal Audit's opinion is positive or negative.

3.15 Discussion with management provided Internal Audit with management's expectation of Internal Audit reports. This commences with management stating through its risk registers what its assessment of risk is in relation to the area subject to audit. The audit report should then give an assessment of the robustness of the control environment established and the level of compliance evidenced measured against management's assessment of risk. Recommendations made by Internal Audit then need to be reviewed by management to determine whether the cost of implementation is justified in view of management's assessment of the risk in not doing so.

3.16 During the discussion it was agreed that whilst there are Corporate and Directorate Risk Registers in place, there is a need to develop operational / functional risk registers to allow the Internal Audit process to measure results of testing against management's assessment of risk. This will be an evolutionary process and, once complete, the need to provide a graded Internal Audit report could be reconsidered, as it is felt that part of the grading mechanism would need to take account of management's assessment of risk.

3.17 Other suggestions made during consultation included having a table in the executive summary detailing the number of recommendations made in the report by classification, and having all recommendations made in an appendix to the report rather than throughout the body of the report as they arise.

3.18 The reporting options that present themselves are as follows:

1. Continue producing fully detailed reports for management, with graded recommendations and no overall report grading, with short executive summary, with the full report presented to Committee (status-quo).

2. Continue producing fully detailed reports for management, with graded recommendations and no overall report grading, with longer, more detailed executive summary, with the full report presented to Committee.

3. Continue producing fully detailed reports for management, with graded recommendations and no overall report grading, with longer, more detailed executive summary, with only the executive summary presented to Committee.

4. The above options but with an overall report grading.

5. The above options but with the executive summary containing a table detailing the number of recommendations by classification in the report.

6. The above options but with the recommendations contained in an appendix to the report rather than throughout the body of the report as they arise.

3.19 Whatever option is decided on, the audit reporting process will continue to evolve as the Council's risk management process matures as described in paragraph 3.16 above.

4. FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from the recommendations of this report.

5. LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from the recommendations of this report.

6. MANAGEMENT OF RISK

6.1 The Internal Audit process considers risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are detailed in the resultant Internal Audit reports. The purpose of this report is to address concerns raised by the Audit, Risk and Scrutiny Committee.

7. OUTCOMES

7.1 There are no direct impacts, as a result of this report, in relation to the Local Outcome Improvement Plan Themes of Prosperous Economy, People or Place, or Enabling Technology, or on the Design Principles of the Target Operating Module.

7.2 However, Internal Audit plays a key role in providing assurance over, and helping to improve, the Council's framework of governance, risk management and control. These arrangements, put in place by the Council, help ensure that the Council achieves its strategic objectives in a well-managed and controlled environment.

8. IMPACT ASSESSMENTS

Assessment	Outcome
Equality & Human Rights Impact Assessment	An assessment is not required because the reason for this report is for Committee to review, discuss and comment on the outcome of an internal audit. As a result, there will be no differential impact, as a result of the proposals in this report, on people with protected characteristics.
Privacy Impact Assessment	Not required
Duty of Due Regard / Fairer Scotland Duty	Not applicable

9. BACKGROUND PAPERS

9.1 Report to Audit, Risk and Scrutiny Committee on 23 November 2017 – Internal Audit Public Sector Internal Audit Standards (OCE/17/26).

10. REPORT AUTHOR DETAILS

David Hughes, Chief Internal Auditor
David.Hughes@aberdeenshire.gov.uk
(01467) 537861

ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny
DATE	8 May 2018
REPORT TITLE	ALEO Assurance
REPORT NUMBER	GOV-18-004
CHIEF OFFICER	Fraser Bell
REPORT AUTHOR	Iain Robertson
TERMS OF REFERENCE	1.2

1. PURPOSE OF REPORT

To provide assurance on the risk management, financial management and governance arrangements of Arm's Length External Organisations (ALEO) within the ALEO Assurance Hub's terms of reference.

2. RECOMMENDATION(S)

That the Committee:-

2.1 Note the level of assurance provided by each ALEO on risk management, financial management and governance;

2.2 Note the future oversight arrangements for each ALEO and to further note that this had been predicated on the level of risk to the Council and the level of assurance provided by the ALEO; and

2.3 Note that Assurance Hub officers and ALEO Service Leads will discuss any outstanding issues with representatives of each ALEO with a view to improving the assessment ratings at the next Hub meeting.

3. BACKGROUND

3.1 The report provides an overview of the ALEO Assurance Hub's second cycle of scrutiny following the Committee's endorsement of an oversight approach which balanced the Council's need for assurance with an ALEO's right to govern itself as an independent entity.

3.2 The Hub continues to adopt a proportionate and risk based approach and receives assurance from ALEOs through exception reporting which allows it to assess the level of ALEO risk to the Council. The reporting is based on the degree of assurance provided on each ALEO's financial management; risk management and governance arrangements.

3.3 The membership of the Hub for this cycle consisted of officers representing Performance and Risk; Finance; and Democratic Services. ALEO Service Leads attended the Hub meeting on 8 March 2018 as advisers and an open invitation continues to be extended to Internal and External Audit to observe proceedings and receive documentation.

3.4 Following the Committee's meeting on 23 November 2017, the ALEO Strategic Partnership has worked with ALEOs to strengthen their governance arrangements in a number of key areas. This has included the provision of in-house training for ALEOs on GDPR implementation on 1st and 5th March 2018 which was attended by Aberdeen Performing Arts, Aberdeen Sports Village, Bon Accord Care and Sport Aberdeen. Furthermore the Council has provided ALEOs with best practice templates and guidance to support business continuity planning. The Hub also welcomes instances where ALEOs have accepted Hub recommendations, these areas include business continuity planning; reviewing financial procedures and developing schemes of delegation.

3.5 The Hub has also addressed the specific resolutions made by this Committee on 23 November 2017.

3.5.1 The Committee requested that the ALEO Service Lead liaise with Aberdeen Sports Village to highlight concerns about its disputed status as a Council ALEO and whether they fall within the remit of the Hub. This request has been actioned with all ALEOs fully participating in the oversight process this cycle.

3.5.2 With regards to Aberdeen Performing Arts (APA), the Committee requested that the ALEO Service Lead discuss its concerns with APA about business continuity planning and the provision of documentation to the Hub. The Hub can report that the documentation provided by APA this cycle was satisfactory and the Hub noted that the APA business continuity plan was discussed by the Board at its Development Day on 16 March and was due to be presented to the Board for final approval on 21 May 2018.

3.5.3 With regards to the Committee's concern in respect of Garthdee Alpine Sports' (GAS) lack of capacity, the Hub noted the decision of the Finance, Policy and Resources Committee on 6 December 2017 and the decision of both the GAS and Sport Aberdeen boards to merge the two organisations, with GAS adopting all relevant Sport Aberdeen policies, procedures and systems.

3.6 Following the decision of the Finance, Policy and Resources Committee on 6 December 2017 to approve the merger of Garthdee Alpine Sports (GAS) and Sport Aberdeen (SA), the Hub no longer provides oversight of GAS, as GAS will be integrated into SA's existing legal and governance structures. Therefore the number of ALEOs within the Hub's remit has been revised to include:-

(a) Aberdeen Heat and Power;
(b) Aberdeen Performing Arts;

(c) Aberdeen Sports Village;
(d) Bon Accord Care; and
(e) Sport Aberdeen.

3.7 In addition to the Hub's regular oversight of risk management, financial management and governance; the Hub focused on the steps ALEOs had taken to comply with the General Data Protection Regulation (GDPR) which comes into effect on 25 May 2018. To ensure that robust assurance could be provided to the Committee, Hub members tasked officers from IT and Transformation and the Legal Governance Team to assess the comprehensiveness of ALEO responses. The Hub's assessment of each ALEO has been attached as **Appendices A – E**.

3.8 With regards to the Barclay Review, the Hub noted the Scottish Government's announcement on 28 November 2017 that leisure and cultural venues currently run by council arm's-length bodies would continue to benefit from charity relief from non-domestic rates. The Hub will continue to monitor if there are any residual implications for ALEOs within its remit.

3.9 Legal officers within Commercial and Procurement Services continue to review ALEO Service Level Agreements which aim to give effect to the ALEO Assurance Framework.

4. FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from this report.

4.2 The role of the Hub is to ensure that ALEOs provide assurance that risks, including financial ones are identified and managed. One of the Hub's primary functions is to ensure that the Council is able to follow the public pound as outlined in Accounts Commission guidance.

5. LEGAL IMPLICATIONS

5.1 The Legal Team within Commercial and Procurement Services are currently overseeing the integration of Adventure Aberdeen and Garthdee Alpine Sports into Sport Aberdeen. The role of the Hub is to provide assurance that processes and resources are in place to manage integration and mitigate any legal, financial or reputational risk to the Council.

5.2 A review of ALEO service level agreements is currently being undertaken by the Legal Team within Commercial and Procurement Services. The introduction of a new approach to monitoring ALEOs will be taken into consideration during this review.

5.3 The Hub will support the Council's governance with regards to the bonds on the London Stock Exchange in that it will identify any projects and/or initiatives that could influence investment decisions of the bond holders or the Council's credit rating and ensure that the appropriate governance is put in place.

6. MANAGEMENT OF RISK

	Risk	Low (L), Medium (M), High (H)	Mitigation
Financial	Financial Failure of ALEOs impacting on the Council and its bond issue.	(L)	ALEOs report financial performance and governance to their boards and present their annual accounts for scrutiny by an external auditor. One of the Hub's key functions is to provide assurance to the Committee on the financial management of Council ALEOs.
Legal	Integration of Adventure Aberdeen and Garthdee Alpine Sports into Sport Aberdeen.	(L)	The Legal Team within Commercial and Procurement Services have oversight of the integration process and the Hub will continue to monitor progress and risk.
Employee	TUPE transfer of Adventure Aberdeen staff into Sport Aberdeen.	(L)	Sport Aberdeen has commissioned an external consultant to support the TUPE process and they continue to engage with Adventure Aberdeen staff going through the TUPE process. The Hub will request further assurance on the TUPE transfer at its next meeting and an ACC Service Lead has been identified to receive regular updates on progress and risk.
Customer	No significant risk.	(L)	Direct responsibility rests with the ALEO Board.
Environment	No significant risk.	(L)	Direct responsibility rests with the ALEO Board.

Technology	GDPR Compliance.	(M)	Each ALEO has demonstrated its awareness of GDPR and its complexity; and have reported implementation plans to their Boards for scrutiny and approval. The Hub received legal advice which assessed GDPR to be at least a medium risk for the Council and its ALEOs due to the complexity of implementing the regulation and the potential cost of a data breach or non-compliance. The Hub will continue to seek assurance on the policies, processes and systems ALEOs put in place to comply with GDPR.
Reputational	ALEO corporate governance or service delivery failure has a negative impact on the Council's reputation.	(M)	The Council shares a significant amount of data with ALEOs and a breach or failure to comply with GDPR by an ALEO may have a reputational impact on the Council. The Hub will continue its oversight of ALEOs approach to data protection and seek assurance that data audits are taking place; policies, procedures and systems are being reviewed and staff training is being delivered.

7. OUTCOMES

Design Principles of Target Operating Model	
	Impact of Report
Customer Service Design	N/A
Organisational Design	N/A

Governance	The Hub supports the principles outlined in the Account Commission's Following the Public Pound guidance by providing oversight of ALEOs to receive assurance on the robustness of their governance arrangements.
Workforce	N/A
Process Design	N/A
Technology	N/A
Partnerships and Alliances	The Hub is one component of the wider ALEO Assurance Framework and complements the work of the ALEO Strategic Partnership which offers ALEO access to senior Council officers and provides a forum to discuss strategic planning, business planning and horizon scanning; with a view to strengthen links between the Council and its partner ALEOs.

8. IMPACT ASSESSMENTS

Assessment	Outcome
Equality & Human Rights Impact Assessment	Sections 1,6 and 8 of the EHRIA have been completed and sent to the Equalities Team on 29 March 2018.
Privacy Impact Assessment	Not required
Duty of Due Regard / Fairer Scotland Duty	Not applicable

9. BACKGROUND PAPERS

ALEO Operating Model - reported to Audit, Risk and Scrutiny Committee, 27 June 2017

ALEO Assurance Hub Terms of Reference - reported to Audit, Risk and Scrutiny Committee, 26 September 2017; and

ALEO Assurance – reported to Audit, Risk and Scrutiny Committee, 23 November 2017.

10. APPENDICES

Appendix A – Assurance on Aberdeen Sports Village
Appendix B - Assurance on Bon Accord Care

Appendix C - Assurance on Sport Aberdeen
Appendix D - Assurance on Aberdeen Heat and Power
Appendix E - Assurance on Aberdeen Performing Arts

11. REPORT AUTHOR CONTACT DETAILS

Iain Robertson
Committee Services Officer
iairobertson@aberdeencity.gov.uk
01224 522869

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Aberdeen Sports Village (ASV)

Sector	Sport and Leisure
Level of ACC Control	Joint Venture with the University of Aberdeen
ACC Funding 2018-19	£919,200
Function	Commissioning

The Hub requested assurance in the following areas:-

1. Governance

1.1 Assurance on existing approach towards Data Protection – Aberdeen Sports Village (ASV) appended a copy of its Data Protection and Information Security Policy which had been reviewed in October 2017 in light of GDPR coming into effect.

1.2 Assurance on General Data Protection Regulation (GDPR) preparations – ASV advised that they had been working closely with the University of Aberdeen Data Protection Officer in preparation for GDPR compliance. The following timetable has been developed:

- September 2017 - Engagement with University of Aberdeen Data Protection Officer (DPO)
- October 2017 - Briefing presentation delivered to ASV Performance Management Team (PMT) by DPO
- October 2017 - Information requested of PMT with regards to those areas which required to be considered as part of the Gap Analysis exercise
- December 2017 - Areas identified, collated and passed to DPO for review
- January 2018 – Information discussed with DPO
- February-March 2018 – Audit performed by DPO
- April 2018 – GDPR Implementation Action Plan produced

ASV confirmed that they remain on track to meet the above timetable. They are currently working with the DPO to identify suitable dates in February and March 2018 to audit each area.

1.3 Assurance on GDPR training – ASV advised that the Performance Team tasked with GDPR implementation had received training from the University of Aberdeen's Data Protection Officer and was due to receive GDPR training from the Council's IT and Transformation Service on 5 March 2018.

1.4 Assurance on GDPR readiness – ASV had been utilising the services of the University DPO to initially brief the Management team and secondly conduct a gap analysis which would allow ASV to prepare a detailed Action Plan to ensure its compliance with GDPR. In terms of resources and capacity, this would be determined once the Action Plan had been produced and discussed with the Board.

Governance Assessment – The Hub received legal advice that ASV's existing Data Protection Policy and Information Security Policy were satisfactory and provided a good benchmark for implementing GDPR. The Hub took comfort from ASV's receipt of training and support from the University of Aberdeen's Data Protection Officer to help them prepare for GDPR and was assured that ASV had taken into account the processes and resources required to ensure compliance. The Hub welcomed that GDPR had been appropriately rated on ASV's risk register.

The Hub agreed that due to the administrative and regulatory demands of implementing GDPR which would involve significant systematic and procedural change; in addition to the higher costs and risks of a data breach, it was felt that a **Medium Risk** rating was the best score it could assign to any organisation (including the Council) but highlighted that this risk may reduce for ASV once GDPR systems, processes and practice became embedded. As such the Hub was as assured as it could be that ASV had readied the organisation appropriately for GDPR implementation and had adequately mitigated risk to the Council.

2. Risk Management

2.1 Assurance on Risk Controls (Mitigation) – ASV appended its risk register which had been presented to the Board meeting in December 2017. The register identified business risks, controls and residual risk ratings. The biggest risks following mitigation for ASV were reductions in partner funding and a lack of capital investment from shareholders.

2.2 Assurance on Business Continuity Planning – ASV attached three documents to provide assurance on business continuity planning:

- Critical incident management procedure
- Business Continuity Management procedure
- IT systems continuity plan

ASV's explained that their Business Continuity Plan (BCP) would be reviewed by the Board in June 2018 and would adopt elements of the Council's BCP template which had recently been provided to ASV.

To provide further assurance, ASV confirmed that a full suite of normal operating procedures (NOP) and emergency action plans (EAP) were now in place and had been reviewed.

2.3 Assurance that the Board takes risk into account at Board meetings – ASV attached a presentation that the Board received in September 2017 which set out ASV's approach towards risk management. ASV also appended a Board report from December 2017 which provided a summary of the risk register and outlined the approach taken by the senior management team to identify, measure and mitigate risk; and detailed levels of responsibility within the organisation in the management of business risk. The report also compared the top ten ASV business risks with the top ten UK business risks.

Risk Management Assessment – The Hub welcomed ASV's provision of a robust suite of documents relating to risk management and noted that ASV was in the process of preparing a Business Continuity Plan (BCP) based on the Council's template which would be submitted to the Board in June. The Hub agreed to request the approved BCP ahead of its next meeting as well as a copy of ASV's service level agreement (SLA) with the University of Aberdeen relating to IT support as this would provide additional assurance on ASV processes for continuing to operate in the event of significant disruption and how they would return to business as usual. The Hub assessed ASV's risk register to be robust, as suitable risks had been identified and appropriate controls were in place to mitigate risk. The Hub was also satisfied that the ASV Board discussed risk prior to decision making as ASV had provided Board papers and minutes to evidence this approach.

Overall, based on the assurance provided, ASV's risk management approach was assessed as **Low Risk.**

3. Financial Management

3.1 Assurance on Management Trading Accounts – ASV provided its set of Management Trading Accounts as at 31 December 2017.

3.2 Assurance on Audited Annual Accounts – ASV provided its audited annual accounts 2016-17 and External Audit's report to the Board. The accounts had been audited by KPMG who issued ASV with a clean audit certificate.

3.3 Assurance on Financial Procedures and Scheme of Delegation – ASV accepted the Hub's recommendation to review its Financial Procedures document and confirmed that this review was due to take place by 30 April 2018. They added

that the development of a scheme of delegation to officers would also be considered as part of this review.

3.4 Assurance that the Board considers financial implications when taking decisions – ASV advised that at its meeting on 23 March 2018 the Board would consider whether to revise its report template to include a Financial Implications section to outline anticipated financial impacts and risk in order to inform decision making.

3.5 Assurance that financial performance is scrutinised by the Board – ASV advised that financial performance was a standing item on Board agendas and highlighted that scrutiny had been robust with members taking an active interest in results and governance to hold senior management to account. ASV appended Board minutes from 8 September and 8 December 2017 which provided assurance that the Board had considered risk and financial implications prior to decision making.

3.6 Assurance on Internal Audit – ASV provided copies of its draft three year Internal Audit Programme and its Management System and Improvement Planning process. They advised that the Internal Audit Programme would be recommended for approval at the Board meeting on 23 March 2018 as internal auditors had been trained and deemed competent to carry out all verification and associated recommendations. ASV appended the minute of its Board meeting from 8 September 2017 which provided assurance that the Board had discussed the findings and recommendations of an audit report on health and safety and a report from QUEST (a sportscotland endorsed UK quality scheme for sport and leisure) following their unannounced entry visit on 7 April 2017. The QUEST evaluators rated ASV's handling of the unannounced visit to be 'Excellent' and the way it measured impacts and outcomes; and contribution to health and wellbeing to be 'Outstanding', with an overall score of 'Outstanding'. ASV also presented a sample of internal audit reports that had been presented to the Board and Senior Management Team.

Financial Management Assessment –The Hub agreed to request further assurance from ASV that their business plan had been updated to account for the planned reduction in Council funding during 2018-19 which had been phased in following an agreement between its partners. The Hub welcomed ASV's planned review of its Financial Procedures and possible adoption of a scheme of delegation, both of which were based on Hub recommendations. The Hub also reviewed ASV's internal audit arrangements and found them to be satisfactory although it agreed to request further detail on the specific areas the audits would cover and how the internal audit programme would link back to the mitigation section within the risk register.

Overall, based on the assurance provided, ASV's financial management was assessed as **Low Risk**.

4. Future Oversight Arrangements - The Hub was assured that ASV was taking appropriate steps to comply with GDPR by 25 May 2018 and that its risk management approach continued to be robust. The Hub welcomed ASV's planned review of its Financial Procedures and possible adoption of a scheme of delegation and agreed to request these documents ahead of its next meeting. The Hub also agreed to request ASV's Business Continuity Plan and IT Support SLA along with updates on GDPR compliance and business planning to account for the phased reductions in the Council's annual funding settlement. Overall, based on the assurance provided, the Hub assessed ASV to be **Low-Medium Risk** to the Council. This risk rating has slightly increased since the Hub's last report to the Audit, Risk and Scrutiny Committee on 23 November 2017 to reflect the complexity of implementing GDPR.

Assurance Standard - May 2018	**Risk Rating**
Unambiguous responses demonstrating clear understanding and comprehensive ability to fulfil ACC requirements, giving full detail as how these are achieved.	**Very Low**
Responses provide evidence of good understanding and compliance although limited detail provided for some areas	**Low**
Responses provide some indication of understanding and compliance	**Medium**
Minimal or poor responses providing little evidence of understanding or compliance.	**High**
Nil or inadequate responses with little or no understanding of requirement or evidence of compliance.	**Very High**

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Appendix B

Bon Accord Care (BAC)

Sector	Health and Social Care
Level of ACC Control	The Council is the sole shareholder of both Bon Accord Care Ltd and Bon Accord Support Services Ltd
ACC Funding 2018-19	£26.88m
Service	Aberdeen City Health and Social Care Partnership

The Hub requested assurance in the following areas:-

1. Governance

1.1 Assurance on existing approach towards Data Protection – Bon Accord Care (BAC) provided copies of its:-

- Data Protection Policy
- Records Management Policy
- Control of Records Policy

1.2 Assurance on General Data Protection Regulation (GDPR) preparations – BAC have nominated their Quality and Compliance Manager to lead on GDPR implementation and advised that a project group has been set up to assess regulatory requirements and to oversee implementation to ensure GDPR compliance by 25 May 2018.

1.3 Assurance on GDPR training – BAC highlighted that the following training had been undertaken or was planned to prepare for GDPR:-

- 'Are You Ready for GDPR?' Delivered through ACC network event – 13 September 2017
- Board Training - 15 December 2017
- GDPR Awareness delivered through Aberdeen Chamber of Commerce (external) – 16 February 2018
- Presentation by Information Commissioner's Office (ICO) delivered through ACVO (external) – 27 February 2018
- Ongoing blogs and alerts being received from ICO on GDPR
- Presentation on Cyber Security through Aberdeen Chamber of Commerce (external) – 28 February 2018
- GDPR Readiness Training for ALEOs delivered by ACC – 1 March 2018
- Signed up for blogs and alerts from ICO on GDPR

1.4 Assurance on GDPR readiness – BAC provided assurance that the Board and organisation have an understanding of the additional requirements of GDPR and have allocated resource and capacity to review current systems. BAC advised they had allocated resource to ensure the implementation plan could be delivered in order to comply with the regulation by 25 May 2018.

Assurance on board recruitment and succession planning – BAC provided a copy of its Board Development Plan dated January 2018 which was now a standing agenda item at Board meetings. The Plan was owned by one of the Board's Non-Executive Directors with support from the Managing Director and aimed to demonstrate the Board's commitment to ensure strategic alignment with the values of the organisation. The Development Plan contained a section on Board Recruitment and its outcomes included:-

- A fair and inclusive recruitment process
- The recruitment of a diverse pool of Board members which reflect the local community
- An understanding of knowledge and skills required for prospective members
- Clarity about the level of contributions and time expected from members
- Regular and timely transition of members

The Board Development Plan also outlined a commitment for 28.5% of all Board members to be female, with at least 20% of all Non-Executive Directors to be female.

Governance Assessment – The Hub received legal advice that BAC had a good understanding of current legislative requirements and that its existing data protection policies appeared to be adequate and provide a good basis for implementing GDPR. The Hub received further assurance through BAC's formation of a project group and its appointment of its Quality and Compliance Manager as the accountable officer that the company was aware of the key steps that needed to be taken to implement GDPR. The Hub also welcomed BAC's approach to training and found its decision to categorise GDPR as the highest risk on its risk register to be appropriate and assessed the controls in place to mitigate risk to be satisfactory.

The Hub agreed that due to the administrative and regulatory demands of implementing GDPR which would involve significant systematic and procedural change in addition to the higher costs and risks of a data breach, it was felt that a **Medium Risk** rating was the best score it could assign to any organisation (including the Council) but highlighted that BAC's level of risk may reduce once GDPR systems, processes and practice became embedded. As such the Hub was as assured as it could be that BAC had readied the organisation appropriately for GDPR implementation and had adequately mitigated risk to the Council.

With regards to Board succession planning, the Hub assessed this area to be **Low Risk**. The Hub was assured through provision of BAC's Board Development Plan which identified the skillsets and experience needed in the event of a Board vacancy.

The Hub also welcomed BAC's development of an induction process and its commitment to move towards a greater gender balance on both the Board and the senior management team.

2 Risk Management

2.1 Assurance on testing of Business Continuity Plan – BAC provided copies of its Business Continuity Plan (BCP) and Business Continuity Workbook. The BCP contained a section on testing the Plan and this was broken down into four methods:-

- Staff briefings and induction sessions
- Awareness sessions - to ensure staff understand their BCP obligations
- Table top exercises – in which a service audit will be carried out four times a year
- Activation – in the event that the BCP had not been activated within 12 months, a critical incident would be simulated to test the BCP.

2.2 Assurance that the Board takes risk into account at Board meetings – BAC provided copies of the Board agenda from 18 January 2018 and a Risk Management report which was submitted to this meeting to provide assurance that risk was considered at Board meetings. The Risk Management report provided an overview of the risk register and risks associated with the company; and the minute of the Risk Management Committee from 9 January 2018 was also appended for members' information.

Risk Management Assessment – The Hub was assured that BAC had identified pertinent risks and developed appropriate controls to mitigate risk. BAC's greatest risks following mitigation were GDPR compliance and Cyber Security. The Hub took the view that BAC's Business Continuity Plan (BCP) was comprehensive and assessed its policy to replicate a critical incident if no such event had occurred within 12 months as good practice. The Hub resolved to request further information ahead of its next meeting on what BAC had learned during BCP testing, and made a recommendation that BAC consider expanding the section on IT system failure to demonstrate how critical frontline systems such as Care First could continue to operate and then be fully restored in the event of an IT failure. Overall, based on the assurance provided, BAC's risk management approach was assessed as **Low Risk**.

3 Financial Management

3.1 Assurance on Management Trading Accounts – BAC appended a financial report presented to the Board on 16 January 2018 which included the company's trading accounts as at 31 December 2017.

3.2 Assurance on Scheme of Delegation – BAC maintained that a scheme of delegation to officers was not relevant for their organisation and referred to the Financial Procedures policy they presented to the Hub in November which in their view was sufficient to meet their governance requirements.

3.3 Assurance that the Board considers financial implications when taking decisions – BAC attached the financial report from its Board meeting on 16 January 2018 which included a Financial Implications section; they also provided the minute from this meeting to provide assurance that the Board discussed financial implications prior to decision making.

3.4 Assurance that financial performance is scrutinised by the Board – BAC referred to the financial report to the Board from 16 January 2018 which included a section on Points for Discussion for members which covered:-

- Contract Value
- December Financial Report
- Holistic Review Savings
- Budgetary Sizing for 2018-19

BAC also attached the minute from this Board meeting to provide assurance that members scrutinised financial performance and held officers to account.

3.5 Assurance on Internal Audit – BAC advised that they had attained ISO9001 -2015 accreditation. This is an internationally recognised standard for quality management systems from the International Organisation for Standardization. BAC satisfied the criteria through their appointment of an external auditor and had demonstrated that internal staff were trained and organisationally placed to provide an internal audit service. BAC also appended copies of its Internal Quality Audit policy, Internal Audit Programme and examples of Internal Audit reports to the Board to provide additional assurance.

Financial Management Assessment – The Hub assessed BAC's accounts and financial documentation to be of good quality, with no significant issues identified. The Hub took comfort from the Council's decision on 5 March 2018 to approve BAC's annual settlement and the Integration Joint Board's confirmation of this at its meeting on 27 March 2018. The Hub took account of BAC's opinion that the organisation did not require a formal scheme of delegation, to which the Hub agreed

to request further information on how the BAC Board delegates decision making powers to officers. The Hub also recommended that BAC set a review date for its Financial Procedures, and agreed to request additional Internal Audit reports as these provided a key source of assurance on BAC's management of financial risk and governance. Overall, based on the assurance provided, BAC's financial management was assessed as **Low Risk**.

4 Future Oversight Arrangements - The Hub was assured that BAC was taking appropriate steps to comply with GDPR by 25 May 2018 and that its risk management approach continued to be robust. The Hub also welcomed BAC's development of a succession plan which placed an emphasis on moving towards greater gender balance on the Board and senior management team. The Hub agreed to request further assurance on procedures relating to IT system failure within BAC's Business Continuity Plan, and how the Board formally delegates decision making power to officers. Overall, based on the assurance provided, the Hub assessed BAC to be **Low-Medium Risk** to the Council. This risk rating remains unchanged since the Hub's last report to the Audit, Risk and Scrutiny Committee on 23 November 2017.

Assurance Standard - May 2018	**Risk Rating**
Unambiguous responses demonstrating clear understanding and comprehensive ability to fulfil ACC requirements, giving full detail as how these are achieved.	**Very Low**
Responses provide evidence of good understanding and compliance although limited detail provided for some areas	**Low**
Responses provide some indication of understanding and compliance	**Medium**
Minimal or poor responses providing little evidence of understanding or compliance.	**High**
Nil or inadequate responses with little or no understanding of requirement or evidence of compliance.	**Very High**

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Appendix C

Sport Aberdeen (SA)

Sector	Sport and Leisure
Level of ACC Control	Council is the sole guarantor
ACC Funding 2018-19	£5,353,082
Function	Commissioning

The Hub requested assurance in the following areas:-

1. Adventure Aberdeen Transfer to Sport Aberdeen

1.1 Assurance on Sport Aberdeen Preparations – SA have commissioned a specialist, external consultant to undertake due diligence on Adventure Aberdeen (AA) and to support the integration process. The consultant has conducted an audit of AA in order to identify inefficiencies and secure best value as it was intended for all AA assets to transfer to SA. SA also confirmed that a Project Integration Team had been established to facilitate the transfer of AA into SA which was led by SA's Business Development Director and accountable to the Board. SA highlighted that the transfer had been added to SA's risk register with appropriate controls developed to mitigate risk.

1.2 Assurance on Adventure Aberdeen Staff Transferring to Sport Aberdeen – SA explained that a TUPE transfer was ongoing and it was intended for AA staff to transfer on their current terms and conditions (as required under TUPE). Any new employees would adopt SA employee terms and conditions; SA added that the extent of pension entitlement would be established by the external consultant and considered within the TUPE process. SA advised that it was their intention for AA to continue to operate as business as usual within the SA governance framework and explained that AA staff would receive an induction on 26-27 March 2018 from the SA Chairman, Managing Director and members of the company's SMT on SA's corporate culture; policies, procedures and systems; financial management; and personal development.

SA took the view that integration would benefit AA as staff would have more direct access to SA management due to its streamlined management structure and AA would have greater access to SA contacts such as corporate sponsors and through programmes like Active Schools. SA had also identified opportunities for maximising AA income through greater use of AA assets for public and corporate events in order to deliver an operating profit within two years.

1.3 Assurance on Managing Outstanding Issues – SA explained that its external consultant had identified a number of key issues that needed to be resolved before AA was fully integrated within SA, these include:-

- Undertaking an Asset Condition Assessment of AA facilities, equipment and transport fleet;
- Finalising the building lease transfer to SA;
- Linking AA IT systems with the SA network (this has now been completed); and
- Determining the most appropriate management alignment

SA advised that the integration of AA into SA did not require any alterations to SA's service level agreement (SLA) as this was covered under the change control process within the existing SLA. They highlighted that the transfer was expected to be complete by 1 April 2018. SA added that they did not expect to receive business rate relief for AA facilities as the Scottish Government had set out its intention in December 2017 to block this method of rate relief in response to mitigating the recommendations of the Barclay review for existing ALEOs.

2. Garthdee Alpine Sports Merger with Sport Aberdeen

2.1 Assurance on Sport Aberdeen Preparations – The SA Project Integration Team, with support from the external consultant is leading on the merger and is accountable to the Board. The merger between SA and Garthdee Alpine Sports (GAS) is more complex than the integration of Adventure Aberdeen into SA as GAS is an independently registered charity, of which the Council is one of five guarantors. SA advised that the three primary bodies involved in the merger (Aberdeen City Council, SA and GAS) have all appointed separate legal representation, with the Legal Team within the Commercial Procurement Service providing legal support for the Council. SA confirmed that the GAS Board had agreed to proceed with the merger in late January 2018 and SA would have oversight of a shadow GAS Board and interim management structure until the merger was finalised. SA highlighted that the transfer required OSCR approval, but assessed the risk of refusal to be low.

2.2 Assurance on the Proposed New Governance Arrangements Following the Merger – SA advised that two spaces on the SA Board would be reserved for Directors with expertise in snow sports and a new SA committee would be established to oversee snow sport and adventurous activity and would include both Board members and co-optees in order to retain contributions from individuals with expertise and a passion for snow sport and adventurous activities. SA also confirmed that the SA Board agreed for all GAS assets and liabilities to be transferred to SA and that GAS staff and facilities would adopt SA policies, procedures and systems; including those in relation to risk management, financial

management and governance. SA highlighted that the merger with GAS had been added to its corporate risk register, with the development of appropriate controls to mitigate risk.

2.3 Assurance on Managing Outstanding Issues - SA explained that they had identified a number of key issues which needed to be resolved before the merger with GAS could be finalised, these include:-

- Undertaking due diligence on GAS assets, equipment and systems; including a building condition assessment of the Snow sport facility and slope in Garthdee

- Establishing the extent of GAS pension entitlements and transferring GAS staff on their current terms and conditions (as required under TUPE);

- Delivering an induction to GAS staff on SA corporate culture; policies, procedures and systems; financial management; and personal development;

- Confirmation by Aberdeen City Council on the value of GAS' annual funding settlement; and

- Confirmation of the Council's position in relation to GAS' financial reserves, particularly if they remained ring-fenced for slope and facility maintenance and whether they would be passported to SA upon completion of the merger.

SA also explained that once notification of the merger had been lodged with OSCR, OSCR would have 42 days to object to the merger and assessed the risk of objection to be low. SA advised that the integration of AA into SA did not require any alterations to SA's service level agreement (SLA) and was covered under the change control process within the existing SLA. SA took the view that there were no significant Barclay Review implications with regards to the merger as they assumed that GAS' relief from business rates would remain in place as the organisation would merge with another ALEO which was also exempt from business rates.

3. GDPR

3.1 Assurance on existing approach towards Data Protection – SA provided a copy of its existing Data Protection Policy.

3.2 Assurance on General Data Protection Regulation (GDPR) preparations – SA provided a report on GDPR that was presented to its Corporate Governance Committee on 2 March 2018. The report outlined the resource allocated towards GDPR compliance and ongoing consultation with Bon Accord Care to share the

services of an external Data Protection Officer. SA explained that an internal working group had been formed with representation from across the organisation to prepare for GDPR implementation and to oversee the creation of a data map, based on an Information Commissioner's Office (ICO) template which audited all types of data held by SA including: electronic; hard copy; photographic and video images.

SA noted that its Business Development Director was accountable to the Board for GDPR implementation and regularly provided progress updates. SA also highlighted that the internal GDPR working group had identified a number of key actions to be completed prior to GDPR coming into effect, these include:-

- Reviewing its third party contracts to ensure data security
- Updating its privacy notice
- Cleansing data held in absence of clear consent
- Securing software to manage data consents
- Strengthening its ICT policy to prevent unauthorised data transfer or loss
- Reviewing its data retention schedules

SA added that they were currently reviewing policies and procedures in the following areas:-

- Data security / storage
- Obtaining consent
- Contracts with third parties
- Subject access requests
- Data retention policy
- Data protection impact assessments
- Data anonymisation
- Personal data breach policy, including recording and notification

3.3 Assurance on GDPR training – SA advised that the senior management team and relevant staff that handle data regularly had received training on GDPR and its implications and had attended training courses provided by SPORTA (National Association of Leisure & Cultural Trusts) and Aberdeen City Council. SA highlighted that they may be commissioning the services of an external Data Protection Officer to provide training for staff between March-May 2018, it was intended that this training would be delivered in two formats:-

1. Introductory (likely online) training for frontline staff who need to have a basic understanding of GDPR; and
2. More detailed training for staff who handle data on a regular basis.

3.4 Assurance on GDPR readiness – SA reported to its Board on 21 March 2018 that the organisation had made satisfactory progress towards being GDPR

compliant and had an implementation plan in place to meet these requirements. The Board noted that the Corporate Governance Committee would be asked to consider and approve SA' s GDPR policy and procedures at its next meeting on 11 May 2018.

4. Assurance Hub Assessment – The Hub noted that SA had appointed a specialist consultant to undertake due diligence on AA and GAS and provide support to the Project Integration Team during the integration process. The Hub took the view that SA had identified the key steps that needed to be taken and allocated sufficient resource to deliver integration. SA had also recognised the risks surrounding integration and had updated their corporate risk register appropriately. The Hub was assured that AA and GAS would adopt SA policies, procedures and systems as the Hub felt that the robustness of SA governance arrangements would strengthen GAS, particularly in areas identified by the Hub as high risk such as data protection and business continuity planning.

The Hub was also assured that SA would have oversight of the shadow GAS Board and interim management team during the transition period and planned to deliver induction training for GAS staff to welcome them into SA. The Hub further welcomed SA's decision to open up two spaces on the SA Board for directors with expertise in snowsports and the formation of a dedicated Snowsports and Adventurous Activity Committee to ensure these remained priority areas and expertise and momentum were not lost.

With regards to GDPR, the Hub received legal advice that SA had made a good start in their preparations and covered a number of key areas that were essential for compliance, these included:-

- Identification of resource
- Recognition of the need to update existing policies and procedures
- Acknowledgement of the need for additional policies and procedures
- Creation of an extensive data map
- Formulation of an action plan which deals with contracts, privacy notices, cleansing of data, update of ICT policies and retention schedules
- Development of training plan to roll out to all staff

The Hub agreed that due to the administrative and regulatory demands of implementing GDPR which would involve significant systematic and procedural change, in addition to the higher costs and risks of a data breach, it was felt that a **Medium Risk** rating was the best score it could assign to any organisation (including the Council) but highlighted that this risk may reduce once GDPR systems,

processes and practice became embedded. As such, the Hub was as assured as it could be that SA had readied the organisation for GDPR implementation and had adequately mitigated risk to the Council.

Overall, based on the assurance provided, SA's governance arrangements were assessed as **Low-Medium Risk** to the Council. In comparison to the level of risk assigned to SA at the Hub's last meeting, there was a negative movement in risk rating from the low risk score reported to the Audit, Risk and Scrutiny Committee on 23 November 2017. The Hub acknowledged that this movement was largely due to the complexity of implementing GDPR and the challenges of integrating AA and GAS into SA and not a reflection on SA's governance arrangements which remained robust. The Hub resolved to request a further update from SA at its next meeting to provide the Committee with assurance on how AA and GAS had been embedded into SA.

Assurance Standard - May 2018	**Risk Rating**
Unambiguous responses demonstrating clear understanding and comprehensive ability to fulfil ACC requirements, giving full detail as how these are achieved.	**Very Low**
Responses provide evidence of good understanding and compliance although limited detail provided for some areas	**Low**
Responses provide some indication of understanding and compliance	**Medium**
Minimal or poor responses providing little evidence of understanding or compliance.	**High**
Nil or inadequate responses with little or no understanding of requirement or evidence of compliance.	**Very High**

Appendix D

Aberdeen Heat and Power (AHP)

Sector	Combined Heat and Power
Level of ACC Control	The Council is the sole guarantor of the company
ACC Funding 2018-19	AHP receives grant funding on a project by project basis
Function	Commissioning

The Hub requested assurance in the following areas:-

1. Governance

1.1 Assurance on existing approach towards Data Protection – Aberdeen Heat and Power (AHP) confirmed that they do not currently have a Data Protection Policy but GDPR will compel the Board to approve a policy to comply with these requirements.

1.2 Assurance on General Data Protection Regulation (GDPR) preparations – AHP noted that their Office Administrator and Accountant had received GDPR training and they reported on compliance requirements to the Board on16 February 2018. AHP appended a copy of this report and minute extract from the meeting in which the Board agreed to set up an implementation taskforce to conduct a data audit; draft procedures; and deliver staff training. The Board agreed that the scope of the data audit should at minimum cover the following areas:-

- Payroll data
- Director data
- Personnel data
- Customer data
- Supplier data
- Heat usage data
- Maintenance information

The Board tasked the Chief Executive Officer to update the risk register accordingly and designated him as the responsible officer for implementation and compliance. The Board remitted responsibility to the Policy and Operations Sub Group to develop and AHP's approach.

1.3 Assurance on GDPR training – AHP sourced an external provider to deliver GDPR training and following this, a programme is being developed to identify relevant information and measures to ensure compliance.

1.4 Assurance on GDPR readiness – AHP advised they had adopted a proactive approach to ensure readiness for GDPR. They explained that following the externally sourced training, a programme had been developed to identify relevant information; in addition to the resource and measures required to ensure compliance. They highlighted that the Policy and Operations Sub-Group would have oversight of this programme. AHP also explained that the organisation had a significant number of dealings with the Council with respect to data held on tenants for implementation of heating systems and confirmed they would ask the Council for a statement of assurance that the Council would be compliant with GDPR by May 2018.

1.5 Assurance on Succession Planning – AHP advised that the Board and Policy and Operations Sub-Group had discussed succession planning on a more regular basis recently as the Chief Executive Officer planned to retire later in the year. AHP appended a letter dated 8 February 2018 that was sent to the Council's Head of Land and Property Assets to provide assurance that a succession plan would be developed to ensure good governance and business continuity. The letter also outlined a proposed recruitment and handover process and the key skills and experience required to support the company. AHP noted the important role the Board would play in this process and explained that a re-familiarisation and training programme would be arranged to ensure the Board could provide senior staff with appropriate support and oversight. AHP confirmed that interviews for the post of Chief Executive Officer were due to take place in April 2018.

Governance Assessment – The Hub received legal advice from the Legal-Governance Team which highlighted that AHP did not appear to have a formal Data Protection Policy in place and therefore it had been difficult to ascertain how they complied with existing legislation and how they would be compliant with GDPR in such a short timescale. The Hub noted that AHP had demonstrated its awareness of the steps required to implement GDPR but to date, a number of key actions like a review of procedures and an information audit had not been undertaken. The legal advice also identified that AHP had installed an IT server which allowed central storage of data and this was linked to external drives and a cloud based storage facility for system security. AHP may need to consider its contractual relationships with providers of external drives and cloud based system and assess whether some aspect of an Information Sharing Agreement was required. The Hub noted that GDPR was appropriately listed as a risk on AHP's risk register.

The Hub agreed to score AHP as **High Risk** due to the administrative and regulatory demands of implementing GDPR which would involve significant systematic and

procedural change in addition to the higher costs and risks of a data breach, particularly given that AHP did not appear to have a Data Protection Policy in place. The Hub noted that this risk rating would be reviewed at the Hub's next meeting upon receipt of a Board approved policy that complied with the requirements of GDPR.

With regards to succession planning, the Hub was advised by AHP's Service Lead that a recruitment process was being arranged to replace the current Chief Executive Officer (CEO) with a new CEO and a Project Manager to take account of the level of expertise and experience needed to fulfil the duties currently carried out by the CEO. The Hub took the view that there was a **Medium Risk** of recruitment failure due to the challenging conditions in the local job market and the specialist heat and power sector that AHP operated within. As such, the Hub recommended that further mitigation should be added to the risk register to take account of recruitment failure and the Hub agreed to request an update on this at its next meeting.

2. Risk Management

2.1 Assurance that the Board takes risk into account at Board meetings – AHP provided a copy of its Board agenda for 16 February 2018 which included an item on the risk register and they confirmed that risk was a standing item. AHP also provided a copy of their risk register which was updated on a regular basis and treated as a living document. The biggest risk for AHP following mitigation was Accidental Damage to Underground Piping.

Risk Management Assessment – The Hub agreed that AHP's risk register was robust and appropriately presented, although members highlighted that further mitigation was recommended for the succession planning risk. The Hub welcomed the expansion of the mitigation section for the risk of Accidental Damage to Underground Piping, as AHP had begun to mark out routes of underground piping in soft ground areas in line with markings for gas pipes and would share this information with the Council.

Overall, based on the assurance provided, AHP's risk management approach was assessed as **Low Risk.**

3. Financial Management

3.1 Assurance on Management Trading Accounts – AHP provided a copy of its December 2017 trading accounts that had firstly been considered by the Policy and Operations Sub-Group and then by the Board on 16 February 2018.

3.2 Assurance on Financial Procedures and Scheme of Delegation – AHP referred to the Accounting and Tendering Procedures which had been presented to the Hub on 1 November 2017 and advised that the scheme of delegation to officers was covered within these procedures.

3.3 Assurance that the Board considers financial implications when taking decisions – To provide assurance, AHP provided a copy of a report to the Policy and Operations Sub-Group on the Provision of District Heating to Blocks Within Stewart Park and Hilton Courts which contained a Financial Issues section that covered expected capital costs and source(s) of capital funding. AHP explained that a standard form of reporting was adopted for all capital projects in which detailed feasibility studies were prepared to outline financial implications to the Board. They noted that these reports received scrutiny from the Development Sub-Group in the first instance before being presented to the Board for final approval.

3.4 Assurance that financial performance is scrutinised by the Board – AHP confirmed that financial performance was a standing item on Board and Policy and Operations Sub Group agendas and provided a copy of the Board agenda from 16 February 2018 which had a section on Finance, including an item on the Monthly Management Accounts.

3.5 Assurance on Business Planning – AHP provided a copy of its Business Plan 2015-2020.

3.6 Assurance on Internal Audit - AHP explained that as a small organisation with limited resource only three internal audits were planned for 2018, of which the audit on Procurement and Tendering Procedures had been completed and approved by the Board. The internal audit was carried out by the Chair of the Policy and Operations Sub-Group. AHP provided a copy of its Internal Audit Programme which included an audit on succession planning.

3.7 Assurance on External Audit – AHP advised that its external auditors, Anderson, Anderson and Brown LLP had audited its accounts and financial statements for 2016-17 and no audit improvement areas had been identified. This report was considered at AHP's Annual General Meeting in November 2017 and they appended a copy of the external audit report to provide additional assurance.

Financial Management Assessment – The Hub assessed AHP's accounts to be satisfactory in terms of presentation and performance. The Hub welcomed AHP's planned review of financial procedures following a Hub recommendation and noted that a scheme of delegation may not be essential for AHP as they only had two full time staff. In reference to the Business Plan, the Hub noted that the plan would remain in effect until 2020 but that financial projections were only recorded up to 31 March 2018. Following the consultation period, AHP advised that the Board sets

budgets for the next two financial years during each cycle which are then reviewed annually. They confirmed that the budgets for 2018-19 & 2019-20 are due to be considered by the Board in May, and added that budget planning takes place from December onwards and goes through a number of re-iterative steps with Policy and Operation Sub Group involvement before final approval by the Board.

Overall, based on the assurance provided, AHP's financial management was assessed as **Low-Medium Risk**.

4. Future Oversight Arrangements – Overall, the Hub assessed AHP to be **Medium Risk** to the Council. This was largely based on AHP's high risk score for GDPR implementation and compliance. The Hub also highlighted that succession planning was a key risk due to the challenging local job market; the specialist heat and power sector that AHP operated within and the limited resource available to the company as it only employed two full time staff. The Hub also identified a number of other areas where there were gaps in assurance that the Hub would ask AHP to provide information on at its next meeting, particularly in relation to business planning. In comparison to the level of risk assigned to AHP at the Hub's last meeting, there was a negative movement in risk rating from the low risk score reported to the Audit, Risk and Scrutiny Committee on 23 November 2017.

Assurance Standard – May 2018	**Risk Rating**
Unambiguous responses demonstrating clear understanding and comprehensive ability to fulfil ACC requirements, giving full detail as how these are achieved.	**Very Low**
Responses provide evidence of good understanding and compliance although limited detail provided for some areas.	**Low**
Responses provide some indication of understanding and compliance.	**Medium**
Minimal or poor responses providing little evidence of understanding or compliance.	**High**
Nil or inadequate responses with little or no understanding of requirement or evidence of compliance.	**Very High**

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Aberdeen Performing Arts (APA)

Sector	Arts, Theatre and Culture
Level of ACC Control	The Council is one of 13 subscriber guarantors of the company
ACC Funding 2018-19	£975,000
Function	Commissioning

The Hub requested assurance in the following areas:-

1. Governance

1.1 Assurance on existing approach towards Data Protection – Aberdeen Performing Arts (APA) provided a copy of its existing Data Protection policy. They advised that in preparation for GDPR, the Leadership Team and a Board Champion would review all policies, procedures and processes relating to data management and security. APA noted that the revised policy would be presented to the Board on 16 March 2018 to ensure it was in place ahead of GDPR coming into effect and it was their intention to review the policy biennially or in response to a specific event.

1.2 Assurance on General Data Protection Regulation (GDPR) preparations – APA advised that in 2016 they created the new post of Head of Business Transformation incorporating the role of data protection and GDPR implementation at a senior level within the organisation. In early 2017, they established a working group to focus on the requirements of GDPR to identify any additional requirements in the management and security of processes for the data they held. The working group is led by the Head of Business Transformation, who has been appointed APA's Data Protection Officer (DPO). The working group's progress is regularly reported to APA's Leadership Team and the Board.

APA identified a number of technical solutions that either have been implemented or are in the process of being assessed as proof of concepts prior to implementation. These technical solutions include, but are not limited to:-

- use of encryption technologies
- implementation of mobile device management
- the procurement of a data audit and management software to identify data flows, permissions, stale data
- implementation of a secure File Transfer Protocol (FTP) service

- implementation of data cleansing software for Customer Relationship Management (CRM)
- procurement of next-generation endpoint security
- procurement of new firewall appliances
- use of email security, archiving and continuity software
- use of network monitoring and logging software

APA explained that GDPR was a core consideration of any procurement process and a Data Protection Impact Assessment (DPIA) would be included if necessary to ensure all supplier partnerships and new business applications were in compliance with the new regulation. APA continues to work with cultural partners such as Culture Republic to understand the impact of GDPR in the sector and have approached an external agency with a view to leading a consultancy project over three days. This project will include stakeholder interviews and a detailed assessment of information systems and ICT infrastructure, culminating in a report capturing the results of these activities.

APA intends to review the following existing policies and protocols in light of GDPR:-

- Business Continuity Plan
- Child Protection Policy
- Crisis Management and Communication Protocols
- Data Protection Policy
- Email Etiquette Policy
- Information Security Policy
- Meetings Protocols
- Privacy Policy
- Records Management Policy
- Recruitment Policy
- Social Network Policy

1.3 Assurance on GDPR training – APA has recognised the importance of training in this area and has undertaken two key training events over the past 12 months. Programmed by cultural partners Culture Republic, APA's Head of Business Transformation and Marketing Manager attended two day-long training workshops led by the Information Commissioner's Office for Scotland to prepare cultural organisations for GDPR. The Director of Finance and Corporate Services, and Head of Business Transformation attended Aberdeen City Council's GDPR training event on 5 March 2018. The Head of Business Transformation also attended a workshop on GDPR at a conference in Birmingham in early March.

Following on from this, APA plans to deliver internal workshops for all staff and volunteers to commence on 19 March 2018. Thereafter a short staff survey would be circulated to assess the effectiveness of the sessions. These workshops will be led by the Head of Business Transformation and/or an external consultant and would

provide an update on all aspects of GDPR and its impact on the business. APA also highlighted that the Board was well equipped to manage and understand the implications of GDPR, as amongst its membership it has two members who lead on GDPR compliance for Robert Gordon University and the University of Aberdeen.

1.4 Assurance on GDPR readiness – APA advised that they have a very clear understanding of the requirements of GDPR and have been working for the past 18 months to understand the impact of the legislation on the organisation. APA has implemented various technical solutions and had been assessing other applications to mitigate risk. APA was in the process of updating all policies and procedures that relate to data management and information systems.

APA highlighted that they had recognised the importance of GDPR well in advance by creating the new senior management post of Head of Business Transformation to lead on GDPR and had appointed key staff onto a working group to manage all parts of the process. They advised that all stakeholders had been involved including the Board; senior management; third-party suppliers; cultural partners; staff; and volunteers. APA provided assurance that they would be GDPR compliant by 25 May 2018.

Governance Assessment – The Hub received legal advice that APA's Data Protection Policy provided a good benchmark for implementing GDPR but highlighted that further work would be required particularly on Subject Access Requests and data breach procedures. The Hub welcomed APA's appointment of a Data Protection Officer to manage the implementation process and found its training arrangements to be satisfactory. The Hub agreed that due to the administrative and regulatory demands of implementing GDPR, which would involve significant systematic and procedural change, in addition to the higher costs and risks of a data breach, it was felt that a **Medium Risk** rating was the best score it could assign to any organisation (including the Council). The Hub noted that GDPR had not been listed on APA's corporate risk register as a risk and took the view that this risk should be recorded, along with appropriate controls to mitigate risk to the organisation.

2 Risk Management

2.1 Assurance on risk registers – APA provided copies of its corporate risk register and Music Hall risk register which were both reviewed in February 2018. The biggest risk for the organisation was the cost of making loan and interest payments to the Council for the Music Hall Project.

2.2 Assurance on Business Continuity Planning –APA advised that its Business Continuity Plan would be reviewed by the Board at its development day on 16 March before being presented to the Board for final approval on 21 May 2018. They added that regular testing was carried out on evacuations and ICT systems.

2.3 Assurance that risk is taken into account at Board meetings – APA advised that the corporate risk register was reviewed by the Board bi-annually and was a standing agenda item on the Finance, Audit and Property Sub-Committee. They confirmed that the Music Hall risk register was reviewed at every Music Hall Strategic Board Meeting.

Risk Management Assessment – The Hub highlighted that GDPR was not listed as a risk on APA's corporate risk register and it recommended that this risk be inserted to take account of the challenges of implementing the regulation as well as the potential sanctions for non-compliance. APA's Service Lead confirmed that the Board had discussed GDPR as a corporate risk during recent meetings and agreed to forward on the Hub's recommendation to Management for consideration. The Hub also noted that Project Delay was appropriately rated as High Risk in APA's Music Hall risk register but took the view that this risk should also be included in the corporate risk register as this risk may have a significant impact on the overall business in terms of revenue generation.

The Hub assessed the Music Hall risk register to be robust but agreed to request further information ahead of its next meeting on how APA would mitigate risks relating to snagging issues after the Music Hall had opened. APA's Service Lead advised that in her view, APA had managed the Music Hall development professionally and had prepared an effective communication strategy to mitigate reputational damage to the organisation and the Council.

Overall, based on the assurance provided, APA's risk management approach was assessed as **Medium Risk** due to the ongoing development of its Business Continuity Plan and GDPR's omission from the corporate risk register. The Hub agreed to request an update on these items at its next meeting and took the view that provision of this assurance would likely result in an improved risk score.

3 Financial Management

3.1 Assurance on Management Trading Accounts – APA provided a copy of its management trading accounts as at 31 December 2017.

3.2 Assurance on Audited Annual Accounts – APA provided a copy of its 2016-17 audited annual accounts which had been prepared by Scott-Moncrieff. They advised that External Audit had reported to the Board in August 2017 and issued APA with a clean audit certificate with no audit adjustments or any outstanding audit improvement actions required. APA also returned a surplus and was managing its reserves appropriately.

3.3 Assurance on Financial Regulations and Scheme of Delegation – APA confirmed they had taken on board the Hub's recommendation for their Financial

Regulations to be reviewed and noted the review would take place at the Board meeting in August 2018. APA added that the Board would also consider the Hub's recommendation to adopt a formal scheme of delegation to officers at this meeting.

3.4 Assurance on Business Planning – APA provided its three year Business Plan: 2018-19 - 2020-21.

3.5 Assurance that the Board considers financial implications when taking decisions – APA advised that as an autonomous charity, the Board and Leadership Team have taken the view that their report template is appropriate and explained that cognisance was given to financial implications on any decision in accordance with good governance principles. APA maintains a clear audit trail of all financial decisions and their implications, as Board discussions and decisions are minuted. The budget is set annually in February by the Board and reviewed on a quarterly basis by the Finance, Audit and Property (FAP) Sub-Committee and the Board. Finance was a standing item on FAP Sub-Committee and Board agendas and implications of financial decisions were discussed and minuted under this item. APA also provided its Board papers from 19 February 2018 which outlined how risk and financial implications were reported to the Board.

3.6 Assurance that financial performance is scrutinised by the Board – APA advised that financial performance was a standing agenda item for discussion at every Leadership Team meeting. Managers and Budget holders meet monthly with Finance colleagues to account for performance and the Finance, Audit & Property Sub-Committee review and discuss financial performance at every meeting. The Board was presented with a Finance report and management accounts at every meeting; in addition to any other specific financial issues requiring decision. APA highlighted that an annual development day had been arranged for the Board and Leadership team to review the business plan. They explained that the litmus test for financial management is the performance of an organisation and noted that APA has healthy reserves; returned a surplus and received a clean external audit for its latest annual accounts.

3.7 Assurance on Internal Audit – APA explained that they had not appointed a single internal auditor as they did not believe this would be cost effective or appropriate for the range of APA business. They advised that the following internal audit work had been carried out over the past year, which included three specialist external reviews and Management had accepted their recommendations and implemented accordingly:-

- External marketing review carried out by an independent consultant
- Pricing Review carried out by an independent consultant
- Ticketing system evaluation carried out by an independent consultant
- Human Resources process audit carried out internally

Financial Management Assessment – The Hub welcomed APA's positive financial performance and identified no significant issues with either how the accounts were presented or the annual business plan which had been reported to the Education

and Children's Services Committee on 14 September 2017. APA's Service Lead informed the Hub that APA had recently retained core funding from Creative Scotland and had been looking to generate additional revenue through marketing its facilities as conference venues. The Hub welcomed APA's acceptance of Hub recommendations to review its Financial Procedures and consider the development of a scheme of delegation at its Board meeting in May 2018.

Overall, based on the assurance provided, APA's financial management was assessed as **Low Risk**. Ahead of its next meeting, the Hub agreed to request further information on APA's internal audit arrangements and how APA reported financial implications to the Board to provide additional assurance to the Audit, Risk and Scrutiny Committee.

4 Future Oversight Arrangements - The Hub found that APA was taking appropriate steps to comply with GDPR but would request an update on whether GDPR had been added to its corporate risk register at its next meeting. The Hub welcomed APA's willingness to consider Hub recommendations in relation to reviewing Financial Procedures and considering a scheme of delegation. The Hub agreed to request further information on APA's Business Continuity Plan; Internal Audit arrangements; reporting financial implications to the Board; and its approach to address snagging issues following the opening of the Music Hall. Overall, based on the assurance provided, the Hub assessed ASV to be **Low-Medium Risk** to the Council. This risk rating has remained the same since the Hub's last report to the Audit, Risk and Scrutiny Committee on 23 November 2017.

Assurance Standard - May 2018	**Risk Rating**
Unambiguous responses demonstrating clear understanding and comprehensive ability to fulfil ACC requirements, giving full detail as how these are achieved.	**Very Low**
Responses provide evidence of good understanding and compliance although limited detail provided for some areas	**Low**
Responses provide some indication of understanding and compliance	**Medium**
Minimal or poor responses providing little evidence of understanding or compliance.	**High**
Nil or inadequate responses with little or no understanding of requirement or evidence of compliance.	**Very High**

ABERDEEN CITY COUNCIL

COMMITTEE	Audit Risk & Scrutiny
DATE	8th May 2018
REPORT TITLE	Protective Monitoring
REPORT NUMBER	CUS/18/007
DIRECTOR	Andy MacDonald
REPORT AUTHOR	Norman Hogg
TERMS OF REFERENCE	1.4

1. PURPOSE OF REPORT

1.1 To provide assurance that Protective Monitoring is performed in line with legislation and best practice and provide further update on the governance process for officers and elected members.

2. RECOMMENDATION(S)

That the Committee: -

2.1 Approves the following documents, attached as appendices, which make up the suite, 'Protective Monitoring':

a) Protective Monitoring Policy
b) Protective Monitoring Privacy Impact Assessment
c) Protective Monitoring Risk Assessment
d) Protective Monitoring Access to Information Procedure
e) Access to Information Guide and Form

3. BACKGROUND

3.1 A report on Protective Monitoring was previously submitted for approval to the meeting of the Finance Policy & Resources Committee held on Wednesday 6th December 2017.

3.2 The Committee resolved:

(i) To defer deliberation of the report until a future meeting of the Committee;
(ii) To instruct officers to include further details within the report regarding the governance process for officers and elected members;

(iii) That officers circulate further details in relation to Airwatch regarding due process;

(iv) That members contact the Head of IT and Transformation with any additional governance and assurance issues that they would like to be addressed and included within the report.

3.3 As the Finance, Policy and Resources Committee has been disestablished, the update under action (ii) is presented to the Audit Risk & Scrutiny Committee in terms of section 1.4 of the terms of reference for the Audit, Risk and Scrutiny Committee.

3.4 Action (iii) has been completed and information was collated and sent in December to Councillor Reynolds by Steven Robertson (Infrastructure Architect). In terms of action (iv), no additional issues were raised by members.

3.5 Protective monitoring is an essential part of cyber security practice. The adoption and implementation of a Protective Monitoring policy is a key requirement of the Council's compliance with Public Service Network (PSN) requirements. If the Council does not have an adequate policy in place, there is a real risk that the Council will not be able to use the PSN and therefore would not be able to deliver its functions.

3.6 Information (or data) is one of the Council's most important assets, and it is vital that the Council adequately protects this asset. Protective Monitoring detects and prevents security incidents and alerts the Council to incidents that require further investigation.

Data protection legislation requires the Council to protect the personal data it processes in a manner that ensures appropriate security of the personal data, including protection against unauthorized or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organizational measures. The adoption and implementation of this Protective Monitoring Policy would be a key component of evidencing compliance with this requirement. The General Data Protection Regulation, enforceable from 25 May 2018, increases the potential monetary penalties in relation to non-compliance with data protection law from £500,000 to €20 million.

3.7 Monitoring must, however, be a balance between protecting the Council and the individual, whilst at the same time respecting the rights of those individuals under such legislation as the Human Rights Act 1998, and data protection legislation. Therefore, the Access to Information Procedure (see Appendix 4) and Access to Information Guide and Form (see Appendix 5) will ensure that any access to individual accounts is carried out in a way which balances these rights with the needs of the Council, and complies with these laws

3.8 The documents created and supplied for review:

- identify why, what and how the Council monitors data;
- demonstrates that the Council has taken a holistic approach in their duty to due diligence;
- demonstrates that the Council has processes in place; and
- demonstrates that protective monitoring protects both the business and the individual.

3.9 The Council is on a programme of digital transformation and the Government emphasise a Cloud First Policy (https://www.gov.uk/guidance/government-cloud-first-policy) which, by their nature shifts the boundaries of the network and it becomes even more important to implement sound protective monitoring strategies within the organisation.

3.10 All staff and elected members have relevant codes of conduct. The Staff Code of Conduct at 7.4 requires that all staff comply with the ICT Acceptable Use Policy. Section 3.16 of the Councillors Code of Conduct, in regard to use of Council facilities, requires elected members to use Council facilities in accordance with the Council's information technology policies.

3.11 Staff, agency workers, elected members, contractors, sub-contractors, and any person who uses or requires access to the Aberdeen City Council Information Technology, Data Assets or associated Infrastructure must comply with the Corporate ICT Acceptable Use Policy . Of particular relevance are items 4.8 and 4.10 of the policy:

4.8 Monitoring

The Council seeks to safeguard Users of its ICT equipment, systems and networks from inappropriate activities and unacceptable material. One of its safeguards is monitoring, others include a suite of defensive measures at the perimeter and within the network. All Council ICT equipment, systems and networks may be monitored for compliance with current legislation and Council policies. Monitoring also has the following purposes:

- *to establish compliance with Council policies;*
- *to investigate any suspected or actual breaches of Council policy;*
- *to investigate system performance;*
- *to gather evidence for investigative or disciplinary purposes; and*
- *for other legal and security purposes.*

Monitoring is undertaken in accordance with the Council's approved Electronic Monitoring of Use Impact Assessment.

4.10 Consequences of Misuse

The Council may, at its sole discretion, suspend or terminate ICT access, withdraw or remove any material uploaded by the User in contravention of this Policy. The Council may take such action as it considers necessary, including taking disciplinary action or disclosing information to law enforcement agencies.

Any other Users that are not employed by the Council and not subject to the Council disciplinary procedure will be subject to provisions in the contract held with them or other acceptable use agreement they have entered into. In any event misuse may result in the withdrawal of ICT access or equipment, legal action or involvement of law enforcement agencies.

Users should be aware that use of Council ICT equipment, systems and networks may be monitored at all times and monitoring information is retained and used for both routine monitoring reports and to support potential misuse reports.

Authorised Release of Account Information

3.12 In order to protect the individual, whether employees, elected members or others, a two-step authorisation process is proposed before the release of any information in regard to an individual account is granted. This is to ensure that the request for release is legally competent in line with requirements under data protection legislation and that processing is lawful and fair. Information will only be released to the requester if the request is deemed to be lawful, justified, proportionate and necessary.

3.13 The authorities for sign off for release of relevant information to a legitimate requester, for information regarding a Council Employee account, is proposed as follows:

- Manager, Chief Officer (optionally the Senior Information Risk Officer (SIRO) or Chief Executive) **and** Human Resources.

3.14 The authorities for sign off for release of relevant information to a legitimate requester, for information regarding elected members and other non-council employed user accounts, is proposed as follows:

The SIRO (currently the Chief Officer - Governance) **and** the Chief Executive.

3.15 The document 'Access to Information Procedure' has been amended appropriately. If the Council agree with the Procedure, this will grant authority to the officers identified in 3.12 and 3.13 to authorise the release of specified information in relation to an account, as long as this is done lawfully in accordance with data protection legislation and the Human Rights Act 1998.

4. FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from the recommendations of this report.

5. LEGAL IMPLICATIONS

5.1 A robust Protective Monitoring process is required so that the Council can meet several legal obligations. Without robust and fair Protective Monitoring, the Council would likely breach several obligations under various pieces of legislation. The proposed suite of Protective Monitoring documents is deemed to be proportionate, fair, robust and lawfully compliant.

5.2 The Data Protection Act 1998 requires that processing of personal data is done so lawfully and fairly, is used for limited specifically stated purposes and used in way that is adequate, relevant and not excessive. It also imposes a duty on the Council to maintain appropriate security measures to protect personal data.

5.3 The General Data Protection Regulation which replaces the 1998 Act from 25th May 2018, requires the Council to process personal data lawfully, fairly and transparently, and requires the Council to secure the personal data it holds. The GDPR is designed to enable individuals to better control their personal data. Penalties for breaches are more severe than under the 1998 Act.

5.4 The Computer Misuse Act 1990 which disallows unauthorised access or acts in relation to computer systems, data or materials. Protective monitoring helps identify and block such attempts and provides evidential audit trails which can exonerate or provide nonrepudiation.

5.5 The Copyright, Designs and Patents Act 1988 protects the rights of creators to control the ways in which their materials are used. There is a duty on the Council to prevent breaches of Copyright. Elements of Copyright infringement can be identified and prevented through protective monitoring.

5.6 The Health & Safety at Work etc. Act 1974, the Council is obliged to protect the health, including mental health of their employees. Protective Monitoring reduces the stress to employees by shielding them from unwanted or inappropriate material and preventing unintentional actions and their associated consequences.

5.7 Article 8 of the Human Rights Act 1998 is the right to respect for family and private life, home and correspondence. This right is not absolute and must be balanced with the need of the Council to protect its information. Therefore, the Council must carefully consider requests for access to peoples' correspondence to ensure that the need to do so outweighs the need to protect an an individual's human rights.

5.8 The Telecommunications (Lawful Business Practices) (Interception of Communications) Regulations 2000 (LBPR) allow interception of communications by businesses on their own telecommunications networks, for instance, to detect employee-mail abuse or to record telephone conversations to evidence transactions.

5.9 Standards

- ISO27001/2 (Information Security standards) - a specification for an information security management system (ISMS). An ISMS is a framework of policies and procedures that includes all legal, physical and technical controls involved in an organisation's information risk management processes. Complying with these standards is industry best practice.

- The Council is obliged to have a Protective Monitoring Policy in place, in order to satisfy strict requirements required by the PSN (Public Services Network). The PSN is a shared information and communications infrastructure, and joins up organisations, departments, Authorities, and agencies that deliver public services, whether national, regional, or local. To provide PSN services, suppliers must meet agreed standards of security, technical performance, service management, and governance. Organisations using PSN must also be PSN-compliant. This compliance ensures seamless, and painless, interconnectivity. Without access to the PSN, the Council would not be able to effectively deliver its functions.

5.10 Regulations

PCI DSS (Payment Card Industry Data Security Standard) – The Council is required to meet this standard in order to take card payments. Requirements include to maintain a firewall to protect cardholder data, protect systems against malware and to track and monitor all access to network resources and cardholder data.

5.11 Best Practice Guides

- National Cyber Security Centre (NCSC) Good Practice Guide 13 - Protective Monitoring (GPG 13) which provides advice on good practice to help meet Protective Monitoring obligations.

- The Information Commissioner's Employment Practices Code; Part 3 Monitoring at Work. (https://ico.org.uk/media/for-organisations/documents/1064/the_employment_practices_code.pdf) is intended to help employers comply with the Data Protection Act and to encourage them to adopt good practice. The code aims to strike a balance between the legitimate expectations of workers that personal information about them will be handled properly and the legitimate

interests of employers in deciding how best, within the law, to run their own businesses. It does not impose new legal obligations.

6. MANAGEMENT OF RISK

	Risk	Low (L), Medium (M), High (H)	Mitigation
Financial	Non-compliance with applicable Data Protection law may lead to enforcement action with monetary penalties and/or financial liability for damages to customers. If the Council does not have an adequate policy in place, there is a real risk that the Council will not be able to use the PSN.	L	Implementing protective monitoring and the adoption of this Protective Monitoring suite of documents will mitigate the risks by identifying potential breaches and demonstrating sound governance.
Legal	Any investigation may give rise to legal challenge. Having adequate policy and practice in place reduces the likelihood of a successful challenge	L	By agreeing the recommendations legal risks are minimised due to evidence of due diligence and consideration of the listed acts and regulations. The document 'Protective Monitoring Risk Assessment' further highlights the risks to the business in performing or not performing protective monitoring.
Employee	Without adequate Protective Monitoring, employees, elected members and others may have their personal data compromised by security breaches, and malware attacks and with a lack of nonrepudiation may be falsely accused of inappropriate actions	L	By agreeing the recommendations risks are minimised for the employee due to policy, procedure and supporting material being documented and communicated. The document 'Protective Monitoring Risk Assessment' further highlights the risks to the individual in performing or

	Employees, elected members and others may be concerned that senior officers are looking through their private correspondence.		not performing protective monitoring. Appropriate measure means that in regard to employee, elected member and other accounts that information is only accessed when absolutely necessary, to the level of detail absolutely necessary.
Customer	Without appropriate protective monitoring, customer data would not be secure breaching legislation. A data breach where protective monitoring was not in place would mean that a significant fine imposed on the Council by the Information Commissioners Office. If the Council does not have an adequate policy in place, there is a real risk that the Council will not be able to use the PSN thereby affecting our service to the public.	L	Implementing protective monitoring and the adoption of this Protective Monitoring suite of documents will mitigate the risk by identifying potential breaches and demonstrating sound governance.
Environment	None	L	
Technology	Without Protective Monitoring, a security breach would infect the Council's IT system.	L	Implementing protective monitoring and the adoption of this Protective Monitoring suite of documents will mitigate the risk by identifying potential breaches and demonstrating sound governance.
Reputational	Realisation of any of the above risks would also be likely to lead to significant reputational damage to the Council.	L	Implementing protective monitoring and the adoption of this Protective Monitoring suite of documents will mitigate the risk by identifying potential breaches and

	If the Council does not have an adequate policy in place, there is a real risk that the Council will not be able to use the PSN.		demonstrating sound governance.

7. OUTCOMES

Local Outcome Improvement Plan Themes	
	Impact of Report

Design Principles of Target Operating Model	
	Impact of Report
Governance	Formally documenting 'Protective Monitoring' ensures the essential governance is in place.
Workforce	'Protective Monitoring' emphasises a culture based around safety and security.
Process Design	'Protective Monitoring' underpins business processes and objectives where these are being conducted electronically.
Technology	'Protective Monitoring' is a key element in any technology we introduce which aims to keep the business, the workforce and the public safe.

8. IMPACT ASSESSMENTS

Assessment	Outcome
Equality & Human Rights Impact Assessment	Required
Privacy Impact Assessment	Required
Duty of Due Regard / Fairer Scotland Duty	Not applicable

9. BACKGROUND PAPERS

9.1 Various documents are referenced within the appendices and listed here in Summary:

9.2 Standards

- ISO27001/2
- PSN

9.3 Regulations

- PCI DSS

9.4 Best Practice Guides

- National Cyber Security Centre (NCSC) Good Practice Guide 13 - Protective Monitoring (GPG 13)
- Information Commissioner's Employment Practices Code; Part 3 Monitoring at Work.

10. APPENDICES (if applicable)

Appdx 1 Protective Monitoring Policy
Appdx 2 Risk Assessment
Appdx 3 Access to Information Procedure
Appdx 4 Access to Information Guide and Form

11. REPORT AUTHOR CONTACT DETAILS

Norman Hogg
Security Architect
nohogg@aberdeencity.gov.uk
01224522407

CORPORATE POLICY

PROTECTIVE MONITORING

Date Created:	October 2017	
Version:	V1.1	
Location:		
Author (s) of Document:	Norman Hogg, Security Architect	
Approval Authority	Audit Risk & Scrutiny Committee	
Scheduled Review:	October 2018	
Changes:	Month YYYY	Brief description of changes

What is this policy for?

This policy defines how Aberdeen City Council aims to detect and prevent potential security incidents, whether technical attacks or abuses of business process. This policy does not describe specific events collected but documents the requirements for collection and analysis in relation to protective monitoring and intrusion detection.

Who is this policy for?

This policy applies to all staff, agency staff, elected members, contractors and sub-contractors, and to any person, without exception, who uses or requires access to the Aberdeen City Council Information Technology, Data Assets or associated Infrastructure.

Why do we need this policy?

Protective monitoring is an essential component of risk management. Various pieces of legislation and codes of practice, including the Data Protection Act (1998), and ISO 27001/2 Standards for Information Security Management Systems, impose a duty on Aberdeen City Council to protect its information assets and provide the assurances that appropriate controls are in place. It is recommended in a number of regulatory and industry best-practices, such as the Payment Card Industry Data Security Standard (PCI DSS) and Cyber Security Essentials. It is also a requirement for connection to the Public Services Network (PSN) that such a policy exists.

Protective monitoring underpins the Shaping Aberdeen Corporate vision by aiming to protect the data that has been entrusted to us by our customers.

What does it mean for the Council? (Policy Statement)

Monitoring, includes the routine supervision of performance and staff behaviour in line with the Employee Code of Conduct (Hyperlink when on Zone). This extends to the use by staff of IT equipment or infrastructure provided by the organisation for business purposes.

Protective Monitoring is a lawful and ethical practice used to assist Aberdeen City Council in the protection of all users, assets and information and to assist in the investigation of misconduct or criminal activity. As such the audit systems may monitor and record all computer based actions conducted using any piece Aberdeen City Council IT equipment or infrastructure.

This policy defines the monitoring and auditing of activity to ensure all compliance with Council Policies and Procedures, and with the standards of behaviour expected by Aberdeen City Council and the public.

This policy does not over-ride any existing policies nor negate any existing guidance regarding information security, data protection or acceptable use. It supplements such policies but with a specific focus on the protective monitoring of the Aberdeen City Council network, and the data held within or transported by it.

The main aims and objectives are:

- To ensure the data integrity of the information held.
- To enhance operational security.
- To identify misuse.
- To monitor exceptional usage.

- To support intelligence led investigations.
- To protect the Council by providing the Fraud Team the means by which they can effectively seek out those who abuse their position for personal gain or benefit of others.
- To protect Council information and assets from malicious or accidental disclosure

All users must note that the monitoring will include any personal use staff make of Council computer equipment or infrastructure, even if undertaken in their own time.

How will we make it happen?

PROTECTIVE MONITORING CONTROLS
The implementation of protective monitoring for the Aberdeen City Council network has been aligned to the requirements of the National Cyber Security Centre (NCSC) Good Practice Guide 13 - Protective Monitoring (GPG 13), as recommended by the UK government. It also aligns with the Information Commissioner's Employment Practices Code, Part 3: Monitoring at Work.

Aberdeen City Council shall implement Protective Monitoring Controls (PMCs) in accordance with the guidance documented in the GPG 13. The PMCs are summarised below and detailed further in Appendix I (see page 5):

- PMC1 Accurate time in logs
- PMC2 Recording relating to business traffic crossing a boundary
- PMC3 Recording relating to suspicious activity at a boundary
- PMC4 Recording of workstation, server or device status
- PMC5 Recording relating to suspicious internal network activity
- PMC6 Recording relating to network connections
- PMC7 Recording of session activity by user and workstation
- PMC8 Recording of data backup status
- PMC9 Alerting critical events
- PMC10 Reporting on the status of the audit system
- PMC11 Production of sanitised and statistical management reports
- PMC12 Providing a legal framework for Protective Monitoring activities

How will we know if it's working?

Statistics are gathered by the Security Architect and provided in the quarterly Information Governance Report. These statistics show the level of identified threat and the number of incidents of significance. A rise in the level of incidents may indicate the solutions are not working, in which case further investigations will be carried out.

How will we manage any risks that affect this policy?

IT Risk Register
The risks to the Council from a failure to perform adequate Protective Monitoring are outlined in the Corporate Governance IT Risk Register, which is managed by the Council's Senior Information Risk Owner (SIRO). This Register is used to document known IT risks of significance and to ensure that the measures and actions identified are controlled and mitigated. See Protective Monitoring Risk Assessment (Hyperlink when on Zone)

Service Risk Registers
Information Asset Owners are responsible for managing risk to the information assets that they are responsible for, these risks are managed through Service Risk Registers and included in Business Continuity planning and disaster recovery arrangements wherever appropriate.

Strategic Risk Register

Information management and security also pose a strategic risk for the Council and this is recorded in the Strategic Risk Register. The SIRO provides the Council's Corporate Management Team with regular updates on the strength of controls in place against this risk.

How will we make sure this policy is kept up to date?

This policy will be reviewed annually by the Council's Security Architect to ensure that it meets requirements of the business, accountability and standards of best practice.

Related Policy Document Suite

Policy and Strategy

- ICT Acceptable Use Policy
- Employee Code of Conduct
- Councillor Code of Conduct

Procedures

- Access to Information Procedure (Hyperlink when on the Zone)

Assessments

- Protective Monitoring Privacy Impact Assessment (Hyperlink when on the Zone)
- Protective Monitoring Risk Assessment (Hyperlink when on the Zone)

Related Legislation and Supporting Documents

Acts

- The Data Protection Act (1998)
  Requires that processing of personal data is done so lawfully and fairly, is used for limited specifically stated purposes and used in way that is adequate, relevant and not excessive.

- General Data Protection Regulation
  From 25th May 2018, this replaces the Data Protection Act (1998) and requires the Council to process personal data lawfully, fairly and transparently, and requires the Council to secure the personal data it holds. The GDPR is designed to enable individuals to better control their personal data. Penalties for breaches are more severe than under the 1998 Act.

- The Computer Misuse Act (1990)
  Disallows unauthorised access or acts in relation to computer systems, data or materials.

- The Copyright, Designs and Patents Act (1988)
  Protects the rights of creators to control the ways in which their materials are used. There is a duty on the Council to prevent breaches of Copyright.

- The Health & Safety at Work Act (1974)
  Protects the health, including mental health of their employees.

- The Human Rights Act (1998)
  The right to respect for family and private life, home and correspondence. This right is not absolute and must be balanced with the need of the Council to protect its information.

- Telecommunications (Lawful Business Practices) (Interception of Communications) Regulations 2000 (LBPR).

Allows interception of communications by businesses on their own telecommunications networks, for instance, to detect employee-mail abuse or to record telephone conversations to evidence transactions.

Related Standards

- ISO27001/2
  A framework of policies and procedures that includes all legal, physical and technical controls.

- PSN
  A public services shared information and communications infrastructure for which we need to remain compliant.

Regulations

- PCI DSS
  The Council is required to meet this standard in order to take card payments.

Best Practice Guides

- National Cyber Security Centre (NCSC) Good Practice Guide 13 - Protective Monitoring (GPG 13)
  Provides advice on good practice to help meet Protective Monitoring obligations.

- Information Commissioner's Employment Practices Code; Part 3 Monitoring at Work.
  Aims to strike a balance between the legitimate expectations of workers and the legitimate interests of employers.

Appendix I

PMC1 – Accurate Time in Logs

Control Description:

- Provide a means of providing accurate time in logs and synchronisation between system components with a view to facilitate collation of events between those components.

Aberdeen City Council Control Process in Place:

- Core network components and monitoring devices are synchronised using the Network Time protocol (NTP). This protocol provides a means of synchronizing to a globally referenced time source.

PMC2 – Recording Relating to Business Traffic Crossing a Boundary

Control Description:

- To provide reports, monitoring, recording and analysis of business traffic crossing a boundary with a view to ensuring traffic exchanges are authorised, conform to security policy, transport of malicious content is prevented and alerted, and that other forms of attack by manipulation of business traffic are detected or prevented.

Aberdeen City Council Control Process in Place:

- Detection of Malware which is then blocked, logged and reported on. Further analysis of logs may take place for specific incidents, to identify trends or as part of an investigation. This data may include information which will identify individuals who have had malware sent to them, whose device is malware infected or have visited websites infected with malware.

- All Internet browsing is routinely logged. An individual's browsing activity is generally anonymous. We do not interrogate activity unless instructed to as part of an investigation and through the Access to Information Procedure. (Hyperlink when on Zone)

- We regularly run reports for security purposes. These reports may identify individuals deliberately or inadvertently putting the organisation at risk or attempting to circumvent Aberdeen City Councils security measures. Any significant identified behaviour will be reported to management. Further investigation will only take place on instruction as part of an investigation and through the Access to Information Procedure. (Hyperlink when on Zone).

- Imported content may be blocked. Certain file types may be quarantined for further analysis before being let into the organisation or may be rejected outright.

- Exported content may be blocked. Certain file types may be quarantined for further analysis before being allowed to leave the organisation or may be rejected outright. Automatic file scanning for Data Loss Prevention may also quarantine a file.

PMC3 – Recording Relating to Suspicious Behavior at a Boundary

Control Description:

- To provide reports, monitoring, recording and analysis of network activity at the boundary with a view to detecting suspect activity that would be indicative of the actions of an attacker attempting to breach the system boundary or other deviation from normal business behaviour.

Aberdeen City Council Control Process in Place:

- Next Generation Firewalls employ threat identification and prevention mechanisms. All 'events' and 'threats' identified by the firewalls are logged, blocked and correlated. Regular high level reports are run on these to identify particular issues or incidents and to provide trending statistics. Along with correlated events these may indicate an infected or compromised machine or system, an individual putting Aberdeen City Council or themselves at risk, or individuals, whether internal or external, attempting to circumvent Aberdeen City Councils security measures.

- Routers direct the flow of traffic within the organisation and into and out of the organisation and provide secure separation at the network boundaries.

- Switches direct the flow of traffic within the organisation and provide a level of secure boundary separation.

PMC4 – Recording of Workstation, Server or Device Status

Control Description:

- To detect changes to device status and configuration.

Aberdeen City Council Control Process in Place:

- Monitoring:

    - A tool called 'System Centre Configuration Manager' (SCCM), regularly checks devices for installed software. This is a key security measure as any unpatched software poses a security risk. This system will also apply patches to any Microsoft software on devices.

- The status of Anti-Virus software on devices is monitored centrally to ensure devices are being updated with new definitions, to gather information on any infections or attempted infections and to remotely roll out updates.

PMC5 – Recording Relating to Suspicious Internal Network Activity

Control Description:

- To monitor critical boundaries and resources within internal networks to detect suspicious activity either by internal users or by external attackers that may indicate attacks, pre-cursor to attacks or breach of regulations or compliance.

- Likely boundaries and resources may include but are not limited to:

    - Core messaging infrastructure (e.g. email servers and directory servers).
    - Sensitive databases (e.g. HR databases, finance, procurement/contracts, etc).
    - Information exchanges with third parties.

Aberdeen City Council Control Process in Place:

- Monitoring:

    - Data traffic levels across the organisation are monitored. Deviations from normal can indicate suspicious activity.

    - Status and performance of infrastructure equipment across the organisation is monitored. Changes can indicate suspicious activity.

    - Firewalls are monitored for changes to their status or deviations from normal activity.

  - Specialist Packet Sniffing technology may be deployed.
  - Endpoint Security mechanisms monitor critical resources.
  - Anti-Virus is installed on servers and Internet facing Firewalls.
  - Core servers are monitored with various protections in place with an aim to detect and prevent unauthorised change.

- Logging:
  - System logs indicating both successful and unsuccessful logins are recorded within some systems.
  - Logging of all Emails sent or received takes place (not the content). This includes Emails that do not reach their destination such as spam, malware infected or quarantined.
  - Logging of all websites visited.
  - Logging of all communication blocked by our security products e.g. Anti-Virus or Firewall threat prevention.

- Auditing:
  - Auditing records are kept on some systems and databases which can give forensic analysis of activities and transactions that have taken place.

- Data loss Prevention:
  - A minimum level of automatic Data Loss Prevention(DLP) techniques are in operation on both the Email communication and Web traffic. This may quarantine or prevent the information from being sent or received.

PMC6 – Recording Relating to Network Connections

Control Description:

- To monitor transient connections to the network such has remote access, virtual private networking, wireless or any other temporary connection.

Aberdeen City Council Control Process in Place:

- Authentication:
  - Necessary for all network access is authentication. Authentication is required whether you are on the main network, wireless network, connecting remotely, over a Virtual Private Network (VPN) or are a 3rd party.

- Logging:
  - Such connections will be logged by various systems such as the Firewall, Directory Services and DHCP. Information that is logged varies but may include, source IP Address, source device, destination IP address, destination device, Logon date/time, Logoff date/time, Username.

PMC7 – Recording of Session Activity by User and Workstation

Control Description:

- To monitor user activity and access to ensure they can be made accountable for their actions and to detect unauthorised activity and access that is either suspicious or is in violation of security policy requirements.

Aberdeen City Council Control Process in Place:

- Logging:
    - System logs indicating both successful and unsuccessful logins are recorded within some systems.
    - Logging of all Emails sent or received takes place (not the content). This includes Emails that do not reach their destination such as spam, malware infected or quarantined.
    - Logging of websites visited by users.
    - Logging of all communication blocked by our security products e.g. Anti-Virus or Firewall threat prevention.
- Auditing
    - Auditing records are kept on some systems and databases which can give forensic analysis of activities and transactions that have taken place.

PMC8 – Recording of Data Backup Status

Control Description:

- To provide a means by which previous known working states of information assets can be identified and recovered from in the event that either their integrity or available is compromised.

Aberdeen City Council Control Process in Place:

- Backups of system shares and drives are performed to a schedule. Tests are regularly performed to ensure integrity and recovery.

PMC9 – Alerting Critical Events

Control Description:

- To allow critical events to be notified in real-time.

Aberdeen City Council Control Process in Place:

- Alerts can be automatically generated when:
    - There are unexpected deviations from normal traffic levels.
    - The status or performance of infrastructure equipment across the organisation changes.
    - There are unexpected deviations from normal monitoring or the status of Firewalls changes.
    - There are attempted failed changes to elevate privileges on domain servers.

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Monitoring in place	9
Monitoring not in place	25

Protective Monitoring Risk Assessment

Risk Assessment

Area covered by this assessment	**Monitoring activity on the network, particularly at the gateway in order to detect and prevent potential security incidents whether these are technical attacks or abuses of business.**

Activity requiring assessment and requestor	**Requested by the business as part of the Privacy Impact Assessment covering Protective Monitoring** **Technical detail** Protective monitoring is an essential component of risk management. Various legislation and codes of practice including the Data Protection Act 1998, and ISO 27001/2 Information Security Management Systems impose a duty on Aberdeen City Council to protect its information assets and to provide the assurances that appropriate controls are in place. It is recommended in a number of regulatory and industry best practices, such as the Payment Card Industry Data Security Standard (PCI DSS) and Cyber Security Essentials. It is also a requirement for connection to the Public Services Network (PSN). This assessment covers the monitoring and auditing of staff activity as a means of ensuring information security and ensuring that all staff comply with Council Policies and Procedures and the standards of behaviour expected by Aberdeen City Council. **Related Policy Document Suite** Policy and Strategy • ICT Acceptable Use Policy • Employee Code of Conduct • Councillor Code of Conduct • Protective Monitoring Policy (Hyperlink when on the Zone) Procedures • Access to Information Procedure (Hyperlink when on the Zone) Assessments • Protective Monitoring Privacy Impact Assessment (Hyperlink when on the Zone) **Related Legislation and Supporting Documents** Acts • The Data Protection Act (1998) Requires that processing of personal data is done so lawfully and fairly, is used for limited specifically stated purposes and used in way that is adequate, relevant and not excessive. • General Data Protection Regulation From 25th May 2018, this replaces the Data Protection Act (1998) and requires the Council to process personal data lawfully, fairly and transparently, and requires the Council to secure the personal data it

holds. The GDPR is designed to enable individuals to better control their personal data. Penalties for breaches are more severe than under the 1998 Act.

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- PSN
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Regulations

- PCI DSS
  The Council is required to meet this standard in order to take card payments.

Best Practice Guides

- National Cyber Security Centre (NCSC) Good Practice Guide 13 - Protective Monitoring (GPG 13)
  Provides advice on good practice to help meet Protective Monitoring obligations.

- Information Commissioner's Employment Practices Code; Part 3 Monitoring at Work.
- Aims to strike a balance between the legitimate expectations of workers and the legitimate interests of employers.

Assessor	**Norman Hogg** **(Security Architect)**	Date of assessment	**25/09/17**	Date of reassessment	

Existing safety measures and assets at risk.	**Existing Measures:** This assessment is measured against the impact on individual rights and the risk to the business based on existing controls in place (which will include Protective Monitoring Policy, Protective Monitoring Privacy Impact Assessment and Access to Information Procedure when approved) ***to be removed from document once approved*** **Assets at risk:** Data. Corporate network. Reputation. Individual Rights.

Approver Signature>	**Steven Robertson** **(SIRO)** *	Date of approval/ rejection	**XX/XX/17**	Date of re-approval	

Decision	**Accept assessment**	
	Reject assessment	

SCORING SYSTEM

Severity	Likelihood of occurrence
5 = Very high	5 = Very high
4 = High	4 = Likely
3 = Moderate	3 = Quite possible
2 = Slight	2 = Possible
1 = Nil	1 = Not likely

Risk rating = Severity x Likelihood.

>10 requires risk acceptance, risk reduction, risk avoidance, risk transference.

Hazard Type

	Risk to Individuals if Monitoring In place				Risk to Business if Monitoring In place			
Hazard Type	**Severity**	**Likelihood**	**Risk Rating**	**Without Monitoring**	**Severity**	**Likelihood**	**Risk Rating**	**Without Monitoring**
1. Monitoring is excessive as most activity is recorded. Risk of accessing personal information.	4	2	8	1	3	2	6	15
2. Violation of rights and liberties. Risk of breaching legislation.	4	2	8	25	3	2	6	25
3. Monitoring is intrusive. Prevents staff performing duties, mistrust.	3	2	6	1	3	2	6	1
4. Passwords and other Personal information may be captured.	3	2	6	20	3	2	6	20
5. Staff are unaware of policy or procedure.	3	3	9	25	3	3	9	25
6. Policy and procedure are inadequate.	4	2	6	25	4	2	8	25
7. Access to logged information is not controlled.	4	2	8	1	4	2	8	20
8. False positive information leads to investigation.	3	2	6	1	3	2	6	16
9. Inability to perform job functions due to Emails or Internet sites being blocked.	2	2	4	1	2	2	4	25

PROPOSED ACTION

In order to ensure appropriate risks and mitigations were identified for this document, consultation and review took place as follows:

Security Architect
Performance and Risk Manager
Infrastructure Architect
Security Analyst x 2
HR Team Leader
Solicitor
Best practice guides
Web Resources
Government Guidelines

Results of Analysis:

	Risk to Individuals if Monitoring In place				Risk to Business if Monitoring In place			
Hazard Type	**Severity**	**Likelihood**	**Risk Rating**	**Without Monitoring**	**Severity**	**Likelihood**	**Risk Rating**	**Without Monitoring**
1. Monitoring is excessive as most activity is recorded. Risk of accessing personal information.	4	2	8	1	3	2	6	15

'The Data Protection Act does not prevent employers from monitoring workers, but where monitoring involves the collection, storage and use of personal information, it must be neither routine nor excessive'

In order to protect both the organisation and the individual it is important that we have both comprehensive and accurate records. Without these records assumptions rather than conclusions can be drawn and evidence of actual facts will be minimal. Without adequate records the business may breach legislation.

Monitoring significantly reduces the risk of the businesses information being compromised.

Please reference the '*Protective Monitoring Privacy Impact Assessment*' (Hyperlink when on Zone) – 'Scope of Monitoring', 'Alternatives to Monitoring' and 'Justification for Monitoring sections'.

	Risk to Individuals if Monitoring In place				Risk to Business if Monitoring In place			
Hazard Type	**Severity**	**Likelihood**	**Risk Rating**	**Without Monitoring**	**Severity**	**Likelihood**	**Risk Rating**	**Without Monitoring**
2. Violation of rights and liberties. Risk of breaching legislation.	4	2	8	25	3	2	6	25

PROPOSED ACTION

A balance must be found between what is monitored and the rights of the individual. To this end:

The majority of monitoring and threat prevention is automated by technology and detailed information is not viewed.

Although certain activities are logged these would only be accessed as part of an investigation.

Where information does have to be viewed it is done so in a controlled manor and only to the level required.

The two main areas where such visibility may take place are with Internet traffic and Email.

Internet traffic: Blocks are in force against sites that are identified as high risk, reports are generated which show attempted access to those sites. Patterns or excessive activity can indicate an infected device, a compromised device or deliberate action by an individual to bypass security measures. In the case of the individual, only where such activity is significantly out of the ordinary and with documented authority will any further investigation take place.

Email: Email containing certain attachments such as executables or compressed Zip files will be quarantined. These are key routes for compromise as they often contain hidden malware. Manual intervention is required before releasing to the recipient.

Monitoring significantly reduces the risk of an individual's information being compromised.
Monitoring significantly reduces the risk of the businesses information being compromised.

Please reference the '*Protective Monitoring Privacy Impact Assessment*' (Hyperlink when on Zone) – 'Scope of Monitoring', 'Justification for Monitoring sections'.

	Risk to Individuals if Monitoring In place				Risk to Business if Monitoring In place			
Hazard Type	**Severity**	**Likelihood**	**Risk Rating**	**Without Monitoring**	**Severity**	**Likelihood**	**Risk Rating**	**Without Monitoring**
3. Monitoring is intrusive. Prevents staff performing duties, mistrust.	3	2	6	1	3	2	6	1

Monitoring is only mildly intrusive. It is transparent to the end user most of the time and normally only becomes apparent when an individual is blocked from accessing a website.
There is no risk associated with this hazard if we do not monitor.

Monitoring adds a low risk for both individuals and the business.

Please reference the '*Protective Monitoring Privacy Impact Assessment*' (Hyperlink when on Zone) – 'Scope of Monitoring', 'Justification for Monitoring sections'.

	Risk to Individuals if Monitoring In place		Risk to Business if Monitoring In place	

PROPOSED ACTION

Hazard Type	Severity	Likelihood	Risk Rating	Without Monitoring	Severity	Likelihood	Risk Rating	Without Monitoring
4. Passwords and other Personal information may be captured.	3	2	6	20	3	2	6	20

Protective Monitoring protects both the business and the individual. Passwords and Personal Information are never targeted for capture, however if such information is sent externally, unencrypted in an Email the Email system will hold a copy unless it is deleted from the senders 'Sent Items' folder.

Protective Monitoring plays a major role in preventing an individual from inadvertently giving such information to a fraudulent actor. For example:

- Many spam and phishing emails are prevented from entering the organisation.
- Individuals are prevented from accessing known websites which are fraudulent, contain malware or that have been compromised.
- Where an individual clicks a fraudulent link or file in an Email, protection measures help prevent the link activating or the file being run.

Monitoring significantly reduces the risk of an individual's information being compromised.
Monitoring significantly reduces the risk of the businesses information being compromised.

	Risk to Individuals if Monitoring In place				Risk to Business if Monitoring In place			
Hazard Type	Severity	Likelihood	Risk Rating	Without Monitoring	Severity	Likelihood	Risk Rating	Without Monitoring
5. Staff are unaware of policy or procedure.	3	3	9	25	3	3	9	25

The following documents will be available on the Zone:

- ICT Acceptable Use Policy (Hyperlink when on Zone)
- Protective Monitoring Policy (Hyperlink when on Zone)
- Protective Monitoring Privacy Impact Assessment (Hyperlink when on Zone)
- Protective Monitoring Risk Assessment
- Access to Information Procedure (Hyperlink when on Zone)
- Access to Information Form (Hyperlink when on Zone)

In addition:

- All staff with management responsibility will be advised of the Access to Information Procedure.
- All IT staff will be advised of the Access to Information Procedure.

There are many policies and procedures in use across the business and it is unrealistic to believe that everyone will know all the policies and procedures. Everyone should know however where to find them when they need to reference them.

PROPOSED ACTION

Policies and Procedures significantly reduce the risk of an individual's information being compromised.
Policies and Procedures significantly reduce the risk of the businesses information being compromised.

	Risk to Individuals if Monitoring In place				Risk to Business if Monitoring In place			
Hazard Type	**Severity**	**Likelihood**	**Risk Rating**	**Without Monitoring**	**Severity**	**Likelihood**	**Risk Rating**	**Without Monitoring**
6. Policy and procedure are inadequate.	4	2	6	25	4	2	8	25

It is an almost impossible task to have Policy, Procedure and Assessments that document all conceivable eventualities. Such documents need to be able to cover the majority of circumstances but should not be considered as all-encompassing.

The Protective Monitoring suite of documents have had input from and been reviewed by:

- IT and Transformation
- Human Resources and Customer Service
- Legal and Democratic Services
- Unions
- Aberdeen City Council Finance, Policy and Resources Committee

Policies and Procedures significantly reduce the risk of an individual's information being compromised.
Policies and Procedures significantly reduce the risk of the businesses information being compromised.

	Risk to Individuals if Monitoring In place				Risk to Business if Monitoring In place			
Hazard Type	**Severity**	**Likelihood**	**Risk Rating**	**Without Monitoring**	**Severity**	**Likelihood**	**Risk Rating**	**Without Monitoring**
7. Access to logged information is not controlled.	4	2	8	1	4	2	8	20

Access to such information is restricted to key staff. Access cannot be obtained via standard user accounts and requires authenticated administrative privileges. Out with this, if information is requested due to a security incident or as part of an investigation then the 'Access to Information Procedure' (Hyperlink when on Zone) shall apply.

Logging/Auditing of administrator access is in place.

Monitoring significantly reduces the risk of the businesses information being compromised.

PROPOSED ACTION

Hazard Type	Risk to Individuals if Monitoring In place: Severity	Likelihood	Risk Rating	Without Monitoring	Risk to Business if Monitoring In place: Severity	Likelihood	Risk Rating	Without Monitoring
8. False positive information leads to investigation.	3	2	6	1	3	2	6	16

Most of the monitoring and preventative measures are automatic and in the majority of cases detail is never seen by human eyes. High level trending statistics may be generated for inclusion in reports.

Where our systems do flag up activity of potential concern these are in most cases not due to activity by individuals.

In the course of their duties, Security Analysts may come across patterns of traffic or information that requires further analysis. A high level but focussed look at the patterns may take place and may identify individuals. In most cases the activity is either not due to the individual or is not deliberate or persistent activity by the individual and requires no further investigation.

Where it is deemed further investigation is required the 'Access to Information Procedure' (Hyperlink when on Zone) will be followed.

There is significant risk to the business of instigating false investigations if we did not have the evidence to back up any claims.

Hazard Type	Risk to Individuals if Monitoring In place: Severity	Likelihood	Risk Rating	Without Monitoring	Risk to Business if Monitoring In place: Severity	Likelihood	Risk Rating	Without Monitoring
9. Inability to perform job functions due to Emails or Internet sites being blocked.	2	2	4	1	2	2	4	25

The blocking of Email or Internet sites should not have an impact on job functions. These are blocked due to the risk they pose to the business or the individual and could have a major impact on the job function if not blocked. Where a particular job role requires that a normally blocked site be open then this can be accommodated on a per user basis where there is a business case and with authorisation.

There is significant risk to the business if restrictions are not put in place.

PROPOSED ACTION

Protective Monitoring
Access to Information Procedure

Owner:	Security Architect
Author:	Norman Hogg
Creation Date:	October 2017
Review Date:	October

Document Status:
Draft

Scope

What is this procedure for?

This procedure is to be followed for requesting access to any information Aberdeen City Council collects as part of Protective Monitoring. This is a high-level procedure which covers:

The circumstances under which access may be granted to accounts or to information in relation to account or network activity.

- The procedure which must be followed when requesting such access.
- The procedure to be followed by ICT staff to fulfil that access.

Who is this procedure for?

This procedure is of importance to all staff, agency workers, elected members, contractors and sub-contractors, and to any person, without exception, who uses or requires access to the Aberdeen City Council Information Technology, Data Assets or associated Infrastructure.

This procedure applies to, and is of particular importance for:

- Anyone who has management responsibilities.
- Anyone who is leading an investigation.

- All ICT staff.

- **If you believe an investigation is likely to result in criminal charges then further advice must be sought. If in the process of an investigation this becomes the case the investigation must immediately stop, and further advice sought. Failure to do so may prevent such charges being brought.**

- **It is important that only the information necessary to any investigation is requested.**

- **Information obtained or supplied must be treated as OFFICIAL SENSITVE [PERSONAL] and held securely (e.g. password protected) so that it cannot be accessed by others.**

Information Request

A request for access to an account or for information in relation to account or network activity may be received from a manager, Chief Officer, the fraud team or official sources e.g. the police. In all cases a strict process and procedure **must** be followed so that the appropriate audit trail and evidence of authorisation can be maintained.

Any request must be justified under the principles of current Data Protection legislation. In summary, they must be:

Lawful. Access must be for legitimate and lawful reasons.

Justified. There must be reasonable suspicion of wrongdoing, not a "fishing" exercise.

Proportionate. The information requested should be proportionate to the seriousness of the suspected wrongdoing.

Necessary. Only information that is actually required should be requested. Access to that information should be the only means available of gathering evidence required for the investigation.

Examples of possible reasons for request:

- Suspected Emailing of confidential information to external or unauthorized addresses.
- As part of an ongoing investigation.
- Suspicion of unlawful activities.
- Suspected breach of the ICT Acceptable Use Policy.

Where the information is being sought in relation to an individual's actions, the individual should in most cases be informed. A failure to do so may contravene the Data Protection and Human Rights acts and you must therefore liaise with an HR adviser in these situations.

There are specific exemptions within the Data Protection Act 1998 and General Data Protection Regulation (GDPR) for not informing the individual if it is in relation to 'the prevention or detection of crime'. It is advised that you liaise with an HR adviser who

will in turn involve the Fraud team and/or Legal and Democratic services colleagues where applicable and appropriate.

Where the Police or other external body requests access to information, specific Data Protection exemptions may also be considered. The Police will send in a completed exemption form, which will be retained for the audit trail. In all cases where an external body requests information this should be handled as a 'Third Party Request for Personal Information'. See Corporate Data Protection Policy

In performance of their duties, ICT security personnel may come across situations of concern regarding an individual. These concerns shall be relayed to the appropriate management or authority. Further analysis must not take place without instruction and approval of said management or authority. In all cases this procedure **must** be followed so that an appropriate audit trail and evidence of authorisation can be maintained.

Where a request concerns a staff member, all such requests **must** be authorised by the Chief Officer or their delegated authority and an HR advisor. Where the Chief Officer is the requester then the Senior Information Risk Owner (SIRO) or their delegated authority **must** authorise the request. Where the SIRO themselves are requesting information then the Chief Executive or delegated authority must also authorise the request.

Where the request concerns a non-staff member such as an elected member, partner organization or third party, all such requests require authorisation by the Senior Information Risk Owner (SIRO) or their delegated authority and the Chief Executive.

In all cases someone more senior than the requester **must** authorise the request.

Information requested may include:

- Browsing history (in depth analysis which may include e.g. links clicked within sites, bandwidth usage, files uploaded/downloaded)
- Email history (this may include e.g. access to logs, access to Emails)
- Access history (this may include access to e.g. logs, audit trails)

Requester Procedure

- When requesting information, the requester must ensure that they are doing so with respect to current Data Protection legislation. If in doubt further advice should be sought from their Chief Officer, IT, or Legal team.

- The requester should log a ServiceNow call either directly or after discussion with an IT Manager or the IT Security Team. This call should contain **minimal** information stating only that it is a request for access for "activity information regarding a member of their team". Details of the person being investigated or the reasons behind the request **should not** be included.

- A Security Team member will send an "Activity Report Request Form(Hyperlink when on Zone)" for completion. This form should be completed giving enough detail as to what information is required and why. The form should be authorised as appropriate (Chief Officer, SIRO, Chief Executive, DPO, HR advisor).

- Completed forms should be scanned and Emailed, hand delivered or sent via internal mail back to the Security team member dealing with the request. If

internal mail is used, please ensure it is in a sealed envelope and marked OFFICIAL SENSITIVE [PERSONAL].

- The Security Team member will then acknowledge receipt to the requester and the authoriser and commence with the request.

- It is the responsibility of the requester to handle any information provided with Data Protection in mind. This may include password protecting information or redaction.

ICT Procedure

- A request coming from any source is logged as a call in ServiceNow under the Security Team. This call should contain minimal information stating only that it is a request for access to "activity information regarding a member of their team". Details of the person being investigated or the reasons behind the request **should not** be included.

- The Security Team will add the ServiceNow reference number to - and send an "Activity Report Request Form" to the requester. The Security Team will update the ServiceNow call stating that this has been done.

- On return of the form the Security Team shall check that adequate information has been supplied to allow the request to proceed and update the ServiceNow call. If adequate information has not been supplied advice should be given and the form sent back for completion. Should the Security Team have any concerns regarding the information requested or the reasons for access then they should challenge and seek further authority if deemed necessary. All actions should be referenced in the ServiceNow call.

- The Security Team **must** ensure that the form request has been authorised appropriately, (Chief Officer, SIRO, Chief Executive, DPO, HR advisor).

- On completion of the paperwork and authorisation the Security Team shall:

    - Scan the form and file the document securely.
    - Send an acknowledgement Email to the requester the authoriser and the HR Advisor if required acknowledging receipt and approval to proceed with investigation.
    - Fulfil the request.

- The information should be treated as sensitive and the following should apply:

    - Where possible mark all documents with OFFICIAL SENSITIVE [PERSONAL] in the document header or on the title page.

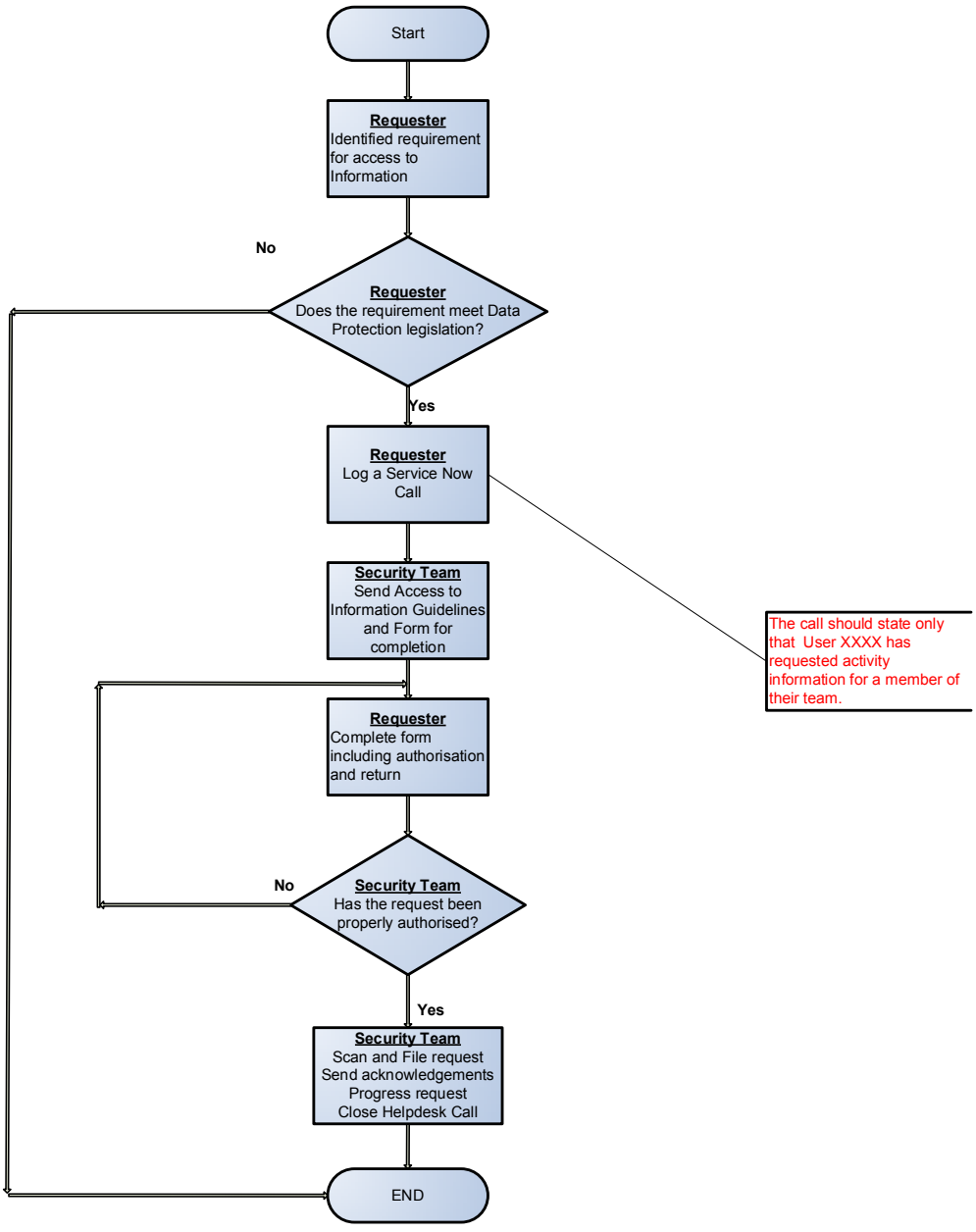
    - Where there are numerous documents, or you are unable to do this the folder containing the documents should have the words OFFICIAL SENSITIVE in the name.

    - Where possible information and documents should be sent password protected or in a password protected Zip file.

- On completion of the Investigation the Security Team should ensure any changes to permissions are reset then update and close the ServiceNow call.

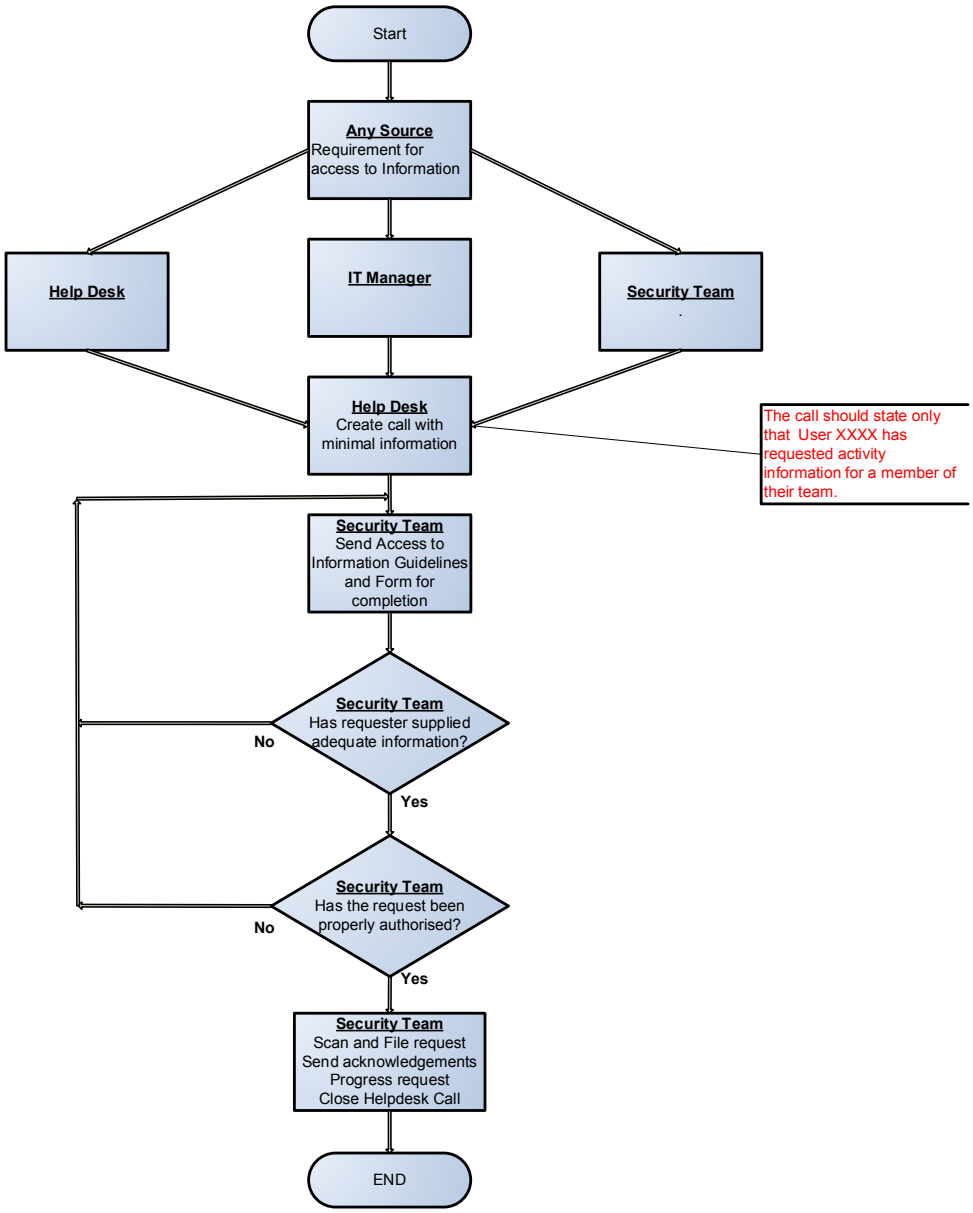
Access to Information
REQUESTER Workflow

Date Last Updated: 06/10/2017
Review Date: Annually
Process Owner: Security Architect



Access to Information
ICT Workflow

Date Last Updated: 06/10/2017
Review Date: Annually
Process Owner: Security Architect



Related Policy Document Suite

Policy and Strategy

- ICT Acceptable Use Policy
- Employee Code of Conduct
- Councillor Code of Conduct
- Protective Monitoring Policy (Hyperlink when on Zone)

Forms

- Access to Information Guide and Form (Hyperlink when on the Zone)

Assessments

- Protective Monitoring Privacy Impact Assessment (Hyperlink when on the Zone)
- Protective Monitoring Risk Assessment (Hyperlink when on the Zone)

Related Legislation and Supporting Documents

Acts

- The Data Protection Act (1998)
  Requires that processing of personal data is done so lawfully and fairly, is used for limited specifically stated purposes and used in way that is adequate, relevant and not excessive.

- General Data Protection Regulation
  From 25th May 2018, this replaces the Data Protection Act (1998) and requires the Council to process personal data lawfully, fairly and transparently, and requires the Council to secure the personal data it holds. The GDPR is designed to enable individuals to better control their personal data. Penalties for breaches are more severe than under the 1998 Act.

- The Computer Misuse Act (1990)
  Disallows unauthorised access or acts in relation to computer systems, data or materials.

- The Copyright, Designs and Patents Act (1988)
  Protects the rights of creators to control the ways in which their materials are used. There is a duty on the Council to prevent breaches of Copyright.

- The Health & Safety at Work Act (1974)
  Protects the health, including mental health of their employees.

- The Human Rights Act (1998)
  The right to respect for family and private life, home and correspondence. This right is not absolute and must be balanced with the need of the Council to protect its information.

- Telecommunications (Lawful Business Practices) (Interception of Communications) Regulations 2000 (LBPR).
  Allows interception of communications by businesses on their own telecommunications networks, for instance, to detect employee-mail abuse or to record telephone conversations to evidence transactions.

Related Standards

- ISO27001/2

A framework of policies and procedures that includes all legal, physical and technical controls.

- PSN
  A public services shared information and communications infrastructure for which we need to remain compliant.

Regulations

- PCI DSS
  The Council is required to meet this standard in order to take card payments.

Best Practice Guides

- National Cyber Security Centre (NCSC) Good Practice Guide 13 - Protective Monitoring (GPG 13)
  Provides advice on good practice to help meet Protective Monitoring obligations.

- Information Commissioner's Employment Practices Code; Part 3 Monitoring at Work.
  Aims to strike a balance between the legitimate expectations of workers and the legitimate interests of employers.

Access to Information Guide and Form

Owner:	Security Architect
Author:	Norman Hogg
Creation Date:	October 2017
Review Date:	October

Document Status:
Draft

Scope

This is a high-level guideline and request form for managers to request access to information for investigatory purposes. Please familiarise yourself with the Protective Monitoring Access to Information Procedure (Hyperlink when on Zone) before completion.

- **If you believe an investigation is likely to result in criminal charges then further advice must be sought. If in the process of an investigation this becomes the case the investigation must immediately stop, and further advice sought. Failure to do so may prevent such charges being brought.**
- **It is important that only the information necessary to any investigation is requested.**
- **Information obtained or supplied must be treated as OFFICIAL SENSITVE [PERSONAL] and held securely (e.g. password protected) so it cannot be accessed by others.**

- This form is for requesting access to any information Aberdeen City Council collects as part of Protective Monitoring
- Where request concerns a staff member, all such requests require authorisation by the Chief Officer and an HR advisor. Where the Chief Officer is the requester then the Senior Information Risk Owner (SIRO) must authorise the request. In all cases someone more senior than the requester **must** authorise the request.
- Where the request concerns a non-staff member all such requests require authorisation by the Senior Information Risk Owner (SIRO) and the Chief Executive.

- Any request must be justified under the principles of current Data Protection legislation. In summary, they must be:

Lawful	Access must be for legitimate and lawful reasons.
Justified	There must be reasonable suspicion of wrongdoing, not just a "fishing" exercise.
Proportionate	The information requested should be proportionate to the seriousness of the suspected wrongdoing.
Necessary	Only information that is actually required should be requested. Access to that information should be the only means available of gathering evidence required for the investigation.

- Information requested may include:
  - Browsing history (in-depth analysis which may include links clicked within sites, bandwidth usage, files uploaded/downloaded, etc.)
  - Email history (this may include access to logs, access to Emails, etc.)
  - Access history (this may include access to logs, audit trails, etc.)

Related Policy Document Suite

Policy and Strategy

- ICT Acceptable Use Policy
- Employee Code of Conduct
- Councillor Code of Conduct
- Protective Monitoring Policy (Hyperlink when on the Zone)

Procedures

- Access to Information Procedure (Hyperlink when on the Zone)

Assessments

- Protective Monitoring Privacy Impact Assessment (Hyperlink when on the Zone)
- Protective Monitoring Risk Assessment (Hyperlink when on the Zone)

Related Legislation and Supporting Documents

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  Aims to strike a balance between the legitimate expectations of workers and the legitimate interests of employers.

Activity Report Request

ServiceNow Reference:	

Access requested to:	**Please tick**
Browsing history	☐
Email history	☐
Access history	☐
Other (please specify)	☐

Details of Request	
Name of Accounts Under Investigation	
PC/Laptop number	
ACC employment status	
Reason(s) for Request – what is the trigger for investigation? Access to account information and/or activity requires a justifiable trigger and should not be requested without sufficient probable cause, 'not a fishing expedition'.	
Why do you believe your requested access is legitimate? Do you have reasonable grounds for investigation?	
Explain why access to information is necessary? (are there any other ways of investigating?)	
Explain why access to information is proportionate? (i.e. level of investigation justifies intrusion)	

Details of Information Requested	
Information Required	
Period to be reported	
Data to be made available to	
Request made by	
Position	
Signed	
Date	

Authorisation by Chief Officer or SIRO	
Request	Approved ☐ Denied ☐
Name	
Position	
Signed	
Date	
Comments	

HR Advisor consulted	
Name	
Position	
Signed	
Date	
Comments	

All authorised forms should be scanned and Emailed back to the sender, delivered by hand or returned in a sealed envelope marked OFFICIAL SENSITIVE [PERSONAL] to:

Security Team, IT & Transformation, Business Hub 17, 3rd Floor North, Marischal College, Broad Street, Aberdeen, AB10 1AB

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ABERDEEN CITY COUNCIL

COMMITTEE	Audit Risk and Scrutiny
DATE	8th May 2018
REPORT TITLE	Scottish Public Services Ombudsman Decisions and Inspector of Crematoria Complaint Decisions
REPORT NUMBER	CUS/18/006
DIRECTOR	Andy MacDonald
REPORT AUTHOR	Lucy McKenzie
TERMS OF REFERENCE	6.9

1. PURPOSE OF REPORT

1.1 This report provides information on all Scottish Public Services Ombudsman (SPSO) and Inspector of Crematoria decisions made in relation to Aberdeen City Council since the last reporting cycle to provide assurance to Committee that complaints and Scottish Welfare Fund applications are being handled appropriately.

2. RECOMMENDATION(S)

2.1 It is recommended that Committee notes the details of the report.

3. BACKGROUND

3.1 A report detailing all Scottish Public Services Ombudsman (SPSO) and/or Inspector of Crematoria decisions relating to Aberdeen City Council is submitted to Audit Risk and Scrutiny Committee each reporting cycle. This is to provide assurance that complaints and Scottish Welfare Fund decisions are being handled appropriately. The last report on this matter was submitted to the 22 February 2018 Committee.

Scottish Public Services Ombudsman (SPSO) Complaint Decisions

3.2 The Scottish Complaints Handling Procedure (CHP) followed by Aberdeen City Council is outlined by the SPSO. Details of the CHP can be accessed at www.aberdeencity.gov.uk/complaints

3.3 There is one SPSO decision relating to Aberdeen City Council complaints to notify the Committee of. The complaint was not upheld by the SPSO. Please refer to Appendix A for further information.

Scottish Public Services Ombudsman (SPSO) Scottish Welfare Fund Review Decisions

3.4 The Scottish Welfare Fund is delivered by Local Councils across Scotland and offers 2 types of grants – Crisis Grants and Community Care Grants. Further information is available at https://www.aberdeencity.gov.uk/services/benefits-and-advice/apply-scottish-welfare-fund

3.5 Since the last reporting period, the SPSO has carried out one Second Tier Review in relation to Aberdeen City Council Scottish Welfare Fund application decisions. The SPSO made the decision to not change the Council's original decision. Although the council's decision was unchanged, it was noted by the SPSO that there had been a misinterpretation of guidance during the decision making process. The SPSO also provided additional feedback including the suggestion to consider adopting a decision making template. Please refer to Appendix B for further information.

Inspector of Crematoria Decisions

3.6 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.

4. FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from the recommendations of this report.

5. LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from the recommendations of this report.

6. MANAGEMENT OF RISK

	Risk	Low (L), Medium (M), High (H)	Mitigation
Financial	Each time a complaint escalates it is more costly to the council then the previous stage due to the effort involved, therefore financially it is in the council's best interest to resolve complaints early	L	The complaint handling procedure encourages resolution at first point of contact whenever possible. The financial benefits of early resolution is highlighted to responding officers in

	in the process. There is also a risk that the council may be required to undertake additional actions as a result of an SPSO decision, including financial compensation.		training.
Legal	There are no legal risks associated with this report.	N/A	Not applicable
Employee	Staff morale may be lowered as a result of a negative outcome of a SPSO decision.	L	Whilst it is not pleasant to receive a complaint, officers are encouraged to view complaints in a positive light, as a learning point going forwards.
Customer	There is a risk to the council's relationship with customers if a complaint or a Scottish Welfare Fund application is not handled correctly.	L	Support in complaint handling is available to responding officers through a variety of methods. In addition, all Stage 2 responses are also quality assured to ensure that responses are appropriate. Officers responsible for Scottish Welfare Fund applications receive comprehensive training to ensure they have the necessary knowledge to undertake assessments.
Environment	There are no environmental risks associated with this report	N/A	Not applicable
Technology	There are no technological risks associated with this report.	N/A	Not applicable
Reputational	Compliance with the Complaints Handling Procedure is audited by Audit Scotland. Non-compliance carries reputational risk.	L	There is a centralised Customer Feedback Team responsible for ensuring that complaints are being handled consistently and appropriately across the council.

	Customer perception of the council could also be negatively impacted if complaints and Scottish Welfare Fund applications are not handled correctly.		

7. OUTCOMES

Local Outcome Improvement Plan Themes	
	Impact of Report
Prosperous People	The report provides assurances that people are supported appropriately when and if necessary.

Design Principles of Target Operating Model	
	Impact of Report
Customer Service Design	The report supports a focus on the delivery of customer centric services through the scrutiny of service delivery to customers. The organisation should look to solve the core issue which led to the complaint and learn from the outcome so to reduce the potential for more / similar complaints. This leads to an improvement in customer service delivery and a reduction in time spent on handling and investigating repeat complaints, which can be a lengthy process for those involved.
Organisational Design	The report focuses on complaints outcomes which provide rich customer insight for the organisation to act upon to help transform service delivery.
Governance	The report ensures transparency around complaint and Scottish Welfare Fund application handling and provides assurances that informed decisions are being made.
Workforce	The outcomes of SPSO decisions are fed back to the relevant staff. This includes both upheld and not upheld decisions to engage staff and ensure they are fully informed of outcomes. The 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.
Process Design	Processes may be redesigned as a result of lessons learnt from a complaint or an SPSO decision to better meet the needs of customers.
Technology	Complaints data can help to inform decisions around

	the use of technology as it provides insight into the customer experience of accessing services digitally.

8. IMPACT ASSESSMENTS

Assessment	Outcome
Equality & Human Rights Impact Assessment	Not required
Privacy Impact Assessment	Not required
Duty of Due Regard / Fairer Scotland Duty	Not applicable.

9. BACKGROUND PAPERS

N/A

10. APPENDICES (if applicable)

Appendix A – Complaint Details and Subsequent SPSO Recommendations
Appendix B - Scottish Welfare Fund SPSO Review Decisions

11. REPORT AUTHOR CONTACT DETAILS

Lucy McKenzie
LucyMcKenzie@aberdeencity.gov.uk
01224 346976

Appendix A - Complaint Details and Subsequent Recommendations

Complaint Received Date	SPSO Decision Date	Complaints Investigated by the SPSO	Directorate	SPSO Decision	SPSO Recommendations	Date Implemented
11 Jan 2017	2 Feb 2018	a) The council failed to comply with section 50(B)(4)(b) of the Local government (Scotland) Act 1973 in relation to item 4 of the minute of the local meeting of Aberdeen City Council on 6 October 2016. b) Council failed to comply with standing order 45(2)(v) in relation to item 4 of the minute of the meeting. c) Council unreasonably allowed costs to be introduced as material considerations in the determination of planning application 160276. d) Council unreasonably allowed the business case to be introduced as a material consideration in the determination of the application. e) Head of Legal and Democratic Services unreasonably refused to answer questions put to him in complainant's email.	Corporate Governance	Complaint not Upheld	Not applicable	Not applicable

Appendix B – Scottish Welfare Fund SPSO Review Decisions

Crisis Grant Application Received Date	Application Type	Aberdeen City Council 1st Tier Review Decision Date	SPSO 2nd Tier Review Decision Date	SPSO Decision	Additional SPSO Feedback	Date Implemented
1st February 2018	Crisis Grant	1st February 2018	6th February 2018	Aberdeen City Council decision upheld	Records of phone calls with the applicant were comprehensive and reflected good practice in decision making. However the council may wish to consider the introduction of a decision making template to make decision making notes clearer.	30th April 2018

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ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny
DATE	8 May 2018
REPORT TITLE	Inspection Report of Aberdeen Crematorium by the Inspector of Crematoria
REPORT NUMBER	OPE/18/012
DIRECTOR	Rob Polkinghorne
REPORT AUTHOR	Graham Keith
TERMS OF REFERENCE	6.9

1. PURPOSE OF REPORT

At its meeting on 1 November 2016, the Communities, Housing and Infrastructure Committee resolved to present resulting reports of audits of Aberdeen Crematorium to the Audit, Risk and Scrutiny Committee for assurance purposes. This report provides the Committee with the Inspector of Crematoria's Inspection Report carried out by the Inspector of Crematoria on 31 January 2018.

2. RECOMMENDATION(S)

That the Committee:-

2.1 notes the inspection report

3. BACKGROUND

3.1 On 1 November 2016, the Communities, Housing and Infrastructure Committee approved a suite of compliance measures with the aim of improving arrangements at the Aberdeen Crematorium. One of these assurance measures was that the Inspector of Crematoria's annual inspection report be presented to the Audit, Risk and Scrutiny Committee.

3.2 The Inspector of Crematoria's Inspection Report is attached as Appendix 1.

3.3 The Inspectors report refers to "plans being progressed as regards a major refurbishment of the building" and "this will include co-locating the administration office". The refurbishment of the chapels and public areas of the Crematorium is currently scheduled to begin at the end of May 2018 with the work expected to take 20 weeks. Cremations will continue to be carried out during this time but the chapels and public areas will be closed. Alternative arrangements for holding services are being investigated and these include the Beach Ballroom, the Winter Gardens at Duthie Park, Churches, Halls and other appropriate Council premises. The Bereavement

Services administration team are scheduled to relocate to Aberdeen Crematorium following the completion of the refurbishment work.

4. FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from the recommendations of this report.

5. LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from the recommendations of this report.

6. MANAGEMENT OF RISK

	Risk	Low (L), Medium (M), High (H)	Mitigation
Financial	None identified	L	Not applicable
Legal	None identified	L	Not applicable
Employee	None identified	L	Not applicable
Customer	None identified	L	Not applicable
Environment	None identified	L	Not applicable
Technology	None identified	L	Not applicable
Reputational	None identified	L	Not applicable

7. OUTCOMES

Local Outcome Improvement Plan Themes	
	Impact of Report
Prosperous People	People and communities are protected from harm

8. IMPACT ASSESSMENTS

Assessment	Outcome
Equality & Human Rights	Full EHRIA not required

Impact Assessment	
Privacy Impact Assessment	Not required
Children's Rights Impact Assessment/Duty of Due Regard	Not applicable

9. BACKGROUND PAPERS

Aberdeen City Council Report to Communities, Housing and Infrastructure Committee Aberdeen Crematorium Performance Indicators (CHI/16/251)
http://committees.aberdeencity.gov.uk/ieListDocuments.aspx?CId=503&MId=3877&Ver=4

10. APPENDICES (if applicable)

Appendix 1 - Inspection Report (Jan 2018) - Aberdeen Crematorium

11. REPORT AUTHOR CONTACT DETAILS

Graham Keith
gkeith@aberdeencity.gov.uk
Tel: 01224 387633

Appendix 1 - Inspection Report (Jan 2018) - Aberdeen Crematorium

Inspector of Crematoria Scotland
Robert Swanson QPM

Tel: 07817 014 508
Email: Robert.swanson@scotland.gsi.gov.uk

Inspection of Crematoria

Name and Address of Crematorium: Aberdeen Crematorium Skene Road Aberdeen	
Name of Cremation Authority: Aberdeen City Council	**Date of Inspection:** Wednesday 31st January 2018
Undertaken by: Robert Swanson QPM Inspector of Crematoria Scotland	**In the presence of:** Graham Keith Performance and Development Manager Angus Beacom Crematorium Manager

1. Operational Hours / Time Between services
Opening Hours: (as advertised) Monday to Friday – 0830hrs to 1630hrs Saturday - 0900hrs to 1200hrs
Time between services: 45 minutes with option of booking extended period.

2. Staffing levels and structure
Staff certificated to carry out cremations: 7 members of staff qualified to carry out cremations.

3. Office Management

Administration Procedure:
The majority of the administration and record keeping is currently carried out by Bereavement Services at Aberdeen Council Headquarters, however, as part of a refurbishment programme (to the Crematorium), the administration office will be relocated to the Crematorium.

Whilst the present arrangement works well, the move is welcomed by the Inspector for a number of reasons, including providing attendees (on Admin. matters) with much improved parking, and minimising the need for manual transfer of documentation.

The administration procedure and process was examined from point of first intimation to disposal of the ashes, and subsequent storage of documentation, with checks carried out on paperwork and computer records.

All were found to be of a high standard with much emphasis placed on ensuring compliance with the applicant's instructions.

Computer System:
BACAS

4. Total Number of Cremations Carried Out

Breakdown by category	**2016:**	**2017:**
Adult:	2410	2162
Under 1 yr:	19	2
1 – 16 yrs:	3	2
Stillbirth:	15	8
Pregnancy Loss: **Individual:** **Shared:**	 142 1360	 163 1343
Body Parts:	13	10

5. Cremation / Identity Card Process
The process and all related documentation was examined and demonstrated from point of arrival of the coffin, throughout all stages, including cremation, cooling, cremulation, storage and dispersal of the ashes, subsequent updating of computer records and storage of the documentation. All were found to be of a high standard with meticulous attention to detail, ensuring the process was fully in compliance with the instructions of the applicant, and with a number of safeguards to minimise the risk of human error resulting in the mislabelling of ashes.

6. Recovery of Ashes
Ashes were recovered from all cremations.

7. Ashes Policy (retain / scatter / inter / storage)
Details of process: There has been no change to the policy since the last Inspection. A check carried out on a dip sample of documentation found that the instructions of the applicant were complied with in all cases, with the disposal outcome clearly documented. Ashes awaiting disposal are stored in a secure room with clear identification and instructions affixed.

8. Cremators
Number of cremators: 4
Make (s): All FT
Size (s): All large

9. Sample of Cremation Register	
Category: Shared Pregnancy Loss **Cremation number:** F6092 **Result:** All documentation and records examined and found to be in order. The cremation was carried out on 8th September 2017, with the ashes scattered by Crematorium staff within the Garden of Remembrance at Hazlehead on 15th September 2017.	**Category:** Individual Pregnancy Loss **Cremation number:** F6124 **Result:** All documentation and records examined and found to be in order. The cremation was carried out on 21st November 2017, with the ashes scattered by Crematorium staff within the Garden of Remembrance at Hazlehead on 28th November 2017.
Category: Adult **Cremation number:** 149526 **Result:** All documentation and records examined and found to be in order. The cremation was carried out on 28th December 2017 with the ashes scattered by Crematorium staff within the Garden of Remembrance at Hazlehead on 4th January 2018.	**Category:** Adult **Cremation number:** 149648 **Result:** All documentation and records examined and found to be in order. The cremation was carried out on 12th January 2018 with the ashes collected by the applicant on 22nd January 2018.
Category: Adult **Cremation number:** 149733 **Result:** All documentation and records examined and found to be in order. The cremation was carried out on 23rd January 2018 with the ashes collected by the applicant on 25th January 2018.	

10. Use of Baby Tray
Number / Source: 4 - FT
When introduced: Re-introduced on 25th November 2013 with extended use applied on 23rd July 2014.

11. Pregnancy Loss Policy / Procedure
NHS / Shared: There has been no change to the policy since the last inspection. The Cremation Authority continue to have a contract/agreement with NHS Grampian for cremation of shared and individual pregnancy loss. Ashes from shared cremations are scattered 7 days after cremation. Ashes from individual pregnancy loss cremations are dispersed in accordance with the instructions of the applicant.

12. Metal Extraction
Policy: All metal extracts are sensitively re-cycled in accordance with the policy of the Cremation Authority, unless otherwise instructed by the applicant. There have been no issues in respect of any aspect of the process.

13. Code of Practice, Cremation Practice Guidance and Policy Statement (on website / displayed)
The inspection confirmed from observations, and examination of documentation and computer records that the Crematorium's procedures are fully in accordance with the Scottish Government Policy Statement on Infant Cremations. All staff have ready access to relevant hard copy documentation and are required to sign acknowledgement when seen. A number of key documents are prominently displayed within the Crematorium. The Cremation Authority website was seen to provide comprehensive information on relevant matters, with links to a number of associated reports.

14. General Observations

All public and private areas seen during the course of the inspection were found to be clean and tidy.

Since the last inspection there has been improved lighting to the car park, with plans being progressed as regards a major refurbishment of the building. As mentioned earlier this will include co-locating the administration office.

It is understood that a defibrillator will be made available on completion of the works.

Whilst it was noted that there had been a reduction in the number of cremations carried out in 2017, this is considered most likely to be due to the opening of a new Crematorium (Baldarroch) in Crathes, in May, 2016. Major road works around Aberdeen during this period are also likely to have had an impact.

15. Overall Assessment

The inspection found there to be no shortcomings in any aspect of the cremation process, with current management and staff to be commended for the high standards they have set and maintained in recent times.

They have overcome hurdles set by their predecessors and appear to have restored public confidence with regards current working practice.

During the course of the inspection the Inspector had the opportunity to speak with a young person, currently on work experience at the Crematorium. The unrestricted access (under supervision) given to that person highlights openness and willingness by the Cremation Authority to demonstrate that all activities conducted within the Crematorium are of the highest standard. Such a secondment or placement is regarded by the Inspector as good practice which should be considered by other Cremation Authorities..

Another area worthy of praise is the high level of regular audit and service updates provided by management, ensuring that high standards are maintained. It should be stressed that these strict measures are not standard throughout the industry.

Aberdeen Crematorium is currently (January 2018) experiencing a very busy winter period, with a significant increase in the number of cremations compared to previous years.

It is with great credit to staff that they are coping with this demand whilst maintaining the same high standards.

Staff clearly have a good working relationship with management and each other at the

Crematorium, which is reflected in their professional and welcoming approach to attendees.

In conclusion, the inspection found working practices and standards at Aberdeen Crematorium to be of a very high standard, with no areas of weakness or concern identified.

Signed: Robert Swanson QPM
Inspector of Crematoria Scotland

Date: 7th February 2018.

ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	8 May 2018
REPORT TITLE	Internal Audit Report AC1807– Aberdeen City Health and Social Care Partnership – Transformational Funding
REPORT NUMBER	IA/AC1807
DIRECTOR	N/A
REPORT AUTHOR	David Hughes
TERMS OF REFERENCE	2.2

1. PURPOSE OF REPORT

1.1 The purpose of this report is to present the outcome of an audit that was included in the Aberdeen City Health and Social Care Partnership Internal Audit plan for 2017/18.

2. RECOMMENDATION

2.1 It is recommended that the Committee notes this report.

3. BACKGROUND / MAIN ISSUES

3.1 The Aberdeen City Health and Social Care Partnership Audit and Performance Systems Committee agreed on 11 August 2016 that outputs from audits relating to the Partnership would be reported, for information, to the Audit Risk and Scrutiny Committee. The Audit and Performance Systems Committee subsequently decided that it wished to receive summary reports from Internal Audit rather than the full report.

3.2 The following summary relates to a review of Transformational Funding which was reported to the Audit and Performance Systems Committee on 2 March 2018. That Committee resolved to note the report.

4. SUMMARY OF INTERNAL AUDIT REPORT

4.1.1 Funding of over £33 million from the Scottish Government's Integrated Care and Delayed Discharge Funds has been earmarked for 2016/17 – 2018/19 to be used to transform the way services are delivered through the partnership of Aberdeen City Council and NHS Grampian in conjunction with Care Organisations in the independent and third sectors. A high level three-year £13.6 million Transformation Programme was approved by the Integrated Joint Board (IJB) at its first meeting on 26 April 2016.

Transformational funds are being used to deliver projects in six key areas which are central to the partnership's objectives including:

- Acute Care at Home;
- Supporting Self-Management of Long Term Conditions and Building Community Capacity;
- Modernising Primary and Community Care;
- Culture Change / Organisational Change;
- Strategic Commissioning and Development of Social Care; and
- Information and Communication Technology, Infrastructure, and Data Sharing.

4.1.2 The objective of this audit was to ensure appropriate governance is in place to manage delivery of funded projects and the use of transformational funds.

4.1.3 Officers have noted that the transformational project management process has been iterative, with improved and more efficient governance arrangements being developed as programme management capacity has increased and programmes have progressed. This was evident in the business cases and supporting documentation for projects reviewed by Internal Audit, which for earlier projects could have been more robust.

4.1.4 As a result of recommendations made in the Internal Audit report, management has now documented procedures and are developing an evaluation framework to better demonstrate project suitability, priority, interdependencies and programme progress.

4.1.5 The Strategic Commissioning Programme Board, one of three programme boards charged with governance over transformation, had not met by the time that the audit was completed, due to delays in recruiting key staff. There is a risk that this could jeopardise the timely delivery of the transformational projects which are within the remit of this Programme Board and it has been agreed that it will meet by the end of January 2018.

4.1.6 Detailed dashboards are presented to each of the Boards as appropriate but they do not indicate where there are interdependencies between projects either within a Board's remit or between them. Without this information there is a risk that any delays may impact on other projects without appropriate mitigating action being taken. For future projects a Transformation Programme Review Group has been established to identify such relationships between projects and programmes and the Service has agreed to ensure that interdependencies are clearly identified for the benefit of Programme Managers and Project Staff.

4.1.7 The Programme Dashboards contain £13.6 million of intended transformational projects as well as un-costed ideas for future consideration. Some projects relate to the provision of existing services or continuous improvement rather than to the costs of transforming these. This could detract from focus on the Programme's objective to transform

service delivery and funding mainstream activity from transformational funds is also unlikely to be sustainable. The Service has agreed to review the content of programme dashboards to ensure that effort and expenditure is focused on transformational projects.

4.1.8 Reports to Committee show that costs are not being included in programme dashboards timeously and is based on defrayed expenditure only. As a result, the reported spend figures gave a limited indication of committed spend. The Service has noted that new file sharing facilities have been implemented which have improved the efficiency of project finance monitoring and it has been agreed that the adoption of a commitment based accounting and reporting process will be considered to better reflect committed expenditure. The Service has also agreed to ensure that Committee reports provide sufficient detail of action, spend and progress to provide adequate assurance and enable challenge where necessary.

4.1.9 Management has given an assurance that all recommendations will be implemented by the end of March 2018.

5. FINANCIAL IMPLICATIONS

5.1 There are no direct financial implications arising from the recommendations of this report.

6. LEGAL IMPLICATIONS

6.1 There are no direct legal implications arising from the recommendations of this report.

7. MANAGEMENT OF RISK

7.1 The Internal Audit process considers risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are as detailed in the attached appendix.

8. OUTCOMES

8.1 There are no direct impacts, as a result of this report, in relation to the Local Outcome Improvement Plan Themes of Prosperous Economy, People or Place, or Enabling Technology, or on the Design Principles of the Target Operating Module.

8.2 However, Internal Audit plays a key role in providing assurance over, and helping to improve, the Council's framework of governance, risk management and control. These arrangements, put in place by the Council, help ensure that the Council achieves its strategic objectives in a well-managed and controlled environment.

9. IMPACT ASSESSMENTS

Assessment	Outcome
Equality & Human Rights Impact Assessment	An assessment is not required because the reason for this report is for Committee to review, discuss and comment on the outcome of an internal audit. As a result, there will be no differential impact, as a result of the proposals in this report, on people with protected characteristics.
Privacy Impact Assessment	Not required
Duty of Due Regard / Fairer Scotland Duty	Not applicable

10. REPORT AUTHOR DETAILS

David Hughes, Chief Internal Auditor
David.Hughes@aberdeenshire.gov.uk
(01467) 537861

ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	8 May 2018
REPORT TITLE	Internal Audit Report AC1812 – Financial Ledger
REPORT NUMBER	IA/AC1812
DIRECTOR	N/A
REPORT AUTHOR	David Hughes
TERMS OF REFERENCE	2.2

1. PURPOSE OF REPORT

1.1 The purpose of this report is to present the planned Internal Audit report on the Financial Ledger.

2. RECOMMENDATION

2.1 It is recommended that the Committee review, discuss and comment on the issues raised within this report and the attached appendix.

3. BACKGROUND / MAIN ISSUES

3.1 Internal Audit has completed the attached report which relates to an audit of the Financial Ledger.

4. FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from the recommendations of this report.

5. LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from the recommendations of this report.

6. MANAGEMENT OF RISK

6.1 The Internal Audit process considers risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are as detailed in the attached appendix.

7. OUTCOMES

7.1 There are no direct impacts, as a result of this report, in relation to the Local Outcome Improvement Plan Themes of Prosperous Economy, People or

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Privacy Impact Assessment	Not required
Duty of Due Regard / Fairer Scotland Duty	Not applicable

9. APPENDICES

9.1 Internal Audit report AC1712 – Financial Ledger.

10. REPORT AUTHOR DETAILS

David Hughes, Chief Internal Auditor
David.Hughes@aberdeenshire.gov.uk
(01467) 537861

ABERDEEN
CITY COUNCIL

Internal Audit Report

Finance

Financial Ledger System

Issued to:
Steven Whyte, Director of Resources
Sandra Buthlay, Interim Chief Officer - Finance
Fraser Bell, Chief Officer - Governance
Carol Smith, Accounting Manager
Graham Stubbins, Finance Manager (Systems)
External Audit

Date of Issue: March 2018 **Report No. AC1812**

EXECUTIVE SUMMARY

The Council utilises its financial ledger system for the Council's budget and accounting requirements. The annual system support and maintenance cost for the system is £90,000.

The objective of this audit was to consider whether appropriate control is being exercised over the system and that interfaces to and from other systems are accurate and properly controlled. In general, this was found to be the case, however recommendations have been made and agreed in relation to procurement; system access; data protection; timetabling; and, manual data input to the system.

1. INTRODUCTION

1.1 The Council utilises the Advanced Business Software and Solutions Limited (ABS) eFinancials v 5.0 financial ledger system for the Council's accounting requirements. The system is capable of reporting the Council's budgeted and actual financial position. A number of additional reporting tools are used in conjunction with eFinancials by budget holders and finance staff, including: Collaborative Planning; eAnalyser; and SAP Business Objects. Collaborative Planning is also used for budgeting and forecasting.

1.2 The annual system support and maintenance cost for eFinancials for 2017/18 is £90,000.

1.3 The objective of this audit was to consider whether appropriate control is being exercised over the system and that interfaces to and from other systems are accurate and properly controlled.

1.4 The factual accuracy of this report and action to be taken with regard to the recommendations made have been agreed with Carol Smith, Accounting Manager and Graham Stubbins, Finance Manager (Systems).

2. FINDINGS AND RECOMMENDATIONS

2.1 Written procedures and Training

2.1.1 Comprehensive and clear written procedures are available on the Zone on the use of eFinancials. These cover a number of areas including: screen navigation; financial codes; general ledger enquiries; journal input and journal reversals. Clear written procedures are also available on the use of eAnalyser, Business Objects and Collaborative Planning.

2.1.2 An online course on the use of eFinancials and eAnalyser is available on the Zone. The course is interactive, includes relevant screen shots and requires the user to correctly answer questions before progressing.

2.1.3 User Administration procedures are available within the eFinancials application on: adding an eAnalyser licence to a user profile; adding access rights to a role; adding a cost centre to a user profile, user session tracking, confirming and amending a user authority limit and how to reset a user password. Written procedures are also available within the Finance Systems Team (FST) on how to process interfaces.

2.2 System Supply and Maintenance

2.2.1 A software license, maintenance and support agreement was made between the Council and the supplier in November 1998, with a license for 150 users to use eFinancials. The agreement remains in force until terminated in writing by either party and has been amended three times since introduction.

2.2.2 In October 2006, professional services were procured from the supplier to implement the reporting tool software, Collaborative Planning. In August 2007, a contract change made eFinancials, eAnalyser, Collborative Planning and the web based journal upload software Xcel uploader available to unlimited Council users through a new license, at a cost of £117,000. A further contract change agreement was subsequently made in March 2012 by the supplier granting the following SAP Business Objects licenses at a cost of approximately £119,000, including installation:

Software	Licences
SAP Business Objects Enterprise professional for Query, Reporting, Analysis (User)	220 Named Users
Business Objects Webi	40 Named Users
Xcelsius Enterprise Interactive Viewing (User)	10 Named Users
SAP Business Objects Xcelsius Enterprise (Designer)	1 Named User

The FST maintains a list of staff using Business Objects licenses for monitoring purposes.

The 2012 Contract Change Agreement has not been signed by the Council nor by the supplier. This increases the risk of contractual disputes.

Recommendation
The Contract Change Agreement should be signed by the Council and the supplier of the financial ledger system.

Service Response / Action
Agreed.

Implementation Date	Responsible Officer	Grading
March 2018	Finance Manager (Systems)	Significant within audited area

2.2.3 The Procurement Reform (Scotland) Act 2014 requires contracting authorities to maintain a register of regulated procurements detailing the date of award; name of the contractor; the subject matter; the estimated value; the start date; the end date; and the duration the contract can be extended. The support and maintenance contract for the Financial Ledger System is absent from the Council's contract register.

Recommendation
The Contract Register should be updated to include the details of the Financial Ledger System support and maintenance contract.

Service Response / Action
Agreed.

Implementation Date	Responsible Officer	Grading
May 2018	Category Manager	Significant within audited area

2.2.4 The supplier of the financial ledger system has remained unchanged for approximately 19 years, on a rolling annually renewed contract. The annual support and maintenance cost of eFinancials is £90,000. The Council's Financial Regulations state it is a statutory duty for the Council to obtain best value and that all purchasing must comply with the Council's Procurement Regulations. Procurement Regulations and The Procurement (Scotland) Regulations 2016 require procurements over £50,000 to be adequately advertised to ensure open competition. The Council's Procurement Regulations also require procurements over £50,000 to be approved by Committee prior to being undertaken.

2.2.5 Finance took part in a recent "soft review" of financial ledger system availability and concluded that the system currently in use continues to provide the necessary functionality. However, it is important to demonstrate continuing value for money and, in this regard, the Service should consult with Commercial and Procurement Services to determine the best way of doing so and of complying with procurement legislation.

Recommendation
The Service should consult with Commercial and Procurement Services to ensure that best value can be demonstrated in continuing with the current system and that procurement legislation is complied with

Service Response / Action
Agreed.

Implementation Date	Responsible Officer	Grading
June 2018	Finance Manager (Systems)	Significant within audited area

2.2.6 Support for eFinancials is provided by the FST, IT, the software supplier, and the Council's Data Centre provider. Problems affecting the application, its interfaces, the databases or servers are referred, in the first instance, to IT. Where an issue cannot be resolved locally and relates to the servers it is referred to the Data Centre provider whilst those relating to the application, database and interfaces are raised with the software supplier. Details relating to open and closed support calls can be viewed on the supplier portal.

2.2.7 The Finance Manager stated that problems were experienced closing the Debtors system for period 8 with the process that began on 30 November not being complete until 2 December 2017. This problem has occurred previously and a call has been raised with the software supplier to investigate.

2.2.8 The FST receives weekly reports from ICT on the status of open eFinancials calls and details of those that have been closed in the previous week. One high priority call classed as 'awaiting user information' was raised in October 2016. This related to automating the process for transferring files for BACS transmission. The Finance Manager (Systems) advised that there used to be regular meetings with IT to discuss system performance issues such as these. The meetings have ceased meaning there is less awareness by the FST of how calls are progressing with IT.

Recommendation
Consideration should be given to reinstating meetings with IT to discuss system performance issues.

Service Response / Action
Agreed. A lift and shift review and planning meeting is to be held with IT and system owners. This will be considered at this meeting.

Implementation Date	Responsible Officer	Grading
February 2018	Finance Manager (Systems)	Important within audited area

2.2.9 The software supplier issues maintenance packs for system updates containing code and instructions on how to carry out the maintenance activity. The maintenance packs are reviewed by the FST and applied where possible. Where this is not possible, IT will be requested to apply the maintenance pack. Prior to maintenance packs being applied to the live system, they are tested by the System Owner. Software patches are recorded on a spreadsheet maintained by the FST which details when the patch was received, when it was tested, whether it resolved the problem and when the revised version of eFinancials went live.

2.2.10 The last system upgrade was in June 2017. The software supplier upgraded eFinancials to version 5.0 from version 4.1 at a cost of £35,675. IT assisted with this process by preparing servers, installing software, exporting data from the original database ready to be imported into the upgraded database and setting up database backups.

2.3 System Access

2.3.1 Access is granted to eFinancials by the FST on receipt of an authorised new user form, detailing the required access rights. Access rights of 'Enquiry', 'Input' and 'Training' are available for the eFinancials general ledger and 'Enquiry' and 'Training' for eAnalyser. The financial codes which the user can have access to must also be specified.

2.3.2 Access levels can be amended or removed on receipt of an authorised 'Amendments to eFinancials / eAnalyser Access' form. Access levels can be added or removed for enquiry and input as well as financial codes. Users who have left the Council are required to be notified to the FST using the form so that access to the financial system can be removed. It is not possible for the system to automatically remove access rights after a defined period of inactivity.

2.3.3 It is important that users are granted access to the financial system commensurate with their role, whilst simultaneously giving due consideration to segregation of duties. Guidance is unavailable to Third Tier Managers approving forms on what constitutes appropriate access for the purposes of authorising access forms.

Recommendation
Guidance should be made available to authorised signatories on what constitutes appropriate access to the financial ledger.

Service Response / Action
New user forms for eFinancials, PECOS and ICON are to be consolidated with choice of access for users being removed from the forms. The new form will require a description of why access to the system is required and the person's post details so that the FST can determine the appropriate access to be granted.

Implementation Date	Responsible Officer	Grading
April 2018	Finance Manager (Systems)	Important within audited area

2.3.4 A unique user ID and a temporary password, which must be changed when the user first logs in, are provided by the FST. The Council's ICT Acceptable Use Policy requires passwords used to protect systems and applications to be maintained securely and comply with current guidelines. The Corporate Information Management procedure requires passwords to be at least 8 characters long and contain a mixture of numbers, letters and special characters. eFinancials only requires a minimum of 6 characters and there is no requirement for a mixture of numbers, letters and special characters. Ensuring longer, complex passwords enhances the security over system access.

Recommendation
The Service should amend system password requirements in line with the Corporate Information Management procedure.

Service Response / Action
Agreed. Password requirements have been updated within eFinancials in line with the Corporate Information Management procedure.

Implementation Date	Responsible Officer	Grading
Implemented.	Finance Manager (Systems)	Important within audited area

2.3.5 Test and Train versions of eFinancials are available for testing software updates and training staff and these contain the same data as the live system up to the point at which they were last refreshed. The systems are subject to the same password controls as the live system.

2.3.6 Access to eFinancials is blocked after 3 incorrect password attempts. This was confirmed by Internal Audit. The system does not produce reports on multiple failed log-in attempts however the FST is required to be notified by the user by email for the user's password to be unlocked, and a temporary password, that has to be changed when first used, is emailed to the user.

2.3.7 The system automatically logs an audit trail of user activity which the user cannot amend or delete, however these logs are not monitored or reviewed. There are 7 superusers of eFinancials within the FST, who can add and amend access to the system. Superuser activities are not currently monitored or reported. This increases the risk of fraud and error.

Recommendation
Superuser activity should be regularly reviewed by a Finance officer outwith the Finance Systems team.

Service Response / Action
Agreed. The FST will investigate if an automated monthly BOXI report of superuser activity can be set up and sent to the Accounting Manager for review.

Implementation Date	Responsible Officer	Grading
April 2018	Finance Manager (Systems)	Significant within audited area

2.3.8 As at 15 December 2017 there were 680 active users on eFinancials. A sample of 5 new users since April 2017 was selected and each was supported by an authorised form and access rights were considered appropriate.

2.3.9 The FST receive reports of leavers from HR on a monthly basis and remove access to the system for any users who have left the Council. There were 7 eFinancials users who left the Council in October 2017. As at the 15 December 2017 the user account of 1 of these leavers was still active, increasing the risk of unauthorised access to the system.

Recommendation
Leavers' access to eFinancials should be deleted timeously.

Service Response / Action
Agreed. The FST has not been receiving leaver reports from HR recently. The Finance Manager (Systems) will investigate whether this can be reinstated for the purpose of removing leavers.

Implementation Date	Responsible Officer	Grading
May 2018	Finance Manager (Systems)	Important within audited area

2.4 Data Protection

2.4.1 The Council's Data Protection Policy requires all staff who process personal information to undertake specified Data Protection Training at the commencement of their employment and also to complete regular refresher training thereafter. The financial ledger system includes personal information including payroll details of employees and therefore staff with access to the system should be aware of how such confidential data is required to be treated to avoid financial penalties and reputational damage resulting from any inappropriate use or loss of data.

2.4.2 The Council has three Data Protection related training courses: 'Data Protection – Essentials', which focusses on Data Protection, the employee Induction, which covers core Council policies for new employees and 'For Your Eyes Only', focussed on Information Security.

2.4.3 A sample of 25 employees who have access to eFinancials was selected to ensure they have completed Data Protection Training:

- 6 employees in the sample have not completed Data Protection Essential Training or For Your Eyes Only Training.
- 3 employees have not completed refresher training since 2012 and 1 employee has not done so since 2013.

Recommendation
Data Protection training should be completed by all staff with access to the financial ledger system in line with the Council's Data Protection Policy.

Service Response / Action
Agreed. The new access form will seek confirmation that Data Protection has been completed before access is granted to the financial ledger system.

Implementation Date	Responsible Officer	Grading
July 2018	Finance Manager (Systems)	Significant within audited area

2.4.4 The software licence, maintenance and support agreement signed by the software supplier in November 1998 includes a Data Confidentiality agreement. This states that if, during servicing or upgrading the software, it becomes necessary to access the Council's data, the supplier undertakes to ensure that the data will not be conveyed or transmitted in any form, to any other person or organisation other than the duly authorised representative of the supplier, and that data will be treated as strictly confidential. This provides contractual assurance that software supplier staff will manage Council data appropriately.

2.5 Timetabling

2.5.1 Annual eFinancials timetables which detail the creditor, debtor, purchase order and ledger period closure dates, as well as the processing dates each period relate to, are published on the Zone. The timetable is maintained and updated by the FST with the current version last updated on the 13 December 2017. This version included closure dates up to the 28 February 2018.

2.5.2 Budget monitoring key dates are made available through the Financial Monitoring timetable published on the Zone. These include dates for budget holders to have updated Collaborative Planning with their most recent forecasts, deadlines for finance staff to update the ledger with accruals and prepayments, and reporting deadlines to Corporate Accounting, the Head of Finance, Service Management Teams and Corporate Management Team (CMT). The last timetable available is for 2016/17. This increases the risk that budget holders and Finance staff will be unaware of deadlines required to update the financial ledger.

Recommendation
A 2017/18 Financial Monitoring Timetable should be created and posted to the zone.

Service Response / Action
Agreed.

Implementation Date	Responsible Officer	Grading
Implemented	Finance Manager (Systems)	Significant within audited area

2.5.3 Comprehensive year end procedures have been posted on the Zone for the 2017/18 year end, which include schedules for Services to return to Finance by 23 March 2018, which are required for the preparation of the Annual Accounts. Schedules include the year end stock position and details of accruals and prepayments.

2.5.4 The FST does not have a timetable or a rota for tasks carried out by the team. This increases the risk that team members will be unable to carry out all key tasks to gain experience and also increases the risk that tasks will be omitted in error.

Recommendation		
A rota should be established within the FST, detailing deadlines for tasks completed by the team, responsible officers, and the date tasks have been completed.		
Service Response / Action		
Agreed. A review of FST duties is currently underway as part of the Target Operating Model. Responsibilities for FST tasks will be documented as a result of this process.		
Implementation Date	**Responsible Officer**	**Grading**
May 2018	Finance Manager (Systems)	Important within audited area

2.6 Interfaces and Reconciliations

2.6.1 System interfaces update the ledger with creditors, debtors and general ledger journal transactions. Creditor interfaces include: the payroll system, the Social Work case management system; the Education Maintenance Allowance and clothing grant databases; and the non-housing repairs system. Debtor interfaces include: the cash receipting system and the housing rents; music fees; hanging baskets; and property factoring systems. General ledger journal interfaces include journals uploaded via Xcel journal uploader; cash e-Returns and 'K-Batchs' which include Council Tax and Business Rates journals.

2.6.2 Interface files run overnight and are posted to a CLINK holding area within eFinancials. The system has a number of automated checks which identify failures for Systems Analysts in IT to take corrective action as required. Successful interfaces are sent to the Processing Team by IT for posting to eFinancials, with details of the batch name, date, net amount, VAT and number of transactions. In the case of creditor interfaces, system owners also send details of the interface batch, net amount, VAT and number of transactions. A reconciliation is then carried out by the Processing Team confirming the interface details, amount and number of transactions per the clink file, per ICT and per the System Owner (for creditors interfaces) agree. If these balance the interfaces are posted to the ledger by the Processing Team.

2.6.3 Duplicate interface uploads are recognised by eFinancials based on batch references and invoice numbers and are automatically rejected, with rejected transactions held in the CLINK holding area. System generated exception reports are produced for the batches containing rejected transactions. The Processing Team reviews these reports and rejected transactions are queried with System Owners who are required to investigate the query and inform the Processing Team if rejected transactions should be deleted or processed. Exception reports for low value VAT differences will not be queried with System Owners and instead be corrected by the FST. A sample of 10 exception reports was selected from April to December 2017 to ensure System Owners had been notified of the rejections for investigation where required. This was found to be the case and transactions were posted after making the necessary corrections or deleted as appropriate by the FST. As at 26 January 2018, the CLINK holding area contained no transactions that required to be cleared.

2.6.4 A sample of 15 interfaces from May to January 2018 was selected to ensure that reconciliations were completed by the Processing Team and posted in a timely manner. This was found to be the case.

2.7 Manual Data Input

2.7.1 Journals are used to make manual accounting adjustments in the financial ledger. On receipt of a journal voucher which is complete, balanced and adequately authorised, the

Processing Team will post the journal. A Journal Input manual is available on the Zone, providing clear instructions with screenshots on how to post a journal in eFinancials. A journal description is required, as is the period, amount and financial coding. Journal references are automatically generated by the system when the journal is saved. Journals cannot be posted until mandatory fields have been completed and the debits and credits balance. Whilst the instructions are clear, they were produced in May 2008 and do not describe the responsible officers for preparing, authorising and posting journals.

Recommendation
The Journal Input Manual should be updated to include details of the responsible officers for preparing, authorising and posting journals.

Service Response / Action
Agreed. The Journal Input manual is out of date and will be removed from the Zone. The current journal procedure will be documented including responsible officers.

Implementation Date	Responsible Officer	Grading
May 2018	Finance Manager (Systems)	Important within audited area

2.7.2 A sample of 30 journals was selected from between 31 March 2017 and 20 December 2017. These were checked to ensure that they were properly authorised, there was segregation of duties between preparer and authoriser, supporting documentation was present and the journals were input timeously and accurately by the FST.

2.7.3 Two payroll journals were prepared and authorised by the same person. It was also noted that financial code corrections were required for two journals due to approved journals including invalid financial codes. The subsequent amended journals were not authorised before being posted.

Recommendation
All journals should be approved by an authorised signatory.

Service Response / Action
Agreed. An instruction will be issued to payroll staff.

Implementation Date	Responsible Officer	Grading
April 2018	Finance Manager (Systems)	Significant within audited area

2.7.4 The period a journal should be posted to is recorded on the journal voucher sent to the Processing Team. Requests to post journals to closed ledger periods are referred to the FST who review the journal and determine whether it is reasonable to backpost it. There is no procedure for determining whether journals should be backposted.

Recommendation
A procedure should be prepared of acceptable reasons for re-opening closed ledger periods and shared with Finance staff.

Service Response / Action
Agreed.

Implementation Date	Responsible Officer	Grading
April 2018	Finance Manager (Systems)	Important within audited area

2.8 Suspense

2.8.1 Journals posted with invalid financial codes results in the associated transaction being posted automatically in eFinancials to a suspense account. The FST monitors this suspense account, sending details to the journal authoriser, to provide the appropriate correcting financial code. The suspense code transaction detail since 1 April 2017 was reviewed and it was confirmed transactions were regularly being cleared by the FST. The suspense code balance as at 16 February 2017 was nil.

2.9 Business Continuity and Disaster Recovery

2.9.1 The Council's Business Continuity Policy requires each Service to develop, implement and maintain Business Continuity Plans to ensure that: all critical functions are identified; the impact of the loss or disruption of these functions is understood and recorded; and arrangements are in place to ensure the continuance of critical functions at a predefined level in the event of emergency. Each Service must ensure these Plans are reviewed and tested at least annually.

2.9.2 The Finance Service Business Continuity Plan was last tested in October 2017, whilst the current version was prepared in December 2017. This describes eFinancials as a system which would be difficult to replace and the supplier as a Key Supplier. Services are required to obtain completed Key Supplier Assessment Questionnaires, to determine the adequacy of the Key Supplier's business continuity arrangements. Key Supplier Assessment Questionnaires were identified as being absent for all Key Suppliers in report AC1804 Business Continuity Planning in which a recommendation was made to update Procurement Guidance Notes to highlight the requirement for these questionnaires.

2.9.3 Business critical systems, including eFinancials, are backed up in full on a weekly basis and incrementally on a daily basis by the Council's Data Centre provider. Thirty days of backup files are held locally with a ninety day backup held offsite.

2.9.4 eFinancials is maintained on Oracle version 12 databases. Transactions are backed up to the Oracle archive log continuously and each night the database and the day's archived logs are backed up to the Storage Area Network (SAN) at the Council's Data Centre provider. The Data Centre has configured the eFinancials Servers to have 'Snapshots' taken at intervals of less than a minute which can be used to rebuild a replica of the server.

2.9.5 The Incident and Problem Co-ordinator carries out disaster recovery testing in conjunction with the Data Centre provider on agreed dates. A schedule of systems to be tested in the next 4 years has been set up with testing dates included where known. eFinancials is included as one of the systems due to be tested however a date has yet to be agreed with the Council's Data Centre provider. A recommendation to schedule disaster recover testing has already been included in report AC1810 Major IT Business Systems.

AUDITORS: D Hughes
A Johnston
A Einoryte

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. Financial Regulations have been consistently breached.
Significant within audited area	Addressing this issue will enhance internal controls. An element of control is missing or only partial in nature. The existence of the weakness identified has an impact on a system's adequacy and effectiveness. 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 and Scrutiny Committee
DATE	8 May 2018
REPORT TITLE	Internal Audit Report AC1820 – PECOS
REPORT NUMBER	IA/AC1820
DIRECTOR	N/A
REPORT AUTHOR	David Hughes
TERMS OF REFERENCE	2.2

1. PURPOSE OF REPORT

1.1 The purpose of this report is to present the planned Internal Audit report on the PECOS System.

2. RECOMMENDATION

2.1 It is recommended that the Committee review, discuss and comment on the issues raised within this report and the attached appendix.

3. BACKGROUND / MAIN ISSUES

3.1 Internal Audit has completed the attached report which relates to an audit of the PECOS System.

4. FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from the recommendations of this report.

5. LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from the recommendations of this report.

6. MANAGEMENT OF RISK

6.1 The Internal Audit process considers risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are as detailed in the attached appendix.

7. OUTCOMES

7.1 There are no direct impacts, as a result of this report, in relation to the Local Outcome Improvement Plan Themes of Prosperous Economy, People or

Place, or Enabling Technology, or on the Design Principles of the Target Operating Module.

7.2 However, Internal Audit plays a key role in providing assurance over, and helping to improve, the Council's framework of governance, risk management and control. These arrangements, put in place by the Council, help ensure that the Council achieves its strategic objectives in a well-managed and controlled environment.

8. IMPACT ASSESSMENTS

Assessment	Outcome
Equality & Human Rights Impact Assessment	An assessment is not required because the reason for this report is for Committee to review, discuss and comment on the outcome of an internal audit. As a result, there will be no differential impact, as a result of the proposals in this report, on people with protected characteristics.
Privacy Impact Assessment	Not required
Duty of Due Regard / Fairer Scotland Duty	Not applicable

9. APPENDICES

9.1 Internal Audit report AC1720 – PECOS.

10. REPORT AUTHOR DETAILS

David Hughes, Chief Internal Auditor
David.Hughes@aberdeenshire.gov.uk
(01467) 537861

ABERDEEN
CITY COUNCIL

Internal Audit Report

Finance

Professional Electronic Commerce Online System (PECOS)

Issued to:
Steven Whyte, Director of Resources
Sandra Buthlay, Interim Chief Officer - Finance
Fraser Bell, Chief Officer - Governance
Carol Smith, Accounting Manager
Graham Stubbins, Finance Manager (Systems)
External Audit

Date of Issue: March 2018 **Report No. AC1820**

EXECUTIVE SUMMARY

The Council utilises the Scottish Government's cloud based 'purchase to pay' Professional Electronic Commerce Online System (PECOS) system, to request, order and receipt goods and services, through a workflow based approval process. When requisitions are approved and orders raised, suppliers are notified via email. Between April 2017 and January 2018, 44,420 orders were placed by the Council using the system with a value of £57.379 million.

The objective of this audit was to consider whether appropriate control is being exercised over the system and that interfaces to and from other systems are accurate and properly controlled. In general, this was found to be the case, however recommendations have been made and agreed in relation to supply and maintenance; system access; user testing; data protection and business continuity planning.

The Finance Manager confirmed that results of testing are not fully documented prior to implementing system updates and upgrades. This increases the risk that system changes will not have been adequately tested resulting in unintended disruption to service users. It was recommended that the Service introduce a testing checklist for completion and approval prior to changes being implemented. The Service has advised that they do not have the resources available to test all PECOS updates. however they do make sure basic functions work prior to applying updates and upgrades and will document this in future.

1. INTRODUCTION

1.1 The Council utilises the Scottish Government's cloud based 'purchase to pay' Professional Electronic Commerce Online System (PECOS) system, to request, order and receipt supplies and services. Between 1 April 2017 and 31 January 2018, 44,420 orders were placed by the Council using the system with a value of £57.379 million. A monthly breakdown is as follows:

Month	Orders	Order Lines	Value £
April	3,780	21,843	5,765,494
May	5,751	36,772	6,414,216
June	5,399	35,292	5,696,249
July	1,985	10,349	5,671,420
August	3,511	23,037	5,461,479
September	5,005	31,494	3,887,131
October	3,833	23,642	4,015,878
November	5,907	38,362	5,360,086
December	4,220	27,896	6,703,060
January	5,029	32,889	8,403,582
	44,420	281,576	57,378,595

1.2 PECOS enables requisitions, purchase orders, order changes and the receipt of goods and services to be made electronically through a workflow approval process. When requisitions are approved and orders raised, suppliers are notified via email.

1.3 The objective of this audit was to consider whether appropriate control is being exercised over the system and that interfaces to and from other systems are accurate and properly controlled.

1.4 The factual accuracy of this report and action to be taken with regard to the recommendations made have been agreed with Carol Smith, Accounting Manager, and Graham Stubbins, Finance Manager, Corporate Governance.

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 As well as an on-line learning course on PECOS, there are a number of user guides available which can be accessed through the Zone. These cover all areas from setting up suppliers, requisitioning through approval to receiving of the goods / services. The manuals also include requesting access to the system and notifications when staff leave.

2.1.3 There are also a wide range of system administrator manuals and guides, covering all aspects of the system, available within the Finance Systems network folders. These provide detailed notes along with screen shots.

2.2 System Supply & Maintenance

2.2.1 PECOS is hosted by the developer on behalf of the Scottish Government and is available to the Council and other public sector bodies under the Scottish Government's eCommerce shared service Software License Agreement, free of charge. The Scottish Government has software license agreements in place with the developer and an IT professional services supplier for its support. A software license agreement must be signed by the Council to allow access to PECOS.

2.2.2 Annual support and maintenance is provided to the Council by a data centre provider, who download the Council's PECOS files from the developer's hosted site and convert these to the necessary format ready for uploading into the Council's eFinancials ledger system by that system's supplier.

2.2.3 The current data centre supply and maintenance contract, which expires in November 2018, costs £5,000 per annum and was procured through a Scotland Excel Support and Maintenance Framework. The annual interface contract with the Council's eFinancials supplier costs £8,200 and expires in March 2018.

2.2.4 The Council has a corporate license for PECOS with no limit on the number of users. A reporting package accompanies the system although only three licenses are provided free of charge. Two are held by the Finance Systems team and the other by Commercial & Procurement Services (C&PS). The Council should hold a copy of the software license agreement for the use of PECOS however a copy could not be located by C&PS or Finance.

Recommendation
A copy of the software license agreement should be obtained from the Scottish Government.

Service Response / Action
Agreed. This can be requested, but implementation will be dependent on the Scottish Government response.

Implementation Date	Responsible Officer	Grading
June 2018	Finance Manager (Systems)	Important within audited area

2.3 System Access

2.3.1 Access is granted to PECOS by the Finance Systems Team (FST) on receiving a new user form, available on the Zone. A new requisitioner must be authorised by a Directorate Support Manager or third tier officer while a new approver must be authorised by a third tier officer. It is important that authorised users are granted appropriate access levels commensurate with their role, whilst simultaneously giving due consideration to segregation of duties. A unique user ID and a temporary password, which must be changed when the user first logs in, are provided by the FST. Changes to requisitioner or approval details require to be notified and authorised in the same way as new users.

2.3.2 As at 17 January 2018, there were 1,361 active users, each with a unique user ID. 24 users had administrator rights, however, these have variable permissions dependent on the user's role: for example, some Finance staff can only reset passwords. Only the FST have full administrator rights to allow them to manage the system. A review of the administrator rights granted showed them to be appropriate with the staff role. A review of orders raised between 1 April and 31 December 2017 identified that that only three orders had been raised by system administrators and these were for Services related to the PECOS or eFinancials systems, which related specifically to the member of staff's role within the FST. No orders were approved by an administrator.

2.3.3 The system maintains an automatic audit trail of user activity which the user cannot amend or delete, however these are not capable of being reported locally. Each order has an online audit trail recorded and is visible on-screen for enquiry purposes. It details the progress of the procurement journey, with the date, user and action undertaken. A separate audit log is reportable for any tasks undertaken by system administrators, when setting up new users, suppliers or other system management tasks. The log is not reviewed, and the FST was unaware of its existence until the audit was undertaken. The absence of review of system administrator activity increases the risk of error and fraud.

Recommendation
System administrator activity should be regularly reviewed by a Finance officer out with the Finance Systems team.

Service Response / Action
Agreed. In order to view the log in the system, system administrator access is required however a report will be extracted on a monthly basis and forwarded to a Finance Officer who is not an administrator.

Implementation Date	Responsible Officer	Grading
June 2018	Finance Manager (Systems)	Important within audited area

2.3.4 The Council's ICT Acceptable Use Policy requires passwords used to protect systems and applications to be maintained securely and comply with current guidelines. The system has a default 6 character password although this can be increased by system administrators. It does not force special characters but can enforce alpha/numeric requirements. The Corporate Information Management procedure requires passwords to be at least 8 characters long and contain a mixture of numbers, letters and special characters. Ensuring longer, complex passwords enhances the security over system access.

Recommendation
The system password requirements should comply with the Council's Corporate Information Management procedure.

Service Response / Action
Agreed. The system will be updated to require an 8 character alpha / numeric password.

Implementation Date	Responsible Officer	Grading
May 2018	Finance Manager (Systems)	Important within audited area

2.3.5 The system allows a user three attempts to log on before the account is locked, requiring a system administrator to unlock it. There is no written request required, and administrators will carry out the task based on a phone call or email from the user. The system then generates a random password and emails it direct to the email address held against that user. There are no records kept of password resets carried out and no review is undertaken to identify any patterns.

2.4 User Testing

2.4.1 As at 17 January 2018 there were 2,871 user records on PECOS: 1,361 active and 1,510 inactive. Roles include requisitioner, receiver, approver, administrator and enquiry only.

2.4.2 A sample of 5 PECOS users set up in the current financial year was selected and each was supported by a fully completed and authorised New User Form and approval limits were considered appropriate.

2.4.3 It is the employing Service's responsibility to notify the FST when a member of staff with PECOS access leaves. Details of leavers recorded in the payroll systems for the current financial year was extracted and compared by name to the active PECOS users. 43 active users on PECOS appeared to have left the Council. While it is incumbent on Services to notify the FST of leavers, as there is no common identifier between payroll and PECOS (e.g. employee payroll number) it is not possible to run an automated check. The Service has advised that there is no available field in PECOS for this purpose.

Recommendation
The FST should consider carrying out regular user audits.

Service Response / Action
Agreed. An initial review of users for the purpose of removing leavers will be carried out once the Target Operating Model has been implemented. An annual user audit will be carried out subsequent to the initial review.

Implementation Date	Responsible Officer	Grading
June 2018	Finance Manager (Systems)	Significant within audited area

2.4.4 PECOS has a test / training version which is also hosted. The system supplier will upload any patches or improvements onto the test system and allow the FST to check that they work correctly using archived live data. Provided there are no issues then the FST will notify the supplier and the changes will be applied to the live system. It can also be used by users for training purposes as the access rights mirror the live system as does the user name and password.

2.4.5 The Finance Manager confirmed that results of testing are not fully documented prior to implementing system updates and upgrades. This increases the risk that system changes will not have been adequately tested resulting in unintended disruption to service users.

Recommendation
The Service should consider introducing a testing checklist for completion and approval prior to system changes being implemented.

Service Response / Action
The Service does not have the resources available to test all PECOS updates particularly with the very tight deadline given by the Scottish Government for applying these. Prior to general release for testing, specific local authority users have already tested updates and we tend to rely on that testing. The Service makes sure basic functions work prior to applying updates and upgrades and this will be documented.

Implementation Date	Responsible Officer	Grading
April 2018	Finance Manager (Systems)	Significant within audited area

2.5 Data Protection

2.5.1 The Council's Data Protection Policy requires that all staff who process personal information undertake specified Data Protection Training at the commencement of their employment and to complete regular refresher training thereafter.

2.5.2 The Council has three Data Protection related training courses – 'Data Protection – Essentials', which focusses on Data Protection, the employee Induction which covers core Council policies for new employees, and 'For Your Eyes Only', focussed on Information Security.

2.5.3 The FST has stated that it is not a requirement for new users accessing PECOS to have undertaken data protection training. However, Legal and Governance has confirmed that some data contained in the system would constitute personal data as defined by the Data Protection Act 1998. A sample of 25 employees who have access to PECOS were checked to ensure / ascertain if they had all completed Data Protection Training. Six had undertaken training although each worked in a Service where they would have access to other sensitive personnel information.

Recommendation
All employees accessing PECOS should complete Data Protection training.

Service Response / Action
Agreed. The new access form will seek confirmation that Data Protection has been completed before access is granted to the PECOS system.

Implementation Date	Responsible Officer	Grading
July 2018	Finance Manager (Systems)	Significant within audited area

2.5.4 Schedule 1 of the Data Protection Act 1998, principal 5, states "Personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose or those purposes." The data held on PECOS has never been purged, therefore it holds data relating back to when the system was first used. Current requirements from HMRC are for purchase orders to be retained for six years to comply with VAT regulations. Therefore if personal data is being held beyond this, the Council is at risk of breaching principle 5 of the DPA.

Recommendation The Council should contact the Scottish Government and ascertain the way in which the PECOS system can be updated to comply with document retention rules and principal five of the Data Protection Act. **Service Response / Action** Agreed.		
Implementation Date July 2018	**Responsible Officer** Finance Manager (Systems)	**Grading** Significant within audited area

2.6 Interfaces

2.6.1 The purpose of system interfaces are to update PECOS with new / amended catalogues and the eFinancials system with details of purchase orders raised and goods / services received.

2.6.2 Scotland Excel produces catalogues for suppliers who are part of Framework Agreements and is responsible for ensuring that the pricing and items contained within the catalogues are correct. CPS relies upon Scotland Excel's measures and does not undertake checks on the catalogues, which are copied into the correct format for PECOS by CPS staff and forwarded to the FST to be uploaded into the system. Catalogues for specialist goods are prepared by CPS Procurement Specialists in conjunction with appropriate Service Managers and are then forwarded for uploading in the same way.

2.6.3 Bulk uploads of orders placed on PECOS are done overnight, while ongoing variations or goods receipts are interfaced every 30 minutes. System e-mails are sent to an FST email address notifying them of a successful upload, or reporting and detailing any failures. The FST review the failure reports to ascertain the reason, and either notify the requisitioning Service to make a correction (e.g. incorrect financial code to be corrected), or where administrative action is required, make amendments to PECOS or eFinancials (e.g supplier closed in eFinancials but open in PECOS allowing order). The interface will not accept any non-active financial ledger codes, which will be reported as failures, and therefore no suspense entries will be generated.

2.6.4 A review of the successful and rejected interface reports for the beginning of January 2018 showed no rejections relating to the previous months. A sample of three weeks within January found that the same rejections were not remaining outstanding between weeks.

2.6.5 Orders and receipts interfaced from PECOS to eFinancials are placed in a holding area each day until 3.30 pm, when a "matching" job is processed. For an invoice to be processed successfully, the system will look for a three way match between the purchase order, goods received and invoice. If invoices relating to purchase orders placed through PECOS are matched, they will be accepted automatically for payment in eFinancials, once the invoice information is entered to the system.

2.6.6 The current error tolerance limit is £2 for all suppliers except a catering supplier, for which the tolerance level is £50. The tolerance limit has been set at this level following discussions with Services, who accept that there may be variances in the types of foodstuffs and quantities delivered from that ordered, and are satisfied with the tolerance level.

2.6.7 A reconciliation between PECOS and eFinancials is not carried out on a regular basis. Reliance is placed on the interface reporting being accurate. If at any point an invoice is

received and the matching process within eFinancials fails due to inconsistencies with the order within eFinancials then the FST will carry out a reconciliation check to ascertain the reason for the order not being rejected during the upload.

2.6.8 A sample of 45 orders (5 per month April to December 2017) was tested and it was confirmed that all details had been accurately transferred to the financial ledger, including the financial ledger code, supplier, goods / service description, and amount.

2.6.9 Reports of orders raised in November 2017 showed that 5,907 were raised on PECOS and 5,818 matched the e-financials data. The difference of 89 related to cancelled orders or orders which had not yet been approved.

2.7 Manual Data Input

2.7.1 Orders are all raised manually within PECOS which has mandatory fields along with drop down menus to facilitate data input.

2.7.2 In November 2017, the Council raised 5,907 orders to the value of £5,360.086 through the system. The system automatically allocates a purchase order number when the order is created, and orders cannot be deleted. Orders can either be approved and issued, cancelled, or remain incomplete. A review of the order number sequence found there were no gaps.

2.7.3 The PECOS system allows larger quantities to be receipted than had been ordered. These “extras” are not subject to the same approval process as the original order. However, payment for additional goods received will be limited to the payment tolerances described in paragraph 2.6.5, above.

2.7.4 Where an order is incomplete it will be highlighted in the requisitioner’s PECOS workflow, making the user aware that work still has to be completed prior to it being issued. There is no overview by FST or Commercial and Procurement Services (C&PS) of orders that have not been fully completed. A report extracted from the system by Internal Audit indicated that some incomplete orders dated back years.

2.7.5 The Council has a combined PECOS / creditors new / amended supplier form (FST99A). The form is used to collect supplier details along with bank details, although this is only recorded in e-financials and not PECOS. It is also used by C&PS for establishing whether a supplier should be set up on the system for use, depending on whether Procurement Regulations have been complied with. The form is completed in part by the requisitioner and part by the supplier before being approved and passed to C&PS. If C&PS are satisfied that the goods / services are not already covered by an existing contract / framework and the justification is adequate, they will forward on through workflow to the payments section and FST, to set up the supplier in eFinancials and PECOS.

2.7.6 As at 23 January 2018, PECOS held 7,077 suppliers, of which 6,858 were active. In the current financial year (April to January) 326 new suppliers were set up in PECOS. A sample of 25 was tested and it was confirmed that the required information had been fully completed on the form, and the supplier details were correctly input to PECOS.

2.8 Performance Monitoring

2.8.1 The Scottish Government does not require performance information from the Council. The FST has stated the system has had no issues or extended downtime, and the main concern from users has tended to be in relation to internet performance as the system is hosted and accessed online.

2.9 Suspense

2.9.1 PECOS does not require correct financial ledger codes to be entered when an order is raised however the interface to eFinancials will only accept a valid ledger code. Therefore, no transactions which are accepted into eFinancials will have an invalid ledger code and no transactions will be posted to a suspense account as a result.

2.10 Business Continuity Planning / Confidentiality

2.10.1 PECOS is hosted by the developer on behalf of the Scottish Government. The Scottish Government website states that the system is backed up to a disaster recovery data centre in a separate location.

2.10.2 The Council's IT Operations Management Standard requires that where a 3rd party network provider supplies services it must be established at the outset that confidentiality, integrity and availability requirements can be met, and SLA and contracts are well defined. The Finance Service business continuity plan (BCP) identifies the PECOS supplier as a key supplier and therefore confirmation should be available that it has adequate business continuity arrangements in place of its own. This should be included within the service contract or a Key Supplier Business Continuity Planning Assessment Questionnaire should be completed by the supplier.

2.10.3 Finance had assumed the software license agreement covered both of the above requirements. However as a copy of the agreement is not held by the Council, this cannot be confirmed. Should the two requirements not be included then separate agreements will have to be entered into with the PECOS software provider.

2.10.4 The Scottish Government P2P Service Integration Support and Maintenance Agreement with the interface data centre supplier, responsible for converting PECOS files to a format ready for eFinancials, states that the terms and conditions applicable to the support agreement are as per the Scottish Government's P2P Service Management contract. Confidentiality and business continuity terms and conditions are not included separately within the signed contract with this supplier.

Recommendation
If required, a 3rd party confidentiality agreement and key supplier business continuity assessment questionnaire should be completed by the PECOS and interface software providers.

Service Response / Action
Agreed. This can be requested from the interface software provider / Scottish Government but implementation is dependent on their response.

Implementation Date	Responsible Officer	Grading
June 2018	Finance Manager (Systems)	Significant within audited area

AUDITORS: D Hughes
A Johnston
G Flood

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. Financial Regulations have been consistently breached.
Significant within audited area	Addressing this issue will enhance internal controls. An element of control is missing or only partial in nature. The existence of the weakness identified has an impact on a system's adequacy and effectiveness. 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 and Scrutiny Committee
DATE	8 May 2018
REPORT TITLE	Internal Audit Report AC1826 – Out of Authority Placements
REPORT NUMBER	IA/AC1826
DIRECTOR	N/A
REPORT AUTHOR	David Hughes
TERMS OF REFERENCE	2.2

1. PURPOSE OF REPORT

1.1 The purpose of this report is to present the planned Internal Audit report on Out of Authority Placements.

2. RECOMMENDATION

2.1 It is recommended that the Committee review, discuss and comment on the issues raised within this report and the attached appendix.

3. BACKGROUND / MAIN ISSUES

3.1 Internal Audit has completed the attached report which relates to an audit of Out of Authority Placements.

4. FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from the recommendations of this report.

5. LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from the recommendations of this report.

6. MANAGEMENT OF RISK

6.1 The Internal Audit process considers risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are as detailed in the attached appendix.

7. OUTCOMES

7.1 There are no direct impacts, as a result of this report, in relation to the Local

Outcome Improvement Plan Themes of Prosperous Economy, People or Place, or Enabling Technology, or on the Design Principles of the Target Operating Module.

7.2 However, Internal Audit plays a key role in providing assurance over, and helping to improve, the Council's framework of governance, risk management and control. These arrangements, put in place by the Council, help ensure that the Council achieves its strategic objectives in a well-managed and controlled environment.

8. IMPACT ASSESSMENTS

Assessment	Outcome
Equality & Human Rights Impact Assessment	An assessment is not required because the reason for this report is for Committee to review, discuss and comment on the outcome of an internal audit. As a result, there will be no differential impact, as a result of the proposals in this report, on people with protected characteristics.
Privacy Impact Assessment	Not required
Duty of Due Regard / Fairer Scotland Duty	Not applicable

9. APPENDICES

9.1 Internal Audit report AC1826 – Out of Authority Placements.

10. REPORT AUTHOR DETAILS

David Hughes, Chief Internal Auditor
David.Hughes@aberdeenshire.gov.uk
(01467) 537861

ABERDEEN
CITY COUNCIL

Internal Audit Report

Operations

Out of Authority Placements

Issued to:
Rob Polkinghorne, Chief Operating Officer
Bernadette Oxley, Chief Officer – Integrated Children's and Family Services
Fraser Bell, Chief Officer – Governance
Sandra Buthlay, Interim Chief Officer - Finance
Anne Donaldson, Lead Service Manager
Lesley Stopani, Service Manager Inclusion
Eleanor Sheppard, Transformation and Improvement Manager
External Audit

Date of Issue: April 2018 **Report No. AC1826**

EXECUTIVE SUMMARY

The Council is under a statutory obligation to provide education for children up to 18 years of age that are living in the Aberdeen City area, including those with additional support needs. In addition, the Council has a duty to offer looked after young people, born after 1 April 1999, a care placement until the age of 21. Historically, the budget for providing out of authority placements has been under pressure with some significant overspends being reported to Committee through budget monitoring reports. During 2013/14, consultants completed an Inclusion Review which made a number of recommendations impacting on out of authority placements.

The objective of this audit was to review progress with implementing the applicable recommendations of the Inclusion Review and to consider whether the system used to make and review on-going out of authority placements is robust and that alternatives are considered before decisions are made which commit expenditure.

The Service has developed a well-defined process for determining whether placements need to be made with an external provider or can be delivered by the Council. Despite this, the 2017/18 budget for out of authority placements of £9.29 million, which had been increased to take account of the historical pressures, is forecast to be overspent by 18%.

Required reviews of placements are, in general being completed timeously, although a small number of exceptions were identified. Where reviews are not completed timeously, there is a risk of costs being incurred that are not required. The Service has agreed to address this and ensure that all placements are recorded in CareFirst.

Recommendations made in the Inclusion Review have been implemented but not all have been fully evaluated. The Service has agreed to do this by August 2018, including the impact of policies, roles and remits, and the transformation of services, which will help inform future service delivery.

1. INTRODUCTION

1.1 The Council is under a statutory obligation to provide education for children up to 18 years of age that are living in the Aberdeen City area, including those with special needs. In addition, the Council has a duty to offer looked after young people, born after 1 April 1999, a care placement until the age of 21. The governing legislation is derived primarily from the Children (Scotland) Act 1995, Education (Additional Support for Learning) (Scotland) Act 2004 (as amended), the Looked After Children (Scotland) Regulations 2009 and the Children and Young People (Scotland) Act 2014. Where a child's needs are best met by an external provider, the Council's Out of Authority Placement (OAP) scheme facilitates the provision of specialist support from outwith the Council.

1.2 OAPs may be made in residential children's homes, residential special schools, day placements in special schools or fostering placements. Children who pose a significant risk to themselves or the community may be placed in secure care by the Chief Social Work Officer on the recommendation of the Children's Panel or the Court, and the Council is also liable for these costs. These placements are reviewed every 4 weeks by the Chief Social Work Officer.

1.3 As at 31 March 2018, 56 children were in out of authority residential placements and 42 children with higher support needs were in out of authority foster placements. The 2017/18 approved budget for this provision was £9.29 million (2016/17 - £6.52 million), whilst the forecast outturn for the year was £10.94 million (an overspend of 18%) (2016/17 - £10.66 million or 64%). Children's Social Work contributes 63% of the budget and the Education Inclusion Service contributes 37%. These percentages reflect the costs for both care and education when a child is placed out of authority.

1.4 The objective of this audit was to review progress with implementing the applicable recommendations of the Inclusion Review and to consider whether the system used to make and review on-going out of authority placements is robust and that alternatives are considered before decisions are made which commit expenditure.

1.5 The factual accuracy of this report and action to be taken has been agreed with Bernadette Oxley, Head of Children's Social Work, and Anne Donaldson, Lead Service Manager.

2. FINDINGS AND RECOMMENDATIONS

2.1 Policies and Procedures

2.1.1 It is essential that robust written procedures are in place to guide OAP activity and prevent duplication of effort, confusion over responsibilities, and inconsistencies. In addition, comprehensive written procedures which are easily accessible by all members of staff 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 OAP administration is part of the Integrated Children's Services Plan, the current version of which was approved by the Education and Children's Services Committee in June 2017. The Plan, which covers 3 years and is due to be reviewed in 2020, is intended to show that the Council is meeting its statutory responsibilities as part of the Children and Young People (Scotland) Act Statutory Guidance Section 3 regarding children's services planning. This requires each Local Authority and Associated health board to develop a 3 year plan to improve the lives of children and young people by embedding the Getting it Right for Every Child approach. Decisions on and administration of OAP are considered and agreed by the Child Specialist Services Forum (CSSF). This is a joint financial decision making group made up of representatives from Education and Children's Services (E&CS). The Health and Social Care Partnership has been invited to join this group. A policy covering the remit and aims of the CSSF was approved by CMT on 8 January 2018. The policy is considered to be comprehensive and up to date.

2.1.3 There are a number of different guidance documents for staff relating to different duties across the Service, including: guidance for Social Workers, Educational Psychologists and managers on presenting requests for placements; guidance for staff responsible for carrying out reviews of looked after children; procedures for using the CareFirst system; and procedures on performing Service-specific Accountancy tasks. These were considered to be comprehensive and, for the most part, up to date. Some guides refer to obsolete arrangements, but these have been identified and are in the process of being updated by the Service.

2.2 Reviews and Placements

2.2.1 According to a November 2016 Service report, the average cost for each vulnerable child or young person being placed out of authority with an external provider in 2016 was £250,000 a year compared to approximately £165,000 per year for a placement in an Aberdeen City Council children's home. As a result a placement within the authority offers a substantial cost saving. The Service also has a strategic priority of inclusion within mainstream settings wherever possible. Whilst the average cost of placements for looked after children is considerably lower than the above costs, it is important that the Service consider requests for OAP carefully before committing to expenditure.

2.2.2 All looked after children (LAC) must, under the 2009 Regulations, have their needs and care provision reviewed at least every 12 months. If a child has needs that may be best met by an external provider, this could be identified through this LAC review, or from multi-agency case conferences or Children's Hearings recommendations. The needs are identified by staff supporting the child, such as school staff, Social Workers or Educational Psychologists, and these needs are then presented to the CSSF for consideration. Alternatively a child may require to be placed after a decision made by the Health and Education Chamber of the First-tier Tribunal for Scotland, formerly the Additional Support Needs Tribunal for Scotland. Requests cannot be made directly by service users to the CSSF.

2.2.3 CSSF meetings are held fortnightly and are attended by representatives from both Education and Children's Social Work. Cases are scheduled for consideration by either required review date or requests arising from a recent review. Since 2017, reports approved by managers in both Education and Children's Social Work, to ensure that only appropriate cases are presented to the CSSF, and in such a way that decisions can be made promptly without further information being requested, are considered. These describe the areas of concern, interventions currently in place, and the desired outcome from a specialist service.

2.2.4 In order to establish more consistent and impartial decision making, the type of provision and provider are decided on by the CSSF after discussing and considering the submitted request, based on the identified needs of the child. Prior to 2017, the type of provision was requested and justified by the Social Workers and Educational Psychologists presenting the request.

2.2.5 Suppliers are identified using a Framework Agreement through Scotland Excel, which was approved for use in 2014. This agreement was due to expire in 2016 but was extended until March 2018. If a suitable supplier cannot be identified through the Framework one will be sourced by the Service and a contract governing the placement arranged with the support of Commercial and Procurement Services. Contracts for services have also been agreed with two providers not on the Framework who are regularly used by the Service.

2.2.6 Decisions are made by the First-tier Tribunal for Scotland on appeals against the refusal of requests for placements at specified providers and may confirm that the authority should place the child in the identified / requested provision; this decision is legally binding on the Council. Decisions of the Children's Panel may specify a placement; however the Service has worked with the Children's Hearings staff to produce guidance that decisions should identify need and allow the local authority to identify suitable placements.

2.2.7 Once the placement has been agreed an Individual Placement Agreement (IPA), also called a Service Agreement, is drawn up. IPAs detail the parties involved, the level of provision required to meet the child's specific needs, and the desired outcomes. They are prepared by the child's Social Workers, based on the identified need as discussed in the submission to the CSSF, and are then passed to the Lead Service Manager for CSW for authorisation. The IPAs are saved in the Service shared drive and copies are sent to the CareFirst team to be manually input to CareFirst once the CareFirst team has confirmed the forms are complete and correct. An email notification of new, amended and terminated placements is sent to Finance on a weekly basis by the CareFirst team.

2.2.8 In addition to case recording, CareFirst is used to control payments to external care providers. When invoices are received they are compared to IPAs recorded in the system to ensure the level of service and fees being charged match the agreement.

2.2.9 The Service advised that a small number of Education placements are not currently recorded in CareFirst. Historically there were fewer Education placements and, although they were approved by the CSSF, since they were paid for from the Education budget, they were administered solely by Education staff, who did not have access to CareFirst. As a result, a number of day placements at special schools are not yet in the CareFirst system. The Service Manager Inclusion stated that there was an ongoing process to identify all such placements and arrange for them to be input to CareFirst, but was not able to advise how many such placements existed or how long this process would take.

2.2.10 If placements are not recorded consistently there is a risk that invoices may be paid inappropriately or expenditure may not be tracked. Having all placements recorded in CareFirst would ensure consistency and allow more efficient monitoring of payments and performance.

Recommendation		
The Service should identify all current placements not recorded in CareFirst and arrange for them to be input as soon as possible.		
Service Response / Action		
Agreed		
Implementation Date	**Responsible Officer**	**Grading**
May 2018	Service Manager Inclusion	Important within audited area

2.2.11 Service provision is checked against the IPA every time an invoice is received by CareFirst. The provider performance and the child's progress is reviewed at the LAC Review and during the annual CSSF review meeting.

2.2.12 25 looked after children who had been assessed by the CSSF were identified from Service records and details of the review were examined by Internal Audit. In all cases the request forms had been submitted; however in 2 cases the form had not been fully authorised. Since the request for service form acts as a purchase order, failure to fully authorise is potentially a breach of Procurement Regulations. These were subsequently authorised and the Service advised that this was a practice issue that has now been addressed.

2.2.13 In all cases tested, the assessment process and decision were fully recorded in extensive notes and supporting evidence had been retained. Information on resource gaps contributing to the need to move out of authority was collated and reported, and the decision was communicated promptly to all parties.

2.2.14 As discussed above all providers should be Framework or contract suppliers and IPAs must be approved and input to CareFirst before the placement begins. A sample of 25 placements that were current during 2017/18 was selected from the Service files and reviewed. With one exception, where the placement had commenced in 2014 and the form had not been kept, all placements had been appropriately approved before the placement began. The Service stated that older documents were not retained due to data protection concerns.

2.2.15 All providers were sourced from the Framework Agreement with one exception. The Service advised that no suitable provider in the Framework had been available resulting in another provider being used. Commercial and Procurement Services confirmed that procurement procedures had been followed and a contract was in place.

2.2.16 All placements had an IPA filed in the shared drive and were recorded in CareFirst with all IPAs having been authorised and input to CareFirst before any invoices were paid. Paid invoices were reviewed for each placement and all had been processed correctly, authorised within CareFirst, and paid timeously.

2.2.17 Service provision is monitored through regular reviews. These should be carried out at least annually and the case meeting minute should include a date for the next review meeting to ensure this target is met. In one case the most recent review was over 12 months ago (last review November 2016); no scheduled review date had been input to the case meeting minute form. In two other cases the review had been carried out within the last year but no review date had been input to the form. The Service advised that action would be taken to ensure that these cases were reviewed promptly and to remind staff to ensure that review dates were input during case meetings.

2.2.18 If CSSF placement reviews are not carried out timeously there is a risk of inappropriate provision, which could mean costs are incurred unnecessarily. Currently a Word document is used to record details of future CSSF meetings and children's details are entered into this to schedule reviews. The Service is currently working with the CareFirst system to create a scheduling system which will flag when reviews are due.

Recommendation		
The Service should ensure all placements are regularly reviewed.		
Service Response / Action		
Agreed		
Implementation Date	**Responsible Officer**	**Grading**
June 2018	Lead Service Manager	Significant within audited area

2.2.19 Two of the placements reviewed had ended but one of these had not been terminated in CareFirst. A delay in closing off a terminated placement in CareFirst increases the risk that invoices may be paid inappropriately.

Recommendation		
The Service should ensure that terminations are input to CareFirst promptly.		
Service Response / Action		
Agreed		
Implementation Date	**Responsible Officer**	**Grading**
June 2018	Lead Service Manager	Important within audited area

2.3 Budget Monitoring

2.3.1 The Out of Authority budget includes the cost of the following provision:

- Residential Children's Home placements
- Residential School placements
- Respite care provision for children with high support needs
- Secure care
- Higher support needs for children in external foster placements
- Education placements
- Additional support, normally in the form of PSA support, when a looked after child or young person is in an out of authority mainstream school.

2.3.2 The CSSF holds a Business Meeting every two months, which is also attended by representatives from Finance, Commercial and Procurement Services, and the CareFirst support team. The purpose of Business Meetings is to monitor the budget, review decision making and gaps in service provision. Meeting agendas show that meetings are being held regularly and are well attended by relevant staff; progress reports were given and actions assigned to staff.

2.3.3 Budget monitoring is carried out by a team in Finance. In addition to the Business Meetings, Accountants meet with Service Managers on a monthly basis to discuss spending trends. These meetings consider overall budget, trends, contracts, and provide updates on significant forecast to budget variations.

2.3.4 Finance maintains a tracking spreadsheet showing all looked after children, establishments and costs charged by providers, which is used to create spending forecasts and budget monitoring reports for the Service. The tracking spreadsheet is updated regularly with detailed information on placement costs and timings. It is understood that the CareFirst System cannot produce data in the required format.

2.3.5 Five of the children within the sample tested could not be identified in the spreadsheet as names had been redacted and a number of CareFirst P number identifiers were missing. Finance advised that sometimes they are not given the P number initially and the sheet might not be updated later as they did not use these numbers for primary identification. This means that children with similar details, or who use more than one name, might not be properly identified in discussions between the Service and Finance; Internal Audit was unable to receive assurance this was not the case as the complete sheet was not provided for review.

Recommendation
Finance should ensure that the tracking spreadsheet contains the unique CareFirst identifiers for each child and that it is up-to-date.

Periodic reconciliations should be undertaken between CareFirst and the spreadsheet.

Service Response / Action
Part 1: Agreed.

Part 2: Agreed. Reconciliations will be carried out on a monthly basis.

Implementation Date	Responsible Officer	Grading
May 2018	Finance Partner	Significant within audited area

2.3.6 Budget monitoring reports for 2015/16 – 2017/18, presented to the Education and Children's Services Committee were reviewed. They were in a clear and consistent format; the level of detail provided was appropriate; and OAP costs were identified as a cost pressure. However, in each report the same form of words was used, explaining that unforeseen costs were imposed externally and that work was being carried out by the Service to reduce the cost and number of placements.

2.3.7 Annual budgets are based on expected costs of service delivery plus growth required, as identified through discussions between Finance and the Service. The 2017/18 budget was presented to Full Council on 22 February 2017 for approval, and included a substantial increase for OAP. The Service advised that this was the result of a general change in approach reflected through the Reclaiming Social Work model which led to a more realistic budget setting process.

2.3.8 The percentage of looked after children cared for at home is reported to the Education and Children's Services Committee on a quarterly basis as part of the Directorate Performance Improvement Scorecard, since the principle of assisting families to remain together in a supported environment is key to delivery of the Directorate's improvement objectives around the care and support of vulnerable children. It is benchmarked against national performance. The Council is slightly below the national average and the reported goal is to improve this to at least match the average through the implementation of the Reclaiming Social Work model (see below).

2.4 Strategic Changes

Inclusion Review

2.4.1 A year-long review of inclusive practice within the Council was undertaken by external consultants in 2013/14. This was intended to ascertain the extent to which the Council had taken account of Scottish Government legislation and guidance covering equalities and support for learning, and how Service approaches compared with national legislation and international best practice.

2.4.2 The Review found that while many schools and Services offered good examples of inclusive practice, and there was a high level of commitment from staff, there was an insufficient understanding of the presumption of mainstreaming (as outlined in the Standards in Scotland's Schools Act 2000) and an unusually high number of specialist provisions. The review made a number of recommendations, with those impacting on Out of Authority placements being that an Inclusion Team be put in place to lead, implement and quality assure developments; and that the Service put measures in place to better use existing provision in order to reduce the number of children whose needs cannot be met within the authority, including building a new special school and creating a Virtual School to ensure effective support for Looked after Children.

2.4.3 A Head Teacher was appointed in November 2015 to work with the Looked After Children Teacher in the Virtual School, which aims to support the educational achievement of the children it looks after, regardless of where they are enrolled. The Virtual School is not a physical place but an organisational tool created to coordinate support. The role of the Virtual School Head Teacher is to support improvements in the educational progress and attainment and achievement of all children looked after by the authority, including those that have been placed in schools in other authorities.

2.4.4 A new special school, Orchard Brae School, opened in August 2017, replacing a number of smaller resources across the City. In addition to offering specialist educational services it is designed to be a resource for outreach services and ASN teaching and training, and a multi-agency facility for health, education, social work and family support. In this way places are maintained within the Council area for children who require specialist education, while other children with less complex needs can be more effectively supported to remain in mainstream schools.

2.4.5 The Service confirmed that a formal evaluation of some of the applicable recommendations of the Inclusion Review has not been carried out as yet, meaning it has not been established if the above changes have had a positive impact on service provision / outcomes.

Recommendation
The Service should review the impact of the changes made as a result of the Inclusion Review to determine their impact on Out of Authority Placements.

Service Response / Action
Agreed. This will include:

- Minimising Exclusion Policy
- The role and remit of the Virtual School
- The Transformation of support services

Implementation Date	Responsible Officer	Grading
August 2018	Service Manager Inclusion	Significant within audited area

Reclaiming Social Work

2.4.6 The Council is in the process of implementing a new model for Children's Social Work called Reclaiming Social Work (RSW). This model sees cases being allocated to Units staffed by a number of workers, rather than to an individual Social Worker. Feedback from staff operating within a Unit model mirrors that of other Local Authorities who have implemented RSW whereby staff feel supported and better able to manage situations of risk and support families to affect change, without the need for the child to be accommodated. This feeds into the Service strategic priority of reducing the number of children who are accommodated, including those in high cost out of authority placements. It is intended that the model will be fully implemented by 2020.

2.4.7 Through improving support and provision for children with a high level of need, and implementing the RSW model to help Social Workers manage case loads more effectively, the Service has worked to reduce OAP spending by striving to keep looked after children within the authority area. In spite of these efforts the number of placements has increased each year since 2014. The Service advised that they continue to apply pressure to reduce the number and cost of external placements and that officers from across the Directorate are undertaking a rigorous review of case files, systems and processes; however, ultimately provision must be based on the needs of the child.

AUDITORS: D Hughes
A Johnston
L Jarvis

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. Financial Regulations have been consistently breached.
Significant within audited area	Addressing this issue will enhance internal controls. An element of control is missing or only partial in nature. The existence of the weakness identified has an impact on a system's adequacy and effectiveness. 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 and Scrutiny Committee
DATE	8 May 2018
REPORT TITLE	Internal Audit Report AC1818 – Capital Plan
REPORT NUMBER	IA/AC1818
DIRECTOR	N/A
REPORT AUTHOR	David Hughes
TERMS OF REFERENCE	2.2

1. PURPOSE OF REPORT

1.1 The purpose of this report is to present the planned Internal Audit report on the Capital Plan.

2. RECOMMENDATION

2.1 It is recommended that the Committee review, discuss and comment on the issues raised within this report and the attached appendix.

3. BACKGROUND / MAIN ISSUES

3.1 Internal Audit has completed the attached report which relates to an audit of the Capital Plan.

4. FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from the recommendations of this report.

5. LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from the recommendations of this report.

6. MANAGEMENT OF RISK

6.1 The Internal Audit process considers risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are as detailed in the attached appendix.

7. OUTCOMES

7.1 There are no direct impacts, as a result of this report, in relation to the Local Outcome Improvement Plan Themes of Prosperous Economy, People or

Place, or Enabling Technology, or on the Design Principles of the Target Operating Module.

7.2 However, Internal Audit plays a key role in providing assurance over, and helping to improve, the Council's framework of governance, risk management and control. These arrangements, put in place by the Council, help ensure that the Council achieves its strategic objectives in a well-managed and controlled environment.

8. IMPACT ASSESSMENTS

Assessment	Outcome
Equality & Human Rights Impact Assessment	An assessment is not required because the reason for this report is for Committee to review, discuss and comment on the outcome of an internal audit. As a result, there will be no differential impact, as a result of the proposals in this report, on people with protected characteristics.
Privacy Impact Assessment	Not required
Duty of Due Regard / Fairer Scotland Duty	Not applicable

9. APPENDICES

9.1 Internal Audit report AC1818 – Capital Plan.

10. REPORT AUTHOR DETAILS

David Hughes, Chief Internal Auditor
David.Hughes@aberdeenshire.gov.uk
(01467) 537861

ABERDEEN
CITY COUNCIL

Internal Audit Report

Capital Plan

Issued to:
Steven Whyte, Director of Resources
Fraser Bell, Chief Officer – Governance
Sandra Buthlay, Interim Chief Officer – Finance
Craig Innes, Head of Commercial & Procurement Services
John-Paul Cleary, Senior Programme Manager, Commercial & Procurement Services
External Audit

Date of Issue: April 2018 **Report No. AC1818**

EXECUTIVE SUMMARY

The objective of this audit was to ensure that robust procedures are in place for setting, progressing and monitoring the Capital Programme. A review of Capital Programme Governance reported to the Audit, Risk and Scrutiny Committee of 27 June 2017 highlighted the need for improved Project Management Governance and Principles to be applied to Capital Plan Projects. The audit therefore focused on ensuring that the new processes are being applied and to provide assurance over setting and delivery of the Capital Plan.

New processes have been implemented, and provide a robust framework for managing the Capital Programme. However, some projects which commenced prior to implementation have still to ensure all of the documentation is updated, and a small number of actions identified in the Programme Management Office's (PMO) reviews of the process and individual programmes have still to be completed. The PMO anticipates concluding these by June 2018.

Project documentation to support and document approval of changes to timing and costs is not always being completed consistently and retained. Project cost forecasts are not well completed, and the impact of risks on the outturn is not always being factored in to project cost monitoring timeously. The PMO, with support from the Director of Resources and Chief Officer – Finance, will remind project sponsors and managers of the requirements, and reinforce these through quality control checks.

1. INTRODUCTION

1.1 Financial Regulations require that the Council's Capital Programme be developed in accordance with instructions from the Head of Finance who then submits this to Full Council for approval.

1.2 The Council's 5 year Capital Budget (at the time of testing) was approved at Full Council on 22 February 2017:

Year	Non-Housing Capital Programme £'000	Housing Capital Programme £'000
2017/18	£239,518	£55,318
2018/19	£214,429	£30,078
2019/20	£139,213	£24,632
2020/21	£76,458	£24,914
2021/22	£37,555	£25,556
5 year total	£707,173	£160,498

1.3 The objective of this audit was to ensure that robust procedures are in place for setting, progressing and monitoring the Capital Programme. A review of Capital Programme Governance reported to the Audit, Risk and Scrutiny Committee of 27 June 2017 highlighted the need for improved Project Management Governance and Principles to be applied to Capital Plan Projects. The audit therefore focused on ensuring that the new processes are being applied and to provide assurance over setting and delivery of the Capital Plan.

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 – Director of Resources, and John-Paul Cleary – Senior Programme Manager, Commercial & Procurement Services.

2. FINDINGS AND RECOMMENDATIONS

2.1 Project Approval and Management

2.1.1 New processes were put in place following the review of Capital Programme Governance reported to the Audit, Risk and Scrutiny Committee on 27 June 2017, with the support of the Programme Management Office (PMO), in order to apply additional Project Management governance and principles to Capital Plan Projects. There is a new Governance Structure (comprising 6 Programme Boards), terms of reference detailing guidance and responsibilities, and training packages are being provided to appropriate staff.

2.1.2 The revised Project Management Process has 4 stages (Define, Implement, Close, Measure), within which each Project must pass 7 Gate stages in order to proceed. Although the previous methodology followed a similar process, it included only 4 Gate stages through which a project had to pass to ensure it had been properly defined and managed:

Stage	Previous Gates	Current Gates
Define	Approve Proposal Approve Business Case	Approve Proposal Approve Business Case
Implement		Approve Project Initiation Document (PID), Designs and Plans Approve Procurement Six Monthly Reviews
Close	Project Close	Project Close
Measure	Benefits Review	Benefits Review

2.1.3 The Programme Management Toolkit on the Zone provides further guidance for each of the stages and Gates. Although the PMO home page and Project Management Process Diagram have been updated on the Zone to show the new Gates, the "Project Review Points: The Gates" page on the Zone has not yet been updated to show the new gates, and includes only 4 Gate stages. All guidance should be finalised providing a clear reference point for staff and giving Management assurance over the processes to be followed.

Recommendation
The PMO should ensure up to date comprehensive guidance is published.

Service Response / Action
Agreed.

Implementation Date	Responsible Officer	Grading
Implemented	Senior Programme Manager	Significant within audited area

2.1.4 The PMO has made progress with implementing the 71 actions identified as part of its review, however in January 2018 there were 12 actions where the original due dates had not been met. The number of overdue actions has reduced to 8 following a further review by the PMO in March 2018. These include: ensuring all projects have all of the required project documentation; benefits realisation plans; reviews of interdependencies; a central database of lessons learned; further clarification of specific roles and responsibilities; communication with utilities companies; review of the closure process; and review of contingencies.

2.1.5 Until all projects have the full suite of supporting documentation there is a risk that the quality and consistency of application of the new process will vary, reducing assurance over capital programme governance.

Recommendation
All recommendations in the implementation plan should be concluded.

Service Response / Action
Agreed. Work is progressing to conclude the remaining actions which include further development of the programme management process.

Implementation Date	Responsible Officer	Grading
June 2018	Senior Programme Manager	Significant within audited area

2.1.6 The PMO also undertook a number of in depth reviews of programme management and identified further action points specific to each Programme. Whilst the Capital Board has tracked progress with some actions, the PMO has still to follow up to obtain assurance that all of the actions have been implemented as planned.

Recommendation
Programme Boards should ensure they can demonstrate that PMO review action points have been addressed.

Service Response / Action
Agreed. The PMO will review and follow up actions to demonstrate the progress made.

Implementation Date	Responsible Officer	Grading
June 2018	Senior Programme Manager	Significant within audited area

2.1.7 Officer representation on Programme Boards, and therefore the Boards' capacity may be constrained following staff changes. The Chair for the City Centre Programme Board left the Council on 31 December 2017 and the Chair of the AECC Programme Board has provided cover in the interim. There is a risk that chairing more than one Board might have an impact on capacity. The Service has stated that recruitment to the Target Operating Model is ongoing, interim appointments are being made, and the governance arrangements for the capital plan will be developed to take account of these changes.

2.1.8 Internal Audit sought to review 6 projects with planned expenditure in 2017/18 to ensure that they were prioritised and assessed for affordability, that there was a Business Case, and that the project spend was appropriately authorised at Committee:

Programme Board	Project
AECC	ACC Project Share
City Centre	Art Gallery Redevelopment Broad Street Provost Skene's House Refurbishment
Energy	Energy From Waste Procurement & Land Acquisition
Transportation	A96 Park & Choose / Dyce Drive Link Road

2.1.9 The Programme Manager was unable to provide documentation in respect of the AECC project within the period allocated for this audit. The remaining 5 projects' documentation was reviewed in detail.

2.1.10 A Business Case shows that projects are (or remain) viable, achievable and beneficial to the Council's priorities, and provide best value. In 4 cases there were Business Cases on file showing that the projects had been appropriately assessed prior to commencing.

2.1.11 Change control requests, or for significant changes revised Business Cases, should be completed if there is a requirement to change a project's scope, timing, budget or other key elements. This documentation shows that changes have been subject to appropriate scrutiny and approval, and that projects continue to offer best value.

2.1.12 The Broad Street project had originally formed part of a wider project, but no separate Business Case was set out when it was separately progressed.

2.1.13 The A96 project had a Business Case completed in 2011, outlining spend of £13 million, though this was incomplete as it did not have a full options analysis. This was superseded by a report to Full Council on 6 March 2013 which set out a revised cost of £15 million, but no revised Business Case is on file to support the change.

2.1.14 Changes to the timing of key elements within projects were not always supported by either a change control request or updated Business Cases.

- Art Gallery
  - 4 extension of time requests have been received from the contractor, with the third and fourth currently under review. There are no change requests on file covering the first and second, and the others present a risk which has still to be quantified, addressed and documented in the standard format.
- Broad Street
  - Project Status Reports show that Construction and Project completion dates were deferred by 6 months, but there are no change requests covering these.
- Energy from Waste
  - Project Status Reports show that that Conclusion of Procurement has been deferred by 6 months, but there is no change request covering this.
  - Other change control requests are on file for £61,000 of additional expenditure

2.1.15 Programme Managers have indicated that in some cases there may be limited merit to preparing change requests for circumstances which are outwith their control, which could then be superseded by changing circumstances. In some of the instances above decision making was escalated, therefore changes were not within the Capital Board's remit. However, comprehensive documentation should still be held for the project to demonstrate that appropriate consideration has been given to these changes, their impact, and appropriateness, in advance, regardless of where those decisions have been made.

Recommendation
All changes to projects should be supported by change control requests or a revised Business Case.

Service Response / Action
Agreed. Director of Resources to write and remind all project sponsors and managers of the need to comply.

Implementation Date	Responsible Officer	Grading
April 2018	Director of Resources	Significant within audited area

2.1.16 In each case the appropriate authorisation was sought where appropriate at Committee prior to expenditure being incurred.

2.2 Project Monitoring

2.2.1 Finance provides monthly ledger reports to Project Managers to aid in scrutiny of individual Projects. Thereafter Project Status Reports (PSR's) are prepared detailing milestones reviewed, expenditure and forecasts. Dashboards are then produced for Programme Boards, Highlight Reports produced to the Capital Board and a Summary Highlight Report provided to Corporate Management Team / Administration Leaders.

2.2.2 Capital Plan monitoring is included within the quarterly financial reports provided to Finance, Policy and Resources Committee. Internal Audit confirmed that with one minor exception these reports reconciled back to ledger data for the projects examined.

2.2.3 For the 5 projects reviewed (see 2.1.8) there was evidence that these are being reviewed regularly and PSR's produced (3 were reviewed from each). However, content and quality varies.

2.2.4 Minor errors or omissions in respect of dates and periods were identified in 4 of 15 PSR's reviewed. This has been resolved following changes to the PSR format.

2.2.5 Financial Monitoring should demonstrate expenditure to date, profiled future spend, and a full term forecast. Where there are anticipated variances against the budget, explanations and actions being taken to mitigate these should be provided.

2.2.6 In the Energy from Waste project, 2 out of 3 PSR's included the wrong funding figure due to a typographical error. This was resolved in the 3rd iteration.

2.2.7 For 4 out of 5 projects (all except the A96 project) Project Managers had used additional financial data to that provided by Finance to populate the PSR. Although including commitments or valuations of work in progress aids in demonstrating project implementation, it reduces comparability with financial ledger data, which is used in the Capital Plan reports to Finance, Policy and Resources Committee. Project Managers stated that they reviewed the ledger data for accuracy, however in one case (Art Gallery) an External Project Manager had taken over completion of the PSR and no similar review was being completed.

2.2.8 In these projects, other elements of the financial section of the PSR were also incomplete. Whilst actual spend to date had been completed, forecasts, monthly and future years' profiled spend had not been updated. As a result the impact of progress and expenditure to date on overall project costs and timing have not been taken into account in this section of the PSR. This data is used to update a status indicator (Red, Amber or Green), which in the cases reviewed did not therefore accurately reflect the financial status of the project at that point in time.

2.2.9 Each stage of the project and programme monitoring process summarises the stages beforehand, and detail is removed, therefore it is important that the Project Status Reports are completed consistently and correctly. The Programme Boards, Capital Board, CMT and Administration Leaders will not know if the Project Status Reports do not match the ledger or if they are not completed correctly, and may take assurance or make decisions on the basis of incorrect information.

Recommendation
The PMO should ensure Project Managers complete the financial section of the PSR fully and accurately.

Service Response / Action
Agreed. Project Managers have all received training and will be reminded of the

requirements including use of financial ledger data, profiling and forecasts. The PMO will implement quality control mechanisms to provide ongoing assurance and a letter from the Director of Resources will reinforce this.

Implementation Date	Responsible Officer	Grading
April 2018	Senior Programme Manager and Director of Resources	Significant within audited area

2.2.10 The PSR shows planned dates for project milestones, and a Red, Amber or Green status indicator for each. However, there is no record of actual completion dates. Where there have been delays the status will change to Amber or Red (though in one case reviewed an overdue milestone still had a Green indicator – Energy from Waste) until the issue is resolved, after which point the status becomes Green, whether the original due date was met or not. Including actual completion dates would aid in analysing progress and assist in the completion of post project reviews.

Recommendation
The PMO should review the PSR to provide additional clarity on progress.

Service Response / Action
Agreed. The format of the PSR will be reviewed to determine whether dates and status indicators provide sufficient detail.

Implementation Date	Responsible Officer	Grading
June 2018	Senior Programme Manager	Significant within audited area

2.2.11 In some cases forecasts were not being updated promptly following the identification of potential additional costs. Although the issues were typically being disclosed in narrative in reports to the Programme and Capital Boards, because the anticipated outcome was not known with certainty the potential impact on forecast expenditure was not factored in to the capital monitoring.

Recommendation
Forecasts should be updated promptly to take risk factors into account.

Service Response / Action
Agreed. It will not always be appropriate to update financial forecasts until there is more certainty, and there may be commercial sensitivities to take into account. Risk registers and changes should however be reported to the relevant programme board. Project Managers will be reminded of their responsibilities.

Implementation Date	Responsible Officer	Grading
April 2018	Senior Programme Manager and Director of Resources	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. Financial Regulations have been consistently breached.
Significant within audited area	Addressing this issue will enhance internal controls. An element of control is missing or only partial in nature. The existence of the weakness identified has an impact on a system's adequacy and effectiveness. 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 and Scrutiny Committee
DATE	8 May 2018
REPORT TITLE	Internal Audit Report AC1825 – Housing Support Budget
REPORT NUMBER	IA/AC1825
DIRECTOR	N/A
REPORT AUTHOR	David Hughes
TERMS OF REFERENCE	2.2

1. PURPOSE OF REPORT

1.1 The purpose of this report is to present the planned Internal Audit report on the Housing Support Budget.

2. RECOMMENDATION

2.1 It is recommended that the Committee review, discuss and comment on the issues raised within this report and the attached appendix.

3. BACKGROUND / MAIN ISSUES

3.1 Internal Audit has completed the attached report which relates to an audit of the Housing Support Budget.

4. FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from the recommendations of this report.

5. LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from the recommendations of this report.

6. MANAGEMENT OF RISK

6.1 The Internal Audit process considers risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are as detailed in the attached appendix.

7. OUTCOMES

7.1 There are no direct impacts, as a result of this report, in relation to the Local Outcome Improvement Plan Themes of Prosperous Economy, People or Place, or Enabling Technology, or on the Design Principles of the Target Operating Module.

7.2 However, Internal Audit plays a key role in providing assurance over, and helping to improve, the Council's framework of governance, risk management and control. These arrangements, put in place by the Council, help ensure that the Council achieves its strategic objectives in a well-managed and controlled environment.

8. IMPACT ASSESSMENTS

Assessment	Outcome
Equality & Human Rights Impact Assessment	An assessment is not required because the reason for this report is for Committee to review, discuss and comment on the outcome of an internal audit. As a result, there will be no differential impact, as a result of the proposals in this report, on people with protected characteristics.
Privacy Impact Assessment	Not required
Duty of Due Regard / Fairer Scotland Duty	Not applicable

9. APPENDICES

9.1 Internal Audit report AC1825 – Housing Support Budget.

10. REPORT AUTHOR DETAILS

David Hughes, Chief Internal Auditor
David.Hughes@aberdeenshire.gov.uk
(01467) 537861

Internal Audit Report

Customer

Housing Support Budget

Issued to:

Andy MacDonald, Director of Customer Services
Derek McGowan, Chief Officer – Early Intervention and Community Empowerment
Fraser Bell, Chief Officer – Governance
Sandra Buthlay, Interim Chief Officer – Finance
Alana Nabulsi, Support Services Manager
External Audit.

Date of Issue: April 2018 **Report No. AC1825**

EXECUTIVE SUMMARY

The Council is under a statutory obligation to assist people presenting as homeless or at risk of homelessness and must offer a minimum of temporary accommodation, advice and assistance. Clients considered intentionally homeless should be provided with temporary accommodation for a "reasonable" amount of time, although the time period is not defined in legislation.

The budget for homeless temporary accommodation has historically overspent. For 2016/17, the Council set a net budget of £3.632 million for Housing Support, with a resultant outturn of £4.364 million (overspend 20%). However, the 2017/18 net budget was set at £4.677 million and the actual net outturn was £4.395 million, an underspend of £282,000 (6%).

As at 23 February 2018 there were 448 households in temporary accommodation, comprising: 269 in Council-owned furnished flats; 56 in the Council's 3 accommodation units; 108 in accommodation let from private landlords; and 15 in Bed and Breakfast (B&B) accommodation.

The objective of this audit was to consider whether adequate control is being exercised over income and expenditure, and that best value is being obtained. The Service was found to have adequate procedures in place that reflect current arrangements and, in general, practice was found to comply with these procedures, with the homeless person placement process being well managed.

However, in order to make improvements, recommendations have been made and agreed in relation to written procedures; the review of the use of agency staff causing the staffing budget to overspend; the voids process, due to delays rehousing homeless clients causing a loss of income; the recording of out of hours requests for accommodation; the use of occupancy agreements for B&B tenancies, to ensure tenants are aware of their responsibilities; housing benefit since homeless clients are failing to apply, resulting in rent arrears; debt recovery action for rent arrears since an instance was identified when this was not applied as required; and the requirement to raise purchase orders for supplies and services since excluding contracted payments and metered services, 158 payments out of 3,015 (5.2%) reviewed, were not supported by a purchase order.

1. INTRODUCTION

1.1 In accordance with Part II of the Housing (Scotland) Act 1987 as amended by the Housing (Scotland) Act 2001, the Homelessness etc. (Scotland) Act 2003, and the Homeless Persons (Unsuitable Accommodation) (Scotland) Order 2004, the Council has a legal duty to assist people presenting as homeless or at risk of homelessness and must offer a minimum of temporary accommodation, advice and assistance. Clients considered intentionally homeless should be provided with temporary accommodation for a "reasonable" amount of time, although the time period is not defined in legislation.

1.2 Where the person is found to be unintentionally homeless, the Council is duty bound to assist them in securing permanent accommodation. Priority need clients include pregnant women, persons with dependent children, and persons considered vulnerable due to age, illness or disability. In addition, clients must have a local connection (e.g. family members, past residency, employment), or be a refugee to be housed in Aberdeen. The Council's duty is discharged by making one reasonable offer of permanent accommodation in any area of the city, in a council tenancy or housing association tenancy.

1.3 As at 23 February 2018 there were 448 households in temporary accommodation, comprising: 269 in Council-owned furnished flats; 56 in the Council's 3 accommodation units; 108 in accommodation let from private landlords; and 15 in Bed and Breakfast (B&B) accommodation.

1.4 For 2016/17, the Council set a net budget of £3.632 million for Housing Support, with a resultant outturn of £4.364 million. The 2017/18 net budget was set at £4.677 million and the actual net outturn was £4.395 million, an underspend of £282,000 (6%).

1.5 The objective of this audit was to consider whether adequate control is being exercised over income and expenditure, and that best value is being obtained.

1.6 The factual accuracy of this report and action to be taken with regard to the recommendations made have been agreed with Derek McGowan, Chief Officer – Early Intervention and Community Empowerment, Alana Nabulsi, Support Services Manager, and Bellann Wylie, Acting Housing Access Service Manager.

2. FINDINGS AND RECOMMENDATIONS

2.1 General

2.1.1 The Homelessness chapter of the Aberdeen City Local Housing Strategy 2018 – 2023 was approved by the Communities, Housing and Infrastructure Committee on 16 January 2018. This aims to prevent and alleviate homelessness across the City and includes the following key objectives:

- earlier interventions and a housing options approach to mitigate the need for temporary accommodation;
- a prevention approach which will reduce the requirement to use bed and breakfast accommodation;
- a reduction in the average length of time spent in temporary accommodation with a target of no more than 90 days;
- where appropriate, private sector housing will be utilised in order to discharge accommodation duties.

2.1.2 Periods spent in temporary accommodation for the period ending 31 December 2017 showed an average stay of 105.6 days, down 27.9 days from the corresponding period for 2016/17 but exceeding the current strategic target of 90 days approved by CH&I Committee on 16 January 2018. The average stay for households accommodated in bed and breakfast accommodation for the period ending 31 December 2017 was 64.0 days, down from 97.6 for the corresponding 2016/17 period in line with the current strategic target.

2.2 Legislation and 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 Although there are written procedures in place, and a user manual for the Housing System, the Service is in the process of updating procedures to reflect changes in service delivery, and therefore may not yet reflect current processes. In addition, the Service is reorganising the teams involved in delivery of Homelessness assessment, temporary accommodation and support, and intend to update written procedures to reflect that reorganisation. A recommendation has been made for tracking purposes.

Recommendation
The Service should update written procedures to reflect appropriate changes.

Service Response / Action
Agreed pending completion of Service reorganisation.

Implementation Date	Responsible Officer	Grading
January 2019.	Support Services Manager.	Significant within audited area

2.2.3 The Council Website offers advice to clients who are, or are under threat of being, homeless and includes information on temporary accommodation offered by the Council. The advice includes details of three accommodation units, however information available on The Zone, and on the Housing System, there are four properties described as being an accommodation unit. The Service is addressing this issue.

2.3 Staffing Costs

2.3.1 Placement in hostel accommodation, furnished lets, bed and breakfast accommodation, and related administration is provided by 89 Full Time Equivalent staff. The annual budget for staffing for 2017/18 is £3.407 million, with a forecast outturn, as at 31 December 2017, of £3.590 million. The over spend has resulted from the use of agency staff to fill hours that would ordinarily be covered by posts that are currently vacant. Staff costs were overspent in 2016/17 and 2015/16 by £132,000 for the same reason.

2.3.2 The staffing budget is established by Finance reviewing payroll data, any overtime worked in the previous year, and any new starts or increments due. Actual payments are coded directly to the relevant ledger code by the Payroll System. The forecast overspend of £183,000 noted above is attributed to the use of Bon Accord Care agency staff to fill part time hours when required. Although there is evidence that the budget is being adequately monitored, it has not been established if this is a recurring pressure on the budget.

Recommendation
The Service should review use of external staff to cover staffing vacancies to determine if it is the most cost effective way of providing cover.

Service Response / Action
Agreed. The Service now has changing staffing needs, and agency staff dependency will be greatly reduced from the end of June 2018 as a result of changes to the rota and staffing of accommodation units.

Implementation Date	Responsible Officer	Grading
September 2018.	Support Services Manager.	Significant within audited area

2.4 Provision of Accommodation & Recovery of Costs

2.4.1 Applications for homeless accommodation are made in person with the assistance of a Case Officer. The application records the reason for homelessness; 5 year accommodation history; details of local connection; sources and amount of income; whether temporary accommodation is required; whether furniture storage / uplift is required; any health issues; and whether there are any threats to the individual's safety. The application form is then signed and dated by the applicant and Case Officer.

2.4.2 The iWorld Housing system records application responses, enabling a decision to be made on whether or not homelessness is intentional, and if the applicant has a local connection. Applicants from outwith Aberdeen may present as homeless and have details taken, but can be referred to the local authority to which they have a local connection. The assessment process will allow the case officer to determine if the applicant is in need of temporary accommodation.

2.4.3 Records relating to 40 homeless persons placed in temporary accommodation (furnished flats, private sector lets and accommodation units) were reviewed to ensure that all were supported by an application form, that intentionality and local connection had been established, that a tenancy had been created on iWorld, that a permanent offer had been made to unintentionally homeless clients, and that where a client contribution towards rent existed, the contribution was recovered, and rent arrears action was taken where appropriate.

2.4.4 All tenancies, with the exception of one discretionary ongoing mainstream tenancy, were supported by a homeless person's application, and had been assessed for intentionality and local connection. Four temporary units had been let to clients who had been assessed

as being intentionally homeless. Three had left the unit per the terms of the assessment letter, which specifies an end date for the temporary tenancy. However, for one tenancy which was due to end by 26 November 2017, the client was still in a temporary unit as at 27 February 2018, and had accrued arrears of £4,032. The Service advised that the client had not successfully challenged the intentionality decision, therefore the Council had no statutory duty beyond 26 November 2017, however the client was not given a Notice to Quit due to the risks of evicting a vulnerable client during winter. The client has been working with the Council's homelessness advice and information provider towards a solution, and the Service is to review the case. Continuing provision of temporary accommodation where a client is intentionally homeless, uses resources that could be used for unintentionally homeless clients, and in this case has potentially increased the value of irrecoverable rent arrears. The Service advised that a meeting is held weekly to discuss long term open homeless applications.

2.4.5 The Service no longer issues an occupancy end date to intentionally homeless persons for temporary accommodation. This previously indicated when the Council believed their statutory responsibility to provide reasonable opportunity to secure alternative accommodation had been delivered. This is due to the fact the occupancy end date was frequently exceeded following the issue of a Notice to Quit, resulting in court proceedings to recover accommodation, with the individuals concerned often presenting as homeless again regardless. Intentionally homeless cases are now referred to a commissioned service, who work with the individual to find alternative accommodation, with a view to improving the individual's prospects of obtaining alternative permanent accommodation.

2.4.6 Two offers of a permanent tenancy had not been accepted by the client by the offer expiry date. Although iWorld indicated that the temporary tenancies are pending termination, the offer deadline dates for the cases had expired by 56 and 19 days respectively at the time of testing. Where there is a delay in the void / permanent accommodation allocation process there is a risk that homeless clients are in temporary accommodation longer than is necessary, which means appropriate temporary accommodation for new clients may not be available and void periods will be extended preventing offers being made to other clients. The Service advised that the temporary tenancies have now been terminated, and the clients have taken up their permanent tenancies.

2.4.7 Building Services has confirmed that, whilst the above delays included the Christmas and New Year period, which would not count towards their 10 day turnaround target, the target in these cases was exceeded due to further repair and maintenance work that was required in addition to achievement of the minimum letting standard. Where an extension to a void period is necessary to carry out repairs, Building Services should notify the Housing Service through the iWorld system, however this was not carried out. Staff have been reminded of the importance of providing these updates.

2.4.8 A sample of 30 clients placed in 3 B&B providers was selected from 10 invoices and reviewed. All were supported by a completed homeless persons application form with one exception where a person presented as homeless, and was provided with temporary accommodation on a discretionary basis for one night, but no evidence could be found of an application, or a tenancy being created on iWorld. Where temporary accommodation is not supported by an application form and iWorld tenancy, there is a risk that clients will not be charged for accommodation provided. The Service advised that clients approaching the Service out of hours may be provided with accommodation for the night, but may subsequently fail to formally present as homeless the following day, meaning a homeless person's application will not be completed.

Recommendation
All instances of temporary accommodation provided should be supported by a tenancy created on iWorld.

Service Response / Action
The Service will investigate the possibility of recording out of hours' approaches for temporary accommodation in iWorld.

Implementation Date	Responsible Officer	Grading
September 2018.	Support Services Manager.	Significant within audited area

2.4.9 To assist vulnerable clients maintain tenancies, the Service provides Housing Support to those who would benefit from that support to help them live independently. Where there is an indication that support may be required, a client will be referred by the caseworker to the Support Team so the client can have their needs assessed. Where a need is identified, the client will be placed with an appropriate Support Officer, or referred externally to a commissioned provider. The iWorld system will be updated with details of the referral and support provided.

2.4.10 Records relating to 30 homeless applicants placed in B&B accommodation were reviewed to establish that where a potential need was identified, the client was referred for assessment, and provided with appropriate support. 15 of those 30 indicated a potential need, and all were assessed for housing support. Of the 15, 13 were provided with support, and two were assessed as being able to live independently.

2.4.11 Homeless clients may be entitled to Housing Benefit, which is means tested, assessed on eligible rent, and can reduce the client's liability to pay rent. As part of the tenancy sign up process, the Service requires that clients complete a claim for Housing Benefit, although they have limited influence on ensuring the claim progresses to assessment of entitlement as the successful completion of a HB claim is dependent on the claimant submitting all relevant information to Benefits staff timeously. A review of Housing Benefit claims for clients in temporary accommodation noted that 23/40 temporary accommodation clients were in receipt of Housing Benefit. Of the 17 clients who do / did not have Housing Benefit in payment, 16 had rent arrears present, with six clients each having arrears in excess of £2,500.

2.4.12 23/30 B&B clients had Housing Benefit in payment. For the 7 who did not, rent arrears were present in all cases, with one client having accrued arrears in excess of £6,400. Given the circumstances of clients, it is likely that such arrears would be irrecoverable. The provision of support for clients to complete the Housing Benefit claim process to ensure entitlement is determined, would reduce the risk of arrears accruing.

Recommendation
The Service should consider providing ongoing support, specifically for the Housing Benefits claim process.

Service Response / Action
Agreed. Proposals are being looked at for changing job profiles to address rent arrears and a dedicated resource is currently being piloted.

Implementation Date	Responsible Officer	Grading
September 2018.	Support Services Manager.	Significant within audited area

2.4.13 Homeless clients placed in temporary accommodation units are required to sign an occupancy agreement, which details the responsibilities of the tenant and the landlord. Currently, occupancy agreements for tenants are held centrally in hard copy format for Council owned flats and Private Sector Leasing tenants, and at accommodation units, and are scanned and held on iWorld for former tenants. Testing confirmed an occupancy agreement was present for all clients in the sample.

2.4.14 Occupancy agreements are not in place for clients placed in B&B accommodation. The Service advised that this is due to B&B proprietors having conditions of occupancy specific to their establishment. However, an occupancy agreement between the Council and the referred homeless person would provide clarity over the responsibilities of both parties.

Recommendation
Occupancy agreements should be put in place for B&B accommodation tenancies.

Service Response / Action
The Service will explore this possibility further. It may not be practical to take forward in every instance due to the process being managed by third party providers.

Implementation Date	Responsible Officer	Grading
June 2018.	Support Services Manager.	Important within audited area

2.4.15 Temporary flats used for housing homeless clients are furnished units, therefore each has an inventory of furniture and equipment, which each tenant is required to sign for. The inventory is held on file, and is checked at the end of the tenancy to ensure all furniture and equipment is present and in good condition. However, when a tenancy ends, the inventory is destroyed, therefore there is no evidence that an inventory was signed for by former tenants.

Recommendation
Inventories relating to former tenancies should be scanned and held on iWorld prior to the original documents being destroyed.

Service Response / Action
Agreed.

Implementation Date	Responsible Officer	Grading
June 2018.	Support Services Manager.	Important within audited area

2.5 Rent Arrears

2.5.1 As at 31 January 2018, rent arrears across all temporary accommodation for homeless clients was £6.095 million. The majority of this balance relates to former tenants (£5.547 million). The balance has increased from £5.057 million as at 31 March 2017. The Service has advised that they have introduced a number of options aimed at reducing rent arrears, including requesting Housing Benefit claim evidence at first contact to expedite claims, a pilot targeting initial support to collect claim evidence and direct referral to the Financial Inclusion Team for clients most likely to incur high levels of rent arrears, such as self-employed clients.

2.5.2 With one exception, rent arrears action, which is implemented when arrears exceed £100, with further escalation when arrears exceed £1,500, had been taken in accordance with homeless persons rent arrears procedures. One case was noted where arrears of £1,300 had accrued, but no action was documented on iWorld. Although it is acknowledged that

recovering arrears from vulnerable clients may be difficult, not applying arrears procedures further increases the risk of bad debt.

Recommendation		
Rent arrears procedures should be applied to all tenancies where arrears are present.		
Service Response / Action		
Arrears action will be prioritised when staffing resources allow.		
Implementation Date	**Responsible Officer**	**Grading**
September 2018.	Support Services Manager.	Significant within audited area

2.6 Procurement and Purchasing

2.6.1 The Service utilises the PECOS purchase ordering system to raise orders for goods and services for the Homeless Persons service, including furniture, accommodation, cleaning services and support. The Council's Financial Regulations require that an order be issued for all work, goods and services, although an order would not be expected for regular contract payments, or for metered services.

2.6.2 All supplier payments made up to and including November 2017, coded to cost centres for hostels, temporary flats, private sector leases and administration, were reviewed to ensure payments were supported, where appropriate, by a PECOS purchase order. Excluding contracted payments and metered services, 158 payments, out of 3,015 were not supported by a purchase order. Where a purchase order is not raised, there is a risk that there may be insufficient budget in place, or that unauthorised purchases may be made. In addition, it is a breach of Financial Regulations.

Recommendation		
Purchase orders should be raised for all goods and services, in accordance with Financial Regulations.		
Service Response / Action		
Agreed.		
Implementation Date	**Responsible Officer**	**Grading**
June 2018.	Support Services Manager.	Significant within audited area

2.6.3 A sample of 30 paid invoices was reviewed to ensure they had been authorised independently of the purchase order, matched that order, were accurate, complied with VAT regulations, and were reasonable. All invoices were appropriately processed.

2.6.4 The Council has procured accommodation facilities at a number of bed and breakfast establishments, and pays proprietors on a monthly basis for accommodation provided. For the 2017/18 financial year to 31 January 2018, £229,450 had been paid to three B&B providers. Procurement regulations require that where contract spend exceeds £50,000 then a tendering exercise should be undertaken. The Service has liaised with Commercial and Procurement Services, and Governance, with a view to undertaking a competitive tender for the procurement of B&B accommodation. An invitation to tender was issued on the Public Contract Scotland website on 29 March 2018, for the provision of temporary homeless accommodation, with a response return date of 26 April 2018.

2.6.5 The Council procures specialist services to support homeless persons that it may not be able to provide internally. For the 2017/18 financial year up to 28 February 2018,

payments totalling £2.24 million had been made to external bodies for the provision of specialist services, such as mental health services. Documentation relating to all (seven) providers paid in excess of £100,000 was reviewed and it was confirmed that a contract is in place for the service provided.

2.7 Voids

2.7.1 Where a tenancy ends, there is a void period to allow for any cleaning and / or repairs to be carried out before the tenancy can be allocated to another homeless person. During the void period, any rent due from potential tenancies is lost. To 28 February 2018 for the current year, 24,433 days (75.0 days per unit) were lost due to voids, with a corresponding lost rental income of £341,000 (8.5% of gross rent). In 2016/17, a total of 23,362 days (71.7 days per unit) were lost due to voids, with a corresponding lost rental income of £447,000 (9.5 % of gross rent). This is based on 269 Council owned furnished flats and 57 'units' at the 3 Council owned hostels / accommodation units.

2.8 Statutory Returns

2.8.1 All local authorities are required to make quarterly returns to the Scottish Government on homeless applications received, households and priority needs cases in temporary accommodation, to allow monitoring on compliance with the Unsuitable Accommodation Order, and types of accommodation offered for all applicants. The HL-2 quarterly return to the Scottish Government describes the number of homeless applications received and completed in the quarter and the number of households in temporary accommodation at the end of the quarter by type of accommodation. The returns for the first 3 quarters of 2017/18 were submitted to the Scottish Government in a timely manner. At the time of the audit the submission for the fourth quarter was not due.

2.8.2 The Council received 1,375 homeless applications in 2016/17, exceeded only by Glasgow, Edinburgh, Fife, North Lanarkshire and South Lanarkshire. Homeless applications have been largely static in recent years, following a substantial decline in 2011/12. Homeless applications to the Council are charted below. Homeless applications for 2017/18 are expected to be approximately 1,706, which the Service attributes to an increased number of applications from young people, an increase in private tenancy evictions and work to enhance access to homeless services.

2.9 Budget and Monitoring

2.9.1 The budget setting and monitoring process is carried out in line with guidance issued by Finance, with Budget Holders being responsible for monitoring their budgets. Monitoring is carried out on a monthly basis, and is discussed between the Support Service Manager and Team Leaders at monthly and one-to-one meetings. In addition, budget monitoring is discussed at monthly meetings between the Support Services Manager and Finance, and is reported to the Communities, Housing & Infrastructure Committee on a quarterly basis.

2.9.2 Budget monitoring as at 31 December 2017 had a forecast 2017/18 overspend of approximately £686,000, although this was offset by an adjustment in debtors' income of £746,000. The Service Accountant advised that overspends were apparent on staff and property costs. The Service is working to identify savings to mitigate these cost pressures, with a reduction in the use of agency costs and reduction in the length of voids having been identified as areas to be addressed in 2018/19.

AUDITORS: D Hughes
A Johnston
N Ritchie

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. Financial Regulations have been consistently breached.
Significant within audited area	Addressing this issue will enhance internal controls. An element of control is missing or only partial in nature. The existence of the weakness identified has an impact on a system's adequacy and effectiveness. 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

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	8 May 2018
REPORT TITLE	Internal Audit Report AC1828 – Care Management
REPORT NUMBER	IA/AC1828
DIRECTOR	N/A
REPORT AUTHOR	David Hughes
TERMS OF REFERENCE	2.2

1. PURPOSE OF REPORT

1.1 The purpose of this report is to present the planned Internal Audit report on Care Management.

2. RECOMMENDATION

2.1 It is recommended that the Committee review, discuss and comment on the issues raised within this report and the attached appendix.

3. BACKGROUND / MAIN ISSUES

3.1 Internal Audit has completed the attached report which relates to an audit of Care Management.

4. FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from the recommendations of this report.

5. LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from the recommendations of this report.

6. MANAGEMENT OF RISK

6.1 The Internal Audit process considers risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are as detailed in the attached appendix.

7. OUTCOMES

7.1 There are no direct impacts, as a result of this report, in relation to the Local Outcome Improvement Plan Themes of Prosperous Economy, People or Place, or Enabling Technology, or on the Design Principles of the Target Operating Module.

7.2 However, Internal Audit plays a key role in providing assurance over, and helping to improve, the Council's framework of governance, risk management and control. These arrangements, put in place by the Council, help ensure that the Council achieves its strategic objectives in a well-managed and controlled environment.

8. IMPACT ASSESSMENTS

Assessment	Outcome
Equality & Human Rights Impact Assessment	An assessment is not required because the reason for this report is for Committee to review, discuss and comment on the outcome of an internal audit. As a result, there will be no differential impact, as a result of the proposals in this report, on people with protected characteristics.
Privacy Impact Assessment	Not required
Duty of Due Regard / Fairer Scotland Duty	Not applicable

9. APPENDICES

9.1 Internal Audit report AC1828 – Care Management.

10. REPORT AUTHOR DETAILS

David Hughes, Chief Internal Auditor
David.Hughes@aberdeenshire.gov.uk
(01467) 537861

ABERDEEN
CITY COUNCIL

Internal Audit Report

Care Management

Issued to:
Judith Proctor, Chief Officer, Aberdeen City Health & Social Care Partnership
Tom Cowan, Head of Operations, Aberdeen City Health & Social Care Partnership
Alex Stephen, Chief Finance Officer, Aberdeen City Health & Social Care Partnership
Fraser Bell, Chief Officer – Governance
Sandra Buthlay, Interim Chief Officer – Finance
Claire Duncan, Lead Social Work Officer
Katharine Paton, Service Manager
External Audit

Date of Issue: April 2018 **Report No. AC1828**

EXECUTIVE SUMMARY

The Health and Social Care Partnership has a statutory duty to undertake assessments of those in need of community care services; this includes assessment of the needs of Carers. Individuals who are entitled to assessment of their needs are those affected by illness or disability, older people, people with learning disability, mental health issues, physical disability and substance misuse issues. Eligibility criteria are then applied and people who have high and urgent needs are prioritised for care and support. Support may be financial, including one-off assistance or regular care / support provided through an ongoing service agreement, determined after consideration of self-directed support (SDS) options.

The objective of this audit was to obtain assurance that care needs are being identified, planned, and recorded accurately, and that costs charged are appropriate and adequately controlled.

Whilst in general staff understand their roles and processes, written procedures are in need of review and re-issue to ensure CareFirst system records are updated promptly and provide a full and accurate record of care needs, plans, reviews and planned costs. The Service has agreed to review procedures to ensure they are clarified, including a review of delegated authorisation levels and the circumstances in which segregation of duties is required, and determining how care reviews can be more consistently documented. Existing procedures for recording and evidencing the use of one-off financial assistance will also be reiterated to staff, as practice in this area varies.

There are regular payments for care which are being processed outwith the CareFirst system. In some instances there is no record of the particular care which has been paid for on the system, and payments have been authorised retrospectively. Although there is evidence that this care was required, without a CareFirst service agreement there is effectively no purchase order for these services, which is a breach of Financial Regulations. In other instances payments had not been matched against existing CareFirst records, resulting in a duplicate payment in one case. The Service has agreed to review non-CareFirst payments to determine where these should have a CareFirst record.

SDS Option 2 payments to a third party (currently only the Council) to manage on behalf of a service user are not currently recorded on CareFirst. Although there are processes for obtaining approval for payments, and a tracker system to monitor payments to the third party, important elements of the process including: development and application of indicative budgets on the system, and monitoring variations in the use of funds to ensure they remain within the allocated budget over a specified period, have still to be developed before this can be set up. The SDS Programme Board will determine an action plan for implementation.

The Service maintains and leases out a small portfolio of residential property. This is currently under review in conjunction with Housing to determine the most appropriate arrangements for its management.

1. INTRODUCTION

1.1 The Health and Social Care Partnership has a statutory duty to undertake assessments of those in need of community care services; this includes assessment of the needs of Carers. Individuals who are entitled to assessment of their needs are those affected by illness or disability, older people, people with learning disability, mental health issues, physical disability and substance misuse issues. Eligibility criteria are then applied and people who have high and urgent needs are prioritised for care and support. Support may be financial, including one-off assistance or regular care/support provided through an ongoing service agreement, determined after consideration of self-directed support options.

1.2 The objective of this audit was to obtain assurance that care needs are being identified, planned, and recorded accurately, and that costs charged are appropriate and adequately controlled. This involved a review of supporting documentation for care expenditure and discretionary support payments completed by a sample of adult services teams.

1.3 The factual accuracy of this report and action to be taken with regard to the recommendations made have been agreed with Claire Duncan, Lead Social Work Officer, and Katharine Paton, Service Manager.

2. FINDINGS AND RECOMMENDATIONS

2.1 Written Procedures

2.1.1 There are various procedure notes on The Zone covering administration and CareFirst data entry, however very few of these cover the whole process, or why it is done in a particular way. For example, there is a procedure note detailing how to enter service agreements on the system for one off section 12 payments (see 2.3.8 below), but nothing to set out the circumstances in which this would be required. These procedures are also not all up to date. Whilst existing staff understand their roles and procedures, staff changes could compromise the process.

Recommendation
The Service should update, standardise and simplify their written procedures, and ensure all staff have access to them.

Service Response / Action
Agreed. There are existing practice and process notes in place but these will be revised, expanded and shared to ensure all practitioners are aware of what should be recorded on the system and when.

Implementation Date	Responsible Officer	Grading
September 2018	Team Manager, Performance Management and Adult Social Work Service Managers	Significant within audited area

2.1.2 There are few notes on the financial process, and no list of delegated authority levels for either care packages or one-off support. When discussed with staff it was evident that each understood their role and their part of the process for administering payments (e.g. limits of £20 for social workers to approve one off support, £50 for senior social workers), but this does not appear to have been explicitly documented. Few staff were aware of limits beyond their own, which could make it more difficult to identify the most appropriate signatory for particular circumstances. Without clear delegated authority levels there is a risk of funding being committed without sufficient management oversight.

2.1.3 In emergency or out of hours cases the duty worker may make a decision without obtaining further authorisation. This practice is not documented in an official procedure, and there does not appear to be any requirement to obtain retrospective approval / acknowledgement from a senior officer. Authorisations are also not always being recorded – some are verbal.

2.1.4 In one instance records indicate that the Social Worker paid for accommodation on a service user's behalf, and then recovered the cost via the financial assistance application process. Although for cash payments there is approval at a later date when the petty cash reclaim is completed, this will be after cash has already been paid out.

Recommendation
The Service should set out a schedule of delegated authorisation levels, including any approved exceptions, and ensure all staff are aware of how this should be applied and evidenced.

Service Response / Action
Agreed. There are already delegations in place however these would benefit from

review. Service Managers and Finance will meet to review and approve financial authorisation levels, and guidance will be issued to reflect.

Implementation Date	Responsible Officer	Grading
May 2018	Business Manager	Significant within audited area

2.2 Planned Care

2.2.1 A sample of payments in respect of 20 service users was reviewed to ensure care needs are being identified, planned, and recorded accurately, and that costs charged are appropriate and adequately controlled.

2.2.2 In each case reviewed there was evidence that payments made related to a supported person whose details are held on the CareFirst system. Although there is a section on the system for 'care plans' these are not typically populated.

2.2.3 Assurance was therefore taken from 'assessments' recorded in a separate part of the system, which set out the level of needs identified, and from which a reasonable level of support can be determined. However, where assessments are held on the system they are not always recent or being reviewed regularly and updated to demonstrate that services which are being paid for continue to be relevant to supported people's needs. In 10 of 20 cases reviewed there was no record of an assessment within the last 2 years, or the notes did not clearly indicate the extent of the person's requirements. Whilst in many cases needs are likely to be continuing, i.e. because the conditions requiring support are not of a type which will improve, this will not necessarily always be the case. Changes are however being made, e.g. to hours and services, even in cases where there is no updated review, therefore other supporting information must be used to inform these decisions.

Recommendation
The Service should ensure that it can demonstrate that service agreements are and remain relevant to supported peoples' needs.

Service Response / Action
Agreed. At present there is no uniform method for recording completion of a review of service agreements. Service users are initially assessed, and there are follow up reviews of their care and outcomes scheduled. When a service specification is developed, the practitioner inputs a service agreement and should schedule a review activity, however such reviews will be taking place as part of the care and outcomes review and may not always be separately recorded. A review will be undertaken to determine how records should be updated to demonstrate that subsequent reviews of the agreed care are taking place as planned.

Implementation Date	Responsible Officer	Grading
October 2018	Adult Social Work Service Managers	Significant within audited area

2.2.4 Service agreements with external service providers are costed based on agreed rates, and the service users' needs as documented in a service specification. Service agreements, costs, and their authorisation, are documented on CareFirst.

2.2.5 Records show that 16 of 24 agreements reviewed (relating to the 20 individuals) were input after the service was intended to commence, and in 19 of 24 cases the agreements were authorised after the service commenced. There were only 2 cases where the service agreement was input a day or more in advance of the service commencing. In 5 instances,

delays in entering the agreement to CareFirst of over 1 month were identified (in one case almost 4 years).

2.2.6 In one case a one off payment was made to reimburse a service user for a course they had already paid for. Whilst the Service has demonstrated that the payment was made correctly, formal agreement was only recorded after the Service had effectively committed to funding the course.

2.2.7 Authorisations on CareFirst varied: Social Workers, Care Managers, Senior Social Workers, Team Managers, and Service Managers all authorised care packages of various values, with no clear pattern of more senior staff authorising higher value cases. In conjunction with the absence of a list of delegated authorisation levels (as discussed at 2.1.2) it is unclear whether or not authorisation was appropriate.

2.2.8 In 8 of 24 cases the same Social Worker or Care Manager has both input and authorised the service agreement on CareFirst, indicating a lack of segregation of duties in the system.

Recommendation
The Service should ensure there is evidence of advance separate authorisation at an appropriate level for all care agreements.

Service Response / Action
The Service is satisfied that within certain limits practitioners have delegated authority to apply professional judgement and enter into service agreements. There are compensating controls including care management reviews and case monitoring. The extent of delegated authority, and any requirements for further approval, will be considered and documented as part of the meeting taking place in response to 2.1.4 above.

Implementation Date	Responsible Officer	Grading
May 2018	Business Manager	Significant within audited area

2.2.9 The Finance team receives invoices and checks them against service agreements on CareFirst. Where there is a variation there is an element of discretion for the Finance team. Where variations were identified in the sample these were adequately explained by the Service. In all cases reviewed the payments made compared reasonably with service agreements and values on the system.

2.2.10 In one case there appeared to be two concurrent agreements for the same care service. In another an agreement had been left open on the system after a client was deceased. In such instances there is a risk that an erroneous invoice could be matched against an open service agreement, resulting in payment being made for services that have not been received.

2.2.11 Although the CareFirst team sends out reports to management to highlight such cases these may not be sufficiently regular or being acted upon timeously. Following an Internal Audit query the CareFirst team identified two omissions from management reports which have now been corrected. If the reports were reviewed regularly omissions could be highlighted and resolved more promptly.

Recommendation
The Service should ensure system data is reviewed regularly to identify and correct potential duplicate or expired records.

Service Response / Action
Agreed.

Implementation Date	Responsible Officer	Grading
September 2018	Team Manager, Performance Management; Lead Social Work Officer	Important within audited area

2.2.12 Rate increases are being applied and invoiced retrospectively, and payments backdated. This makes it more difficult to match care payments with service agreements, particularly whilst changes are being processed.

2.2.13 Increases are not all being updated on CareFirst promptly – in one case two years of rate increases had not been updated. Whilst in this instance the differences were minor, and Finance can process variations to match minor adjustments, it would provide more assurance that payments are correct if they are updated on the system promptly.

Recommendation
The Service should ensure cost rates are updated on the system promptly following agreed changes.

Service Response / Action
Agreed. Controls are in place and corrections have been made as appropriate.

Implementation Date	Responsible Officer	Grading
Implemented	CareSupport Implementation Officer	Important within audited area

2.3 Additional Support

2.3.1 There are regular payments for care which are being processed outwith the CareFirst system. These may relate to arrangements which have been put in place or changed on an interim basis and not formalised, though one case was identified where regular payments had been made but no record had been added to the system for four years. Whilst the invoices are being approved by a Service Manager, this is after the services are being delivered, which is inefficient and offers limited opportunity to challenge or amend the payment before it has to be made.

2.3.2 In addition, some invoices which could be matched against existing records in CareFirst are being processed through Accounts Payable instead. These invoices are bypassing the matching process, obtaining separate authorisation, and presenting a risk of duplicate payments. In one case a duplicate payment was made as a result, though this has subsequently been resolved.

Recommendation
The Service should ensure payments for care provision are not processed unless they have been formally approved, registered and matched on the CareFirst system.

Service Response / Action
Agreed. There are some exceptions including SDS Option 2 (see following report paragraphs) and block funding arrangements where there is no specific service user against which to record care payments. All other care should be recorded on the system. Current payments that are not on the system will be reviewed to see if they can be brought on.

Invoices should be forwarded to processing and matched accordingly where the invoices relate to specific service users. The Individual Services Order issued by Contracts tells providers to send invoices to processing and in general, this is adhered to.

There are robust controls in place in order to capture potential duplicate payments. The CareFirst invoice number field has been corrected to match e-financials and as such, provides assurance that the chances of duplicate payments are minimal. This fix had not been implemented at the time of the duplicate payment identified by Internal Audit.

Implementation Date	**Responsible Officer**	**Grading**
September 2018	Finance Support Manager	Significant within audited area

2.3.3 Agreements to make payments for Self Directed Support (SDS) Option 2 (payments to a third party on behalf of the service user) are not currently being entered on CareFirst. Although there are processes for obtaining approval for payments, and a tracker system to monitor payments to the third party, important elements of the process including: development and application of indicative budgets on the system, and monitoring variations in the use of funds to ensure they remain within the allocated budget over a specified period, have still to be developed before this can be set up. Coordination and reporting of care may be less efficient as a result.

2.3.4 There is a risk that clients contracting with providers under Option 2 may not obtain the same value as may be available through care providers directly contracted by the Council, however each service user is allocated a budget based on the equivalent cost of directly provided services, and is supported to select an Option. Once selected they must work within that budget to maximise their agreed outcomes. The examples reviewed by Internal Audit showed payments to care providers who were not at the time on a relevant supplier framework. Client choice is integral to SDS therefore the Service has to procure as directed, however expenditure on this care still counts as Council procurement, which is subject to corporate and national regulations. Commercial and Procurement Services continues to monitor national developments in this area.

2.3.5 Although there are no current cases, it is also an option under Option 2 to have a third party manage funds on behalf of a service user, similar to a Direct Payment (SDS Option 1) arrangement. How this would be managed and recorded has still to be considered.

Recommendation
The Service should ensure arrangements for budgeting, managing payments via CareFirst, and monitoring third party use of funds, are developed for SDS Option 2.

Service Response / Action
Agreed. The SDS Programme Board will be asked to determine an action plan.

Implementation Date	**Responsible Officer**	**Grading**
September 2018	Lead Strategy and Performance Manager	Significant within audited area

2.3.6 In some cases multiple invoices are being received (e.g. both weekly and monthly covering the same period and services) increasing the risk of duplicate payment. Where it is being used, CareFirst reduces the risk of error. The recommendation at 2.3.2 applies.

2.3.7 Suppliers may also send a single invoice covering multiple service users. These take longer to match, and cause difficulties and delays if details for one or more service users / agreements are incorrect. Consultation and contractual arrangements with suppliers

could be used to streamline care payment processes for mutual benefit.

Recommendation
The Service should encourage suppliers to invoice per client and for fixed periods.

Service Response / Action
Agreed. Invoicing requirements are built in to new contracts, however there is limited control over this for existing contracts and externally procured frameworks (e.g. Scotland Excel). Finance has been asked to pass details to Commercial and Procurement Services where invoice formats cause difficulty, and this will be reviewed with suppliers.

Implementation Date	Responsible Officer	Grading
Implemented	Social Care Procurement and Contracts Manager	Important within audited area

2.3.8 One off financial assistance may be provided under certain circumstances. This should be recorded as a service agreement on CareFirst, however there is mixed practice with several teams using the 'observations', 'initial contacts', or 'classifications' fields on the system to record these instead. Whilst these options still provide a record of the activity taking place, unless they are documented in the correct part of the system it will not be possible to obtain an overview of all financial support provided for each person.

2.3.9 In one instance reviewed there was no record of the supported person in CareFirst. Whilst there is a Financial Assistance Application Form to support the transaction, the absence of system records reduces assurance that the support was appropriate.

2.3.10 In some cases there are a number of financial assistance applications and payments for the same person within a short space of time, with each treated as a separate one-off case. In such cases, or if there are delays in adding records to CareFirst, there is a risk that authorisation limits will be exceeded in total without management consideration being given to the level of care being provided.

Recommendation
The Service should ensure all one off assistance is recorded promptly on CareFirst as a service agreement against a supported person.

Service Response / Action
Agreed. The requirements and procedure will be reinforced to all staff.

Implementation Date	Responsible Officer	Grading
May 2018	Lead Social Work Officer	Significant within audited area

2.3.11 There is mixed practice in respect of obtaining signatures or receipts from service users to demonstrate that funds have been handed to them. The Financial Assistance Application Form requires a service user signature but this is not always being completed. Often the audit trail ends with the Social Worker drawing the cash. In other cases funds are given to someone else on the client's behalf. Whilst in some instances this is well documented, there is no clear procedure for it.

2.3.12 There is also only a limited audit trail for indirect support (i.e. non-care services) being purchased on behalf of service users, as these are subject to the same controls and documentation as cash financial support and the information is not recorded on CareFirst.

2.3.13 Without clear processes and consistent evidence there is less assurance that financial assistance has been provided to and used by the supported individual as intended.

Recommendation
The Service should ensure it can demonstrate that financial assistance has been delivered to the end user / used for the purposes intended.

Service Response / Action
Agreed. The requirements and procedure will be reinforced to all staff.

Implementation Date	Responsible Officer	Grading
May 2018	Lead Social Work Officer	Significant within audited area

2.3.14 There are residential properties being managed and let by the Service directly to service users. The Service is unable to demonstrate whether or not these arrangements represent best value, has limited capacity for managing these, and the arrangements are not aligned with current best practice which recommends supporting people to increase skills and self-reliance. The Service is already reviewing this with Housing and a recommendation is made to track progress.

Recommendation
The Service should conclude the review of its residential property portfolio in conjunction with Housing.

Service Response / Action
Agreed.

Implementation Date	Responsible Officer	Grading
September 2018	Housing Strategy Officer	Significant within audited area

2.3.15 There were substantial redundancy costs paid following the breakdown of an SDS arrangement. As needs and arrangements could change at any time, including change of needs or even the death of a client, provision for redundancy should be built in to SDS payments where personal assistants are going to be employed for more than two years. The Service has clarified that this instance was an exception and such costs should normally be covered by contingencies and insurance which are included in all direct payment agreements. However, this needs to be clear for service users to ensure they can make appropriate arrangements.

Recommendation
The Service should ensure SDS option 1 service users are made aware of the risks and processes to be followed should they have to make staff redundant.

Service Response / Action
Agreed. The Policy on redundancy payments is to be revised. The SDS Co-ordinator will contact Governance to discuss and make required changes to the Direct Payment application. A revised Policy will be submitted to the Programme Board to sign off on.

Implementation Date	Responsible Officer	Grading
June 2018	Lead Strategy and Performance Manager	Important 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. Financial Regulations have been consistently breached.
Significant within audited area	Addressing this issue will enhance internal controls. An element of control is missing or only partial in nature. The existence of the weakness identified has an impact on a system's adequacy and effectiveness. 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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KPMG

Aberdeen City Council

Interim management report and audit status summary

For the year ended 31 March 2018

For Audit, Risk and Scrutiny Committee consideration on 8 May 2018

13 April 2018

Contents

About this report

This report has been prepared in accordance with the responsibilities set out within the Audit Scotland's *Code of Audit Practice* ("the *Code*").

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Nothing in this report constitutes an opinion on a valuation or legal advice.

We have not verified the reliability or accuracy of any information obtained in the course of our work, other than in the limited circumstances set out in the introduction and responsibilities section of this report.

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Complaints

If at any time you would like to discuss with us how our services can be improved or if you have a complaint about them, you are invited to contact Andy Shaw, who is the engagement leader for our services to the Council, telephone 0131 527 6673 email: andrew.shaw@kpmg.co.uk who will try to resolve your complaint. If your problem is not resolved, you should contact Hugh Harvie, our Head of Audit in Scotland, either by writing to him at Saltire Court, 20 Castle Terrace, Edinburgh, EH1 2EG or by telephoning 0131 527 6682 or email to hugh.harvie@kpmg.co.uk. We will investigate any complaint promptly and do what we can to resolve the difficulties. After this, if you are still dissatisfied with how your complaint has been handled you can refer the matter to Fiona Kordiak, Audit Scotland, 4th Floor, 102 West Port, Edinburgh, EH3 9DN.

Introduction

Purpose of document

In line with our audit strategy we have completed an interim audit. Key activities performed were the testing of a selection of system controls and holding discussions with management to update our understanding and our assessment of the key risks and audit focus areas.

This report provides the Audit, Risk and Scrutiny Committee with an update on:

1) Significant risks and other focus areas (pages four and five);
2) The results of the control testing, encompassing overarching governance and systems controls (pages six to eight).
3) Best Value approach (page nine).

Significant risks and other focus areas in relation to the audit of the financial statements as identified in our audit strategy document dated 9 February 2018:

The significant risks identified were:

- fraud risk from management override of controls;
- fraud risk from income revenue recognition;
- revaluation of property, plant and equipment;
- retirement benefits; and
- capital expenditure.

The other focus areas identified were:

- Faster accounts close.

Acknowledgements

We would like to take this opportunity to thank officers and Members for their continuing help and co-operation throughout the audit work.

Significant risks and other focus areas

Update: significant risks

We outline below the significant risks and other focus areas included within the audit strategy document, together with an update following the interim audit. We will conclude on these areas in the ISA 260 report.

Significant risk	Update from strategy
Fraud risk from management override of controls This is an assumed risk from ISA 240 'the auditor's responsibilities relating to fraud in an audit of financial statements' on which we are required to report.	We performed controls testing over expenditure, bank reconciliations, budget monitoring and journals. In addition, we tested a sample of procurement arrangements for compliance with the relevant Council controls. The results of the testing are set out on pages six to eight. We did not identify instances where management override of control had occurred. Substantive procedures will be performed during the year end audit, including testing journal entries processed throughout the year, assessing accounting estimates and significant transactions that are outside the Council's normal course of business, or are otherwise unusual.
Fraud risk from income revenue recognition This is an assumed risk from ISA 240**.** We consider the fraud risk from other income such as charges or service income to be significant. We rebutted the assumed fraud risk in respect of government grants, local taxes and regulated rental income. We consider only the fraud risk from recognition of 'other income' to be significant.	We discussed sources of other income with officers across different services to develop our understanding of the service income which is received and developed our knowledge of the composition of 'other income' in the financial statements. Testing over controls are set out on page six, with no exceptions identified. Substantive procedures will be performed during the year end audit. The potential for other income to be incorrectly recognised will be addressed through further substantive procedures. We will consider each source of income and analyse results against budgets and forecasts, performing substantive analytical procedures and tests of details (including agreeing sample rental income to rent agreements).
Revaluation of property, plant and equipment In order to comply with the 2017-18 Code and IFRS accounting requirements, Council assets are subject to rolling valuations, with a tranche of 'other land and buildings' being subject to valuation in 2017-18. The Council also holds £85 million of investment property, which must be revalued on an annual basis. In both cases, there is a level of judgement involved associated with valuation assumptions which gives rise to a risk of misstatement.	We met with the valuations team and discussed the areas being revalued in 2017-18 as well as reviewing the five year rolling programme. To support the faster accounts close, the 2017-18 valuations are being prepared as at 30 November 2017. As part of our year end audit KPMG's in-house valuer will review the assumptions and valuation methodology used to confirm they are reasonable and in line with Code of Practice on Local Authority Accounting ('the Code'). A sample of revaluations will then be considered in more detail, including any potential impact on the valuation between 30 November 2017 and 31 March 2018. We will verify that the revaluation has been correctly disclosed in the accounts and that the accounting entries are correct.

Significant risks and other focus areas (continued)

Update: significant risks (continued) and other focus areas

Significant risk	Update from strategy
Retirement benefits The Council is a member of the North East Scotland Pension Fund and recognises a net defined benefit liability on its balance sheet being £250 million as at 31 March 2017. This comprises assets of £1.22 billion offset by liabilities of £1.47 billion. The determination of the net deficit is inherently judgemental and is based on a number of assumptions.	Our controls testing over the transfer of pension data to the pension administrators is set out on page eight, with no exceptions noted. The remaining procedures will be performed during the year end audit, including review of relevant assumptions and testing them against our understanding of the Council. Prior to the fieldwork beginning in May, we will request the agreed assumptions for 2017-18 from management to facilitate this consideration and benchmarking by our internal actuary. We will also review the disclosures made in the financial statements against the requirements of the Code.
Capital expenditure The Council has a five year £1 billion capital plan which is focused around the city centre masterplan and includes some innovative methods of delivery. These can give rise to more complex accounting arrangements. Due to the significance of this capital investment programme and complexity of some of the projects, we consider there to be a risk of misstatement. We also consider that large capital projects inherently bring increased risk.	We tested controls over capital monitoring and procurement of capital projects. The results are set out on page six, with no exceptions noted. We met with management to discuss the progress of the key capital projects below, as well as beginning to consider the legal documentation associated with those developments, which may gave rise to accounting implications. We have reviewed the capital budget and plan for both 2017-18 and future years and we will perform substantive procedures over capital spend at the final audit. This will include substantive sampling methods to evaluate the appropriateness of capital or revenue accounting classification by reference to supporting documentation, review of manual journals, testing additions and specifically considering the following major projects overall, which may include more complex accounting treatments: ▪ Marischal Square; ▪ Aberdeen Art Gallery redevelopment; and ▪ Aberdeen Exhibition and Conference Centre.
Other focus area	
Faster accounts close The Council intends to accelerate the timetable for the production and audit of the financial statements by three months. This acceleration increases the risk of error.	We performed enquiries to gain a better understanding of the Council's revised accounts preparation and audit timetable and assessed management's arrangements to comply with the public inspection rules. We also conducted a substantive audit of those financial statement numbers which had been finalised to the end of quarter three. Further procedures will be undertaken at year end.

Control framework

System controls

In accordance with ISA 330; "the auditor's response to assessed risks", we have designed and performed tests of controls to obtain sufficient appropriate audit evidence as to the operating effectiveness of relevant controls over the main financial systems. Audit testing took place during February and March 2018. Overall we concluded that the control environment is effective.

Test	Description	Results
Bank reconciliations	Bank reconciliations are prepared weekly or monthly by the income team and reviewed by a more senior officer. We test a sample of 40 bank reconciliations across all bank accounts to verify they had been authorised and completed on a timely basis. This sample extends beyond the date of our interim fieldwork.	Testing is ongoing and we will conclude during our final audit. No deficiencies have been identified in the testing conducted to date. ***Conclusion to be reported in the ISA 260 report in June***
Budget monitoring	The Council has a robust budget setting process, with involvement of key members of staff. Performance against budget is monitored on a regular basis and formally reported to the relevant committees via the budget monitoring reports. Three quarters' reports were considered to confirm that a sufficient level of detail was presented to and considered by the committees and that a level of precision is used to determine which variances require further analysis and discussion.	Testing confirmed that budget monitoring arrangements are designed, implemented and operating effectively. ***Satisfactory***
Procurement testing	The Council has well defined processes for the awarding of contracts, with written procedures to be followed for each contract type and value. Procurement testing covered a sample of 25 contracts awarded in the year, split between those which had gone through the quotation process and those which required to be tendered. We confirmed that they had followed the correct procurement route based on value and reviewed the evidence of the tender evaluation process.	Testing confirmed that the selected contracts had followed the correct procurement route based on value. ***Satisfactory***
Journals authorisation	A sample of 40 journals were selected and checks carried out to confirm segregation of duties exist between who raises and who authorises journal entries. We also considered the back up available for each journal to verify the authoriser could carry out an appropriate review and conclude the journal is correct.	All journals selected were raised and approved by a different officer, as appropriate. Each journal was supported with back up detail available to the authoriser. ***Satisfactory***

Control framework (continued)
System controls (continued)

Test	Description	Results
Payroll	In order to obtain comfort over payroll processes, we tested controls related to employee standing data, when joining, leaving and making changes. This included testing five starters, seven leavers and 13 amendments to employee standing data for appropriate authorisation and evidence of segregation of duties. As a final control, a member of the Council's HR team completes a checklist to ensure that all appropriate and necessary documentation was included in the employee's file. We also tested this step of the process as part of our controls testing.	All changes to the payroll system followed the established process, with appropriate authorisation and segregation of duties. Several employees were missing the final checklists on their file. We consider that evidence is available to support segregation of duties in making changes is sufficient, however management may want to consider ensuring the checklist is used in all cases. ***Satisfactory***
Cost of services (non-payroll expenditure)	A sample of 25 purchase orders were tested by agreeing to invoice and goods received note, to verify appropriate authorisation.	All purchase orders could be matched through the purchase cycle, with appropriate authorisation. ***Satisfactory***
Capital expenditure review	Capital expenditure is subject to monthly and quarterly review to ensure that the split between revenue and capital expenditure is correct and appropriate. We tested three monthly reviews of capital expenditure to verify that only items above the threshold of £6,000 were capitalised and see evidence of review. We also tested two quarterly reviews to confirm they had taken place and appropriate cross-referencing to the fixed asset register had taken place.	Review of revenue and capital expenditure is operating effectively. ***Satisfactory***

Control framework (continued)
System controls (continued)

Test	Description	Results
Pension data	In order to determine the completeness and accuracy of the information that the actuary uses to produce the pension liability/asset estimation and actuarial gain/losses, we tested controls around the transfer of pension data from the pension team to the actuaries. We reviewed two monthly reconciliations to confirm that the pension data submitted to the actuary matched the data in the payroll system, and that the appropriate validation checks were completed for both months.	For the sample, complete and accurate data is sent from payroll to the pension fund, and subsequently to the actuary, and necessary documentation complete and on file. ***Satisfactory***
Loan ledger reconciliation	We tested three monthly reconciliations to confirm that the loan ledger is appropriately reconciled and reviewed on a timely basis. This reconciliation is between the loan ledger fund on eFinancials and a spreadsheet of all Council loans maintained and updated by the finance team. The purpose of this reconciliation is to ensure the completeness and accuracy of the loan ledger fund on eFinancials.	Loan ledger reconciliation is operating effectively. ***Satisfactory***
General IT controls	We intend to perform testing over key IT systems on which we will place reliance on as part of our audit. This includes ICON, eFinancials and Northgate: — programme changes — user access; — leavers; and — system administrators.	We met with management to understand the key systems and approach to controls in advance of testing by a specialist KPMG team. This testing will be performed in advance of the final audit. ***Conclusion to be reported in the ISA 260 report in June***

Wider Scope and Best Value

The Code of Audit Practice sets out four audit dimensions which, alongside Best Value, set a common framework for all audit work conducted for the Accounts Commission. These areas are; governance and transparency, financial management, financial sustainability and value for money. During our interim audit we commenced our consideration these areas and will conclude our assessment in our Annual Audit Report. We provide an update below of work carried out so far on Best Value.

Area	Audit update
Best Value	We held planning discussions with officers to obtain an understanding of the Council's approach to Best Value and how this is embedded within the Council's culture. In year one (2016-17), in line with guidance from the Accounts Commission, we reported on the areas of Financial Governance and Resource Management and Financial Planning. This year (2017-18) we are considering the areas of Leadership and Governance, and Improvement. Our conclusions will be included within the Annual Audit Report. We reviewed publically available evidence across the two Best Value areas and discussed with management further support and evidence required to enable us to perform the review. We will continue to gather information and meet with officers to build our knowledge of Best Value in order to conclude on the two focus areas in our Annual Audit Report in September.
Wider Scope	Specific risks in this area are set out in our audit strategy document and include the implementation of changes following the Council's governance review and effectiveness of transition to the Target Operating Model. As part of our audit work, we attended the Strategic Transformation Committee, reviewed the Council's update reports, key policies and staff updates. We also reviewed governance policies and procedures including elected members' registers of interest to confirm that they are up to date. We will audit the senior officers register as part of the year end procedures. We have reviewed the Council's revenue and capital budget to continue to consider long term financial sustainability and will complete testing during the final audit fieldwork. We submitted a return to Audit Scotland in February 2018, assessing the Council's participation in the NFI against Audit Scotland criteria. The results show that overall engagement with NFI is good, with only minor improvements identified.

Contacts

The contacts at KPMG in connection with this report are:

Andy Shaw

Director

Tel: 0131 527 6673

andrew.shaw@kpmg.co.uk

Michael Wilkie

Senior Manager

Tel: 0141 300 5890

michael.wilkie@kpmg.co.uk

Natalia Shamkina

Assistant Manager

Tel: 01224 416 887

natalia.shamkina@kpmg.co.uk

Flavia Czika

Audit Assistant

Tel: 0131 527 6624

flavia.czika@kpmg.co.uk

ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	8 May 2018
REPORT TITLE	Internal Audit Reports – Follow-up of Agreed Recommendations
REPORT NUMBER	IA/18/007
DIRECTOR	N/A
REPORT AUTHOR	David Hughes
TERMS OF REFERENCE	2.3

1. PURPOSE OF REPORT

1.1 This report advises the Committee of progress made by Services with implementing recommendations that have been agreed in Internal Audit reports.

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. BACKGROUND / MAIN ISSUES

3.1 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 2018 have been completed, these are no longer shown in the appendices.

3.2 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 on the first page of appendix B. Details of overdue recommendations are now also being monitored by the Corporate Management Team.

4. FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from the recommendations of this report.

5. LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from the recommendations of this report.

6. MANAGEMENT OF RISK

6.1 The Internal Audit process considers risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are detailed in the resultant Internal Audit reports. Recommendations are made to address the identified risks and Internal Audit follows up progress with implementing those that are agreed with management. Those not implemented by their agreed due date are detailed in the attached appendices.

7. OUTCOMES

7.1 There are no direct impacts, as a result of this report, in relation to the Local Outcome Improvement Plan Themes of Prosperous Economy, People or Place, or Enabling Technology, or on the Design Principles of the Target Operating Module.

7.2 However, Internal Audit plays a key role in providing assurance over, and helping to improve, the Council's framework of governance, risk management and control. These arrangements, put in place by the Council, help ensure that the Council achieves its strategic objectives in a well-managed and controlled environment.

8. IMPACT ASSESSMENTS

Assessment	Outcome
Equality & Human Rights Impact Assessment	An assessment is not required because the reason for this report is for Committee to review, discuss and comment on the outcome of an internal audit. As a result, there will be no differential impact, as a result of the proposals in this report, on people with protected characteristics.
Privacy Impact Assessment	Not required
Duty of Due Regard / Fairer Scotland Duty	Not applicable

9. APPENDICES

9.1 Appendix A – Position with Agreed Recommendations – Summary.

9.2 Appendix B – Position with Agreed Recommendations – Cross Service.

9.3 Appendix C – Position with Agreed Recommendations – Commissioning.

9.4 Appendix D – Position with Agreed Recommendations – Customer.

9.5 Appendix E – Position with Agreed Recommendations – Operations.

9.6 Appendix F – Position with Agreed Recommendations – Resources.

9.7 Appendix G – Position with Agreed Recommendations – Governance.

9.8 Appendix H – Position with Agreed Recommendations – Health and Social Care Partnership.

10. REPORT AUTHOR DETAILS

David Hughes, Chief Internal Auditor
David.Hughes@aberdeenshire.gov.uk
(01467) 537861

APPENDIX A – SUMMARY

POSITION WITH AGREED RECOMMENDATIONS AS AT 25 APRIL 2018

The following table provides a summary of progress being made by Services with completing agreed recommendations.

On 22 February 2018, the Committee was advised that, as at 9 February 2018, there were 66 recommendations which were due to have been completed by 31 December 2017 which were not fully complete. This has reduced to 39.

The total not fully complete, which had an original due date of before 28 February 2018, is 45. Full details relating to progress, on a report by report basis, are shown in appendices B to H.

	Recommendations						**Grading of Overdue Recommendations**		
SERVICE	Agreed in reports shown in Appendices B to H	Due for completion by 31.12.17	Confirmed complete by Service	New in January to February 2018	Confirmed complete by Service	**Not fully complete by original due date**	Major	Significant	Important
Cross Service	52	52	46	0	0	**6**	0	3	3
Commissioning	39	37	32	0	0	**5**	0	5	0
Customer	19	0	0	9	9	**0**	0	0	0
Operations	168	119	98	13	12	**22**	1	16	5
Resources	52	7	5	11	9	**4**	0	1	3
Governance	41	16	12	8	7	**5**	0	5	0
Health & Social Care	71	24	23	17	15	**3**	0	3	0
Total	442	255	216	58	52	**45**	1	33	11

KEY TO COLOURING USED IN FOLLOWING APPENDICES

Recommendation Grading:

Grading	Definition
Major	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. Financial Regulations have been consistently breached.
Significant	Addressing this issue will enhance internal controls. An element of control is missing or only partial in nature. The existence of the weakness identified has an impact on a system's adequacy and effectiveness. Financial Regulations have been breached.
Important	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.

Length of time overdue

Over 12 months
6 to 12 months
Less than 6 months

APPENDIX B

CROSS SERVICE

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1604	**Corporate Policies and Procedures**	March 2016	2	2	1	**1**	1 Important

The position with the overdue recommendation is as follows:

Chief Officer	Overdue Recommendation	Grading / Due Date	Position
Governance	The Council should ensure a timetable is put in place for implementation of a policy framework for all Council policies (2.1.5)	Important March 2017	As reported to Committee since June 2017, the Governance Review Board is monitoring progress of this project through the wider Governance Review Programme and had agreed to extend the collation / housekeeping aspect to the end of August 2017. Since September 2017, the Committee has been advised that the draft Framework has been developed and was ready to be submitted to the Governance Review Board in September 2017 for consideration. This did not happen as the Board was prioritising the Scheme of Governance documentation as per a Council decision. The Committee was advised in February 2018, that the Service had advised was that the Corporate Policy Framework will be referred to the Governance Delivery Board on the 15 February, 2018, with a recommendation that the Governance Function (which will include the remit for Corporate Policies) take ownership of it and ensure that it is in keeping with the design of the new function. The latest update from the Service is that a register of policies has been established and that work to develop a Policy Framework outlining the process and key principles to be followed for developing, categorising, approving and reviewing policies is aimed for completion by December 2018.

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1623	**Compliance with Procurement Legislation**	June 2016	28	28	27	**1**	1 Significant

The position with the overdue recommendations is as follows:

Chief Officer	Recommendation	Grading / Due Date	Position
Integrated Children's and Family Services	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 (2.4.7)	Significant September 2016	As reported previously, the Service was in the process of identifying expenditure across the schools. It was anticipated that this would be completed by March 2017 and that expenditure across other Directorates would have to be considered. The Service then advised that, as there is currently no system to allow identification of collected spend on an item by item basis, it was more appropriate at that time to adopt a common sense approach to tackling the issue of compliance in overall school spend. The Service was therefore targeting the commodities that all schools would have a requirement for, eg transport for school trips. In the case of school trips, there is significant spend not currently covered by contract and the creation of a contract would significantly reduce the time taken by schools when seeking quotes for transport. The update at the September 2017 meeting of the Committee was that the Service anticipates that it will take until March 2018 to address this one issue. The latest update from the Service is that this work is now being progressed through the development of the newly introduced procurement work plan. It is anticipated that the work plan will be in place by June 2018.

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1716	**Timesheets and Allowances**	February 2017	9	9	8	**1**	1 Significant

Progress with implementing the four recommendations that are overdue is as detailed below.

Chief Officer	Recommendation	Grading / Due Date	Position
People and Organisation	Where it is agreed that breaks will be paid, a register should be maintained of agreements providing details of the staff groups affected (2.3.5 (2))	Significant July 2017	As reported to the September 2017 meeting of Committee, HR advised that, due to the nature of work being undertaken in the area identified, there will be no deduction of unpaid break and risk assessments will be carried out for working over 6 hours with no break. Work is underway to seek approval for an amendment to the collective agreement the Council has with the Trade Unions for this group of staff. It was anticipated that this will take until the end of December 2017 to resolve. The latest update from the Service, as advised to Committee in February 2018, is that there are some issues to resolve in relation to the content of the document and it is still the Service's aim to try and get agreement from all recognised Trade Unions. However, it is anticipated that this will take until the end of June 2018 to achieve.

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1804	**Business Continuity Planning**	August 2017	13	13	10	**3**	1 Significant 2 Important

Progress with implementing the recommendations that are overdue is as detailed below.

Chief Officer	Recommendation	Grading / Due Date	Position
Head of Commercial & Procurement Services	CPS should update Procurement Guidance Notes to reflect the requirement to obtain a Key Supplier Assessment Questionnaire for Key Suppliers (2.4.2)	Significant October 2017	The Committee was advised in February 2018 that The Service had advised that this was being included in a review of procurement guidance notes which would be complete by the end of February 2018. The latest update from the Service is that the manual is anticipated to completed and distributed by June 2018.
Governance	Service Risk Registers should be put in place for all service areas (2.7.2 a i)	Important December 2017	The Committee was advised in February 2018 that the Service had advised that a Risk Management Framework will be reported to AR&S Committee in February 2018 which will require business continuity plans to be considered as a control to reduce the impact of a risk, and that 'functional' risk registers (in the new structure) are to be reviewed at least quarterly by the new function management teams and directors. It is anticipated that the requirements of the Framework will be implemented by June 2018.
Governance	The Corporate, Directorate and Service Risk Registers should be reviewed to identify emergent risks requiring to be mitigated by Business Continuity Plans (2.7.2 a ii)	Important December 2017	

APPENDIX C

COMMISSIONING

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1619	**Social Work Tendering**	April 2016	14	13	13	**0**	0
AC1621	**ALEOs**	February 2016	10	10	6	**4**	4 Significant

The position with the overdue recommendations is as follows:

Chief Officer	Recommendation	Grading / Due Date	Position
Head of Commercial & Procurement Services	Services should ensure that there is an up to date Service Level Agreement with each ALEO (2.2.6 (a))	Significant June 2017	As reported to Committee since September 2017, Commercial and Procurement Services have stated that it is anticipated it will take around 12 months to get new agreements in place. Implementation of these recommendations will, therefore, be delayed until August 2018.
Head of Commercial & Procurement Services	Services should ensure all ALEO SLAs confirm performance reporting requirements, and state that ongoing funding is subject to evidenced satisfactory performance (2.2.6 (b)	Significant June 2017	
Head of Commercial & Procurement Services	Services should ensure financial clauses in all SLAs accurately reflect the partners' intentions (2.4.9 (i))	Significant June 2017	

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations

(AC1621 – ALEOs – Continued)

Chief Officer	Recommendation	Grading / Due Date	Position
Head of Commercial & Procurement Services	Services should ensure all material ALEO SLAs contain a requirement for Internal Audit arrangements, and facilitate reporting of assurance gained through these arrangements to the Council (2.4.11)	Significant June 2017	As above.

AC1722	**ALEOs – Management by Services**	August 2017	15	14	13	**1**	1 Significant

The position with the overdue recommendation is as follows:

Chief Officer	Recommendation	Grading / Due Date	Position
Head of Commercial & Procurement Services	Education and Children's Services should review options for performance management within future ALEO agreements (2.4.3)	Significant September 2017	This forms part of Education and Children's Services review of ALEO management arrangements. Two of the Sports ALEOs are being reviewed and a report was to be presented to the Finance, Policy and Resources Committee in December 2017. Following a decision at that Committee, the Service Operating Agreement in place is to be amended and will include revised performance monitoring indicators. It is anticipated that this will be complete by June 2018.

APPENDIX D

CUSTOMER

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1810	**Major IT Business Systems**	December 2017	11	8	8	**0**	0
AC1822	**YourHR**	February 2018	8	1	1	**0**	0

APPENDIX E

OPERATIONS

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1602 AW	**Craft Workers Terms and Conditions**	October 2015	9	9	5	**4**	1 Major 3 Significant

The position with the overdue recommendations is as follows:

Chief Officer	Recommendation	Grading / Due Date	Position
Operations and Protective Services	The Service should renegotiate the Agreement based on current working practice (2.2.6)	Major June 2016	As reported previously, the Service advised that all recommendations were being progressed through discussion and negotiation, and that it was anticipated they would all be resolved by December 2016. The Service then advised that they were discussing a renewed craft agreement with trade workers and unions. Meetings had taken place and others were due in January leading into February 2017. The Service was hopeful that an agreement could be signed as soon as possible in 2017. The June 2017 meeting of the Committee was advised that the craft agreement had to be agreed at a regional level by the unions. At that stage, until other union matters are resolved, progress had stalled but it was hoped that discussions would resume in the near future. The update provided to Committee in September 2017 was that this has been delayed further to June 2018.

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 31.03.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations

Chief Officer	Recommendation	Grading / Due Date	Position
(AC1602AW – Craft Workers Terms and Conditions – Continued)			
Operations and Protective Services	The Service should complete the roll out of the hand held system to ensure that periods of stand-by are covered (2.3.13)	Significant June 2016	As reported previously, this had been partially implemented and piloted and would be fully implemented with the new craft agreement. The June 2017 meeting of the Committee was advised that the craft agreement had to be agreed at a regional level by the unions. At that stage, until other union matters are resolved, progress had stalled but it was hoped that discussions would resume in the near future. The update provided to Committee in September 2017 was that this has been delayed further to June 2018.
Operations and Protective Services	The Service should consider whether such payments remain appropriate (2.3.14)	Significant June 2016	As reported previously, this is being reviewed as part of the new craft agreement, as per 2.2.6 above.
Operations and Protective Services	The Service should consider whether calls that have been cancelled within a short period of having been lodged should be verified to confirm the identity of the caller (2.3.16)	Significant June 2016	As reported previously, this was being reviewed as part of the new craft agreement, as per 2.2.6, above, and discussions will take place with housing management. The June 2017 meeting of the Committee was advised that this will be addressed when additional IT is introduced to the call out service. The update provided to Committee in September 2017 was that this has been delayed further to June 2018.

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1608	**Trade Waste**	January 2016	14	14	10	**4**	2 Significant 2 Important

The position with the overdue recommendations is as follows:

Chief Officer	Recommendation	Grading / Due Date	Position
Operations and Protective Services	The Service in conjunction with Finance should review the charging system for extraordinary uplifts (2.1.9)	Important June 2016	The Service has advised, as reported to Committee in February 2018, that these recommendations are dependent on implementation of a new management system. This is due to go live in February 2018 for household waste and April 2018 for Trade Waste.
Operations and Protective Services	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 (2.1.10)	Significant September 2016	
Operations and Protective Services	The Service should introduce checks to ensure the accuracy and completeness of all invoices raised (2.1.12)	Significant September 2016	

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 31.03.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations

Chief Officer	Recommendation	Grading / Due Date	Position
(AC1608 – Trade Waste – Continued)			
Operations and Protective Services	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 (2.1.13 (a))	Important June 2016	See above.

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1618	**Vehicle and Driver Records**	April 2016	22	22	20	**2**	2 Significant

The position with the overdue recommendations is as follows:

Chief Officer	Recommendation	Grading / Due Date	Position
Operations and Protective Services	Fleet should work with Services to determine their ongoing fleet requirements, in line with these principles, in advance of any further significant procurement exercises (2.1.2ii)	Significant November 2016	As reported previously, the Service advised that surveys were sent out to all Services in late 2016 requesting information on vehicle and plant usage. The returns indicated that all Services required their vehicles for the maximum time with no spare capacity. The results of the telematics trial detailed below will help inform decisions.

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations

Chief Officer	Recommendation	Grading / Due Date	Position
(AC1618 – Vehicle and Driver Records – Continued)			
Operations and Protective Services	Fleet should seek to identify 'excess' vehicles promptly in order to maximise resale value where vehicles are not required (2.1.2iii)	Significant November 2016	As reported previously, in January 2017, the Communities, Housing and Infrastructure Committee approved a telematics trial that would take place on 10 vehicles over a 3-6 month period. Should this trial prove successful, Fleet would present the results and seek further approval to implement a telematics system for all fleet vehicles and plant. The results of the trial would demonstrate vehicle performance, driver behaviour and utilisation; the benefits will include increased utilisation and potential fleet reduction saving cost pressures on maintenance, fuel and department budgets. Initial results were anticipated by September 2017. The Committee was advised in November 2017 that information from the above trial was expected by the end of October 2017 whilst a further 2 or 3 systems were about to be trialled. The outcome would be known by the end of December 2017. The latest update from the Service is that a further three additional systems have been on trial (all free) and data from these is expected by the end of May 2018.

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1705	**Roads Payroll**	August 2016	22	21	20	**1**	1 Important

The position with the overdue recommendations is as follows:

Chief Officer	Recommendation	Grading / Due Date	Position
Operations and Protective Services	The Service should review options to ensure all relevant duties (including supervision, administration and vehicle checks) can be completed within contractual hours (2.2.13)	Important February 2017	As reported previously, the Service advised that this will now form part of a wide restructure of the Roads Service which was underway. Once the two senior posts are recruited to, the working patterns will be part of the formal review for the remainder of the Service. It was anticipated that this would take to the end of December 2017 to complete. The latest update from the Service, as reported to Committee in February 2018, is that recruitment to the two posts has not been successful. Internal Audit will follow-up progress after August 2018.

AC1808	**Vehicle Maintenance**	October 2017	20	8	8	**0**	0

AC1817	**Vehicle Usage**	January 2018	8	2	2	**0**	0

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1604 AW	**Payment Controls in Children's Social Work**	February 2016	19	19	18	**1**	1 Important

Progress with the overdue recommendations is as follows:

Chief Officer	Recommendation	Grading / Due Date	Position
Head of Commercial & Procurement Services	Relates to C&PS reviewing and rationalising supplier numbers to ensure that there are no duplicates (2.2.15)	Important June 2016	As reported previously, implementation of the enhanced reporting tool that would have enabled this recommendation to be completed has been delayed. The Service was working with the provider, C&PS and ICT colleagues to resolve the issues and expected that this would be achieved by the end of November 2016. The Service then advised that this should be complete by the end of February 2017. In June 2017 the Committee was advised that implementation of the reporting tool remained ongoing and it was anticipated that this would be in place by the end of September 2017. In the interim, duplicate suppliers are being identified and dealt with as they come to light as part of normal monitoring. The latest update from C&PS is that the software has now been updated and monitoring will commence by the end of April 2018.

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1803	**Health and Safety - SSERC**	September 2017	17	16	11	**5**	5 Significant

Progress with the overdue recommendation is as follows:

Chief Officer	Recommendation	Grading / Due Date	Position
Integrated Children's and Family Services	The Service should ensure that schools comply with the SSERC Safety in Microbiology Code of Practice (2.6.5).	Significant September 2017	The Service has stated that the following plan has been put in place: 1. Check that each school has appropriately trained staff to prepare and manage the microbiological samples. 2. Check that each school has the correct risk assessments in place which cover the items as described by SSERC. 3. Check that a process is in place where only the trained staff undertake the tasks in the event of absence for whatever reason of the qualified technician etc 4. Meet with and write to the faculty heads and business support managers or persons responsible for the management of the technicians at each school identifying their responsibilities for the management of compliance within each establishment. 5. Under take spot checks on the process being used at each school. Part 1 is almost complete and the Service has researched the availability of training. Whilst recognising that this will be an on-going process to ensure compliance, Internal Audit will treat the recommendation as complete once items 1 to 4 have been completed. The update from the Service, as reported to Committee in February 2018, was that work is continuing with the above plan. This will be complete by August 2018. A further update has been provided to Internal Audit which gives assurance of continuing progress being made.

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations

Chief Officer	Recommendation	Grading / Due Date	Position
(AC1803 – Health and Safety - SSERC – Continued)			
Integrated Children's and Family Services	The Service should determine the training that is considered necessary for all appropriate staff in relation to the areas under review, and put a timetable in place to ensure that the required training is completed (2.4.7 a)	Significant October 2017	The Service advised, as reported to Committee in February 2018, that training needs had been identified but training had still to be arranged. This was to be done by the end of February 2018, but the Service was awaiting responses from training providers. A timetable to deliver training will now be put in place by the end of June 2018. The latest update from the Service is that the training plan will be distributed to technicians in May. Plans are in place to use external SSERC accredited trainers and link with the internal H&S team for areas such as COSHH and Working at Heights training. Some external providers are reporting limited capacity and this has led to a delay in making the programme available. The training programme and timetable should be in place by the end of June 2018.
Integrated Children's and Family Services	A standardised chemical stock list including chemical location, quantity, hazards, immersion test results, condition test results, date of last tests, date tests are due, and disposal dates should be maintained centrally (2.6.4 a)	Significant November 2017	The Service has confirmed, as reported to Committee in February 2018, that they have been looking at this and identified that some schools have already purchased dedicated software which is only licensed for single site use, and use different networks and servers. Work is continuing to establish the most suitable form for recording this data in a secure and efficient manner. As the staff who will complete this work are currently ensuring that pupils class work and examination practices are dealt with, and dealing with other recommendations from this report, the recommendation will be implemented over the summer break and concluded by August 2018.

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations

Chief Officer	Recommendation	Grading / Due Date	Position
(AC1803 – Health and Safety - SSERC – Continued)			
Integrated Children's and Family Services	Academies should be advised of the requirement to review their chemical stock and update the central list (2.6.4 b)	Significant November 2017	The Service has advised that this cannot be completed until 2.6.4 a, above, is implemented.
Integrated Children's and Family Services	Training should be provided to all staff required to undertake testing or visual inspections of portable electrical appliances (2.8.3 c)	Significant November 2017	The Service has advised, as reported to Committee in February 2018, that training is being provided by SSERC and, as the earliest that they can provide it is April 2018, will require an extension until the end of May 2018. The latest update from the Service is that SSERC currently have some capacity issues. The Service anticipates provisional dates for PAT testing by the end of April. This should be concluded by September 2018.

AC1809	**Care of Children**	February 2018	9	0	0	**0**	0

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1811	**Placing Requests**	November 2017	9	6	5	**1**	1 Significant

Progress with the overdue recommendation is as follows:

Chief Officer	Recommendation	Grading / Due Date	Position
Integrated Children's and Family Services	The Service should prepare detailed procedures for the placing request process (2.1.3)	Significant January 2018	The Service has advised that in considering the design of the electronic processing of school placing requests, process mapping was undertaken as part of the Digital School Placings project. The Service has not yet finalised the detailed procedures for the full process, however with the work that has been completed so far in the mapping of current processes, together with more defined and prescriptive procedures arising from the recommendations of the audit report and being implemented by the Service, it is anticipated that this action could be completed by 31 July 2018.

AC1815	**Pre-School Commissioned Places**	December 2017	6	2	2	**0**	0

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1709	**Care First System**	November 2016	13	13	9	**4**	3 Significant 1 Important

Progress with the overdue recommendations is detailed below:

Chief Officer	Recommendation	Grading / Due Date	Position
Integrated Children's and Family Services	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 (2.1.4)	Significant April 2017	As reported previously, the Service advised that terms for an extension to the contract for three years to March 2020 have been agreed and Committee approval will be sought for this in September 2017. The Committee was advised in September 2017, that the latest update from the Service was that a report had been drafted and would be discussed at the Education and Children's Services Committee on 16 November 2017. The latest update from the Service is that this will be reported to the Strategic Commissioning Committee in June 2018.
Integrated Children's and Family Services	The Service should establish a written protocol to demonstrate where amendments and deletions requested in the CareFirst system require authorisation or supporting detail (2.4.11)	Important April 2017	As reported previously, the Service advised that this would be complete by the end of September 2017 as the CareFirst team had been prioritised on other tasks. As reported to Committee in September 2017, the Service had advised that the current policy and procedures were still in place, however, the document needs to be updated to reflect the creation of the Education & Children's Services directorate and the Health and Social Care Partnership. A working group had been created to move this forward. The latest update from the Service is that the Case Recording Policy is being review to ensure it is compliant with GDPR. This process for reporting amendments will be reviewed as part of the update. This will be completed by the end of May 2018.

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations

Chief Officer	Recommendation	Grading / Due Date	Position
(AC1709 – Care First System – Continued)			
Finance	Finance should review the instances where service users have not been reassessed and charged correctly (2.5.6 (ii))	Significant March 2017	As reported to Committee in June 2017, the Service advised that further investigation of the work required in order to complete this action has identified that there is considerably more involved than was first anticipated. A significant project is now underway involving Housing, Social Care and Finance to address the past issues and streamline the process to ensure that every applicant is charged accordingly under a set of procedures with specific timelines. The first draft of the Project plan was approved at CMT in April 2017and further work is ongoing. It is likely that this will not be completed before 30 June 2018.
Integrated Children's and Family Services	The Service should ensure that Business Continuity Plans adequately reference how activities will continue to operate in the event of loss of CareFirst access (2.7.4)	Significant April 2017	As reported to Committee since June 2017, the Service advised that this would now be complete by the end of September 2017 as the CareFirst team has been prioritised on other tasks. The Committee was then advised in November 2017 that this would be complete by the end of November 2017. The Committee was advised in February 2018, is that work was progressing and the Business Continuity plans are now being reviewed to determine whether they provide cover for periods when the Care First system is not available. This was to be complete by the end of March 2018. The latest update from the Service is that Reviewed Business Continuity Plans have been received from all Children's Social Work establishments and are currently being quality checked to ensure that each one addresses how activities will continue to operate in the event of loss of CareFirst access. This will be complete by the end of May 2018.

APPENDIX F

RESOURCES

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1719	**Revenue Budget Setting**	May 2017	4	4	2	**2**	1 Significant 1 Important

The position with the overdue recommendations is as follows:

Chief Officer	Recommendation	Grading / Due Date	Position
Finance	More targeted guidance on the budget process for budget holders and team members should be created (2.1.7)	Important June 2017	As reported to the September 2017 meeting of the Committee, Finance had advised that the budget process had been subject to review during May and June 2017. This made a number of proposed changes to the process and was being taken to CMT for approval on 31 August 2017. Further to that approval, revised detailed guidance would be drawn up by 1 October 2017. The Service advised in November that CMT did not approve the proposed changes and further work was required to agree the process and finalise documentation. This was agreed to be done by the end of December 2017. A revised process was under development through the Transformation Programme. The latest update from the Service, as reported to Committee in February 2018, is that the revised process continues to be under development through the Transformation Programme. The 2018/19 budget is at an advanced stage of progress. The core tasks of preparing salary budgets, forecasting changes due to inflation and other cost drivers and legislative requirements, and interpreting the funding settlement are complete. Options have been developed through the transformation programme. Following the conclusion of the 2018/19 budget process, the approach taken will be documented by May 2018. This will cover all core controls of the process that will remain in place in future.

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations

(AC1719 – Revenue Budget Setting – Continued)

Chief Officer	Recommendation	Grading / Due Date	Position
Finance	Finance should ensure there is a clear audit trail to show that all budget adjustments agreed through the budget process have been applied, and disclosed, appropriately (2.3.8)	Significant July 2017	As reported to the September 2017 meeting of the Committee, Finance had advised that, as part of the revised process, new documentation was being prepared to record the full documented audit trail and meet the requirements of the audit recommendation. These would be implemented as at 1 September 2017. The Service advised in November that CMT did not approve the proposed changes and further work is required to agree the process and finalise documentation. This was to be done by the end of December 2017. The latest update from the Service, as reported to Committee in February 2018, is that for the 2018/19 budget process currently underway, the audit trail is being recorded using the existing recording and reporting methods of service cost model, ledger, budget packs, budget report and budget tracker. Once the 2018/19 budget process is complete, then the specific audit trail and disclosure information for budget adjustments will be documented and incorporated into the future budget setting guidance by May 2018.

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1805	**Attendance Management**	August 2017	9	5	3	**2**	2 Important

The position with the overdue recommendations is as follows:

Chief Officer	Recommendation	Grading / Due Date	Position
People and Organisation	The Service should review, and update where necessary, the Maximising Attendance policy, guidance and training (2.1.3)	Important February 2018	The Service has advised that a revised draft has been compiled but will need to be agreed with Service teams and trade unions before being approved by Committee. This will be complete by the end of September 2018.
People and Organisation	HR should report absence monitoring statistics to Committee on a regular basis (2.5.4)	Important December 2017	The Service has advised that absence will be reported to the Staff Governance Committee which has its first meeting on 4 May 2018.

AC1806	**Corporate Landlord Responsibilities**	September 2017	9	2	2	**0**	0
AC1814	**Travel Costs**	November 2017	13	4	4	**0**	0
AC1816	**Training for Councillors**	January 2018	9	0	0	**0**	0
AC1819	**Capital Contracts**	February 2018	8	3	3	**0**	0

APPENDIX G

GOVERNANCE

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1714	**Land and Buildings**	February 2017	9	6	3	**3**	3 Significant

Progress with the overdue recommendation is detailed below:

Chief Officer	Recommendation	Grading / Due Date	Position
Governance	Filing documentation should be updated to ensure there is a full audit trail for all title held (2.9.6)	Significant December 2017	The Service has advised, as reported to Committee in February 2018, that it has been exploring the viability, including resource implications, of updating the current Ordnance Survey Maps, and creating a digital mapping system to facilitate a more streamlined and efficient method of identifying property owned by the Council. The Service is formulating a Business Case for Digitisation of Mapping and Title Deeds that will include the use of a digital mapping system. The latest update from the Service is that a business case has been presented to the Chief Officer – Governance designed to give effect to the recommendations. The Chief Officer – Governance will review before determining the next course of action.
Governance	Consideration should be given to digitising the Council's title deeds and linking these to the Council's asset register system (2.9.10)	Significant December 2017	
Governance	The Asset Register and title documents should be cross referred using the Asset Register reference number (2.9.7)	Significant August 2017	As reported to Committee previously, the Service has advised that this recommendation was agreed in principle and that it agreed to carry out an appraisal to explore the viability for such cross-referencing to be carried out electronically. As noted above, it was anticipated that a Business Case would be presented during February 2018. The previous deadline was not achieved as a result of a combination of competing priorities and a secondment of the Service Support Manager who was sponsoring the project. The business case is now with the Chief Officer – Governance for a decision.

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1614	**Risk Management**	November 2015	10	10	9	**1**	1 Significant

The position with the overdue recommendation is as follows:

Chief Officer	Recommendation	Grading / Due Date	Position
Governance	A Risk Management annual report should be prepared and presented to the Audit, Risk and Scrutiny Committee (2.1.19)	Significant April 2016	As reported previously, 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 had not commenced and it was intended to report to the November 2016 meeting of the Audit, Risk and Scrutiny Committee. The Committee was advised in November 2016 that the benchmarking data had been received in draft form only and, as a result of having not received final data, the exercise has been delayed further. The June 2017 meeting of the Committee was advised that the output of the benchmarking exercise has been aligned with the priorities in the risk and assurance review project which is under way. The project was previously reported to Audit, Risk & Scrutiny Committee before the output was received and it was agreed that updates would be provided to future meetings as the project progressed. This will still be the case. The project is now part of the wider Performance, Risk and Improvement Programme. The September 2017 meeting of the Committee was advised that an annual risk management report will be presented to the Audit, Risk and Scrutiny Committee in alignment with the Annual Governance Statement in June 2018.

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1824	**Bond Governance**	February 2018	22	8	7	**1**	1 Significant

Progress with the overdue recommendation is detailed below:

Chief Officer	Recommendation	Grading / Due Date	Position
Governance	The Service should remind Councillors of the requirement to return the acknowledgement slips to ensure the Council complies with Article 18 of the Market Abuse Regulation (2.6.8)	Significant February 2018	Councillors were reminded at the Audit, Risk and Scrutiny Committee of the requirements. Five acknowledgement slips are outstanding and reminders have been sent via Members' Support.

APPENDIX H

HEALTH AND SOCIAL CARE PARTNERSHIP

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1617	**Self-Directed Support**	October 2016	21	21	20	**1**	1 Significant

Progress with the overdue recommendations is detailed below:

Chief Officer	Recommendation	Grading / Due Date	Position
Head of Strategy and Transformation (ACC H&SCP)	The Service should finalise and implement the Contributing to Your Care and Support Policy and guidance (2.4.2)	Significant March 2017	As reported to Committee in June 2017, the Service advised that draft guidance has been produced and was being reviewed. The policy and guidance will not be implemented until the end of October 2017. The Committee was advised in November 2017 that this will now be completed by April 2018 to allow a review of the charging process through the budget process and to consider implications of the Carers Act. The latest update from the Service is that work is progressing and a working group has been established to take forward the topic of charging for the Partnership. The Partnership is piloting the Equivalency Model as a method of Resource Allocation for self-directed support. The identification of a client's agreed budget allocation via a robust resource allocation system is a pre-requisite to enable the Partnership to move forward with the implementation of the Contributing to Your Care Policy. This will be reported and monitored through the Self Directed Support Board. Full implementation is now planned for September 2018.

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1801	**Adult Client Transport**	September 2017	13	9	8	**1**	1 Significant

Progress with the overdue recommendation is detailed below:

Chief Officer	Recommendation	Grading / Due Date	Position
Head of Operations (ACC H&SCP)	PTU and ACH&SCP should regularly share and reconcile their data on service user transport to ensure arrangements are in place as agreed (2.2.13ii)	Significant January 2018	The Service has advised that Service user transport usage forms are on the Carefirst system and officers will share and reconcile data through running reports off the system. It is proposed that Officers meet to reconcile data in July, 2018 and every 6 months after that.

AC1813	**Financial Assessments**	February 2018	15	6	6	**0**	0

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.18	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1821	**Social Work Payroll**	January 2018	22	5	4	**1**	1 Significant

Progress with the overdue recommendation is detailed below:

Chief Officer	Recommendation	Grading / Due Date	Position
Chief Finance Officer (ACH&SCP)	HR has made guidance available to ensure consistency of approach to TOIL, additional hours and overtime claims. Service management will review and reiterate practice with senior staff to ensure consistent application (2.3.17)	Significant February 2018	The Service has advised that an initial email with the guidance has been made available to senior social work managers. Further work and training is planned for June 2018.

Exempt information as described in paragraph(s) 6 of Schedule 7A
of the Local Government (Scotland) Act 1973.

Document is Restricted

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