Public Document Pack

To: Councillor Macdonald, Convener; Councillor Houghton, Vice-Convener; and Councillors Ali, Allard, Bonsell, Bouse, Fairfull, McLellan, Massey, Nicoll, Radley, Stewart and van Sweeden.

Town House,
ABERDEEN 6 December 2022

AUDIT, RISK AND SCRUTINY COMMITTEE

The Members of the **AUDIT, RISK AND SCRUTINY COMMITTEE** are requested to meet in **Council Chamber - Town House on TUESDAY, 13 DECEMBER 2022 at 2.00 pm. This is a hybrid meeting and Members may also attend remotely.**

The meeting will be webcast and a live stream can be viewed on the Council's website. https://aberdeen.public-i.tv/core/portal/home

JENNI LAWSON
INTERIM CHIEF OFFICER - GOVERNANCE

B U S I N E S S

Members, training on the new Internal Audit methodology will be given at 13.45, just prior to the Committee. A separate appointment was issued for those joining remotely.

NOTIFICATION 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 OR TRANSPARENCY STATEMENTS

3.1. Members are requested to intimate any declarations of interest or transparency statements

DEPUTATIONS

4.1. There are no requests at this time

MINUTE OF PREVIOUS MEETING

5.1. Minute of Previous Meeting of 27 September 2022 (Pages 5 - 12)

COMMITTEE PLANNER

6.1. Committee Business Planner (Pages 13 - 18)

NOTICES OF MOTION

7.1. There are none at this time

REFERRALS FROM COUNCIL, COMMITTEES AND SUB COMMITTEES

8.1. There are none at this time

COMMITTEE BUSINESS

Risk Management

9.1. ALEO Assurance Hub (Pages 19 - 40)

External Audit

9.2. External Audit Report - to follow

Annual Accounts

9.3. Audited Annual Accounts for those registered charities where the Council is the sole trustee - RES/22/260 - to follow

9.4. Annual Accounts 2022-23 - Key Dates and Actions - RES/22/261 (Pages 41 - 46)

Legal Obligations

9.5. Use of Investigatory Powers Quarterly Report - COM/22/258 (Pages 47 - 54)

Scrutiny

9.6. Scottish Public Services Ombudsman Decisions, Inspector of Crematoria Complaint Decisions - CUS/22/259 (Pages 55 - 62)

9.7. Inspection Report of Aberdeen Crematorium by the Senior Inspector of Burial, Cremation and Funeral Directors - OPE/22/256 (Pages 63 - 74)

Internal Audit

9.8. Internal Audit Update Report - IA/22/006 (Pages 75 - 94)

9.9. Transformational Programme - IJB - IA/AC2211 (Pages 95 - 114)

9.10. Commissioning - IA/AC2205 (Pages 115 - 128)

9.11. Attendance Management - IA/AC2216 (Pages 129 - 134)

9.12. Children with Disabilities - IA/AC2206 (Pages 135 - 156)

9.13. Corporate Health and Safety - IA/AC2304 (Pages 157 - 172)

EXEMPT/CONFIDENTIAL BUSINESS

10.1. None at the time of issuing the agenda

EHRIAs related to reports on this agenda can be viewed here

To access the Service Updates for this Committee please click here

Website Address: 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

Audit, Risk and Scrutiny Committee

ABERDEEN, 27 September 2022. Minute of Meeting of the AUDIT, RISK AND SCRUTINY COMMITTEE. Present:- Councillor Macdonald, Convener; and Councillors Allard, Bonsell, Bouse, Clark (as substitute for Councillor Hutchison), Fairfull, Farquhar (as substitute for Councillor Houghton), McLellan, Massey, Radley, Stewart, van Sweeden (as substitute for Councillor Nicoll), Watson and Yuill (as substitute for Councillor Radley from item 9.3, article 8 until 9.9, article 15) .

The agenda and reports associated with this minute can be found here.

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 indicated that questions relating to the Service Update issued for the Review of Items Recorded as 'Missing' from Art Gallery and Museums Collections that was circulated to members outwith the Committee would be taken at a later point on the agenda.

DETERMINATION OF EXEMPT BUSINESS

2. The Convener proposed that the Committee consider item 9.13 (IT Infrastructure Resilience) with the press and public excluded.

The Committee resolved:-
in terms of Section 50A(4) of the Local Government (Scotland) Act 1973, to exclude the press and public from the meeting during consideration of item 9.13 on the agenda (article 19) so as to avoid disclosure of exempt information of the class described in paragraph 14 of Schedule 7(A) of the Act.

DECLARATIONS OF INTEREST OR TRANSPARENCY STATEMENTS

3. There were no declarations of interest or transparency statements intimated.

MINUTE OF PREVIOUS MEETING OF 30 JUNE 2022

4. The Committee had before it the minute of its previous meeting of 30 June 2022.

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

AUDIT, RISK AND SCRUTINY COMMITTEE
27 September 2022

COMMITTEE BUSINESS PLANNER

5. The Committee had before it the Committee Business Planner as prepared by the Interim Chief Officer – Governance.

The Committee resolved:-
(i) to delete items 4 (Internal Audit Progress Report); 5 (Internal Audit Follow up on Recommendations), 24 (Internal Audit Progress Report) and 25 (Internal Audit Follow up on Recommendations);
(ii) to note that items 7 (Transformational Programme (IJB Risk, Audit and Performance Committee)), 15 (Commissioning), 16 (Attendance Management), 17 (Children's Social Care – Children with Disabilities), had been delayed until December 2022; and
(iii) to otherwise note the content of the business planner.

INFORMATION GOVERNANCE ANNUAL REPORT - CUS/22/190

6. The Committee had before it a report by the Director of Customer which presented the annual report on the Council's Information Governance Performance, including information about the changes implemented through the Council's information assurance improvement plan.

The report recommended:-
that the Committee note the information provided about the Council's information governance performance at sections 3.1 – 3.5 and in the Information Governance Report at Appendix 1.

The Committee resolved:-
(i) to note that information relating to the targets set would be captured for future reports; and
(ii) to otherwise approve the recommendation contained in the report.

INTERNAL AUDIT PROGRESS REPORT - IA/AC/006

7. The Committee had before it a report by the Chief Internal Auditor which provided an update on the progress against the approved Internal Audit plans, audit recommendations follow up and other relevant matters for theCommittee to be aware of.

The report recommended:-
that the Committee -
(a) to note the progress of the Internal Audit Plan;
(b) to note the progress that management has made with implementing recommendations agreed in Internal Audit reports;
(c) to note the approach to be taken for the 2023-26 audit planning process; and

(d) to note the current staffing levels within Internal Audit.

In response to a question relating to what happened to the outstanding recommendations with no response from management, the Chief Internal Auditor advised that Internal Audit would follow up with the relevant officers and provide an update at the next Committee meeting.

The Chief Officer – Finance provided an update in relation to three outstanding actions from his Cluster and advised that he would provide the details to the Chief Internal Auditor.

The Committee resolved:-
(i) to note the responses to members questions; and
(ii) to otherwise approve the recommendations.

IJB PERFORMANCE MANAGEMENT REPORTING - AC/2109

8. The Committee had before it a report by the Chief Internal Auditor which presented an audit in relation to IJB Performance Management Reporting which was undertaken to provide assurance that robust data was reported accurately and timeously to the IJB in order to provide an appropriate level of assurance regarding service performance and delivery of the IJB Strategic Plan. The report had already been presented to the IJB Risk, Audit and Performance Committee.

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.

CARE MANAGEMENT - IA/AC/007

9. The Committee had before it a report by the Chief Internal Auditor which presented an audit in relation to Care Management which had been requested to obtain assurance over coordination, recording and payment for care services.

Due to the reprioritisation of resources by the H&SCP to support an external inspection and to develop and implement a new Care Management System during 2021 and 2022, it was not possible to carry out a full in-depth review and instead a review was undertaken of the plans and progress with implementation of the new system to obtain assurance that these adequately cover risks in respect of care management recording and payments. An audit of the new Care Management System would be undertaken during 2023-24.

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

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

PAYROLL AND HR SYSTEM AMENDMENTS - AC/2114

10. The Committee had before it a report by the Chief Internal Auditor which presented a report in relation to Payroll and HR System Amendments which was undertaken to obtain assurance over the accuracy and completeness of the payroll as a result of changes to the workforce.

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

In response to a question relating to whether all overpayments had been identified, the Chief Internal Auditor advised that Internal Audit reviewed a small sample of payments.

In response to a question relating to whether the annual accounts contained details of salary arrears for employees who had left their employment with the Council, the Chief Officer – Finance advised that information was not usually captured. The Chief Officer – People and Organisation advised that where a pay award was applied after an employee had left employment, they were entitled to claim for the additional pay from the payroll team and that the leavers procedures had been updated to include details on how to make a claim.

The Committee resolved:-
(i) to note the responses to members questions; and
(ii) to otherwise endorse the recommendations for improvements as agreed by the relevant Function.

STAFF RESOURCING - AC/2215

11. The Committee had before it a report by the Chief Internal Auditor which presented an audit in relation to Staff Resourcing which was undertaken to examine adherence to procedures for three staff resourcing solutions, namely: internal recruitment and movement of staff, use of relief pool workers, and agency worker engagement.

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

The Committee resolved:-
to endorse the recommendations for improvement as agreed by the relevant Function.

DEBT RECOVERY - AC/2209

12. The Committee had before it a report by the Chief Internal Auditor which presented an audit in relation to Debt Recovery which was undertaken to ensure that procedures for recovering sundry debts were adequate, efficient, and consistently applied.

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

In response to a question relating to whether the review of the processes would apply to any potential crisis, the Chief Officer – Finance advised that the review would take into account the current financial situation and ensure that the processes in place were fit for purpose.

The Committee resolved:-
(i) to note the responses to members questions; and
(ii) to otherwise endorse the recommendations for improvements as agreed by the relevant Function.

BUILDING MAINTENANCE SYSTEM - AC/2111

13. The Committee had before it a report by the Chief Internal Auditor which presented an audit in relation to the Building Maintenance System which was undertaken to provide assurance over system controls, including access controls, system security and backups, interfaces, business continuity and contingency plans.

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

In response to a question relating to staff transferring to Digital and Technology and the impact this may have on resources, the Director of Customer Services advised that resources would be prioritised and allocated to the relevant areas when required.

In response to a question relating to whether the recommendations had been implemented, the Chief Officer – Operations and Protective Services advised that the transition was still ongoing which had delayed full implementation of the recommendations.

The Committee resolved:-
(i) to note the responses to members questions; and
(ii) to otherwise endorse the recommendations for improvements as agreed by the relevant Function.

REVIEW OF ITEMS RECORDED AS 'MISSING' FROM ART GALLERY AND MUSEUMS COLLECTIONS - QUESTIONS

14. At this juncture, the Convener referred to the Service Update that had been circulated to members out with the meeting and indicated that questions from members would be taken at this point.

Members asked various questions in relation to the process for recovering the missing items. Further questions were asked in relation to what was being done to ensure that the same issue didn't happen again. The Director of Commissioning advised that the modern way for recording items was more robust and was assured that a similar scenario would not happen in the future.

The Committee resolved:-
(i) to note that the Director of Commissioning would liaise with colleagues and circulate by email a response in relation to the process in place for recovery of items if found on Auction sites; and
(ii) to note that an internal audit in relation to Heritage and Historical Assets was in the Internal Audit Plan and would be reported to this Committee at the earliest opportunity in the New Year.

EXTERNAL AUDIT ANNUAL REPORT

15. The Committee had before it a report by KPMG, External Auditor which presented their draft annual external audit report and summarised their audit opinions and conclusions on significant issues arising from the audit of the Council's 2021/22 annual accounts.

The Committee resolved:-
(i) to note the content of the report; and
(ii) to note that this was the last year of KPMG as External Auditors and to note the thanks to them for their work over their term.

AUDIT, RISK AND SCRUTINY COMMITTEE
27 September 2022

AUDITED ANNUAL ACCOUNTS 2021-22 - RES/22/210

16. The Committee had before it a report by the Director of Resources which provided an overview of the Council's 2021/22 audited Annual Accounts.

The report recommended:-
that the Committee -
(a) approve the Council's audited Annual Accounts for the financial year 2021/22 as presented, subject to the final amendments being agreed with external auditors as highlighted in their report, following consultation with the Chief Executive and five political group leaders; and
(b) note that the presentation of the audited Annual Accounts 2020/21 for those registered charities where the Council is the sole trustee has been deferred until the next meeting of this committee on 13 December 2022.

In response to a question relating to whether the annual accounts for the charities were usually submitted at a later meeting, the Chief Officer – Finance advised that they would usually be presented at the same time, however with the OSCR deadline for submitting the charity accounts being 31 December, this allowed for the Council's annual accounts to be given priority.

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

USE OF INVESTIGATORY POWERS QUARTER 2 REPORT - COM/22/209

17. The Committee had before it a report by the Director of Commissioning which was presented to ensure that Elected Members reviewed the Council's use of investigatory powers on a quarterly basis and had oversight that those powers were being used consistently in accordance with the Use of Investigatory Powers Policy.

The report recommended:-
that the Committee note the update within the report in respect of the Council's use of investigatory powers during Quarter 2 of the current year.

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

SPSO DECISIONS, INSPECTOR OF CREMATORIA COMPLAINT DECISIONS - CUS/22/208

18. The Committee had before it a report by the Director of Customer Services which provided information on all Scottish Public Services Ombudsman (SPSO) and Inspector of Cremations decisions made in relation to Aberdeen City Council since the last

reporting cycle, to provide assurance that complaints and Scottish Welfare Fund applications are being handled appropriately.

The report recommended:-
that the Committee note the details of the report.

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

In accordance with Article 2 of this minute, the following item was considered with the press and public excluded.

IT INFRASTRUCTURE RESILIENCE - AC/2201

19. The Committee had before it a report by the Chief Internal Auditor which presented an audit in relation to IT Infrastructure Resilience which was undertaken to obtain assurance over the procurement and adequacy of the Council's IT infrastructure systems.

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

The Committee resolved:-
(i) to note the responses to members questions; and
(ii) to otherwise endorse the recommendations for improvement as agreed by the relevant Function.

- **SANDRA MACDONALD, Convener**

	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**	**Delayed or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
3	**13 December 2022**								
4	Use of Investigatory Powers Quarterly Report	to present the quarterly use of investigatory powers report	Agenda Item 9.5	Jess Anderson	Governance	Commissioning	5.2		
5	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.	Agenda Item 9.6	Lucy McKenzie	Customer Experience	Customer	6.4		
6	Internal Audit Update Report	To provide an update on progress of the Internal Audit Plan, Audit Recommendations Follow Up and other relevant information for the Committee.	Agenda Item 9.8	Jamie Dale	Governance	Commissioning	2.2		
7	Transformational Programme (IJB Risk Audit & Performance Committee)	To provide assurance that the IJB is continuing to make progress with delivery of its transformation agenda.	Agenda Item 9.9	Jamie Dale	Governance	Commissioning	2.2		
8	Commissioning	Review of plans and progress with implementation of the Council's Strategic Commissioning Approach set out in the Council Delivery Plan	Agenda Item 9.10	Jamie Dale	Governance	Commissioning	2.2		
9	Attendance Management	To obtain assurance over compliance with corporate policy and determine whether the Council's absence improvement plan is having a positive impact on attendance.	Agenda Item 9.11	Jamie Dale	Governance	Commissioning	2.2		
10	Children's Social Care - Children with Disabilities	To obtain assurance that care is being arranged and paid for in accordance with procedure to secure best value outcomes.	Agenda Item 9.12	Jamie Dale	Governance	Commissioning	2.2		

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11	External Audit Report for Charity Accounts	To present the External Audit report in relation to the Audited Annual Accounts for those registered charities where the Council is the sole trustee	Report Expected Agenda Item 9.2	Michael Wilkie	Governance	Commissioning	3.1		
12	Audited Annual Accounts for those registered charities where the Council is the sole trustee	ARSC Cttee 27 Sept 22 to note that the presentation of the audited Annual Accounts 2020/21 for those registered charities where the Council is the sole trustee has been deferred until the next meeting of this committee on 13 December 2022.	Report Expected Agenda Item 9.3	Lesley Fullerton	Finance	Resources	4.1		
13	ALEO Assurance Hub Update	To provide an update of risk and financial management and governance arrangements in accordance with Hub TOR and annual workplan	Agenda Item 9.1	Ronnie McKean	Governance	Commissioning	1.3		
14	Inspection Report of Aberdeen Crematorium by the Senior Inspector of Burial, Cremation and Funeral Directors	To provide the Committee with the Inspection Report of Aberdeen Crematorium carried out by the Senior Inspector of Burial, Cremation and Funeral Directors on 11 October 2022.	Agenda Item 9.7	Graham Keith	Operations and Protective Services	Operations	6.4		
15	Annual Accounts Key Dates	to provide Elected Members with high level information and key dates in relation to the 2022/23 Annual Accounts including linkages to the plans and timetables of the Council's External Auditors	Agenda Item 9.4	Lesley Fullerton	Finance	Resources	4.1		
16	Corporate Health and Safety	To provide assurance that appropriate processes are being employed in managing health and safety at a corporate level.	Agenda Item 9.13	Jamie Dale	Governance	Commissioning	2.2		
17	**2 February 2023**								
18	Use of Investigatory Powers Annual Report	to present the annual use of investigatory powers report		Jessica Anderson	Governance	Commissioning	5.2		

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19	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 McKenzie	Customer Experience	Customer	6.4		
20	Internal Audit Update Report	To provide an update on progress of the Internal Audit Plan, Audit Recommendations Follow Up and other relevant information for the Committee.		Jamie Dale	Governance	Commissioning	2.2		
21	Internal Audit Reports	Reports which have been finalised will be presented to the Committee.		Jamie Dale	Governance	Commissioning	2.2		
22	**23 March**								
23	Use of Investigatory Powers Quarter 1 Report	to present the quarterly use of investigatory powers report		Jessica Anderson	Governance	Commissioning	5.2		
24	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 McKenzie	Customer Experience	Customer	6.4		
25	Internal Audit Update Report	To provide an update on progress of the Internal Audit Plan, Audit Recommendations Follow Up and other relevant information for the Committee.		Jamie Dale	Governance	Commissioning	2.2		
26	Internal Audit Reports	Reports which have been finalised will be presented to the Committee.		Jamie Dale	Governance	Commissioning	2.2		
27	Internal Audit Plan 2023-2026	to present the Internal Audit Plan for 2023-26		Jamie Dale	Governance	Commissioning	2.1		

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28	ALEO Workplan 2023 and Terms of Reference	To present the ALEO Assurance Hub Workplan for 2023 including the dates for reporting.		Vikki Cuthbert	Governance	Commissioning	1.3		
29	Business Continuity Annual Review	To present the annual review of the Council's Business Continuity arrangements.		Ronnie McKean	Governance	Commissioning	1.2		
30	Corporate Risk Register and Assurance Maps	To present the Corporate Risk Register and Assurance Maps.		Ronnie McKean	Governance	Commissioning	1.1		
31	Annual Review - Risk Appetite Statement	The purpose of this report is to present the Council's updated Risk Appetite Statement.		Ronnie McKean	Governance	Commissioning	1.1		
32	Best Value Auditing	To present information regarding the change to how Best Value will be audited and reported.		Vikki Cuthbert	Governance	Commissioning	3.1		
33	**11 May**								
34	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 McKenzie	Customer Experience	Customer	6.4		
35	Internal Audit Update Report	To provide an update on progress of the Internal Audit Plan, Audit Recommendations Follow Up and other relevant information for the Committee.		Jamie Dale	Governance	Commissioning	2.2		
36	Internal Audit Reports	Reports which have been finalised will be presented to the Committee.		Jamie Dale	Governance	Commissioning	2.2		
37	Unaudited Annual Accounts 2022-23	To present the unaudited accounts for 2022-23		Lesley Fullerton	Finance	Resources	4.1		
38	**27 June**								
39	Use of Investigatory Powers Quarter 2 Report	to present the quarterly use of investigatory powers report		Jessica Anderson	Governance	Commissioning	5.2		

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40	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 McKenzie	Customer Experience	Customer	6.4		
41	Internal Audit Update Report	To provide an update on progress of the Internal Audit Plan, Audit Recommendations Follow Up and other relevant information for the Committee.		Jamie Dale	Governance	Commissioning	2.2		
42	Internal Audit Reports	Reports which have been finalised will be presented to the Committee.		Jamie Dale	Governance	Commissioning	2.2		
43	Audited Annual Accounts 2022-23	To present the audited accounts for 2022-23.		Lesley Fullerton	Finance	Resources	4.1		
44	ALEO Assurance Hub Update	To provide an update of risk and financial management and governance arrangements in accordance with Hub TOR and annual workplan.		Vikki Cuthbert	Governance	Commissioning	1.3		
45	**14 September**								
46	Use of Investigatory Powers Quarter 3 Report	to present the quarterly use of investigatory powers report		Jessica Anderson	Governance	Commissioning	5.2		
47	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 McKenzie	Customer Experience	Customer	6.4		
48	Internal Audit Update Report	To provide an update on progress of the Internal Audit Plan, Audit Recommendations Follow Up and other relevant information for the Committee.		Jamie Dale	Governance	Commissioning	2.2		
49	Internal Audit Reports	Reports which have been finalised will be presented to the Committee.		Jamie Dale	Governance	Commissioning	2.2		
50	Information Governance Annual Report	to present the annual report for the Council's Information Governance		Caroline Anderson	Data Insights	Customer	1.3		

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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.**								
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51	**23 November**								
52	Use of Investigatory Powers Quarter 4 Report	to present the quarterly use of investigatory powers report		Jessica Anderson	Governance	Commissioning	5.2		
53	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 McKenzie	Customer Experience	Customer	6.4		
54	Internal Audit Update Report	To provide an update on progress of the Internal Audit Plan, Audit Recommendations Follow Up and other relevant information for the Committee.		Jamie Dale	Governance	Commissioning	2.2		
55	Internal Audit Reports	Reports which have been finalised will be presented to the Committee.		Jamie Dale	Governance	Commissioning	2.2		
56	ALEO Assurance Hub Update	To provide an update of risk and financial management and governance arrangements in accordance with Hub TOR and annual workplan.		Vikki Cuthbert	Governance	Commissioning	1.3		
57	**Service Updates**								
58	Reconciliation of Granite - Union Terrace Gardens	**ARSC 30 June 2022 - Item 3** (v) to add two Service Updates to the business planner, those being: Reconciliation of Granite, Union Terrace Gardens and Review of Items Recorded as 'Missing' From Art Gallery & Museums Collections	Review of Items Recoreded as Missing from Art Gallery and Museums Collections was provided in September 2022	John Wilson	Capital	Resources			

ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Commitee
DATE	13 December 2022
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	ALEO Assurance Hub Update
REPORT NUMBER	COM/22/280
DIRECTOR	Gale Beattie
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TERMS OF REFERENCE	Remit 1.3

1. PURPOSE OF REPORT

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

2. RECOMMENDATION(S)

That the Committee:-

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

2.2 Notes that the report incorporates Hub officers' initial levels of assurance of the governance arrangements, risk management and financial management of bp Aberdeen Hydrogen Energy Limited;

2.3 Notes that the Assurance Hub officers and ALEO Service Leads will discuss any outstanding issues specified in the appendices and identified at the Audit, Risk and Scrutiny Committee with ALEO representatives, with a view to further improving the assessment ratings at the next Hub meeting.

3. CURRENT SITUATION

3.1 The report provides an overview of the ALEO Assurance Hub's most recent cycle of scrutiny following the Committee's endorsement of an oversight approach which balances 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 governance arrangements, risk management and financial management.

3.3 The Hub met in October and identified the following key assurance areas, in accordance with the workplan previously reported to the Committee:-

Governance Arrangements

1. Assurance that all governance documentation is regularly reviewed and supports the organisation's governance framework.
2. Assurance that ALEOs have a complaints procedure embedded within the organisation.

Risk & Resilience Management

1. Assurance that risks are being regularly reviewed in accordance with the organisation's agreed risk management policy, are kept under regular review with control actions monitored to completion and are linked to the achievement of outcomes for the ALEO and the Council.
2. Assurance that ALEOs are actively considering risk appetite in their decision making.
3. Assurance that appropriate business continuity arrangements are in place including testing and exercising arrangements or schedules; that each organisation has an awareness of the Council's responsibilities as a Cat 1 responder under the Civil Contingencies Act and has agreed mechanisms in place to support these; and that each organisation is fully conversant with the implications for their operations of the CONTEST Strategy (UK Govt strategy for counter-terrorism)
4. Follow up of Internal and External Audit arrangements with Aberdeen Heat and Power.

Financial Management

1. Assurance that accounts are being managed within budget, that the level of financial risk to the Council is low through quarterly trading accounts.
2. Assurance that ALEOs undertake medium-term financial planning or have incorporated medium term planning into a Business Plan to provide assurance that ALEOs are prepared for core funding pressures.
3. Assurance that accounts are being managed within budget, are in line with statutory requirements and that the level of financial risk to the Council is low.

3.4 The Assurance Standards and Risk Ratings are set out at Appendix A. The Hub's overall assessment of each ALEO, based on the information returned, has been attached within the summary report at Appendix B. Appendices C-H provide a summary of requests to and responses from, each ALEO, along with a breakdown of risk ratings. These have been agreed with the ALEOs, with follow up 121s offered to ensure agreement on the position taken by the Hub.

3.5 Medium risk ratings reflect the current commercial and economic challenges including continued recovery from the pandemic, energy market volatility and inflationary pressures/cost of living. These factors are affecting each ALEO to varying degrees however, the Hub is satisfied that financial stewardship arrangements continue to be robust and present as low risk to the Council.

3.6 The Hub's overall risk rating for bp Aberdeen Hydrogen Energy Limited reflect the current phase of the organisation's development. It is anticipated that risk ratings will continue to improve as the organisation continues to develop.

3.7 ALEOs attended scenario planning sessions with Extended Corporate Management Team (ECMT) in November and December, based on the potential for planned power outages over the winter months. ECMT and ALEOs have considered the potential implications for their operations and are in the process of making adjustments to business continuity plans and risk registers, in order to provide collective assurance that they can respond to disconnection if required, over the winter period. The Hub will review any activation of these plans, and their effectiveness, in the next cycle of meetings.

4. FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from the recommendations in 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 Legal officers within Commercial and Procurement Services have reviewed ALEO Service Level Agreements which aim, amongst other things, to facilitate the ALEO Assurance Framework. These have been modified to recognise the requirements of the Assurance Hub to receive assurance regarding systems of governance, company outcomes and risk management and mitigation.

5.2 The ALEO Assurance Hub will help identify any projects and/or initiatives that could influence investment decisions of Bond holders or the Council's credit rating and ensure that the appropriate governance is put in place. This adds a further layer of assurance to the Council's existing Bond governance arrangements.

6. ENVIRONMENTAL IMPLICATIONS

6.1 There are no direct environmental implications arising from the recommendations of this report.

7. RISK

7.1 The assessment of risk contained within the table below is considered to be consistent with the Council's Risk Appetite Statement.

Category	Risks	Primary Controls/Control Actions to achieve Target Risk Level	*Target Risk Level (L, M or H)	*Does Target Risk Level

			*taking into account controls/control actions	Match Appetite Set?
Strategic Risk	Ability of ALEOs to support the Council in meeting its strategic outcomes.	The Assurance Hub process mitigates against this risk by monitoring ALEO contribution to ACC strategic outcomes. This includes review of ALEO risk registers.	M	Yes
Compliance	ALEO service level agreements are not up to date and ALEOs are not delivering on Council outcomes. Non-compliance against GDPR, Health and Safety and other statutory responsibilities.	Commercial and Procurement Services has reviewed ALEO service level agreements to ensure they remain robust and fit for purpose. The Strategic Commissioning Committee has oversight of how ALEOs are achieving Council outcomes and complying with the terms of their service level agreements. The Hub will continue its oversight of ALEOs' approach to embedding strong governance, including audits, policies, procedures and systems to ensure that these are being reviewed and staff training is being delivered to mitigate the risk of governance failure. The Legal Regulatory and Compliance Team provide support and advice to the Hub on the steps ALEOs are taking on GDPR	L	Yes

		compliance in order for the Hub to provide assurance to Committee on ALEOs' management of this risk.		
Operational	Failure of ALEOs to deliver services according to agreed Service Level Agreements	Monitored by Strategic Commissioning Committee which has oversight of ALEO strategic business plans.	L	Yes
Financial	Financial failure of ALEOs impacting on the Council and its credit rating.	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 Committee on the financial management of Council ALEOs. City Growth and Resources Committee monitors financial performance and viability, including business planning.	L	Yes
Reputational	Impact of performance or financial risk on reputation of ACC.	Regular reporting to this Committee from the Hub provides adequate control.	L	**Yes**
Environment / Climate	Service delivery or operations impacting negatively on City net zero targets.	Regular reporting to this Committee from the Hub provides adequate control.	L	Yes

8. OUTCOMES

8.1 The recommendations within this report have no direct impact on the Council Delivery Plan.

9. IMPACT ASSESSMENTS

Assessment	Outcome
Integrated Impact Assessment	Full impact assessment not required.
Data Protection Impact Assessment	Not required.

10. BACKGROUND PAPERS

None

11. APPENDICES

11.1 **Appendix A** – Assurance Standards and Risk Ratings
Appendix B – Summary of ALEO Risk Ratings
Appendix C – Aberdeen Heat and Power
Appendix D – Aberdeen Performing Arts
Appendix E – Aberdeen Sports Village
Appendix F – Bon Accord Care
Appendix G – bp Aberdeen Hydrogen Energy Limited
Appendix H – Sport Aberdeen

12. REPORT AUTHOR CONTACT DETAILS

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Appendix A

Assurance Standard	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

	Overall Risk Rating									
	Mar-18	Sep-18	Feb-19	June-19	Dec-19	Oct-20	May-21	Sept-21	June-22	Dec-22
Aberdeen Heat and Power	Low/ Medium	Low/ Medium	Low	Very Low/ Low	Very Low/ Low	Low/ Medium	Very Low/ Low	Very Low/ Low	Low/ Medium	Medium
Aberdeen Performing Arts	Low/ Medium	Low	Low/ Medium	Low/ Medium	Low/ Medium	High	Medium	Medium	Low/ Medium	Low/ Medium
Aberdeen Sport Village	Low/ Medium	Low/ Medium	Low/ Medium	Low	Very Low/ Low	Low/ Medium	Very Low/ Low	Very Low/ Low	Low/ Medium	Low/ Medium
Bon Accord Care	Low/ Medium	Low/ Medium	Low/ Medium	Very Low/ Low	Very Low/ Low	Low/ Medium	Low/ Medium	Very Low/ Low	Very Low/ Low	Low
Sport Aberdeen	Low/ Medium	Low	Low	Very Low	Very Low/ Low	Medium	Very Low/ Low	Very Low/ Low	Low/ Medium	Low/ Medium
bp Aberdeen Hydrogen Energy	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Low/ Medium

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Aberdeen Heat & Power - Appendix C

Area of Assurance	Assurance Request	ALEO Response and Hub Commentary	Risk Rating
Governance	Assurance that all governance documentation is regularly reviewed and supports the organisation's governance framework. The following are examples of documents which may be requested: - Delegated powers - Codes of Conduct - Procurement Regulations	The Hub noted that although minutes had been provided, there was no reference in these to the goverance documents therefore agreed to seek further clarification that these were reviewed at Board meetings. It was noted that the documents provided had clear dates where revisions had been made however. In terms of the Standing Orders, the Hub further noted that the version provided was from 2019 and that the document was to be reviewed every three years and agreed to request information on the timeline for any upcoming review of the documentation. Further information provided from AH&P stated that due to COVID and the energy crisis, the document review had been delayed, however documents were due before the Board at its next meeting. It is therefore suggested that evidence of this review be requested for the next report. The documentation provided evidence of the delegations to the Board and the various Sub Groups. Evidence was provided of procurement regulations and purchasing processes, handling of data protection and fraud / information breach policies as requested. The Hub noted that privacy notices were in place and that a review was to be undertaken of all documentation around data protection. AH&P have advised that this will commence in January and be complete by April 2023. It is therefore proposed that an update be sought after April as to progress with the review. The Hub noted that although staff were recruited with a pre-existing knowledge of DP, specific training was not in place for staff and the Hub considered that this was an area which could be reviewed, perhaps to provide refresher training to those staff to ensure knowledge was retained. AH&P have responded to agree that this will be taken forward in 2023.	Very low (No Change)
	Complaints Procedure	The Hub noted that there was a comprehensive complaints procedure in place which was readily available to the public on the website and which aligned with the MCHP, providing clear information on stages of complaints and contacts for support.	Very low
Risk Management	Assurance that risks are being regularly reviewed in accordance with the organisation's agreed risk management policy, are kept under regular review with control actions monitored to completion, and are linked to the achievement of outcomes for the ALEO and the Council.	The Hub reviewed the risk register provided. The risks are categorised within in accordance with the risk policy previously reviewed by the Hub. The risk register is reviewed and updated periodically by AH&P staff and is presented for review at two of the board subgroups in addition to the full Board. Any new risks added to the risk register are raised specifically as an agenda item for discussion at the relevant meetings. A major review of the risk register was conducted in February and March. The review was conducted to ensure that the risks specified within the risk register were still relevant to the operational risk climate and resulted in the previous risk relating to EU-Exit being absorbed into other risks contained within the register. The risk register reflects the risks associated with inflationary pressures including energy costs and risks around reduction of Government grants and incentives. There is consistency across the risk register in the way that risks are assessed, graded, and controlled and this, in addition to the periodic reviews by staff, the Board and subgroups provides AH&P will a strong risk management framework.	Very low (No Change)
	Assurance that ALEOs are actively considering risk appetite in their decision making.	AH&P has established a risk appetite and tolerance level relating to the achievement of strategic objectives and this is set out within the Risk Policy. Risk appetite is also considered within decision making and this is evidenced within the Decision Flow Chart contained within the Connection Policy.	Very low
	Assurance that ALEOs have risk-based internal and external audit plans in place and a process to address and close out audit recommendations to completion. Assurance that there have been no internal control failures or that any failures have been addressed and/or notified if they are of significance to the Council.	The Hub reviewed the 2021/22 Internal Audit Follow Up Report produced by Wylie & Bisset. The report concluded that of the 16 recommendations made in 2020/21, 8 had been fully implemented, 6 remain either partially or not implemented and 2 have been superseded. The Hub was advised that work is ongoing to progress the recommendations that are partially or not implemented and will follow up on these at the next reporting cycle. The Hub had previously agreed to follow up on the recommendations resulting from the Business Continuity & Disaster Recovery Audit and were pleased to note that these recommendations were fully implemented. AH&P advised that a full review of documentation is currently underway and the output of this review will facilitate future internal audit planning. The Hub will follow up progress on this activity at the next reporting cycle.	Low (No Change)

	Assurance that appropriate business continuity arrangements are in place including testing and exercising arrangements or schedules; that each organisation has an awareness of the Council's responsibilities as a Cat 1 responder under the Civil Contingencies Act and has agreed mechanisms in place to support these; and that each organisation is fully conversant with the implications for their operations of the CONTEST Strategy (UK Govt strategy for counter-terrorism)	AH&P provided a copy of the current Business Continuity Plan which was updated recently to include a training element to ensure that individuals are aware of roles and responsibilities within the plan. The Hub were advised that not specific training or testing of the Business Continuity Plan has been conducted although the AH&P team and subcontractors are aware of their individual roles and responsibilities in the event of plan activation. The Hub notes that although the plan has been reviewed and updated it has not been tested recently and no testing plan is currently in place. AH&P confirmed that the existing plan will be tested by April/May 2023. The Hub will review progress in this areas at next reporting cycle. AH&P advised that CONTEST online training has been undertaken by the CEO and the Business Support Administrator.	Low
Finance	Assurance that accounts are being managed within budget, that the level of financial risk to the Council is low and that there is compliance with the Following the Public Pound Code of Practice.	The Hub confirmed that extensive detailed forecast and monitoring figures along with any potential financial risks form part of the regular Board papers. This includes year to date as well as detailed prior year comparisons. Fluctuating energy prices and analysis continue to be examined by the Board as as AH&P seek to enter into a new energy contract to cover the period November 2022 to March 2023. Whilst AH&P have analysed the effect on its operations at various energy pricing levels, the final effect on the current years financial accounts will depend upon the final energy contract price agreed plus how any government price cap will affect this.	High (From Medium)
	Assurance that ALEOs undertake medium-term financial planning or have incorporated medium term planning into a Business Plan to provide assurance that ALEOs are prepared for core funding pressures. Again this ensures compliance with the Following the Public Pound Code of Practice.	The Hub noted that the MTFP had been produced but also noted that these will need to be updated once Gas contracts are put in place and the effect of the energy supplier price cap is determined	Medium (No change)
	Assurance that accounts are being managed within budget, are in line with statutory requirements and Following the Public Pound Code of Practice, and that the level of financial risk to the Council is low.	Draft annual accounts show AH&P made a profit during 2021-22. As these will not be finalised until November 2022 anyadditonal information arising from these accounts will be reported to a future committee.	Low (No Change)

Aberdeen Performing Arts - Appendix D

Area of Assurance	Assurance Request	ALEO Response and Hub Commentary	Risk Rating
Governance	Assurance that all governance documentation is regularly reviewed and supports the organisation's governance framework. The following are examples of documents which may be requested: - Delegated powers - Codes of Conduct - Procurement Regulations	The Hub noted from minutes provided that the Scheme of Delegation and Memorandum and Articles had last been reviewed in 2018 and 2019 respectively, however a review of the Scheme of Delegation was scheduled for November 2022. The Hub agreed to request copies of any revised documentation following this review. Procurement was covered within the Financial Regulations provided. The Hub noted that there was nothing to report in terms of code of conduct for Board members. The Hub noted that a comprehensive induction plan had been put in place for the new Chief Executive however there had been a delay to the recruitment of new Board members. The Hub noted that it was expected to begin this process by November and agreed to request a further update from APA once this had been undertaken. It was noted that assurance had been provided that data protection and privacy policies and procedures were in place and had been recently reviewed (May 2022), with training provided to staff through various methods. The Hub considered that the governance risks were generally very low, although there was a risk around the delay to the Board member recruitment as a result, but were assured that this was mitigated through the additional support being provided to senior managers.	Very Low (No change)
	Complaints Procedure	The Hub noted based on the responses provided that the complaints procedure generally followed the MCHP, although Stage 3 of the process was not to the SPSO. Records of complaints were reviewed on a monthly basis by Customer Experience Managers, and then on a quarterly basis by the leadership team and a Board sub-committee. Upon request, the Hub was provided with a copy of the 'Customer Service Standards' for APA which is used in place of a complaints procedure. The Hub noted that while the procedure was advised to those who approached staff with a complaint, it was not currently available publicly, and the APA website used a 'Contact Us' form which did not specifically mention complaints.	Very Low (No change)
Risk Management	Assurance that risks are being regularly reviewed in accordance with the organisation's agreed risk management policy, are kept under regular review with control actions monitored to completion, and are linked to the achievement of outcomes for the ALEO and the Council.	APA confirmed that the risk register is subject to a formal, annual review by the board on an annual basis each November and evidenced this with minutes of the November 2021 meeting, in addition the risk register is also regularly reviewed by the leadership team. APA confirm that the updated risk register will reflect the current risk environment. This will include the risk of funding cuts resulting from pressures on public finances. The risks and potential impacts to the business resulting from external factors such as inflationary pressures and the cost of living increases. APA anticipate that these external factors will impact ticket sales and income generation whilst inflationary pressures will affect cost base/operating costs such as increased production costs, real living wage increases and energy costs. APA recognise that risks and impacts to the business resulting from Covid have reduced however, there are risks in this area such as impact on shows resulting illness (artists, supporting staff etc.) which may result in sales and refund requests. APA confirm that the risk register will incorporate activities and plans required to mitigate these risks including financial planning, having fixed rates/contracts in place at competitive rates and reducing energy consumption. A copy of the current risk register was not provided for the current reporting cycle as it is currently under review for the board meeting in November. The Hub will review the register in the next reporting cycle.	Very Low (No change)

	Assurance that ALEOs are actively considering risk appetite in their decision making.	APA confimed that a risk appetite policy is in place and was reviewed and approved by the Board in November 2021. This policy is reviewed every three years.	Very Low
	Assurance that appropriate business continuity arrangements are in place including testing and exercising arrangements or schedules; that each organisation has an awareness of the Council's responsibilities as a Cat 1 responder under the Civil Contingencies Act and has agreed mechanisms in place to support these; and that each organisation is fully conversant with the implications for their operations of the CONTEST Strategy (UK Govt strategy for counter-terrorism)	APA confimed that business continuity arrangements have been tested regularly during the pandemic on a "live" basis and so planned exercises were not required. Acitivation of business continuity plans and arrangements has allowed APA to assess the effectivness of the plans and to update and change the plans based upon lessons learned.	Very Low
Finance	Assurance that accounts are being managed within budget, that the level of financial risk to the Council is low and that there is compliance with the Following the Public Pound Code of Practice.	The Hub has reviewed the Cashflow/forecast projections provided by APA. These would indicate a positive position at the end of 2022-23. Forecasts are regularly updated and reported to the Board. The organisation is aware of changes in customer behaviours and spending patterns and potential effects on income arising from such changes. APA's reserve strategy was reviewed by their Finance Sub Committee prior to year end and these have been updated with a view to increasing financial resilience going forward.	Low (No change)
	Assurance that ALEOs undertake medium-term financial planning or have incorporated medium term planning into a Business Plan to provide assurance that ALEOs are prepared for core funding pressures. Again this ensures compliance with the Following the Public Pound Code of Practice.	The Hub will review the next iteration of the MTFP as it becomes available in February 2023. This would be in the next ALEO reporting cycle. As reported in the June ALEO committee report the assumptions and cashflow figures provided at that time indicated adequate controls were in place. There is evidence within the draft 2021-22 accounts that the Board is aware of potential risks arising from the current economic climate and is looking to mitigate and reduce financial risk arising from this.	Medium (No change)
	Assurance that accounts are being managed within budget, are in line with statutory requirements and Following the Public Pound Code of Practice, and that the level of financial risk to the Council is low.	The Hub noted that the audited 2020-21 annual accounts were filed timeously and the auditors raised no matters of concern. Draft Accounts for financial year 2021-22 have been submitted but as these are still subject to audit they will be reported to a future committee. The draft figures indicate APA had a surplus against budget for 2021-22.	Low (No change)

Aberdeen Sports Village - Appendix E

Area of Assurance	Assurance Request	ALEO Response and Hub Commentary	Risk Rating
Governance	Assurance that all governance documentation is regularly reviewed and supports the organisation's governance framework. The following are examples of documents which may be requested: - Delegated powers - Codes of Conduct - Procurement Regulations	ASV have advised that the Head of Finance is currently reviewing all finance policies and procedures and that an updated Financial Regulations and Procedure document would be available next cycle which would cover the governance documents requested. The Hub therefore agreed to request this for the next cycle. In terms of training and induction for new Board members, the Hub noted that while documentation had not been provided as to the current training process, this was due to the process currently being reviewed. It was noted that the Board members had been consulted on areas for development. The Hub noted that this review was due to be complete by December 2022 and agreed to follow up on this next cycle. The Hub noted that there were no code of conduct matters to be reported. The Hub noted that there was regular provision of data protection and data management training, with 200 members of staff trained in 2021-2022. The Hub further noted that a new DPO had been appointed as of 5 October and a review would be undertaken of existing processes and procedures. The Hub were advised that ASV expected that the review and subsequent update of the action plan would take into the New Year to complete and agreed to request further details of this at a future cycle.	Low
	Complaints Procedure	The Hub noted that a comprehensive complaints procedure was available, which aligned to the MCHP and included all necessary information to support customers in making a complaint, including clear detail of what could not be addressed through the complaints procedure and signposting to relevant organisations for support.	Very low
	Assurance that risks are being regularly reviewed in accordance with the organisation's agreed risk management policy, are kept under regular review with control actions monitored to completion, and are linked to the achievement of outcomes for the ALEO and the Council.	ASV continue to demonstrate effective risk recording and management arrangements. A copy of the September 2022 Business Risk Report to the Board was provided along with a copy of the Risk Register and the format of the register and risk categorisation is consistent with the last review. The report to Risk Report to the board noted that the residual risk scored in the “Top 5” risks had increased, one risk has been removed from the register whilst two new risks have been added including a risk associated with the Cost of Living which could result in reduction in customer numbers and associated income. Existing risk scores relating to Increased Energy Costs and Increased Expenditure Demands have been increased and reflects ASV’s current operating climate.	Very Low - No Change

Risk Management	Assurance that ALEOs are actively considering risk appetite in their decision making.	ASV confirmed that the Board has agreed that they are satisfied with existing Risk Management arrangements and that a separate Risk Appetite Statement is not a business requirement at this time. The Hub accepts this decision and will look for evidence of risk appetite assessment in decision making and the management of risk in the next report cycle. ASV advised that the existing risk assessment policy is currently under revview and may be updated to reflect business risk as in addition to Health and Safety risks. The Hub wil follow up on this review at the next reporting cycle.	Very Low
	Assurance that appropriate business continuity arrangements are in place including testing and exercising arrangements or schedulres; that each organisation has an awareness of the Council's responsibilities as a Cat 1 responder under the Civil Contingencies Act and has agreed mechanisms in place to support these; and that each organisation is fully conversant with the implications for their operations of the CONTEST Strategy (UK Govt strategy for counter-terrorism)	ASV confirmed that Business Continuity arrangements are supported by the Critical Incident Plan which is subject to an annual review. A review of the plan is underway and will include a review of Business Impact assessments and plan testing frequency. ASV confirmed that the updated documentation will be available for the Hub to review at the next reporting cycle. ASV noted that Business Continuity arrangements have been testing on a “live” basis as plans had been activated and used effectively during the pandemic to respond to events such as facility closures, staffing shortages and facility re-opening. ASV confirmed that the testing frequency and a review business impact assessments is currently underway. The Hub will follow up on this review at the next reporting cycle.	Very Low (no change)
Finance	Assurance that accounts are being managed within budget, that the level of financial risk to the Council is low and that there is compliance with the Following the Public Pound Code of Practice.	The Hub noted that financial monitoring data is provided to the Board on a regular basis. It was seen that information provided is both timeous and detailed and discussions take place around potential business risks and mitigation where required/possible	Very Low (No change)
	Assurance that ALEOs undertake medium-term financial planning or have incorporated medium term planning into a Business Plan to provide assurance that ALEOs are prepared for core funding pressures. Again this ensures compliance with the Following the Public Pound Code of Practice.	This was reviewed as part of the June ALEO report and found to be reasonable. This is supported by regular monitoring and forecasting data being reviewed by the Board and Funding partners	Medium (No Change)
	Assurance that accounts are being managed within budget, are in line with statutory requirements and Following the Public Pound Code of Practice, and that the level of financial risk to the Council is low.	The Hub noted that as the financial year for ASV ends on June 2022, no draft annual accounts are available at this time, although financial data for the year has been provided which would indicate, subject to audit, that ASV achieved a break even position	Low (\No change)

Bon Accord Care- Appendix F

Area of Assurance	Assurance Request	ALEO Response and Hub Commentary	Risk Rating
Governance	Assurance that all governance documentation is regularly reviewed and supports the organisation's governance framework. The following are examples of documents which may be requested: - Delegated powers - Codes of Conduct - Procurement Regulations	The Hub noted that governance documentation had been provided and that it was clearly set out in the delegation of authority (DoA) that changes to those documents would be reviewed via the Board and Managing Director. The Hub further noted that the good practice of having a modifications log throughout the year was utilised and that the documentation was reviewed with annual approval by the Board, and although minutes had not been provided to evidence this review, the Hub noted that the DoA and procurement policy were currently under review to be presented in November for approval. The Hub agreed to request the revised documents once these were approved. Similarly, the Hub noted that the Counter Fraud Policy was under review in November, and also agreed to request this document once it was approved. The Hub noted that there was a data protection policy in place, last reviewed in May 2021 and were assured by the information that as part of the SLA, all BAC staff had to undertake data protection training, with a one year refresher. It was noted that 83.6% staff had undertaken the training, and the Hub agreed to seek assurance that arrangements were in place to ensure that the remaining members of staff undertook the training. The Hub further noted that the course had been updated in May 2022 to ensure it remained fit for purpose.	Very Low
	Complaints Procedure	The Hub was advised that the complaints procedure was currently under review through the company wide policy review group, however assurance was provided that the current procedure followed the model complaints handling procedure. The Hub agreed to follow up on this for the next committee and request a copy of the procedure once it had been reviewed.	Low
	Assurance that risks are being regularly reviewed in accordance with the organisation's agreed risk management policy, are kept under regular review with control actions monitored to completion, and are linked to the achievement of outcomes for the ALEO and the Council.	BAC confirmed that the risk register is reviewed and updated by the BAC Executive Team. Changes and updates are highlighted for discussion with the Board and a copy and copies of the Board papers covering the July and September 2022 were provided as examples of the review. BAC continue to demonstrate effective risk management and are in the process of producing risk registers that contain the risks relating to BAC committees including; Audit and Assurance, Clinical and Governance and People and Development. A copy of the Financial Risk Register was provided, this register contained financial and operational risks identified by the organisation including risks around inflationary costs pressures whilst the existing Corporate Risk Register contains risks including Recruitement and Retention of Staff and Gobal Pandemic. The Hub will review the additional committee risk registers in the next reporting cycle.	Very Low - (No change)

Risk Management	Assurance that ALEOs are actively considering risk appetite in their decision making.	BAC provided a copy of the Board Governance Handbook which contains the Risk Appetite Statement (RAS) approved by the Board in April 2022. The RAS will be reviewed by the Board on an annual basis and sets out how BAC balances both risks and opportunities in order to achieve strategic objectives. The Risk Appetite summary section sets out the types of risks recognised by BAC and the risk grading table set out the tolerance from Zero/Minimal to Moderate/High. Supporting narrative provides summary detail of BAC appetite and tolerance for each type of risk.	Very Low
	Assurance that appropriate business continuity arrangements are in place including testing and exercising arrangements or schedules; that each organisation has an awareness of the Council's responsibilities as a Cat 1 responder under the Civil Contingencies Act and has agreed mechanisms in place to support these; and that each organisation is fully conversant with the implications for their operations of the CONTEST Strategy (UK Govt strategy for counter-terrorism)	BAC has a Business Continuity arrangements in place supported by a Business Continuity Policy and Plans. The last Business Continuity test/exercise was conducted in July 2021 and BAC confirmed than an exercise will be undertaken by December 2022. The Hub will follow up on the outputs from the planned exercise in the next reporting cycle.	Very Low - (No change)
Finance	Assurance that accounts are being managed within budget, that the level of financial risk to the Council is low and that there is compliance with the Following the Public Pound Code of Practice.	Quarterly Management Accounts have been provided to the Hub. Based upon their quarter 1 results, and current actions being taken to monitor areas of financial challenge BAC is currently forecasting to achieve a break even position by year end. The effect of the recent pay award on the trading position requires to be finalised.Funding for a 3% pay award was provided within the current year but the nature of the BAC staff is such that the average pay award may be 7-8%. BAC will need to examine ways in which to mitigate these additonal costs in order to bring in a balanced budget for 2021-22 and how this will affect their 2022-23 budget. The Hub will require evidence of how BAC intend to manage pay awards, in order to reduce the risk rating.	Medium (Change from Low)
	Assurance that ALEOs undertake medium-term financial planning or have incorporated medium term planning into a Business Plan to provide assurance that ALEOs are prepared for core funding pressures. Again this ensures compliance with the Following the Public Pound Code of Practice.	Will not be available for review until next cycle. The Hub will review the MTFP when it has been completed and will provide any comments when appropriate.	Low (No change)
	Assurance that accounts are being managed within budget, are in line with statutory requirements and Following the Public Pound Code of Practice, and that the level of financial risk to the Council is low.	The Hub noted that Audited Accounts have been provided and the auditors have expressed no concerns.	Low (No change)

bp Aberdeen Hydrogen Energy- Appendix G

Area of Assurance	Assurance Request	ALEO Response and Hub Commentary	Risk Rating
Governance	Assurance and progress on implementation of Governance and decision making structures and arrangments.	A copy of the Shareholders Agreement (SHA) was provided to the hub for review. The Hub was advised that the company operation is defined by a Shareholders Agreement (SHA) and Articles of association. Director's and shareholder reserved matters are also detailed in the SHA. A delegation of financial authority matrix has been established to deal with Financial (inc. expenses, and payment of invoices) and procurement (inc. setting up of suppliers and raising purchase orders) matters that fall within the delegations of the directors. The Board meets four times a year in person in Aberdeen. In between these meetings there are catch-up calls, these calls ensure that the board maintains contact on a 6-weekly basis. The Board meetings are attended by the company secretary and provide statements of the intent for each section covered including "for noting", "for board approval" and/or "board decision ahead of shareholder approval"	Very Low
	Assurance and progress on implementation of processes and procedures including: 1) Reporting arrangements 2) Powers reserved for the board 3) Delegated powers to executive officers	Reporting arrangements, powers reserved for the board and powers delegated to executive offers are all defined within the SHA.	Very Low
	Composition & capacity of the board	The organisations board consists of 6 Directors, comprising two Directors from ACC and four from bp. Two of the four bp positions have executive positions, CEO and CFO. Chair and fourth bp directors are non-executive. All of the bp Directors appointed have extensive experience across bp operations. No director is remunerated for board activity. It is antipated that this rating will be improved to Low/Very Low in the next reporting cycle by an overview of training completed by Board Members.	Medium
	Progress toward the development of key policies	The Hub was advised that the development of key policies is underway and that once complete, they are reviewed by shareholders and are signed/approved using docusign. Policies currently being drafted include T&E Policy and Accounting Policy. Procurement and Sourcing Technical Note was provided as an example of a completed policy. The organisation is working towards completion of key policies by 1st April 2023.	Medium
	Compliance and accreditation	The Hub was advised that the organisation is considering compliance/accreditation with ISO9001 quality management system. Progress and developments in this area will be reviewed in the next reporting cycle.	Medium

Risk Management	Assurance and progress on the development of Risk Management arrangements.	The Hub was advised that risks are identified using PESTL' (Political, Environmental, Social, Technological and Legal) approach and are recorded onto a risk register once identified. A risk register has been developed to recording technical and commercial risks. A copy of the current risk register was provided for review, the risk register details the risk identified, pre and post mitigation impacts and action plan to mitigate. Risk management arrangements are currently aligned to the bp risk management framework.	Low
	Assurance and progress on the development of Business Continuity plans and arrangements.	The organisation are currently working towards completion of a Business Continuity Plan by 1st April 2023.	Medium
	Assurance and progress on the development of Internal and External Audit arrangements.	Internal and External planning and reporting are not applicable at this stage of the businesses development.	Medium
Finance	Assurance and progress on the development of Financial Management procedures and processes.	Financial systems and procedures are already in place to produce detailed budget monitoring which will then form part of the Board papers for review. Board meetings have already commenced.	Medium
		Accounting policies are being developed and will finalised in the following months. It is anticipated that Finance ratings will be improved to Low/Very Low in the next reporting cycle upon completion of the policies under development and confirmation of external and internal audit arrangements.	Medium

Sport Aberdeen - Appendix H

Area of Assurance	Assurance Request	ALEO Response and Hub Commentary	Risk Rating
Governance	Assurance that all governance documentation is regularly reviewed and supports the organisation's governance framework. The following are examples of documents which may be requested: - Delegated powers - Codes of Conduct - Procurement Regulations	The Hub noted that a copy of the Scheme of Delegation had been provided and had been recently reviewed (September 2022) and approved at Committee in October 2022. Financial procedures (including changes made to procurement regulations) had been reviewed and updated in March 2022 and minute evidence was provided that these had been discussed at the Board. The data protection policy had also been recently reviewed and presented for approval at the March 2022 Board meeting. Relevant privacy notices were confirmed as being in place and had been reviewed in June 2022 and training on DP was provided every three years for appropriate staff. The Hub noted that there had been nothing to report in terms of Code of Conduct for Board members.	Very Low
	Complaints Procedure	The Hub noted that a complaints procedure was currently in place and that a revised procedure to reflect SPSO revisions from April 2021 was due to be presented to the Board in November 2022 for approval. The Hub therefore agreed to request that a copy of the revised procedure be provided for a future cycle to enable the Hub to review the revised document.	Low
Risk Management	Assurance that risks are being regularly reviewed in accordance with the organisation's agreed risk management policy, are kept under regular review with control actions monitored to completion, and are linked to the achievement of outcomes for the ALEO and the Council.	Sport Aberdeen continues to demonstrate effective risk management and reporting. A copy of the Strategic Risk register which is reviewed on a 6 monthly was provided to the Hub. The Hub noted that the register is due to be reported to the Sport Aberdeen Board in November. The risk register contains the Top 12 risks identitied by the organisation and provides risk scores, control measures and further actions required in order to manage the risks identified. The Hub noted the new risks added to the Strategic Risk Register – Operating Model Review, Staff Recuitment and Retention and Impact of the War in Ukraine (increased energy costs) The risk register also captures risks relating to Inflationary Pressures (utility costs) and the Cost of Living increases on Sport Aberdeen members and customers.	Very Low (No Change)
	Assurance that ALEOs are actively considering risk appetite in their decision making.	Sport Aberdeen confirmed that they have established a risk appetite and that this has been incorporated into existing reporting processes for specific items of business to committees and the board. The Hub noted that risk appetite has also been incorporated into the Strategic Risk Register. The Hub will review reports that reflect risk appetite in the next reporting cycle.	Very Low (No Change)

	Assurance that appropriate business continuity arrangements are in place including testing and exercising arrangements or schedules; that each organisation has an awareness of the Council's responsibilities as a Cat 1 responder under the Civil Contingencies Act and has agreed mechanisms in place to support these; and that each organisation is fully conversant with the implications for their operations of the CONTEST Strategy (UK Govt strategy for counter-terrorism)	Sport Aberdeen confirmed that a live test of the Business Continuity Plan took place in July 2022. The scenario exercised tested the organisations plans and arrangements in relation to loss of access to HQ. Improvement actions to the existing plan were identified as a result of the test and these actions have been fully implemented. Compliance with these actions and activities will be reviewed in the first quarter of 2023.	Very Low (No Change)
Finance	Assurance that accounts are being managed within budget, that the level of financial risk to the Council is low and that there is compliance with the Following the Public Pound Code of Practice.	The Hub noted that both monthly and year to date budget monitoring information is submitted regularly to the Board. This includes a narrative on any material variances which may have arisen and any mitigation if required.	Low
	Assurance that ALEOs undertake medium-term financial planning or have incorporated medium term planning into a Business Plan to provide assurance that ALEOs are prepared for core funding pressures. Again this ensures compliance with the Following the Public Pound Code of Practice.	The Hub noted that a one year Business Plan has been produced for 2022-23 which has been signed off by the Board. The setting of a one year Business Plan rather than a 3 year rolling plan as in pre-covid years was agreed by Aberdeen City Council.	Medium (No change)
	Assurance that accounts are being managed within budget, are in line with statutory requirements and Following the Public Pound Code of Practice, and that the level of financial risk to the Council is low.	A copy of the audited annual accounts for financial year 2021-22 have been received and reviewed. The auditors have not expressed any concerns.	Low

ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny
DATE	13 December 2022
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Annual Accounts 2022/23 – Action Plan and Key Dates
REPORT NUMBER	RES/22/261
DIRECTOR	Steven Whyte, Director of Resources
CHIEF OFFICER	Jonathan Belford, Chief Officer – Finance
REPORT AUTHOR	Lesley Fullerton, Finance Operations Manager
TERMS OF REFERENCE	4.1

1. PURPOSE OF REPORT

1.1 The purpose of this report is to provide Elected Members with high level information and key dates in relation to the 2022/23 Annual Accounts including linkages to the plans and timetables of the Council's External Auditors.

2. RECOMMENDATION(S)

1.2 It is recommended that committee notes the information in relation to the 2022/23 annual accounts process contained within the report.

3. CURRENT SITUATION

3.1 The Annual Accounts 2022/23 will summarise the Council's transactions for the period, 1 April 2022 to 31 March 2023 and its financial position at the year-end 31 March 2023. They will be prepared in accordance with the International Financial Reporting Standards (IFRS) based Code of Practice on Local Authority Accounting in the United Kingdom (the Code), and in accordance with The Local Authority Accounts (Scotland) Regulations 2014. There are no changes to these Codes in 2022/23 that will have any significant impact on the Annual Accounts.

3.2 In order to comply with the regulations of being listed on the London Stock Exchange the Council is implementing the same earlier year end closedown as previous years. This means that the unaudited Annual Accounts will be ready for audit by 30 April 2023 and the signed audited Annual Accounts by 30 June 2023.

3.3 There are a number of key dates within this process, and these are summarised as follows:

Date(s)	Description
31 March 2023	End of the financial year 2022/23
Jan – June 2023	Information from Group Entities (including ALEO's)
17 April 2023	Public Notice for the Public Inspection Period to be issued
08 May 2023	Signing of unaudited Annual Accounts by the Proper Officer
11 May 2023	Submission of the Annual Accounts to Auditors
15 May 2023 – 02 June 2023	Public Inspection Period for the unaudited Annual Accounts
27 June 2023 (tbc)	Audit, Risk and Scrutiny Committee to consider and aim to approve the audited Annual Accounts for signature
27 June 2023 (tbc)	Signing of the audited Annual Accounts by the Proper Officer, Chief Executive and Council Co-Leaders.
30 June 2023	Statutory deadline for the Proper Officer to sign the unaudited Annual Accounts, submit to the Auditor and publish on the website, along with the accounts of all subsidiary bodies
14 July 2023 (tbc)	Deadline for submission of the unaudited Whole of Government Accounts (WGA) to the Scottish Government
30 September 2023	Deadline for submission of the signed audited Annual Accounts to the Auditor
30 September 2023 (tbc)	Deadline for submission of the audited WGA to the Scottish Government
31 October 2023	Statutory deadline for the publication on the website of the signed Annual Accounts & Audit Certificate, related Auditor report and accounts of all subsidiary bodies
31 December 2023	Deadline for submission of the audited Charitable Trust Annual Accounts to OSCR

3.3.1 <u>31 March 2023</u>

Transactions relating to goods and services received or provided by the Council by 31 March 2023 should be recorded in the 2022/23 financial year.

To facilitate an efficient year end closure, deadlines have been put in place in relation to ordering goods and services, posting/authorising payments, raising invoices and making accruals for material items. These key dates along with relevant guidance have been communicated throughout the Council by messages on the Council's intranet, and meetings between accounting staff and budget holders.

3.3.2 <u>January 2023 – June 2023</u>

The Council is required to consider its interests in all types of entity and prepare Group Accounts which incorporate the material transactions and balances of those entities identified as subsidiaries, associates, and joint ventures. A number of the entities included are also referred to as ALEO's (Arm's Length

External Organisations). Throughout this period there are a number of deadlines for these entities to provide management accounts, draft financial statements with detailed working papers as necessary and audited Annual Accounts.

3.3.3 17 April 2023, 15 May 2023 – 2 June 2023

The Local Authority Accounts (Scotland) Regulations 2014 defines the notice period, the inspection period, the deadline for submission of an objection to the accounts and the information which must be made available for inspection. The latest date by which the public inspection can start is 1 July and a public notice must be issued by 17 June, giving at least 14 days' notice before the start of the inspection period.

3.3.4 8 & 11 May 2023

The Local Authority Accounts (Scotland) Regulations 2014 only requires the unaudited Annual Accounts to be signed by the Proper Officer (Chief Officer - Finance) prior to submission to the Auditor.

The Audit, Risk and Scrutiny Committee will receive the unaudited Annual Accounts 2022/23, including the Annual Governance Statement and Remuneration Report for consideration prior to submission for audit. The Local Authority Accounts (Scotland) Regulations 2014 requires that a committee whose remit includes audit or governance meet to consider the unaudited accounts as submitted to the auditor no later than 31 August. As the body charged with governance it allows members of the committee the opportunity to take ownership of the accounts, to review them such as to be satisfied with their completeness hence effectively "sign off" the governance statement before they are submitted for audit.

3.3.5 11 May 2023

The Regulations also require publication of the unaudited Annual Accounts, as submitted to the Auditor, on the Council's website until the audited accounts can replace them.

3.3.6 30 June 2023

The Audit, Risk and Scrutiny Committee will receive the audited Annual Accounts for consideration. The Local Authority Accounts (Scotland) Regulations 2014 require that the committee aim to approve these accounts prior to their signature by the Proper Officer, Chief Executive and Council Leader having regard to any report made on the accounts and any advice given by the Proper Officer or the Auditor.

The committee will also receive the external auditor's "Annual Report to Members and the Controller of Audit on the 2022/23 audit" for debate and consideration. This report provides observations arising from the audit that are significant and relevant to their responsibility to oversee the financial reporting process and sets out the auditor's responsibilities in relation to the financial audit, the auditor's findings and conclusions from all audit activity undertaken during the year. It highlights the significant issues arising from the audit of the financial statements and informs Elected Members of the proposed audit opinion in advance of the accounts being certified.

The Annual Audit report includes the draft audit opinion on whether the accounts provide a 'true and fair view' of the Council finances and includes a review of 'going concern'. For 2019/20, 2020/21 and 2021/22 there was significant focus on this aspect of the audit due to Covid-19 impact, and this extended to the ALEO's.

3.3.7 14 July & 30 September 2023

The Whole of Government Accounts (WGA) Returns are prepared based on the draft and final annual accounts, and form part of the external audit. There was a delay in the WGA Returns being issued for the 2020/21 and 2021/22 Annual Accounts due to amended deadlines because of the Covid pandemic. Therefore, there is the possibility that these deadlines may be extended for 2022/23 also.

3.3.8 31 October 2023

The Local Authority Accounts (Scotland) Regulations 2014 set out the requirements for publication of the audited Annual Accounts by 31 October, including the signed accounts and audit certificate and all auditor reports relating to those signed accounts. In addition, the Council must publish the accounts of its subsidiaries either on its website or through a link to the relevant page on the company's website. All published documents must be available for at least five years.

3.4 The contract with our current external auditors KPMG ended in 2021/22. With effect from 2022-23 the Council's new external auditors are Audit Scotland. Their contract will be effective for a 5-year period.

3.4.1 Accounting staff have not yet engaged with Audit Scotland, and the dates provided above are based on our early close deadlines that have been in place for several years. It is the intention for Council staff to continue planning to prepare the Accounts to these deadlines until there is engagement with our new external auditors, and an audit plan is in place. Some of these dates, therefore, may be subject to change.

3.5 Local Authority Charities

3.5.1 There is a requirement for full compliance with the Charities Accounts (Scotland) Regulations 2006 which means that a full audit is required for all registered charities where the Council is the sole trustee irrespective of the size of the charity. The Accounts Commission has appointed the current auditor of the Council as the auditor of its relevant charities.

There are several statutory provisions in relation to record keeping and preparation of accounts for such charities as well as the duties of charity trustees in relation to accounting records. The Local Authority Accounts (Scotland) Regulations 2014 also make provision for such bodies in a number of areas.

Taken together this effectively means that separate accounts and audit opinions are required for charities, and this is subject to the same requirements and timetable as detailed above for the Council's accounts.

4. FINANCIAL IMPLICATIONS

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

5. LEGAL IMPLICATIONS

5.1 There is a statutory requirement for the Council to produce both unaudited and audited Annual accounts within certain timescales and to a high standard.

6. ENVIRONMENTAL IMPLICATIONS

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

7. RISK

Category	Risks	Primary Controls/Control Actions to achieve Target Risk Level	*Target Risk Level (L, M or H) *taking into account controls/control actions	*Does Target Risk Level Match Appetite Set?
Strategic Risk	No risks identified	n/a	n/a	n/a
Compliance	No risks identified	n/a	n/a	n/a
Operational	No risks identified	n/a	n/a	n/a
Financial	No risks identified	n/a	n/a	n/a
Reputational	No risks identified	n/a	n/a	n/a
Environment / Climate	No risks identified	n/a	n/a	n/a

8. OUTCOMES

COUNCIL DELIVERY PLAN	
	Impact of Report
Aberdeen City Council Policy Statement	Annual Accounts is an enabler for the delivery of the outcomes and external audits ensure that the Council's stewardship and financial management are robust.

Aberdeen City Local Outcome Improvement Plan	
Prosperous Economy Stretch Outcomes	There are no direct implications on the economy arising from the recommendations of this report.
Prosperous People Stretch Outcomes	A robust year end process and timetable assists budget holders in their role which in turn should enhance the staff experience.
Prosperous Place Stretch Outcomes	There are no direct implications on the environment arising from the recommendations of this report.
Regional and City Strategies	There are no direct implications on the economy arising from the recommendations of this report.
UK and Scottish Legislative and Policy Programmes	The report sets out the key dates for the Annual Accounts 2022/23, which fulfils the requirements placed upon the Council by The Local Authority Accounts (Scotland) Regulations 2014.

9. IMPACT ASSESSMENTS

Assessment	Outcome
Impact Assessment	Not required
Data Protection Impact Assessment	Not required

10. BACKGROUND PAPERS

10.1 None

11. REPORT AUTHOR CONTACT DETAILS

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ABERDEEN CITY COUNCIL

COMMITTEE	Audit Risk and Scrutiny Committee
DATE	13 December 2022
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Quarter 3- Use of Investigatory Powers
REPORT NUMBER	COM/22/258
DIRECTOR	Gail Beattie
CHIEF OFFICER	Jenni Lawson Interim Chief Officer- Governance
REPORT AUTHOR	Jess Anderson, Team Leader- Regulatory & Compliance Team, Legal Services
TERMS OF REFERENCE	5.2

1. PURPOSE OF REPORT

1.1 To ensure that Elected Members review the Council's use of investigatory powers on a quarterly basis and have oversight that those powers are being used consistently in accordance with the Use of Investigatory Powers Policy.

2. RECOMMENDATION(S)

That the Committee:-

2.1 Notes the update within the report in respect of the Council's use of investigatory powers during Quarter 3 of the current year.

3. CURRENT SITUATION

3.1 The Council has powers under the Regulation of Investigatory Powers (Scotland) Act 2000 (RIPSA), and Investigatory Powers Act 2016 (IPA) to use different investigatory techniques. RIPSA provides a legal framework for covert surveillance by public authorities, an independent inspection regime to monitor these activities and sets out a process for the authorisation of covert surveillance by designated officers, for the duration of that authorisation and for the review, renewal or termination of authorisations. It gives the Council powers to conduct two types of covert surveillance:

1. Directed Surveillance (is covert surveillance in places other than residential premises or private vehicles); and

2. the use of a Covert Human Intelligence Source (the use of an undercover officer).

This Committee has had oversight of covert surveillance activity under RIPSA since 2017.

3.2 The IPA permits the Council to acquire Communications Data for a lawful purpose. Communications data is the way in which, and by what method, a person or thing communicates with another person or thing. The IPA sets out the manner and process by which Communications data can be obtained and this is supported by the Home Office's Communications Data Code of Practice[1]. The Council has not used Communications data since approximately 2005, however the ability to acquire it still remained. In response to concerns from the Operations and Protective Services cluster that there is an increase in online offences, more so during the pandemic, Legal Services and Trading Standards are working together to put in place operational procedures to ensure compliance with the requirements of the IPA.

3.3 The Investigatory Powers Commissioner (IPCO) has oversight of both RIPSA and IPA and as such, the Council's use, and management of powers under these will form part of the normal inspection process. The last inspection took place in April 2020 and was reported to this Committee on 8th October 2020[1]. The next is due 2023/2024.

3.4 The Council approved the Use of Investigatory Powers Policy in December 2021[2]. This policy governs compliance with both RIPSA and the IPA. It remains a mandatory requirement that all members of staff wishing to use investigatory power must undertake training prior to being able to make an application to use such investigatory powers.

3.5 Committee is being asked to note the update on the use of these powers, and the Council's compliance with the Policy, particularly in respect of covert surveillance activity during the period (28 September to13 December 2022, namely Quarter 3 of 2022.

Quarter 3- 2022

Covert Surveillance – RIPSA

3.6 In the period from 28th September until 13th December 2022, there has been one authorisation for Directed Surveillance. The authorisation related to test purchases of age restricted goods- namely tobacco and vapour related items. The authorisation was cancelled in accordance the Council's procedure.

[1] Agenda for Audit, Risk and Scrutiny Committee on Thursday, 8th October, 2020, 2.00 pm (aberdeencity.gov.uk)

[2] Agenda for Audit, Risk and Scrutiny Committee on Thursday, 2nd December, 2021, 2.00 pm (aberdeencity.gov.uk)

3.7 There have been no further applications for covert surveillance made, or approved, within this quarter.

3.8 Members should be aware that the directed surveillance operation authorised on 8th July 2022 was not cancelled until 11th November 2022 due to workload pressures. A Directed Surveillance authorisation ceases to have effect three months after it is authorised. The Council's internal procedure states that the Authorising Officer must cancel a directed surveillance if he/she considers it no longer meets the criteria upon which it was authorised. Whilst this cancellation took some time to come through, members should note that the operation itself ceased within a week of the authorisation being granted. The Chief Officer-Governance is making enquiries with other Services to recruit an additional Authorising Officer which should ease the pressure on existing Authorising Officers. Further, officers in Legal Services shall implement a system to provide reminders to Authorising Officers to ensure this risk is minimised in future applications.

Communications Data- IPA

3.9 At the time of writing this report, the Council has not acquired any Communications data but arrangements with NAFN[3], to provide services to the Council required by the IPA, have been concluded. Further, operational procedures are being drafted. It is hoped that these are submitted to the Chief Officer- Governance for approval before the end of 2022. No Communications data shall be acquired until training has been delivered and the operational procedure approved.

3.10 Any activity under the IPA will form part of the normal quarterly reporting cycle to this Committee.

Training

3.11 No training has been delivered to Council staff this quarter. An interactive post was published 2nd December 2022 on the restricted forum. The polls are designed to test knowledge throughout the year and supplements the mandatory training.

Awareness Raising

3.12 The last Authorsing Officer's meeting was 10th November 2022. The Environmental Health Manager came along to speak to Authorising Officers about his role and what investigatory/ enforcement work is carried out. These developments sessions provide Authorising Officers with an insight into how parts of the Council operate and whether there is scope for the use of investigatory powers. Feedback was provided to the Authorising Officers on the audit of authorisation forms made during this quarter.

4. FINANCIAL IMPLICATIONS

4.1 There are no financial implications arising from this report.

5. LEGAL IMPLICATIONS

5.1 The Scottish Government Code of Practice on Covert Surveillance sets an expectation that elected members review and monitor the use of RIPSA on a quarterly basis. This is also a matter which is taken into account by the IPCO when they carry out their inspections.

5.2 The Home Office Code of Practice on Communications Data states that any public authority wishing to acquire Communications Data must have regard to the Code and that there should be a robust process in place for accessing such data which should be overseen by the Senior Responsible Officer.

5.3 Quarterly reporting of the Council's use of investigatory powers to Elected Members provides assurance that the Council's use of such powers is being used consistently and that the standards set by its policy remain fit for purpose.

5.4 The management, knowledge and awareness of those involved with RIPSA activity was something which was commended by the IPCO in his inspection in 2020. Officers hope that reporting on the use of investigatory powers more broadly, enhances transparency and provides another level of scrutiny and assurance on the use of these powers.

6. ENVIRONMENTAL IMPLICATIONS

6.1 There are no environmental/ climate risks arising from the recommendations in this report.

7. RISK

The assessment of risk contained within the table below is considered to be consistent with the Council's Risk Appetite Statement"

Category	Risks	Primary Controls/Control Actions to achieve Target Risk Level	*Target Risk Level (L, M or H) *taking into account controls/control actions	*Does Target Risk Level Match Appetite Set?

Strategic Risk	There are no strategic risks		L	**Yes**
Compliance	That the Council's use of RIPSA is not legally compliant. The Council's acquisition of communications data does not comply with the Home Office Code of Practice.	This Committee receives quarterly and annual reports on its use of investigatory powers under RIPSA and the IPA and related policy mitigates this risk highlighted in this section.	L	**Yes**
Operational	Employees are not suitably trained for surveillance work. Failure to report to and update Committee on surveillance activity means that it would undermine public confidence in the Council and how it operates.	Appropriate and mandatory training arms staff with the correct skills to carry out surveillance and thus, there is little to no risk to staff. All requests for training are met. Reporting to Committee occurs quarterly on surveillance activity.	L	**Yes**
Financial	There are no financial risks arising from this report		L	**Yes**
Reputational	Failure to update Committee on RIPSA activity would mean that the Council would be at risk of	External inspections on RIPSA activity operate every 3-4 years. This provides external assurance to the Committee of the Council's compliance with RIPSA. Further, whilst there is	L	**Yes**

	reputational damage when this is raised by the IPCO in their inspection.	no requirement to report to Committee about the Council's use of Communication Data, the broader reporting of both demonstrates the Council's wish to be transparent about it use of such powers. The Inspection Report is shared with Committee and an Action Plan created (where necessary) and is endorsed and approved by Committee.		
Environment / Climate	There are no environmental or climate impacts arising from this report.		L	**Yes**

8. OUTCOMES

COUNCIL DELIVERY PLAN 2022-2023	
	Impact of Report
Aberdeen City Council Policy Statement	The report does not have an impact on the Policy Statement
Prosperous Economy Stretch Outcomes	Whilst the recommendations of this report are for noting, the use of investigatory powers by the Council as an investigatory tool may have an impact on the economy as a result of enforcement action taken by services such as Trading Standard, e.g. such as in enforcing the law around counterfeit goods.

Prosperous People Stretch Outcomes	Enforcement activity undertaken by the Council by using, where appropriate, its powers under the IPA and RIPSA, may have an impact on this by tackling the selling of counterfeit goods.
Prosperous Place Stretch Outcomes	
Regional and City Strategies	This report does not have an impact on the Regional and City Strategies.

9. IMPACT ASSESSMENTS

Assessment	Outcome
Integrated Impact Assessment	The purpose of this report is to update Committee on the Council's use of investigatory powers. Further, there is no requirement to consider the Fairer Scotland Duty as this report does not seek approval for any Strategic decisions and is merely providing Committee with an update on this type of activity.
Data Protection Impact Assessment	The purpose of this report is to update Committee on the Council's use of investigatory powers. As such, a Data Protection Impact Assessment is not required.
Other	There are no other impact assessments relevant to this report.

10. BACKGROUND PAPERS

10.1 Use of Investigatory Powers Policy, December, 2021[3]

11. REPORT AUTHOR CONTACT DETAILS

Name	Jess Anderson
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Tel	01224 52(2553)

[3] Agenda for Audit, Risk and Scrutiny Committee on Thursday, 2nd December, 2021, 2.00 pm (aberdeencity.gov.uk)

ABERDEEN CITY COUNCIL

COMMITTEE	Audit Risk and Scrutiny
DATE	13 December 2022
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Scottish Public Services Ombudsman Decisions and Inspector of Cremations Complaint Decisions
REPORT NUMBER	CUS/22/208
DIRECTOR	Andy MacDonald
CHIEF OFFICER	Jacqui McKenzie
REPORT AUTHOR	Lucy McKenzie
TERMS OF REFERENCE	6.4

1. PURPOSE OF REPORT

1.1 This report provides information on all Scottish Public Services Ombudsman (SPSO) and Inspector of Cremations 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. CURRENT SITUATION

3.1 A report detailing all Scottish Public Services Ombudsman (SPSO) and/or Inspector of Cremations 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.

3.2 The last report on this matter was submitted to the 27 September 2022 Committee.

Scottish Public Services Ombudsman (SPSO) Complaint Decisions

3.3 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

3.4 The SPSO publish all decision reports on their website at www.spso.org.uk/decision-report-search

3.5 There is one SPSO decision relating to Aberdeen City Council complaints to notify Committee of. The complaint was partially upheld. Further information is detailed in Appendix A.

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

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

3.7 From 12 October 2020, the Scottish Welfare Fund also administer the Scottish Government Self-Isolation Support Grants. Further information is available at www.aberdeencity.gov.uk/services/coronavirus-covid-19/self-isolation-support-grants

3.8 There have been two SPSO Second Tier Reviews in relation to Aberdeen City Council Scottish Welfare Fund application decisions since the last reporting period. As a reconsideration of the decisions has been requested, they will be reported at the next committee cycle, once a final decision has been made.

Inspector of Cremations Decisions

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

6.1 There are no direct environmental implications arising from the recommendations of this report.

7. RISK

7.1 The assessment of risk contained within the table below is considered to be consistent with the Council's Risk Appetite Statement.

Category	Risks	Primary Controls/Control Actions to achieve Target Risk Level	Low (L) Medium (M) High (H) *taking into account controls/control actions	*Does Target Risk Level Match Appetite Set?
Strategic Risk	If we do not handle complaints or Scottish Welfare Fund (SWF) applications correctly then there is risk that we do not meet our strategic objectives.	Support in complaint handling is available to responding officers through a variety of methods and there is a centralised team in place to monitor compliance. The SWF team go through extensive training and ongoing guidance and support is available. Reviews are carried out by senior staff.	L	Yes
Compliance	The (SPSO) is the regulatory body for public services in Scotland. If we are non-compliant in our handling of a complaint or Scottish Welfare Fund application then there is risk that this is	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	L	Yes

	highlighted by the SPSO.	appropriate. Officers responsible for Scottish Welfare Fund applications receive full training to ensure they have the necessary knowledge to undertake assessments.		
Operational	Staff morale may be lowered as a result of a negative outcome of a SPSO decision.	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.	L	Yes
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 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.	The complaint handling procedure encourages frontline resolution whenever possible and there is guidance and training in place to support staff in effective complaint handling. The financial benefit of early resolution is highlighted to responding officers in training.	L	Yes
Reputational	Non-compliance carries reputational risk. Customer	There is a centralised Customer Feedback Team	L	Yes

	perception of the council could also be negatively impacted if complaints and Scottish Welfare Fund applications are not handled correctly.	responsible for ensuring that complaints are being handled consistently and appropriately across the council. Staff within the Scottish Welfare Fund Team receive comprehensive training to ensure applications are handled correctly and there is a robust procedure in place to review decision making when necessary.		
Environment / Climate	There are no environment / climate risks associated with this report.	N/A	N/A	Yes

7. OUTCOMES

COUNCIL DELIVERY PLAN	
	Impact of Report
Aberdeen City Council Policy Statement	Complaints are a vital part of organisational learning and improvement therefore enabling the Council to realise its aims across its policy statement. The report focuses on complaints outcomes which provide rich customer insight for the organisation to act upon to help transform service delivery.
Aberdeen City Local Outcome Improvement Plan	
Prosperous Place Stretch Outcomes	The Scottish Welfare Fund supports the delivery of the LOIP stretch outcome 13 as it can provide short term financial assistance to help with food costs which can relieve the pressure on use of food banks. It also works with partner agencies to identify citizens and signpost them for budget management, debt advice and benefit maximisation.

8. IMPACT ASSESSMENTS

Assessment	Outcome
Impact Assessment	Not required
Data Protection Impact Assessment	Not required
Other	Not required

9. BACKGROUND PAPERS

N/A

10. APPENDICES (if applicable)

Appendix A – SPSO Complaint Decisions

11. REPORT AUTHOR CONTACT DETAILS

Lucy McKenzie
Customer Services Manager
LucyMcKenzie@aberdeencity.gov.uk

Appendix A – SPSO Complaint Decisions

Complaint Received Date	SPSO Decision Date	Complaints Investigated by the SPSO	Cluster	SPSO Decision	SPSO Recommendations	Date Implemented
21 July 2021	12 July 2022	1) The Council failed to invite the complainant to a 72 hour LAC (not upheld) 2) The Council failed to fulfil their obligations to care and plan for the complainant's two youngest children at the LAC review (not upheld) 3) The Council failed to correctly follow the Section 25 Children (Scotland) Act 1995 placement process for the complainant's 2 youngest children (not upheld) 4) The Council unreasonably carried out a face to face visit at the complainant's home (upheld) 5) The Council failed to reasonably handle the complainant's complaints (not upheld)	Integrated Children's and Family Services	Complaint partially upheld https://www.spso.org.uk/decision-reports/2022/september/decision-report-202004290-202004290	1) Apologise to complainant for not following relevant guidance and evidence this 2) Feedback the findings of this investigation to relevant staff for reflection and learning, and to inform future practice.	11 October 2022

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ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny
DATE	13 December 2022
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Inspection Report of Aberdeen Crematorium by the Senior Inspector of Burial, Cremation and Funeral Directors
REPORT NUMBER	OPE/22/256
DIRECTOR	Steven Whyte
CHIEF OFFICER	Mark Reilly
REPORT AUTHOR	Graham Keith
TERMS OF REFERENCE	6.9

1. PURPOSE OF REPORT

1.1 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 Inspection Report of Aberdeen Crematorium carried out by the Senior Inspector of Burial, Cremation and Funeral Directors on 11 October 2022.

2. RECOMMENDATION(S)

That the Committee: -

2.1 notes the inspection report

3. CURRENT SITUATION

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 Senior Inspector of Burial, Cremation and Funeral Directors' annual inspection report be presented to the Audit, Risk and Scrutiny Committee.

3.2 The Senior Inspector of Burial, Cremation and Funeral Directors' Inspection Report is attached as Appendix 1.

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. ENVIRONMENTAL IMPLICATIONS

6.1 There are no direct environmental implications arising from the recommendations of this report.

7. RISK

The assessment of risk contained within the table below is considered to be consistent with the Council's Risk Appetite Statement

Category	Risks	Primary Controls/Control Actions to achieve Target Risk Level	*Target Risk Level (L, M or H) *taking into account controls/control actions	*Does Target Risk Level Match Appetite Set?
Strategic Risk	None identified	N/A	L	**Yes**
Compliance	None identified	N/A	L	**Yes**
Operational	None identified	N/A	L	**Yes**
Financial	None identified	N/A	L	**Yes**
Reputational	None identified	N/A	L	**Yes**
Environment / Climate	None identified	N/A	L	**Yes**

8. OUTCOMES

COUNCIL DELIVERY PLAN 2022-2023	
	Impact of Report
Aberdeen City Council Policy Statement **Working in Partnership for Aberdeen**	This report supports the delivery of the following aspects of the policy statement: - • the delivery of vital local services on which people depend • to ensure that the widest possible range of quality support is given where, and when, it is needed.

Aberdeen City Local Outcome Improvement Plan 2016-26	
Prosperous People Stretch Outcomes	People and communities are protected from harm due to the assurance provided in this report

9. IMPACT ASSESSMENTS

Assessment	Outcome
Integrated Impact Assessment	Full impact assessment not required
Data Protection Impact Assessment	Not required
Other	Not required

10. BACKGROUND PAPERS

10.1 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

11. APPENDICES

11.1 Appendix 1 - Inspection Report - Aberdeen Crematorium (October 2022)

12. REPORT AUTHOR CONTACT DETAILS

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Robert Swanson QPM
Senior Inspector of Burial, Cremation and Funeral Directors

Tel: 07817 014 508
Email: robert.swanson@gov.scot

Inspection of Crematoria

Name and Address of Crematorium: Aberdeen Crematorium Skene Road Aberdeen AB15 8PT	
Name of Cremation Authority: Aberdeen City Council	**Date of Inspection:** Tuesday 11th October 2022
Undertaken by: Robert Swanson QPM Senior Inspector of Burial, Cremation and Funeral Directors. **Observer:** Professor Gordon Findlater Inspector of Burial, Cremation and Funeral Directors.	**In the presence of:** Graham Keith Performance and Development Manager Angus Beacom Crematorium Manager

1. Cremation Fees (as advertised)

Adult Cremation Fee (with chapel service) ……..£704
Cremation (no chapel service) …….. £595
Cremation (no chapel service – early morning slot) ……. .£420
Children (up to the age of 18 years) ……No Charge

2. Staffing levels

Staff certificated to carry out cremations:

5 members of staff on-site qualified to carry out cremations with 3 others undergoing training.

3. Office Management

Administration Procedure:

Since the date of the last inspection the most notable change is that all application forms and associated documentation is now stored electronically, this being one of the provisions of the Cremation (Scotland) Regulations 2019.

The crematorium are one of very few crematoria who have now moved away from retaining all documentation in hard copy.

All funeral directors have access to an on-line booking service and whilst bookings are made this way, a few continue to make bookings by telephone.

Documentation is either received electronically, or if in hard copy is then scanned onto computer.

This system works well for all.

The administration procedure was examined from point of first intimation to dispersal of the ashes with checks carried out on a random selection of documentation.

All was found to be of a high standard with a number of safeguards in place to ensure total compliance with the instructions of the applicant.

It is with great credit to the administration staff that they were able to remain operational throughout the period of the Covid-19 pandemic.

Computer System:

BACAS

4. Total Number of Cremations Carried Out (2021)

Breakdown by category	
Adult:	2090
Child – aged under 1 yr	10
Child – aged 1-17 yrs	4
Stillbirth:	6
Pregnancy Loss: **Individual:** **Shared:**	 175 567
Body Parts:	9
Total:	2861

5. Cremation / Identity Card Process

There has been no change to policy since the date of the last inspection.

All restricted measures which had been put in place during the pandemic have now been removed.

The process and all related documentation was examined from point of arrival of the coffin throughout all stages including cremation, cooling, cremulation, storage and dispersal of the ashes, subsequent updating and storage of computer records.

All were found to be of a high standard with noted safeguards in place to minimise the risk of human error resulting in the mislabelling of ashes, and to ensure continuity of identification throughout the different stages.

Strict procedures are in place to ensure total compliance with the instructions of the applicant at all stages.

6. Recovery of Ashes

Ashes have been recovered from all cremations

7. Ashes Policy

Details of process:

Ashes are dispersed in accordance with the instructions of the applicant.

There has been no change to policy since the date of the last inspection.

Ashes can be retained for a period pending an instruction from the applicant, collected by the applicant, a nominated representative or the funeral director, scattered in the Gardens of Remembrance or interred in the cemetery

There is provision for a change of instruction by the applicant prior to dispersal.

A check of the disposal instructions on a random selection of application forms was found to accurately reflect the disposal outcome.

Ashes awaiting dispersal are stored in a secure room with clear identification and instructions affixed.

8. Cremators

Number of cremators: 4

Make (s): All FT3

Size (s): All Large

9. Sample of Cremation Register

Category: Adult **Cremation number:** 158380 **Result:** All documentation and records examined and found to be in order. The cremation was carried out on 11th May 2022 with the ashes scattered in the Gardens of Remembrance on 18th May 2022.	**Category:** Pregnancy Loss (Individual) **Cremation number:** 8345 **Result:** All documentation and records examined and found to be in order. The cremation was carried out on 25th May 2022 with the ashes retained pending collection by the applicant. (ashes confirmed to be present)
Category Adult **Cremation number:** 158525 **Result:** All documentation and records examined and found to be in order. The cremation was carried out on 10th June 2022 with the ashes collected by the funeral director on same date.	**Category:** Pregnancy Loss (Individual) **Cremation number:** 8344 **Result:** All documentation and records examined and found to be in order. The cremation was carried out on 25th May 2022 with the ashes collected by the applicant on 28th June 2022.
Category: Adult **Cremation number:** 158651 **Result:** All documentation and records examined and found to be in order. The cremation was carried out on 7th July 2022 with ashes collected by the funeral director on 11th July 2022.	

10. Use of Baby Tray

Number / Source:

5 x FT

11. Pregnancy Loss Policy / Procedure

NHS / Shared:

There has been no change to policy or procedure since the date of the last inspection.

The Cremation Authority have a Service Level Agreement with NHS Grampian for the cremation of shared and individual pregnancy loss.

Pregnancy Loss is transported to the crematorium by NHS staff and the cremation is carried out the same day.

Ashes from cremation of shared pregnancy loss are scattered within the Garden of Remembrance 1 week after cremation.

Ashes from cremation of individual pregnancy loss are dispersed in accordance with the instructions of the applicant.

Individual:

The policy and procedure for cremation of individual pregnancy loss does not differ from that of an infant.

A Baby Tray is used for all cremation of pregnancy loss.

12. Metal Extraction

Policy:

Metal extracts are dispersed in accordance with the instructions of the applicant.

Unless otherwise instructed by the applicant, metal extracts are sensitively recycled by Orthometals, as part of the ICCM scheme.

The monies accrued from the recycling programme are donated to local charities.

13. Crematorium Management Plan

Implementation of the Cremation (Scotland) Regulations 2019 on 4th April 2019 required Cremation Authorities to prepare and maintain a Crematorium Management Plan to be made available for inspection by Inspectors of Cremation and members of the public.

The Regulations list a number of matters to be included within the Plan.

These are, as follows:

a) Name, address, and business hours of crematorium

b) Procedures for:

1. The carrying out of cremations
2. Dealing with any unexpected increase in number of cremations
3. The operation and servicing of all equipment used in cremation process
4. The disposal of cremation residue
5. The disposal of ashes
6. Contingency arrangements for unexpected disruption or loss of services

c) Review of the Plan

These are the minimum, allowing Cremation Authorities to also include other matters they consider worthy of inclusion.

The Aberdeen Crematorium Management Plan was examined during the course of the inspection and, as stated in the previous inspection report ,was found to be of a very high standard, and one of the most detailed of all crematorium plans seen by the inspector.

The Plan is held in hard copy within the crematorium and can also be accessed electronically.

14. General Observations / Recent Changes

The only notable change observed since the date of the last inspection is completion of the installation and upgrading of audio / visual / streaming facilities referred to in the last report.

It is however understood that work is scheduled to refurbish parts of the Garden of Remembrance.

All private and public areas seen during the course of the inspection were found to be clean, tidy and in a state of good repair.

The grounds and Gardens of Remembrance were seen to be well maintained with an excellent array of flowers.

The crematorium has a defibrillator on-site.

15. Overall Assessment

The Inspection found there to be no shortcomings to any aspect of the cremation process, with good practice observed throughout the different stages.

Staff are to be commended for their handling of issues relating to the Covid-19 pandemic, particularly during the early stages when the country was operating at different tier levels and attendance numbers were severely restricted.

Whilst cremations were restricted for a short period of time at the beginning, strict working practices ensured that the crematorium remained fully operational throughout the remainder of what was a very difficult and demanding period.

With the impact of the pandemic having eased, staff have resumed the training of crematorium operatives as part of the FBCA training programme.

Their commitment to the training programme, over and above normal duties is recognised, appreciated and praised by crematoria staff throughout Scotland.

The Cremation Authority are very fortunate in having such an experienced, loyal and enthusiastic team, collectively providing a first class service to the local community and beyond.

Signed: Robert Swanson QPM
Senior Inspector of Burial, Cremation and Funeral Directors (Scotland)

Date: 17th October 2022.

ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	13 December 2022
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Internal Audit Update Report
REPORT NUMBER	IA/22/006
DIRECTOR	N/A
CHIEF OFFICER	Jamie Dale, Chief Internal Auditor
REPORT OFFICER	Jamie Dale, Chief Internal Auditor
TERMS OF REFERENCE	2.3

1. PURPOSE OF REPORT

1.1 The purpose of this report is to provide the Committee with an update on Internal Audit's work since the last update. Details are provided of the progress against the approved Internal Audit plans, audit recommendations follow up, and other relevant matters for the Committee to be aware of.

2. RECOMMENDATIONS

It is recommended that the Committee:

2.1 Note the progress of the Internal Audit Plan;

2.2 Note the progress that management has made with implementing recommendations agreed in Internal Audit reports;

3. CURRENT SITUATION

3.1 Internal Audit's primary role is to provide independent and objective assurance on the Council's risk management, control and governance processes. This requires a continuous rolling review and appraisal of the internal controls of the Council involving the examination and evaluation of the adequacy of systems of risk management, control and governance, making recommendations for improvement where appropriate. Reports are produced relating to

each audit assignment and summaries of these are provided to the Audit Committee.

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. ENVIRONMENTAL IMPLICATIONS

6.1 There are no direct environmental implications arising from the recommendations of this report..

7. RISK

7.1 The assessment of risk contained within the table below is to be consistent with the Council's Risk Appetite Statement.

Category	Risks	Primary Controls/Control Actions to achieve Target Risk Level	*Target Risk Level (L, M or H) *taking into account controls/control actions	*Does Target Risk Level Match Appetite Set?
Strategic Risk	Ability of the Council to meet its strategic objectives	The Internal Audit process considers strategic 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, consistent with the Council's Risk Appetite Statement, are made to address the identified risks and Internal Audit follows up progress with implementing those	M	**Yes**

		that are agreed with management. Those not implemented by their agreed due date are detailed in the attached appendices.		
Compliance	Council does not comply with relevant internal policies and procedures and external guidance.	The Internal Audit process considers compliance 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, consistent with the Council's Risk Appetite Statement, 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.	L	**Yes**
Operational	Failure of the Council to deliver agreed services.	The Internal Audit process considers operational 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, consistent with the Council's Risk Appetite Statement, are made to address the identified risks and Internal Audit follows	L	**Yes**

		up progress with implementing those that are agreed with management. Those not implemented by their agreed due date are detailed in the attached appendices.		
Financial	Financial failure of the Council, with risks also to credit rating.	The Internal Audit process considers financial 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, consistent with the Council's Risk Appetite Statement, 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.	L	**Yes**
Reputational	Impact of performance or financial risk on reputation of ACC.	The Internal Audit process considers reputational 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, consistent with the Council's Risk Appetite Statement, are made to address the	L	**Yes**

		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.		
Environment / Climate	Service delivery impacting negatively on City net zero targets.	The Internal Audit process considers environmental/climate 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, consistent with the Council's Risk Appetite Statement, 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.	L	**Yes**

8. OUTCOMES

8.1 The proposals in this report have no impact on the Council Delivery Plan.

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
Impact Assessment	An assessment is not required because the reason for this report is to report Internal Audit's progress to Committee. As a result, there will be no differential impact, as a result of the proposals in this report, on people with protected characteristics.
Data Protection Impact Assessment	Not required

10. BACKGROUND PAPERS

10.1 There are no relevant background papers related directly to this report.

11. APPENDICES

11.1 Appendix A – Internal Audit Update Report

12. REPORT AUTHOR CONTACT DETAILS

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ABERDEEN CITY COUNCIL

Internal Audit

Audit, Risk and Scrutiny Committee
Internal Audit Update Report
December 2022

Contents

1 Executive Summary

1.1 Introduction and background

Internal Audit's primary role is to provide independent and objective assurance on the Council's risk management, control, and governance processes. This requires a continuous rolling review and appraisal of the internal controls of the Council involving the examination and evaluation of the adequacy of systems of risk management, control, and governance, making recommendations for improvement where appropriate. Reports are produced relating to each audit assignment and these are provided to the Audit, Risk and Scrutiny (ARS) Committee. Along with other evidence, these reports are used in forming an annual opinion on the adequacy of risk management, control, and governance processes.

This report advises the ARS Committee of Internal Audit's work since the last update. Details are provided of the progress against the approved 2021-22 and 2022-23 Internal Audit plans, audit recommendations follow up, and other relevant matters for the Committee to be aware of.

1.2 Highlights

Full details are provided in the body of this report however Internal Audit would like to bring to the Committee's attention that since the last update:

- Five reports have been finalised.
- Ten audits are currently in progress.
- Eight audit recommendations have been closed, with eight carried forward.

1.3 Action requested of the ARS Committee

The Committee is requested to note the contents of this report and the work of Internal Audit since the last update.

2 Internal Audit Progress

2.1 2021-22 Audits

Council Area	Audit Area	Position
Cross Service	Commissioning	**Final audit report issued**
Cross Service	Attendance Management	**Final audit report issued**
IJB	Transformational Programme	**Final audit report issued**
Operations	Children's Social Care – Children with Disabilities	**Final audit report issued**

2.2 2022-23 Audits

Service	Audit Area	Position
Commissioning	Contract management	**Review in progress**
Commissioning	Corporate Health and Safety	**Final audit report issued**
Commissioning	ALEOs - Performance and Payments	**Review in progress**
Customer	Benefits	**Review in progress**
Customer	Recruitment	**Not started – Review scheduled for Q4**
HSCP	Adults with Incapacity (Management of funds)	**Not started – Review scheduled for Q4**
Integration Joint Board	IJB Data Sharing	**Review in progress**
Operations	Out of Authority Child Placements	**Review in progress**
Operations	Heritage and Historical Assets	**Review in progress**
Operations	Following the Public Pound	**Review in progress**
Operations	Client transport	**Review deferred[1]**
Operations	Vehicle Maintenance Management	**Review deferred**
Operations	Scottish Milk and Healthy Snack Scheme	**Not started – Review scheduled for Q4**
Pensions	Pension Fund Governance Arrangements Including Risk Management	**Review in progress**
Resources	Corporate Asset Management	**Not started – Review scheduled for Q4**
Resources	Lease Financing	**Review in progress**
Resources	PVG & Disclosure Checks	**Review in progress**
Resources	Creditors System	**Review deferred**

2.3 Audit reports presented to this Committee

Report Title	Assurance Year	Conclusion
AC2205 – Commissioning	2021-22	Positive assurance has been obtained over development and implementation of the Council's Strategic Commissioning Approach. The commissioning cycle has

1 At the February 2022 ARS Committee, it was resolved to delegate authority to the Chief Internal Auditor, following consultation with the Convener and relevant Chief Officer, to defer audits between years within the plan duration. Based on current resources, previous assurances, and other priority areas of work, it has been decided to defer these audits to future years. Planning is currently underway for the 2023-2026 Internal Audit Plan and these reviews will be included as part of this. The deferring of these audits has been deemed to have no negative impact on the Chief Internal Auditor's ability to provide an annual opinion.

Report Title	Assurance Year	Conclusion
		been embedded into the Council's planning and performance management activities, facilitating a data-led approach to delivering against key outcomes prioritised as part of the LOIP, within available resources. Through the Aberdeen Outcomes Framework, in conjunction with community planning partners, the Council has also progressed a variety of improvement projects to further contribute towards the LOIP stretch outcomes. Areas where enhancements to processes could better demonstrate the linkage between individual aspects of service delivery, key measures, plans and the LOIP stretch outcomes they are designed to deliver against, have been highlighted to management. These recommendations are focused on obtaining Best Value and best practice as we found no area to be currently devoid of control, whilst also recognising that this is a complex area with many different stakeholders and overlapping elements. Specific enhancements include clarification of baselines and targets for individual measures, and quantification of the planned and actual contribution of each action to the overall outcomes.
AC2206 – Children with Disabilities	2021-22	In general, care for children with disabilities via contracts and direct payments is being arranged and paid for in accordance with procedure, with due consideration given to child wellbeing and the financial impact of associated care packages. However, Best Value was not always being demonstrated since the procurement of the main contract for provision of residential respite services, care at home services and short breaks, at £825k per annum for three years, with an option to extend by two years, was by direct award, without formalised competition through a tender process, contrary to the Council's Procurement Regulations. In addition, instances were identified where Council arranged provision of services to children with disabilities, was not supported by current contracts reflected on the Council's Contracts Register, as required by the Council's Procurement Regulations and Procurement Legislation. Other areas that would benefit from enhanced controls include preparation of Child Plans and associated Action Plans; delegation of authority to authorise direct payments; retention of signed agreements for direct payments from claimants detailing their responsibilities; segregation of duties in establishing and approving care packages within the care management system; and raising of purchase orders.
AC2211 – IJB Transformational Programme	2021-22	Despite recruitment challenges and the impact of COVID-19, work is continuing to progress delivery of the IJB's transformation agenda. The Aberdeen City Health and Social Care Partnership's (ACH&SCP) Delivery Plan detailed in the Strategic Plan for 2022-25 provides a comprehensive framework for progressing the partnership's priorities over the next three years in the run up to the establishment of the National Care Service, with projects allocated to responsible

Report Title	Assurance Year	Conclusion
		officers and deadlines established and savings allocated at a high level to Strategic Plan aims and enablers. A system of dashboard reporting is in place for Senior Leadership Team and the Risk, Audit and Performance Committee to monitor Delivery Plan progress. In addition, statutory annual performance reporting including progress delivering on national integration outcomes is taking place. Transformation projects have progressed despite the unusual circumstances and challenges presented by COVID-19. Recommendations have been made to enhance controls over project management including formalising project management procedures and enhancing monitoring information available to groups responsible for project delivery, including project level workplans, operational risk logs and budget monitoring information
AC2216 – Attendance Management	2021-22	Assurance has been obtained over compliance and reporting. Following consultation with the Service, however, it has been recognised that improvement work is ongoing to address absence levels across the Council, which according to the most recently available data are higher than the Scottish local Authority mean figure of 9.71 days per employee, with the ACC figure sitting at 10.32 days per employee and changes in the context of working post COVID-19. It was determined that the best use of resources would be to gain the assurance over compliance and reporting and then collaborate with People & Organisational Development going forward. As part of planning for the 2023/24 Internal Audit Plan, we will hold in-depth discussions with management to identify when would be the optimal time to conduct a further review, whilst also supporting People & Organisation Development on a consultancy basis as they implemented the ongoing improvement work.
AC2304 – Corporate Health and Safety	2022-23	The level of net risk is assessed as **MODERATE**, with the control framework deemed to provide **REASONABLE** assurance over the Council's approach to corporate health and safety. The Council has adequate control over its health and safety arrangements, including an agreed policy that clearly sets out both employee responsibilities and corporate and function governance arrangements to ensure appropriate monitoring. Health and safety related data is being presented to the Staff Governance Committee and Function specific health and safety groups meet regularly. There is also a dedicated Health and Safety Team within Governance who provide occupational health and safety advice to members of the Council. However, certain enhancements could be made to improve controls. The Health and Safety Team has advised that a new system is planned to be implemented in October 2022, with the plans in place for this new system addressing a number of the points that Internal Audit identified as part of this review. It would therefore be beneficial to use this opportunity to ensure the system

Report Title	Assurance Year	Conclusion
		addressed the issues noted. Recommendations have also been made around corporate health and safety procedures, completion of mandatory training, documentation of internal procedures, reporting and, monitoring.

2.4 Follow up of audit recommendations

Public Sector Internal Audit Standards require that Internal Audit report the results of its activities to the Committee and establishes a follow-up process to monitor and ensure that management actions have been effectively implemented.

As at 30 September 2022 (the baseline for our exercise), 16 audit recommendations were due and outstanding[2]:

- One rated as Major
- Nine rated as Moderate
- Six rated as Minor

As part of the audit recommendations follow up exercise, eight audit recommendations were closed:

- Four rated as Moderate
- Four rated as Minor

The outstanding position going forward is that of eight audit recommendations[3]:

- One rated as Major
- Five rated as Moderate
- Two rated as Minor

Of the eight outstanding recommendations, all were discussed with management, updates provided and new implementation dates agreed.

Appendix 1 – Grading of Recommendations provides the definitions of each of the ratings used.

Appendix 2 – Audit Recommendations Follow Up – Outstanding Actions provides a detailed breakdown of the nine outstanding audit recommendations that will be taken forward and followed up as part of the next cycle.

[2] Please note that since the last update to the Committee, a mapping exercise has taken place to regrade previous recommendations, made under the historic methodology, to align them with the gradings of the new methodology.
[3] This is the position with regards to recommendations that were due as at 30 September 2022. Recommendations falling due past this date and those made as part of subsequent Internal Audit Reports will be followed up as part of the standard follow up cycle and reported to Committee session on session.

3 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 / within audited area	The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss to the Service/area audited. 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.

4 Appendix 2 – Grading of Recommendations

Risk level	Definition
Corporate	This issue / risk level impacts the Council as a whole. Mitigating actions should be taken at the Senior Leadership level.
Function	This issue / risk level has implications at the functional level and the potential to impact across a range of services. They could be mitigated through the redeployment of resources or a change of policy within a given function.
Cluster	This issue / risk level impacts a particular Service or Cluster. Mitigating actions should be implemented by the responsible Chief Officer.
Programme and Project	This issue / risk level impacts the programme or project that has been reviewed. Mitigating actions should be taken at the level of the programme or project concerned.

Net risk rating	Description	Assurance assessment
Minor	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.	Substantial
Moderate	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified, which may put at risk the achievement of objectives in the area audited.	Reasonable
Major	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	Limited
Severe	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	Minimal

Individual issue / risk	Definitions
Minor	Although the element of internal control is satisfactory there is scope for improvement. Addressing this issue is considered desirable and should result in enhanced control or better value for money. Action should be taken within a 12 month period.
Moderate	An element of control is missing or only partial in nature. The existence of the weakness identified has an impact on the audited area's adequacy and effectiveness. Action should be taken within a six month period.
Major	The absence of, or failure to comply with, an appropriate internal control, such as those described in the Council's Scheme of Governance. This could result in, for example, a material financial loss, a breach of legislative requirements or reputational damage to the Council. Action should be taken within three months.
Severe	This is an issue / risk that is likely to significantly affect the achievement of one or many of the Council's objectives or could impact the effectiveness or efficiency of the Council's activities or processes. Examples include a material recurring breach of legislative requirements or actions that will likely result in a material financial loss or significant reputational damage to the Council. Action is considered imperative to ensure that the Council is not exposed to severe risks and should be taken immediately.

5 Appendix 3 – Audit Recommendations Follow Up – Outstanding Actions

Overall Report Area	Report	Grading	Recommendation	Original Due Date	Current Due Date	Committee Update	Status
Digital and Technology	AC2201 – IT Infrastructure Resilience	**Moderate**	The Service should document outcomes of Cluster risk register reviews at D&T SMT meetings.	Sep-22	Nov-23	D&T standard SMT agenda has been reviewed and includes a risk review as agenda item 4. This meeting occurs monthly and the next scheduled meeting which will use the new agenda is 09/11/2022. The minute will be provided as evidence of compliance.	**In progress**
Finance	AC2009 – Travel Policy	**Moderate**	The Council should ensure that action is taken to comply with its Procurement Regulations in respect of travel related expenditure	Dec-20	Mar-23	The necessary documentation for the award of contract is being drafted and procurement training being undertaken, this will ensure that the various governance gateways are cleared appropriately and will be completed by end March 2023.	**In progress**

Operations	AC2111 – Consilium System	**Moderate**	An up to date third party access agreement should be completed for the revised system	Jul-22	Dec-22	Discussions ongoing with Account Manager.	**In progress**
Operations	AC2111 – Consilium System	**Moderate**	The Service should explore options to lock users after a set period of inactivity with the software provider as part of the system upgrade.	Aug-22	Sep-23	At the moment this cannot be implemented on the current system, but as the upgrade will mean moving to a cloud based product on closing the browser this would force a user to resign into the system. Also worth noting that fresh log in would be required daily on the upgraded system due to the browser being closed when a pc is powered down at the end of the day. We will investigate this further with the vendor during the system upgrade itself.	**In progress**
Operations	AC2111 – Consilium System	**Moderate**	The System Team should carry out an annual audit of users to ensure they still require the access they hold.	Jul-22	Jan-23	After discussions with both HR & IT it would not be possible for the Total team to be notified through the leavers process due to GDPR,	**In progress**

						however a separate process is being worked on with HR at this time which will introduce a quarterly check on staff leavers.	
Health and Social Care Partnership	AC2112 – Mental Health and Substance Abuse	**Minor**	The Service should review policies and procedures to ensure they are up to date. (Service to link with roll out of new D365 system)	Jun-22	Dec-22	There was a slight delay in roll out of D365 but this was completed in October 2022. The review of policies and procedures is partly completed, and this is now scheduled to be concluded by mid-December 2022.	**In progress**
Digital and Technology	AC2201 – IT Infrastructure Resilience	**Major**	The Service should establish accreditation for the PSN.	Sep-22	Dec-22	Date adjusted at the request of independent NCSC auditor.	**In progress**
Health and Social Care Partnership	AC2210 – Learning Disabilities Establishment Visits	**Minor**	The Service should undertake a review to ensure all fees and charges are set in accordance with policy,	Aug-22	Mar-23	This will not be quick fix because the charging policy has already been approved by Committee. We have an idea of what the Shire charge for day care and this needs to be further discussed within the Partnership. This will be followed up with the author of the charging	**In progress**

						policy and aligned with the Council's budget setting process.	

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ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	13 December 2022
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Internal Audit Report AC2211 – Transformational Programme
REPORT NUMBER	IA/AC2211
DIRECTOR	N/A
REPORT AUTHOR	Jamie Dale
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 IJB Transformational Programme

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. CURRENT SITUATION

3.1 Internal Audit has completed the attached report which relates to an audit of IJB Transformational Programme.

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. ENVIRONMENTAL IMPLICATIONS

6.1 There are no direct environmental implications arising from the recommendations of this report.

7. 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 detailed in the resultant Internal Audit reports. Recommendations, consistent with the Council's Risk Appetite Statement, 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.

8. OUTCOMES

8.1 The proposals in this report have no impact on the Council Delivery Plan.

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
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

10. BACKGROUND PAPERS

10.1 There are no relevant background papers related directly to this report.

11. APPENDICES

11.1 Internal Audit Report AC2211 – IJB Transformational Programme

12. REPORT AUTHOR CONTACT DETAILS

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Aberdeen City Health & Social Care Partnership
A caring partnership

Internal Audit Report

Aberdeen City Health & Social Care Partnership

Transformational Programme

Issued to:

Sandra Macleod, Chief Officer
Fraser Bell, Chief Operations Officer
Paul Mitchell, Chief Finance Officer
Alison Macleod, Strategy and Transformation Lead
External Audit

Date of Issue: November 2022 **Report No. AC2211**

EXECUTIVE SUMMARY

Background
At its first meeting on 26 April 2016, the IJB agreed a Transformational and Strategic Commissioning Plan (Transformation Programme), detailing high level investment proposals for over £33m of mainstreamed funding for the 2016-19 period. This was 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. The IJB's transformation agenda has continued through subsequent strategic plans, the most recent of which was approved for 2022-25 by the IJB on 7 June 2022.

Objective
The objective of this audit was to provide assurance that the IJB is continuing to make progress with delivery of its transformation agenda.

Assurance
Despite recruitment challenges and the impact of COVID-19, work is continuing to progress delivery of the IJB's transformation agenda.

The Aberdeen City Health and Social Care Partnership's (ACH&SCP) Delivery Plan detailed in the Strategic Plan for 2022-25 provides a comprehensive framework for progressing the partnership's priorities over the next three years in the run up to the establishment of the National Care Service, with projects allocated to responsible officers and deadlines established and savings allocated at a high level to Strategic Plan aims and enablers. A system of dashboard reporting is in place for Senior Leadership Team and the Risk, Audit and Performance Committee to monitor Delivery Plan progress. In addition, statutory annual performance reporting including progress delivering on national integration outcomes is taking place.

Transformation projects have progressed despite the unusual circumstances and challenges presented by COVID-19. Recommendations have been made to enhance controls over project management including formalising project management procedures and enhancing monitoring information available to groups responsible for project delivery, including project level workplans, operational risk logs and budget monitoring information.

Findings and Recommendations
The project management process applied by the Strategy and Transformational team has yet to be formalised. Key template documentation is available for use, covering the various stages of a project. However, it was noted that this was not always used with certain concluded transformation projects not having project close documentation to reflect on lessons learned and some ongoing Delivery Plan projects not having business cases. In the absence of a clear framework describing when project management documentation is and is not required, and the associated governance arrangements for this documentation, there is a greater risk projects will not be managed as intended and Best Value will not be achieved. A recommendation graded 'Significant within audited area' was raised for the Partnership to ensure that the project management process is formalised.

The IJB approved its budget for 2022/23 and Medium-Term Financial Framework (MTFF) in March 2022. The MTFF sets out the need to achieve £35.6m of saving through a programme of transformation and service efficiencies and allocates these savings across the seven financial years to 31 March 2029 at a high level by each Strategic Plan Strategic Aim; infrastructure enablers; and a full-service redesign. Whilst savings are clearly linked to the Strategic Plan for 2022-25 in the MTFF at a

high level, savings have not been allocated to budget holders for later years. Where savings are not allocated to responsible officers and plans for their delivery established, there is a greater risk they will not be realised.

A sample of five former Transformation Programme projects carried forward into the Delivery Plan for 2022-25 was reviewed to ensure projects were progressing as required and are subject to adequate governance arrangements at a project level. Whilst projects have been allocated to responsible officers, the adequacy of governance arrangements varied.

Detailed workplans monitored by relevant delivery groups with tasks allocated to responsible officers and deadlines were in place for three projects (60%), including the Primary Care Improvement Plan (PCIP), hospital at home (H@H) and commissioning projects reviewed. However, this was not the case for two (40%) reviewed – the staff health and wellbeing and digital records projects. Work to digitise records had not been scoped beyond May 2022. On staff health and wellbeing, a draft Workforce Plan was considered by the IJB on 30 August 2022 describing aims and associated performance measures, high level leads, and deadlines. In addition, the Healthy Working Lives Group has been monitoring delivery of staff health and wellbeing initiatives. However, a detailed workplan of health and wellbeing initiatives was not established with responsible officers and deadlines allocated and an operational risk register / log was not in place. Staff health and wellbeing is recorded in the Strategic Risk Register as a mitigating factor to address the very high risk of potential loss of life and unmet health and social care needs due to insufficient staff. In the absence of a detailed workplan and operational risk register / log, monitored by a delivery group, there is a greater risk necessary improvement to staff health and wellbeing will not be achieved. Recommendations graded 'Significant within audited area' were raised for detailed Delivery Plan project level workplans and risk logs to be monitored for all Delivery Plan projects.

Budget monitoring information was available to project managers where relevant however the quality of information reported to groups responsible for oversight of project delivery varied. The PCIP project has been delayed due to the impact of COVID-19 and recruitment challenges resulting in underspent ring-fenced funding of £4.2m being carried forward from previous years. The budget monitoring information received by the PCIP group on a quarterly basis in relation to the PCIP fund is basic and whilst it breaks down the 2022/23 forecast into the relevant projects making up the PCIP, information is lacking for group members to scrutinise the forecasts, including spend to date and subjective analysis of forecasts. For the H@H delivery project, the budget had been allocated to where it needed to be spent however budget monitoring information for this project was not reported to the group responsible for delivery at all. In the absence of regular oversight of detailed budget monitoring information by the groups responsible for project delivery, there is a greater risk underspends (such as those relating to recruitment) or pressures will not be identified, subject to adequate scrutiny by the officers responsible for delivery and mitigated. A recommendation graded 'Significant within audited area' was raised with the Service for budget monitoring information to be improved at a project level to address this.

Management Response

Aberdeen City Health and Social Care Partnership (ACHSCP) accept the findings of this audit and welcome the recommendations as areas for improvement. Delivering transformation activity during the global pandemic was challenging and whilst some transformations, such as the implementation of digital solutions like 'Near Me' were accelerated, others were paused whilst officers were diverted to the pandemic response. During this time, it was not always feasible to follow robust project management processes. In addition, the Transformation Team were subject to

amalgamation with two other ACHSCP teams and a subsequent restructure with resultant staff changes. As we move out of this phase, we look forward to a more stable environment within which we can continue to deliver on the transformation agenda improving processes and procedures as we go. In relation to the achievement of MTFF savings, this is being considered as part of the 2023/24 budget setting and MTFF refresh process, with engagement with relevant budget holders planned to ensure savings are appropriately allocated for delivery.

13. INTRODUCTION

13.1 The Aberdeen City Health and Social Care Partnership (ACH&SCP) formally came into existence in February 2016 with the approval of its Integration Scheme by Scottish Ministers and the Integration Joint Board (IJB) became responsible for its delegated health and social care functions on 1 April 2016. At its first meeting on 26 April 2016, the IJB agreed a Transformational and Strategic Commissioning Plan (Transformation Programme) detailing high level investment proposals for over £33 million of mainstreamed funding for the 2016-19 period, 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.

13.2 The IJB's transformation agenda has continued through subsequent Strategic Plans, the most recent of which was approved for 2022-25 by the IJB on 7 June 2022. For the first time, a Delivery Plan was developed which detailed how the Strategic Plan would be delivered. The Delivery Plan contains projects which are both transformational and business as usual.

13.3 The Strategy and Transformation Team leads on managing Delivery Plan projects. The current full establishment of the team consists of eight FTE Transformation Programme Managers; 10 FTE Senior Project Managers; six FTE Project Managers; led by a Transformation and Strategy Lead, however it should be noted that this is as a result of an amalgamation and restructure towards the end of 2021, and this was not the resource in place at the time the projects subject to audit were delivered.

13.4 The objective of this audit was to provide assurance that the IJB is continuing to make progress with delivery of its transformation agenda.

13.5 The factual accuracy of this report and action to be taken with regard to the recommendations made have been agreed with Sandra Macleod, Chief Officer, Fraser Bell, Chief Operations Officer, Paul Mitchell, Chief Finance Officer and Alison Macleod, Strategy and Transformation Lead.

14. FINDINGS AND RECOMMENDATIONS

14.1 Written Procedures

14.1.1 Comprehensive written procedures that 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 that correct and consistent instructions are available to staff, which is important in the event of an experienced employee being absent or leaving.

14.1.2 The project management process applied by the Strategy and Transformational team has yet to be formalised. Key template documentation is available for use, covering the various stages of a project, including the development and approval of a full business case; a risk / issues / lessons learned log for monitoring project delivery; and an end of project close report to assess benefits and challenges and reflect on lessons learned. However, it was noted that certain concluded transformation projects did not have completed template project close documentation (see paragraph 2.2.6) to reflect on lessons learned and some ongoing Delivery Plan projects did not have business cases (see paragraph 2.6.2). At the time of review the team had three vacancies at a Programme Manager level, and the post of Programme Management Officer was also vacant. These roles would typically be involved in ensuring project documentation is completed as required. The Service also advised that in the case of business cases, these are not always required for Delivery Plan projects as some are business as usual projects. It is therefore unclear if supporting documentation has not been completed since it is deemed to be not required or if it is due to a shortage in resources.

14.1.3 In the absence of a clear framework describing when project management documentation is and is not required, and the associated governance arrangements for this documentation, there is a greater risk projects will not be managed as intended and Best Value will not be achieved.

Recommendation

The Partnership should ensure that the project management process and the requirement to use associated documentation is formalised.

Service Response / Action00

Agreed. Recruitment to the vacant Transformation Programme Manager roles was completed on 25th October 2022 and the newly appointed Programme Management Officer (PMO) commences mid November 2022. Formalising the project management process and associated documentation will be an area of priority focus.

Implementation Date	Responsible Officer	Grading
September 2023	Strategy and Transformation Lead	Significant within audited area

14.2 Transformation Programme and Strategic Plan

14.2.1 It is a requirement of section 29 of the Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) for Integrated Joint Boards to prepare and publish a Strategic Plan. As described in paragraph 1.2 above, the Strategic Plan 2022-25 was approved by the IJB on 7 June 2022 and is available to the public, as required by the Act, on the Aberdeen City Health and Social Care Partnership website.

14.2.2 The development of the plan began in March 2021 and was monitored throughout by SLT. As required by the Act, the Strategic Plan was developed with consideration given to the national Integration Principles and the partnership's National Health and Wellbeing

Outcomes. Consideration was also given to progress delivering the previous ACHSCP Transformation Programme and work remaining; the population needs assessment 2021; the Local Outcome Improvement Plan and associated Locality Plans; and NHS Grampian's Plan for the Future. In addition, it was reported to the IJB in June 2022 that the views of the public were sought in January 2022 as part of the development of the plan.

14.2.3 The plan (see appendix 1) describes four Strategic Aims that are linked to the Health and Social Care Integration Core Suite of indicators (National Indicators):

- Caring Together
- Keeping People Safe at Home
- Preventing Ill health, and
- Achieving Fulfilling, Healthy Lives

14.2.4 These strategic aims are facilitated by five Enabling Priorities:

- Workforce
- Technology
- Finance
- Relationships
- Infrastructure

14.2.5 Unlike the previous Strategic Plan, for each of the priorities and enablers, the current Strategic Plan includes a more detailed Delivery Plan of projects, with associated responsible officers, deadlines, and a general indication of how performance will be measured. This provides a comprehensive framework for delivering the partnership's priorities over the next three years in the run up to the establishment of the National Care Service.

14.2.6 The former ACHSCP Transformation Programme projects were reviewed to ensure that outstanding work was considered in the development of the Delivery Plan 2022-25. The Service provided details of the project status as shown in appendix 2. Completed projects were evaluated in the main however it was noted that the Near Me Roll Out project was not, meaning lessons for future digital and infrastructure projects were not established. The Service advised this project was implemented urgently in response to the COVID-19 emergency as part of a Grampian wide project and as such fell outwith normal project management processes. However, in the absence of clear guidance on when projects should be evaluated and when they should not there is a risk necessary lessons will not be learned. A recommendation has already been made at paragraph 2.1.3 to formalise the requirement for project close reports for assessing project management outcomes.

14.3 Governance Arrangements

14.3.1 SLT managed priorities between September 2020 and April 2022 through 'huddle' meetings. In June 2021, three groups were established to lead on respective huddles for three programmes of work - 'Right Way'; 'Right Care'; and 'Right Place'. As stated in paragraph 2.2.6 above, the Service advised that the demands of the COVID-19 response and recruitment challenges meant that transformational work during this period did not progress as intended. This is evident based on former Transformation Programme projects being carried forward into the Delivery Plan for 2022-25 as shown in Appendix 2 and based on 2021/22 underspends in budgets ring fenced for transformational work, including the Integration and Change Fund (£152k spend against budget £2.2m) and the Primary Care Improvement Fund (£3.4m against budget £5.2m). However, whilst progress was not as intended between March 2020 and the approval of the new Strategic Plan in June 2022, work was undertaken on a number of projects to varying extents including the sample considered in more detail in section 2.6.

14.3.2 The Strategy and Transformation Lead maintains oversight of the Strategy and Transformation team's management of Delivery Plan projects through a Delivery Plan Workplan dashboard. This is a useful tool capturing at a top level the status of each project on the Delivery Plan (green – on target; amber – at risk of not being delivered on time; red – missed deadline / unable to deliver); along with responsible officers; details of deadlines and any current updates.

14.3.3 SLT receives regular updates on Delivery Plan project status through a system of dashboard reporting. At the time of review this process was being fine-tuned by the Service. Initially SLT received more detailed project 'flash reports', one for each Strategic Aim and another for the Enabling Priorities, on a rolling weekly basis. The reports are generally prepared by the relevant Project Manager and monitored by the Programme Manager before being reported to SLT by the relevant SLT reporting officer. The flash reports are detailed, highlighting project status on a red-amber-green 'RAG' basis, risks to delivery and associated mitigations, and progress since the previous update

14.3.4 This reporting was complemented by Delivery Plan Objective dashboard reports which include various graphs and statistics relating to performance for each of the Strategic Aims.

14.3.5 Following a review of the performance reporting arrangements to SLT in August 2022, various proposals were made on the future of dashboard reporting, with a view to reducing the administrative burden on project managers, whilst ensuring SLT receive regular updates and details of exceptions. SLT agreed on monthly dashboard reporting from October 2022, with a RAG status for all projects and an 'exception only' approach for Flash Reports to be submitted for Red status projects, with reasons for amber or those with escalations.

14.3.6 The Risk, Audit and Performance (RAP) Committee received their first quarterly Delivery Plan 2022-25 progress report in August 2022. This is essentially the same Delivery Plan Objective dashboard, referred to in paragraph 2.3.4 above. As well as the performance statistics the overall status of the projects is shown again using red, amber, green, 'no update', and 'not started'. Whilst it is positive RAP Committee has been updated on project status in a timely manner, the lack of RAG status for 'no update' and 'not started' projects and the reasons why they have no update or have not started, reduces assurance of the delivery of these projects on time to budget. In addition, whilst the dashboard is adequate for management, Internal Audit felt in the absence of more detailed reports, such as flash reports for red and amber status projects, it is difficult to easily establish what the Delivery Plan Objective dashboard is reporting to Committee, including the reasons why specific projects are at risk. A supporting Delivery Plan Overview report was reported to RAP Committee, and whilst this did provide useful information on progress it did not clearly explain why projects were at risk e.g. Mental Health and Learning Disabilities Programme has red status but reasons for this are not provided.

Recommendation

Delivery plan project reporting to RAP Committee should be reviewed to ensure RAG status is reported for all projects, with reasons for projects not starting or having no update and adequate detail is provided to RAP Committee for projects at risk.

Service Response / Action

Agreed. The dashboard reporting has been subject to development since July. It has already been identified that some refinements would be beneficial for Committee, and we aim to present a revised version of the report in February 2023.

Implementation Date	Responsible Officer	Grading
February 2023		

	Strategy and Transformation Lead	Important within audited area

14.4 Strategic Risk Register

14.4.1 The purpose of the Strategic Risk Register (SRR) is to provide the IJB with assurance that it is able to deliver the organisation's strategic goals and objectives. The document classifies the organisation's strategic risks as low, medium, high or very high based on the likelihood and impact of the risk being realised. It therefore focuses the IJB's attention on threats to the organisation that need to be prioritised. For each risk a rationale is provided for the risk rating along with details of existing controls, assurance gaps, and mitigating actions.

14.4.2 The IJB agreed on 15 December 2021 that the SRR was to be subject to a full review following the approval of the Strategic Plan. As reported to the IJB on 30 August 2022, a strategic risk workshop involving SLT and IJB members took place on 15 August 2022 – this covered all 10 strategic risks including risk 7 to deliver transformation change to meet strategic objectives in the face of demographic and financial pressures. Risk 7 on the need for transformation change was assessed as high (possible with a major impact) when reported to the IJB on 30 August 2022 and remained unchanged following review when the SRR was subsequently reported to the IJB on 11 October 2022.

14.4.3 SRR risk 7 identifies a number of controls including the ACHSCP's governance arrangements and the regular reporting on Delivery Plan progress. Reported gaps in assurance included the ability to evidence the impact of IJB's transformation through evaluations and reviewing results to determine what works when seeking to embed new models. A recommendation has already been made at 2.1.3 to formalise requirements relating to the project management process. Staff vacancies in the Strategy and Transformation team and completion of training are also highlighted as assurance gaps in the SRR – at the time of review the Service confirmed interviews were scheduled for vacant posts. A recommendation is included to track progress on programme management training.

Recommendation

Relevant project management training should be completed by staff responsible for managing Delivery Plan projects.

Service Response / Action

Agreed. Managing Successful Programme training has already been scheduled for relevant Strategy and Transformation staff and we are investigating Project management training for others.

Implementation Date	Responsible Officer	Grading
December 2023	Strategy and Transformation Lead	Important within audited area

14.5 Medium Term Financial Framework

14.5.1 The IJB approved its budget for 2022/23 and Medium-Term Financial Framework (MTFF) in March 2022. Pressures identified related to rising demand due to an increasing and longer living population; increasing complexity of clients' need; rising prescription costs; and staff vacancies. The MTFF sets out the need to achieve £35.6m of saving through a programme of transformation and efficiencies and allocates these savings across the seven financial years to 31 March 2029 at a high level by each Strategic Plan Strategic Aim; infrastructure enablers; and a full-service redesign As reported to the IJB in March 2022, the MTFF was linked to the draft Strategic Plan for 2022-25, which was agreed in

June 2022 by the IJB. The Strategic Aims and Enabler for Infrastructure subsequently remained in the approved Strategic Plan for 2022-25. These are detailed in the table below.

Enabling Workstreams	2022/23 £'000	2023/24 £'000	2024/25 £'000	2025/26 £'000	2026/27 £'000	2027/28 £'000	2028/29 £'000
Aim – Caring Together:							
Reshaping our approach to commissioning services	0	(2,434)	(2,586)	(3,093)	(3,405)	(3,571)	(3,743)
Primary Care	0	(150)	(150)	(150)	0	0	0
	0	**(2,584)**	**(2,736)**	**(3,243)**	**(3,405)**	**(3,571)**	**(3,743)**
Aim – Improving Quality of Life:	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Aim - Safe at Home:							
Out of Area Placements	0	(350)	(350)	0	0	0	0
	0	**(350)**	**(350)**	**0**	**0**	**0**	**0**
Aim – Preventing ill health:							
Prescribing	(350)	(750)	(750)	(750)	(750)	(750)	(750)
	(350)	**(750)**	**(750)**	**(750)**	**(750)**	**(750)**	**(750)**
Enabler – Infrastructure:							
Whole system and connected remobilisation	(825)	0	0	0	0	0	0
	(825)	**0**	**0**	**0**	**0**	**0**	**0**
Future Service Redesign	**0**	**(1,164)**	**(1,357)**	**(1,555)**	**(1,759)**	**(1,969)**	**(2,186)**
Total	**(1,175)**	**(4,848)**	**(5,193)**	**(5,548)**	**(5,914)**	**(6,290)**	**(6,679)**

14.5.2 Whilst savings are clearly linked to the Strategic Plan for 2022-25 in the MTFF at a high level as shown above, savings have not been allocated to budget holders for later years of the MTFF. Where savings are not allocated to responsible officers and plans for their delivery established, there is a greater risk they will not be realised.

Recommendation
Finance should liaise with budgets holders and apply MTFF savings as appropriate to H&SCP budgets.

Service Response / Action
Agreed. The budget setting process for 2023/24 and the associated MTFF for future years is currently under development. As part of this process engagement will take place with managers and savings will be allocated in line with MTFF priorities.

Implementation Date **Responsible Officer** **Grading**

April 2023	Chief Finance Officer	Significant within audited area

14.6 Project Management

14.6.1 A sample of five former Transformation Programme projects carried forward into the Delivery Plan for 2022-25 was reviewed to ensure projects were progressing as required and are subject to adequate governance arrangements at a project level. This included:

- SE03 - Staff health and wellbeing
- SE16, SE17, SE18, and SE19 – Various projects on approach to Commissioning
- SE05 - Support the implementation of digital records
- KPS12 – Increase Hospital at Home (H@H) bed base
- CT15 - Primary Care Improvement Plan (PCIP)

Business Cases

14.6.2 Business cases describe the business needs for a given project; options appraisal; costs; benefits; key risks; key milestones and governance arrangements. The required investment for the H@H project was approved in May 2017 by the Executive Programme Board followed by approval of the business case project summary by the IJB in June 2017. Whilst a formal business case was not in place for the PCIP project, the PCIP was approved by the IJB on 28 August 2018, with the detailed plan describing project aims, costs and benefits. However, business cases were not in place for the projects on staff health and wellbeing; approach to commissioning; and the work to digitise records beyond May 2022. The Service advised business cases were not required for these projects as the projects concerned were approved as part of the Strategic Plan 2022-25 and just need to be scoped. Whilst this is the case, the Strategic Plan 2022-25 does not capture the financial implications of projects. A recommendation has already been made at paragraph 2.1.3 above to formalise requirements for project management documentation.

Detailed Workplans

14.6.3 Detailed workplans monitored by relevant delivery groups with tasks allocated to responsible officers and deadlines were in place for the PCIP, H@H and commissioning projects. However, this was not the case for all of the 2022/25 Delivery Plan work related to staff health and wellbeing and digital records projects.

14.6.4 On the digital records project, records used by community nurses, MacMillan nurses and school nurses were digitised using the 'Morse' records management system. Whilst workplans were in place for the roll out of Morse, this was concluded by May 2022 and work for 2022/23 and beyond to 2024/25, to digitise records further, has yet to be scoped in detail and monitored, meaning this work is on hold and is at risk of slipping.

14.6.5 On staff health and wellbeing, a draft Workforce Plan was considered by the IJB on 30 August 2022. This sets out relevant statistics concerning service pressures, staff headcount and WTE, staff absences and workforce budgets. In addition, the plan describes aims and associated performance measures, high level leads, and deadlines adequately. The Strategic Risk Register (SRR) risk 9, defined as insufficient staff to provide patients / clients with services required, is classified as very high risk, meaning an almost certain likelihood of an 'extreme' impact described as potential loss of life and unmet health and social care needs, leading to severe reputational damage. The SRR indicates an increased emphasis on health / wellbeing of staff is a mitigating factor. The revised Workforce Plan, due at IJB on 29th November 2022, was reviewed in line with the SRR to ensure actions contribute to the mitigation of the risks identified.

14.6.6 On staff health and wellbeing, the draft Workforce Plan describes aims and associated performance measures, high level leads, and deadlines. In addition, the Healthy Working Lives Group has been monitoring delivery of staff health and wellbeing initiatives. However, a detailed workplan of health and wellbeing initiatives was not established with responsible officers and deadlines allocated to initiatives. Staff health and wellbeing is recorded in the Strategic Risk Register as a mitigating factor to address the very high risk of potential loss of life and unmet health and social care needs due to insufficient staff. The revised Workforce Plan contains three key themes of recruitment and retention, mental health and wellbeing, and growth and development opportunities. These themes have associated aims and actions identified.

Recommendation
Project plans describing project tasks, responsible officers and task deadlines should be established and monitored for all Delivery Plan projects at a project level.

Service Response / Action
Agreed. The health and wellbeing initiatives were initially introduced in response to the pressure staff were under in relation to Covid and therefore were implemented in a reactive rather than a planned way. We are happy to include this in line with the earlier recommendation around formalising project management process and associated documentation.

Implementation Date	Responsible Officer	Grading
June 2023	Strategy and Transformation Lead	Significant within audited area

Risk / Issues / Lessons Learned Logs

14.6.7 Project level risk / issues / lessons learned logs were in use for the PCIP, H@H and the delivered Morse projects with relevant risks to project delivery highlighted for monitoring purposes, including COVID-19 and recruitment challenges. However, these were not in use for delivery of the approach to commissioning projects (see 2.6.8 below as not applicable) and staff health and wellbeing initiatives.

14.6.8 Commissioning work is monitored by the ACHSCP Strategic Commissioning and Procurement Board (SCPB). Whilst risk logs are not used by the SCPB the workplan used to monitor contracts and grants is detailed, including a RAG status for contract delivery, with associated risks and mitigating actions generally captured adequately.

14.6.9 However, despite the very high risk rating for staff recruitment and retention in the Strategic Risk Register, risks and issues affecting delivery of staff health and wellbeing initiatives are not formally monitored and mitigated at the project initiative level, increasing the risk of staff absences and resignations due to poor health and wellbeing.

Recommendation
Project level risks should be monitored for all Delivery Plan projects by officers responsible for project delivery including for staff health and wellbeing.

Service Response / Action
Agreed. The health and wellbeing initiatives were initially introduced in response to the pressure staff were under in relation to Covid and therefore were implemented in a reactive rather than a planned way. We are happy to include this in line with the earlier recommendation around formalising project management process and associated documentation.

Implementation Date	Responsible Officer	Grading

June 2023	Strategy and Transformation Lead	Significant within audited area

Budget Monitoring

14.6.10 Budget monitoring information is available to all four of the officers responsible for supporting the delivery of ongoing projects in the sample described at 2.6.1 above (excluding the digital records project, which was paused at time of review) however the information available varied.

14.6.11 For the Hospital at Home delivery project, the budget had been allocated to where it needed to be spent however budget monitoring information for this project was not reported to the group responsible for delivery at all. The Service has advised that whilst budget monitoring information is not monitored at a project level, because H@H is based on a staffing model; the staffing budget is monitored by the lead nurse.

14.6.12 The PCIP project has been delayed due to the impact of COVID-19 and recruitment challenges resulting in underspent ring-fenced funding of £4.2m since the project began (includes 2021/22 underspend of £1.8m described at paragraph 2.3.1 above). The Service has advised this underspend is now no longer available for use. The budget monitoring information received by the PCIP group on a quarterly basis in relation to the PCIP fund is basic and whilst it breaks down the 2022/23 forecast into the relevant projects making up the PCIP, information is lacking for group members to scrutinise the forecasts. Spend to date is not reported to the PCIP group, nor is a breakdown of the subjective expenditure and income budgets, and forecasts to facilitate analysis of reasons for pressures / underspends (e.g. for staff costs, administration costs, premises costs etc).

14.6.13 Where relevant (i.e. where a specific project budget is available), in the absence of regular oversight of detailed budget monitoring information by the groups responsible for project delivery, there is a greater risk underspends (such as those relating to recruitment) or pressures will not be identified, subject to adequate scrutiny by the officers responsible for delivery and mitigated.

Recommendation
Where relevant, budget monitoring information should be regularly reported to groups responsible for Delivery Plan projects with sufficient detail to identify project budget underspends and pressures requiring corrective action.

Service Response / Action
Agreed.

Implementation Date	Responsible Officer	Grading
December 2022	Chief Finance Officer	Significant within audited area

14.6.14 The terms of reference of the ACH&SCP Strategic Commissioning and Procurement Board includes identifying the key commissioning and procurement activity for the year and overseeing progress against the established annual work plan. In the case of commissioning work, a specific budget is not in place to deliver improvements however the Service has established a workplan spreadsheet for monitoring contracts and grant awards which adequately captures associated contract / grant budgeted values. It was however noted that the spreadsheet does not capture contract spend to date for comparison to awarded contract values. The Service advised the contracts team monitors spend against approved contract values however this isn't documented. Capturing actual expenditure against budget by contract would be helpful for procurement planning and contract management purposes since in its absence there is a greater risk of expenditure

being incurred without the necessary approval e.g. variations requiring IJB approval, or of excess charges being incurred which are not in line with agreed contracts.

Recommendation
Contract expenditure as compared to awarded contract values should be monitored by the AHSCP Strategic Commissioning and Procurement Board.

Service Response / Action
Agreed. An extract from the BOrganised system will be used to show approved contract value and the spend up to the previous financial year for monitoring purposes.

Implementation Date	Responsible Officer	Grading
April 2023	Strategic Procurement Manager / Commissioning Lead	Important within audited area

14.6.15 It was noted the annual work plan does not currently capture savings planned / realised by contract. Since reshaping the IJB's approach to commissioning makes up a large part of future years savings (£18.8m - 53% MTFF savings) it would be beneficial if savings achieved through commissioning were planned for monitored at a contract / grant level.

Recommendation
Savings associated with the Commissioning annual work plan should be monitored at a contract / grant level.

Service Response / Action
Agreed. As per recommendation 2.5.2 above this is currently being progressed as part of the budget setting and MTFF development process.

Implementation Date	Responsible Officer	Grading
April 2023	Chief Finance Officer / Strategic Procurement Manager / Commissioning Lead	Significant within audited area

14.6.16 For the staff health and wellbeing budget, regular reports concerning the related £60k budget are not issued to the budget holder systematically. The budget holder advised that information is provided on request which Internal Audit feel is adequate given the size of the budget.

14.7 Statutory Reporting

14.7.1 Section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014 requires the IJB to publish an annual assessment of performance in planning and carrying its integration functions. The IJB's annual performance report was approved by the IJB on 30 August 2022. This included progress against Strategic Priorities; priorities for 2022/23 and National Integration Indicator outcomes for 2021/22 as compared to 2019/20 for Aberdeen City and Scotland wide.

AUDITORS: J Dale
A Johnston

Appendix 1 – Strategic Plan

Strategic Aims				
CARING TOGETHER	**KEEPING PEOPLE SAFE AT HOME**	**PREVENTING ILL HEALTH**	**ACHIEVE FULFILLING, HEALTHY LIVES**	
Strategic Priorities				
▸ Undertake whole pathway reviews ensuring services are more accessible and coordinated ▸ Empower our communities to be involved in planning and leading services locally ▸ Create capacity for General Practice improving patient experience ▸ Deliver better support to unpaid carers	▸ Maximise independence through rehabilitation ▸ Reduce the impact of unscheduled care on the hospital ▸ Expand the choice of housing options for people requiring care ▸ Deliver intensive family support to keep children with their families	▸ Tackle the top preventable risk factors for poor mental and physical health including: - obesity, smoking, and use of alcohol and drugs ▸ Enable people to look after their own health in a way which is manageable for them	▸ Help people access support to overcome the impact of the wider determinants of health ▸ Ensure services do not stigmatise people ▸ Improve public mental health and wellbeing ▸ Improve opportunities for those requiring complex care ▸ Remobilise services and develop plans to work towards addressing the consequences of deferred care	
Enabling Priorities				
WORKFORCE	**TECHNOLOGY**	**FINANCE**	**RELATIONSHIPS**	**INFRASTRUCTURE**
▸ Develop a Workforce Plan ▸ Develop and implement a volunteer protocol and pathway ▸ Continue to support initiatives supporting staff health and wellbeing ▸ Train our workforce to be Trauma informed	▸ Support the implementation of appropriate technology-based improvements – digital records, SPOC, D365, EMAR, Morse expansion ▸ Expand the use of Technology Enabled Care throughout Aberdeen ▸ Explore ways to assist access to digital systems ▸ Develop and deliver Analogue to Digital Implementation Plan	▸ Refresh our Medium-Term Financial Framework annually ▸ Report on financial performance on a regular basis to IJB and the Audit Risk and Performance Committee ▸ Monitor costings and benefits of Delivery Plan projects ▸ Continually seek to achieve best value in our service delivery	▸ Transform our commissioning approach focusing on social care market stability ▸ Design, deliver and improve services with people around their needs ▸ Develop proactive communications to keep communities informed	▸ Develop an interim and longer-term solution for Countesswells ▸ Review and update the Primary Care Premises Plan

Appendix 2 – Transformation Programme Projects Status

Project	Status
Digital and Infrastructure	
Care First Replacement (Dynamics 365)	Strategic Plan 2022-25
Technology Enabled Care	Strategic Plan 2022-25
Morse for Community Nursing	Strategic Plan 2022-25
Near Me Roll Out	Complete – no project close report
Integrated Access Point (Single Point of Contact)	Strategic Plan 2022-25
Supporting Management of Long Term Conditions and Building Community Capacity	
Community Link Workers	Complete
Visiting Service (part of PCIP)	Strategic Plan 2022-25
Hospital at Home	Strategic Plan 2022-25
Enhanced Community Support	Complete
Stay Well Stay Connected	Strategic Plan 2022-25
Locality Planning (Locality Empowerment Groups)	Strategic Plan 2022-25
Frailty Pathway	Strategic Plan 2022-25
Rosewell House Redesign	Ongoing – Target Project End Dec 23
Modernising Primary and Community Care	
Primary Care Improvement Plan	Strategic Plan 2022-25
Immunisation Blueprint	Strategic Plan 2022-25
2C Re-design	Complete
Community Treatment and Care (CTAC) services (part of PCIP)	Strategic Plan 2022-25
Organisational Development and Culture	
Promote use of iMatter and development and implementation of Action Plans	Ongoing but business as usual
Staff Health and Wellbeing	Strategic Plan 2022-25
Annual Conference	Future to be determined
Heart Awards	Future to be determined
Commissioning	
New Care at Home Contract (Commissioning for Outcomes)	Complete
Market Position Statement	Complete
Stepped Care (Intermediate Bed Base Project)	Strategic Plan 2022-25
Redesign of Day Care and Day Opportunities (Commissioning Projects)	Strategic Plan 2022-25

Appendix 2 - 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	13 December 2022
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Internal Audit Report AC2205 – Commissioning
REPORT NUMBER	IA/AC2205
DIRECTOR	N/A
REPORT AUTHOR	Jamie Dale
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 Commissioning.

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. CURRENT SITUATION

3.1 Internal Audit has completed the attached report which relates to an audit of Commissioning.

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. ENVIRONMENTAL IMPLICATIONS

6.1 There are no direct environmental implications arising from the recommendations of this report.

7. 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 detailed in the resultant Internal Audit reports. Recommendations, consistent with the Council's Risk Appetite Statement, 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.

8. OUTCOMES

8.1 The proposals in this report have no impact on the Council Delivery Plan.

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
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

10. BACKGROUND PAPERS

10.1 There are no relevant background papers related directly to this report.

11. APPENDICES

11.1 Internal Audit Report AC2205 – Commissioning

12. REPORT AUTHOR CONTACT DETAILS

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Internal Audit Report

Commissioning

Issued to:
Gale Beattie, Director of Commissioning
Martin Murchie, Chief Officer – Data and Insights
Vikki Cuthbert, Interim Chief Officer – Governance
Jonathan Belford, Chief Officer – Finance
External Audit

Date of Issue: November 2022 **Report No. AC2205**

EXECUTIVE SUMMARY

Background
The previously constituted Strategic Commissioning Committee and now the Full Council considers and approves reports relating to key elements of the commissioning cycle, including development of a Population Needs Assessment, refresh of the community planning Local Outcomes Improvement Plan (LOIP), Council Strategies and Outcome Based Performance Management. The Council Delivery Plan and the Council's budget, both agreed by Council, complete the commissioning cycle.

The Council Delivery Plan brings together the Council's annual priorities derived from strategies and requirements identified by Local, Scottish & UK Government; City/Region arrangements; the Community Planning Partnership; and as a single agency. It sets out the Council's business for the year, including the strategy framework, policy statement, and how the Council intends to support delivery of the LOIP through its commissioning intentions. This includes key LOIP drivers, Council commitments, the associated commissioning, and key measures.

Commissioning Intentions define, annually, the contributions which the Council will make, through services, to the delivery of the outcomes set in the LOIP and supporting strategies. This covers internal, arm's length, and external services. These are set out as actions, and are supported by key measures, in the Council Delivery Plan.

Objective
The objective of this audit was to review plans and progress with implementation of the Council's Strategic Commissioning Approach set out in the Council Delivery Plan.

Assurance
Positive assurance has been obtained over development and implementation of the Council's Strategic Commissioning Approach. The commissioning cycle has been embedded into the Council's planning and performance management activities, facilitating a data-led approach to delivering against key outcomes prioritised as part of the LOIP, within available resources.

Through the Aberdeen Outcomes Framework, in conjunction with community planning partners, the Council has also progressed a variety of improvement projects to further contribute towards the LOIP stretch outcomes.

Findings and Recommendations
Areas where enhancements to processes could better demonstrate the linkage between individual aspects of service delivery, key measures, plans and the LOIP stretch outcomes they are designed to deliver against, have been highlighted to management.

These recommendations are focused on obtaining Best Value and best practice as we found no area to be currently devoid of control, whilst also recognising that this is a complex area with many different stakeholders and overlapping elements.

Specific enhancements include clarification of baselines and targets for individual measures, and quantification of the planned and actual contribution of each action to the overall outcomes.

Management Response

Since the time of the initial data and evidence gathering, management has developed the Commissioning process further and embedded their own enhancements into the process. Where some of IA's recommendations are now implemented, others will be considered by management as a means of strengthening the process further.

1. INTRODUCTION

1.1 The Strategic Commissioning Committee approved a Strategy Framework for the Council in November 2019, setting out the strategies in place for the Council and its Partners, and their alignment with the Local Outcome Improvement Plan (LOIP) and its stretch outcomes. These strategies inform the Council's commissioning intentions and are themselves commissioned or recommissioned through an ongoing annual review process.

1.2 The Council's commissioning intentions for 2021/22 were approved in principle by the Strategic Commissioning Committee in November 2020, and were set out in the Council Delivery Plan, approved by Council in March 2021. The LOIP itself was refreshed in July 2021. The commissioning cycle refreshes and updates annually, with a delivery plan annual report last concluded in October 2021, and revised intentions set out in the 2022/23 Council Delivery Plan in March 2022.

1.3 The Commissioning Intentions set out key areas that the Council will prioritise to deliver elements of the LOIP stretch outcomes and supporting strategies, through commissioned services. A list of key measures is set out in the Delivery Plan for each intention.

1.4 The objective of this audit was to review plans and progress with implementation of the Council's Strategic Commissioning Approach set out in the Council Delivery Plan. This involved consideration of the various stages of implementing the approach including planning, governance, monitoring and reporting of progress with fulfilling the Commissioning Intentions.

1.5 The factual accuracy of this report and action to be taken regarding the recommendations made have been agreed with Martin Murchie, Chief Officer – Data and Insights.

2. FINDINGS AND RECOMMENDATIONS

2.1 The Commissioning Cycle

2.1.1 At the time of this review the Strategic Commissioning Committee had the remit to consider and approve reports relating to key elements of the commissioning cycle, including the development of the Population Needs Assessment, the refresh of the LOIP, Council Strategies and Outcome Based Performance Management. Subsequent to this review this role has passed to the Council, which also agrees the Council Delivery Plan and the Council's budget, completing the commissioning cycle.

2.1.2 The Council Delivery Plan brings together the Council's annual priorities derived from strategies and requirements identified by the UK & Scottish Government; City/Region arrangements; the Community Planning Partnership; and as a single agency.

2.1.3 It sets out the Council's business for the year, including the strategy framework, policy statement, and how the Council intends to support delivery of the LOIP through its commissioning intentions. This includes key LOIP drivers, Council commitments, the associated commissioning, and key measures.

2.1.4 Commissioning Intentions define, annually, the contributions which the Council will make, through commissioned services, to the delivery of the outcomes set in the LOIP and supporting strategies. This covers internal, arm's length, and external services. These are set out as actions, and are supported by key measures, in the Council Delivery Plan.

2.1.5 The Budget allocates financial resources to support the delivery of commissioned services at the agreed standards of delivery.

2.1.6 Service Standards define the availability, responsiveness, and quality of, and eligibility for, the services commissioned. Standards have been reviewed alongside demand and design of services, to reduce the potential for negative demand (e.g. through failure or poor design) and to ensure affordability within available resources.

2.1.7 The Delivery Plan, Commissioning Intentions and Service Standards set out a series of outcomes and improvements to be delivered within planned timescales and budgets. Performance against these is monitored, and business intelligence derived therefrom is used to manage delivery and to identify and prioritise future options. This is presented in the Aberdeen Outcomes Framework - an online accessible source of performance data.

2.1.8 Where areas for improvement have been identified, these are being defined, prioritised and projects established for the delivery and analysis of tests of change to meet requirements.

2.2 Planning

2.2.1 The commissioning intentions are set out in the Council Delivery Plan for each financial year. They are wider than a targeted programme of work. They focus on outcomes, and alignment with various strategies, through 'commissioning' of various priority areas. Most of the priorities reflect existing services, but the intentions are used to highlight areas in which there should be changes in focus, content, and application.

2.2.2 Each intention is aligned with a LOIP stretch outcome and includes a set of key measures. Some of the key measures are duplicated across outcomes and intentions in the plan, as they are anticipated to impact more than one element.

2.2.3 Whilst the majority of LOIP stretch outcomes are specific as to the intended impact to be delivered, the commissioning intentions are less so. To an extent this is to be expected - as the LOIP stretch outcomes are ambitious and would not have been included if there were a single straightforward solution to the identified issue. However, there is limited indication of the extent to which measures in the delivery plan are planned to be improved within the current year, or the extent to which each element will contribute to the intentions or outcomes.

2.2.4 Most of the measures are to deliver a specific output, or to measure the number of outputs delivered. The stated intent of the process is to deliver outcomes based commissioning, but this could be strengthened by clearer linking of outputs to outcomes.

2.2.5 Baselines are not clearly set out in the delivery plan for each measure included against the intentions. It may therefore be possible to make claims or assumptions about the data, or the impact of commissioning, which are not directly related to the activity, or where improvements have not been demonstrated.

2.2.6 In both the 2021/22 and 2022/23 delivery plans, it is not clear that every measure and intention has a clear line of sight to the LOIP stretch outcome it is recorded under, to what extent each needs improving, and whether it will if improved result in a specified level of impact on that stretch outcome. There is therefore a risk that measures and improvements will be prioritised and actioned which do not maximise the intended outcomes.

Recommendation

i. The extent to which each commissioning activity is intended to impact on outcomes should be set out clearly in the delivery plan.

ii. The extent to which key measures are intended to improve because of commissioning intentions should be set out clearly in the delivery plan.

Service Response / Action

i. The outcomes and drivers which the Delivery Plan seeks to impact are derived from the LOIP. These are complex socio-economic issues, subject to macro and micro level influences e.g., "Mitigating the causes of immediate and acute poverty." Attribution of impact at this level, at a planning stage or even retrospectively, is challenging. Therefore, although high level outcomes are measured directly, most of the stated commissioning intentions are measured through outputs as a proxy for their impact on an outcome. For example, a commissioning intention in the current Delivery Plan states "…. secure community benefits through ACC procurement ….". This is measured by, amongst other things, the value of community benefits realised. It is not realistic to measure the extent to which this intention impacts on the complex outcome of poverty. In addition, the activity and value of community benefits is reported in detail within the Council's Annual Procurement Performance Report. Whilst the intent of this recommendation is understood, the purpose of the Delivery Plan has not been to quantify nor report on the impact of each commissioning intention. Notwithstanding this, in preparing the Delivery Plan for 2023/24 officers will seek to design its presentation to highlight the anticipated relationship between the proposed intentions and agreed outcomes.

ii. There are >200 key measures in the current Delivery Plan. They span a very broad range of services and they measure activity and outputs at strategic and operational levels. As a general principle, it is widely accepted that targets are appropriate for some measures and not for others. Regardless, targets have not been included in the Delivery Plan, because it is a high-level document which has not been designed to provide this level of detail. This does not mean that targets do not exist for many of these key measures. For example, many of the key measures in the Delivery Plan match those set out in the National Improvement Framework Plan, which includes

measurable targets. Not specifically including these targets within the Delivery Plan has been a choice designed to i. maintain a degree of consistency throughout the document, ii. allow supporting strategies and plans, which do contain these targets and are produced to a variety of timescales, to flex to meet changing requirements during the year and remain consistent with the Council Delivery Plan and iii. not overwhelm the document with detail. Notwithstanding this, in preparing the Delivery Plan for 2023/24 officers will seek to refer to such targets as are appropriate.

Implementation Date	**Responsible Officer**	**Grading**
March 2023	Chief Officer – Data and Insights	Important within audited area

2.2.7 Supporting the development of the commissioning intentions was a suite of service-design analysis. Each cluster undertook a comprehensive annual review of its structure, resources, standards, access, and eligibility, and how these should be applied to mitigate demand, manage risks, and deliver services. Consideration was given to current and future requirements, and any changes required, including potential for cross-functional and complex redesign beyond functional boundaries. These were peer reviewed, and subject to final consideration by Corporate Management Team (CMT).

2.2.8 The main focus was on delivery of services, any planned changes to business as usual, and the level of finance and other resource inputs required to maintain or adjust these as required. The planned impact on outcomes, or on specific performance indicators as a proxy, was not explicitly set out - except in cases where these were encapsulated within existing service performance standards.

Recommendation

Service design should include the planned impacts on outcomes as a result of changes are clear, and that any gaps are filled with complementary commissioning activity.

Service Response / Action

Since the fieldwork for this review, the service design process for council services has changed. Service design is part of the Transformation Programme agreed by Council on 24th August 2022, and will be supported through implementation of Council Strategy, including enabling strategies. Each of these will relate action to the impact on agreed outcomes.

Implementation Date	**Responsible Officer**	**Grading**
September 2023	Chief Officer – Data and Insights	Important within audited area

2.2.9 There are numerous projects aligned with LOIP stretch outcomes and planned for delivery by the Council and other Community Planning Partners. These are being planned, progressed, and monitored using a consistent format developed and supported by the Council.

2.2.10 Each project is intended to contribute towards achieving specified outcomes by 2026. Projects typically set out smaller more focused tests of change, with the remainder of the outcomes to be achieved through wider commissioning activity, service redesign, or business as usual for the Council or its partners. If projects are successful, then it may be possible to scale them up and deliver further improvements and outcomes. At the point they were reviewed by Internal Audit, three of ten selected Council projects had not commenced, with business cases still to be developed and outcomes defined. The extent of impact from each project / intervention / test of change had not been explicitly set out or put in context with business as usual or other commissioned activity, and baselines were not all up to date.

2.2.11 If projects do not deliver at the pace and scale anticipated when they were originally conceived and commissioned, other actions will need to progress to deliver against the LOIP stretch outcomes. This will need to be reflected in the Council's planning and delivery of its commissioning intentions for future years.

Recommendation
The Council should ensure the planned impact on outcomes from projects is clear, and that any gaps are filled with complementary commissioning activity.

Service Response / Action
Agreed. This is complex matter, and it is difficult to isolate Council activity from the wider partnership working which is a feature of the LOIP. It is part of improvement methodology to continuously look for ways to meet the stretch outcomes identified.

Implementation Date	Responsible Officer	Grading
September 2023	Chief Officer – Data and Insights	Important within audited area

2.3 Monitoring and Reporting

2.3.1 Monitoring overall is through the Aberdeen Outcomes Framework, which is an open-access data portal. This collates various sources of Council data, and other LOIP partners, to indicate progress towards delivery of the LOIP stretch outcomes. Performance is regularly reviewed by Chief Officers using dashboards and local data, quarterly by the Strategy Board, and annually as part of the Council Delivery Plan annual report. Community Planning Aberdeen also receives quarterly reports and an annual outcomes improvement report sharing outcomes and achievements with delivering against the LOIP stretch outcomes.

2.3.2 There is an apparent time-lag in updating data. This is common where reliance is placed on other partners and national datasets, e.g. where figures are taken from annual reports that follow a different schedule to the Council's performance framework. From a sample of indicators reviewed on the framework, one third had 'current data' dating back to 2020 or earlier. This included indicators that could be derived from Council service data.

Recommendation
Management should review the data sets utilised and ensure that data is maintained and as up to date where possible.

Service Response / Action
This recommendation reflects ongoing improvement activity. As a matter of policy and practice, data is updated to the Data Observatory (within the Aberdeen Outcomes Framework) when it is available. However, the datasets included are, in many cases, subject to timetabling of national releases which are not within the gift of the Council to change. However, the addition of alternative local datasets is being reviewed.

Implementation Date	Responsible Officer	Grading
March 2023	Chief Officer – Data and Insights	Important within audited area

2.3.3 Whilst the majority of performance data has relevant baselines, the starting point in time for each varies. Determining the impact of actions referenced in the LOIP against the needs and requirements identified when it was developed in 2016 (and refreshed in 2021) may therefore be more difficult - though comparison against any baseline will give an indication of direction of travel. For some of the more specific outcomes (e.g. those which refer to a specific number of people for whom outcomes will be improved) there is a risk

assumption will have to be made as to the impact prior to baselines being established. As noted at 2.2.5 above, the baseline for each measure is also not set out in the Council Delivery Plan.

Recommendation
Management should carry out a programme of work to review the appropriateness of baselines.

Service Response / Action
Agreed. In updating the ACC measures in the Outcomes Framework officers do and will review the appropriateness of baselines.

Regarding the inclusion of baselines within the Council Delivery Plan, as stated above in the Service response to the recommendation at 2.2.6, the Delivery Plan is not intended to be a document that catalogues all the detail of performance or impact. Notwithstanding this, in preparing the Delivery Plan for 2023/24 officers will seek to refer to such targets as are appropriate.

Implementation Date	Responsible Officer	Grading
March 2023	Chief Officer – Data and Insights	Important within audited area

2.3.4 The Council Delivery Plan Annual Report provides highlights of activities and impacts, but in line with the Plan itself the report does not clearly state the extent to which each activity or measure has contributed towards the outcomes to which it was aligned. There is limited clarity in the narrative section of the report as to which commissioning activities have delivered outcomes, and how much of a success or otherwise these have been in the wider context of the issue identified to be addressed in the LOIP.

2.3.5 An appendix to the annual report sets out detailed performance information, including an indication of whether the measures indicate targets have been met, trend direction, and a note of which commissioning intention they relate to. Each intention is matched against a variety of indicators. Again there is no clear link to the extent to which each had an impact on delivering against the overall LOIP objective/s.

Recommendation
The extent to which each commissioning activity has been delivered and improved outcomes should be recorded.

The extent to which key measures have improved as a result of commissioning intentions should be recorded.

Service Response / Action
Not accepted. It is not the purpose of the Council Delivery Plan, nor the annual report, to catalogue the detailed delivery of each of the intentions. Nor is it possible in one document to measure the impact each commission activity will have, or has had, on an outcome.

Internal Audit Comment	Grading
Service response noted in response to this minor recommendation.	Important within audited area

2.3.6 Progress and future milestones are further discussed in the following year's Council Delivery Plan (2022/23 - March 2022), but as with other performance reporting this contained highlights rather than full data, and there were no baselines or comparisons.

2.3.7 The link between past performance and development of new commissioning intentions is less clear. For example, if there are positive outcome indicators, more of the same might be commissioned; and if indications are that outcomes are not being achieved, what could be done differently. Whilst this is likely to form part of the discussion and decision making process that informs the new delivery plan each year, it is not explicitly set out in the final report, and as discussed at 2.2.8 is not detailed in service redesign paperwork.

Recommendation
The impact of performance on development of new plans and commissioning intentions should be made clear.

Service Response / Action
The Council Delivery Plan is a high-level output of the annual commissioning cycle which is structured around a "Plan, Do, Study, Act" model. The commissioning approach includes the Council's Performance Management Framework and reporting, and consideration of performance is done continuously, through a number of methods to a number of audiences. Performance is one of a number of considerations that is distilled into proposed commissioning intentions, along with council policy, statutory duties, government requirements, strategic commitments, citizen need and demand, available resources, and risks. The Delivery Plan has not been designed to include a detailed narrative showing how each factor has influenced every commissioning intention. Notwithstanding this, in preparing the Delivery Plan for 2023/24 officers will seek to strengthen the visibility of the relationship between drivers, including performance, and the proposed intentions.

Implementation Date	Responsible Officer	Grading
September 2023	Chief Officer – Data and Insights	Important within audited area

2.3.8 Although the key measures generally match between plans and performance reports, they have been presented in a different order, and many relate to more than one action, activity, or outcome. There is no cross-referencing between them, e.g. using a unique reference number, to help readers match plans with performance and to track progress. The outcomes framework includes numbers, but these changed following the LOIP refresh in 2021, and are not repeated in subsequent plans and performance reports.

Recommendation
Key measures / indicators should have unique reference numbers to facilitate matching and monitoring between reports.

Service Response / Action
Agree. This work is underway.

Implementation Date	Responsible Officer	Grading
March 2023	Chief Officer – Data and Insights	Important within audited area

2.4 Budgets and Savings

2.4.1 There is a clear, comprehensive, joined up process for developing the Council's delivery plan, commissioning intentions, and delivery (or commissioning) of services to achieve its intended service standards.

2.4.2 Full Council agrees the Council Delivery Plan and the Budget for its delivery.

2.4.3 In advance of this stage, Services are subject to annual challenge over their service design and delivery models, which are pulled together in a consistent format and subject to peer-review and challenge, before sign off by Corporate Management Team (CMT).

2.4.4 Budgets and cost savings are built into this process. Delivery of those changes and savings is demonstrated through budget monitoring, year-end outturn, and subsequent years' review of the service delivery models, budgets and cost savings.

2.4.5 For individual projects, budgets may be agreed - although for the Council projects reviewed this was within existing resources. As they are outcomes based, finance may be one of many priority outcomes. There are existing processes in place to monitor these.

AUDITORS: J Dale
C Harvey
R Brand

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 organisation.
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	13 December 2022
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Internal Audit Report AC2216 – Attendance Management
REPORT NUMBER	IA/AC2216
DIRECTOR	N/A
REPORT AUTHOR	Jamie Dale
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 Attendance 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. CURRENT SITUATION

3.1 Internal Audit has completed the attached report which relates to an audit of Attendance 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. ENVIRONMENTAL IMPLICATIONS

6.1 There are no direct environmental implications arising from the recommendations of this report.

7. 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 detailed in the resultant Internal Audit reports. Recommendations, consistent with the Council's Risk Appetite Statement, 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.

8. OUTCOMES

8.1 The proposals in this report have no impact on the Council Delivery Plan.

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
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

10. BACKGROUND PAPERS

10.1 There are no relevant background papers related directly to this report.

11. APPENDICES

11.1 Internal Audit Report AC2216 – Attendance Management

12. REPORT AUTHOR CONTACT DETAILS

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Internal Audit Report

Attendance Management

Issued to:
Andy MacDonald, Director of Customer
Isla Newcombe, Chief Officer – People & Organisational Development
Kirsten Foley, Manager – Employee Relations & Wellbeing
Vikki Cuthbert, Interim Chief Officer – Governance
Jonathan Belford, Chief Officer – Finance
External Auditor

Date of Issue: October 2022 **Report No. AC2216**

EXECUTIVE SUMMARY

Background
Aberdeen City Council had 8613 employees equating to 7078 Full Time Equivalent (FTE) at the end of September 2022. Monthly absence data indicates that the proportion of staff absent ranged between 4% and 14%, averaging at around 10%, over the past three years.

As set out in the supporting attendance and wellbeing policy, the Council values the contribution made by its employees and recognises that high levels of attendance at work are key to supporting the achievement of the Council's objectives and priorities. The Council is committed to maintaining high levels of attendance whilst ensuring that employees are treated fairly, consistently, and supportively.

Objective
The objective of this audit was to obtain assurance over compliance with corporate policy and determine whether the Council's absence improvement plan is having a positive impact on attendance.

Assurance has been obtained over compliance and reporting. Following consultation with the Service, however, it has been recognised that improvement work is ongoing to address absence levels across the Council, which according to the most recently available data are higher than the Scottish local Authority mean figure of 9.71 days per employee, with the ACC figure sitting at 10.32 days per employee and changes in the context of working post COVID-19. It was determined that the best use of resources would be to gain the assurance over compliance and reporting and then collaborate with People & Organisational Development going forward. As part of planning for the 2023/24 Internal Audit Plan, we will hold in-depth discussions with management to identify when would be the optimal time to conduct a further review, whilst also supporting People & Organisation Development on a consultancy basis as they implemented the ongoing improvement work.

Assurance
The supporting attendance and wellbeing policy was last reviewed and reported to the Staff Governance Committee in November 2018. It sets out that it is to be reviewed every three years. The policy is subject to annual tabletop reviews with unions and management, and guidance has been updated in the interim. Since implementation of the policy, People & Organisational Development has been working on targeted support and intervention as part of ongoing absence improvement work.

There are comprehensive and accessible written procedures covering all aspects of attendance management, and in general there is good awareness of the requirements. Records of absence are maintained on the CoreHR system, which also highlights to managers where trigger points have been reached in respect of recurring absence, to promote active management of risks to attendance.

The system is used to populate the people performance dashboard within PowerBI for monitoring employee related data, including absence. Additional data is available to direct line managers via dashboards held on the CoreHR system. More detailed and interrogable analysis on causes and trends is being developed in Power BI for Service Management Teams (SMT's), with an intention to roll this out in 2022. People & Organisational Development plans to attend Function and Cluster SMT's quarterly to assist interpretation and provide guidance, in addition to existing case by case support where necessary. This reporting roll out and attendance at meetings has now begun.

Summary data is reported to the Staff Governance Committee biannually, and actions have been set out in response to key areas of focus including increasing accessibility and accuracy of data, early intervention, and further training and support for management.

Although system data was confirmed as accurate, supporting records of attendance and wellbeing meetings, or of actions taken (e.g. phased returns) and supporting reasons, are not always being retained by individual line managers. Records were also not always accessible in the event of changes in employment or line management. There is therefore less assurance that prescribed interventions under the policy are taking place as intended. The system provides options for recording whether and when return to work interviews took place, and to retain notes and supporting medical and other documentation. If these system functions are not being used there may be a training requirement – which is being addressed through the rollout of new processes, data, and support from People & Organisational Development described above.

Access to records is not automatically delegated or transferred where employees or managers change. People & Organisational Development will be reviewing options to ensure appropriate detail of absence history is available to new managers.

Management Response
The Service welcomes the report and the findings around compliance and reporting and the recognition that guidance is comprehensive and readily available.

A full review of the Supporting Attendance Policy will be undertaken following this cycle of collaboration with audit and following the this a full audit review. The revised policy will then be reported to Staff Governance Committee. When we look at the most recently available data on the Local Government Benchmarking Framework, we see the following:

Year	ACC non teaching average days per annum	Scottish Local Gov mean non teaching average days per annum	ACC teaching average day per annum	Scottish Local Gov teaching average days per annum
2020/2021	10.32	9.71	4.16	4.16
2019/2020	11.3	11.9	5.37	6.35
2018/2019	11.87	11.49	4.87	6.23

These figures demonstrate that absence levels within ACC have risen in comparison.

Meetings with both function and Cluster SMTs are now in progress, with each Cluster having an allocated P&OD Advisor who will meet with them on a quarterly basis initially (this will be reviewed to meet the needs of each cluster) to undertake a deep dive on the absence data, identify any areas of concern and put in place any support/early interventions that are identified. In addition, the Advisors will work with Service Managers, supporting them to understand their data and monitor ongoing open absences to ensure that these are being managed appropriately. This will include refresher training for supervisors and team leaders to ensure that records are being updated appropriately in the CoreHR system. This will include the recently approved introduction of reasonable adjustment passports. The discussions held at service, cluster, and function level, as informed by the data, will be used to inform local and corporate absence improvement plans; the Internal Audit team have

indicated their willingness to consult on these and assist with the development of the plans and, following implementation of the work, will carry out a further audit of their effectiveness to inform future developments through a cycle of continuous improvement.

The Absence Report on the People Performance Dashboard continues to be further developed and ensuring that Service Managers have access to the data for their services, including historic data for employees who have moved into the service, whilst maintaining appropriate confidentiality, has been identified as a priority development area.

ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	13 December 2022
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Internal Audit Report AC2206 – Children with Disabilities
REPORT NUMBER	IA/AC2206
DIRECTOR	N/A
REPORT AUTHOR	Jamie Dale
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 Children with Disabilities.

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. CURRENT SITUATION

3.1 Internal Audit has completed the attached report which relates to an audit of Children with Disabilities.

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. ENVIRONMENTAL IMPLICATIONS

6.1 There are no direct environmental implications arising from the recommendations of this report.

7. 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 detailed in the resultant Internal Audit reports. Recommendations, consistent with the Council's Risk Appetite Statement, 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.

8. OUTCOMES

8.1 The proposals in this report have no impact on the Council Delivery Plan.

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
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

10. BACKGROUND PAPERS

10.1 There are no relevant background papers related directly to this report.

11. APPENDICES

11.1 Internal Audit Report AC2206 – Children with Disabilities

12. REPORT AUTHOR CONTACT DETAILS

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Internal Audit Report

Integrated Children's and Family Services
Children with Disabilities

Issued to:
Angela Scott, Chief Executive
Rob Pilkinghorne, Chief Operating Officer
Graeme Simpson, Chief Officer – Integrated Children's and Family Services
Alison McAlpine, Lead Service Manager
Sarah Ward, Category Manager – Children's Services and Housing Manager
Vikki Cuthbert, Interim Chief Officer – Governance
Jonathan Belford, Chief Officer – Finance
External Audit

EXECUTIVE SUMMARY

Background

The Council has a duty under the Children's (Scotland) Act 1995 (1995 Act) to assess the needs of children with disabilities within Aberdeen to safeguard and promote their welfare, through the provision of a range of services appropriate to their needs. It is a requirement of the C&YP (Scotland) Act 2014 for the Council to establish a Child's Plan where a child has a wellbeing need and the need is not capable of being met, or met fully, by the taking of action other than by a targeted intervention that will address those needs. In deciding whether a Child's Plan is required the Council must consult the child's 'named person'[1], and in so far as is reasonably practicable, the child and the child's parents. Should a need for a targeted intervention be established, the Council is responsible under the C&YP (Scotland) Act 2014 of ensuring delivery of that targeted intervention.

Integrated Children's and Family Services work with NHS Grampian and the Aberdeen Health and Social Care Partnership to deliver services aimed at improving the quality of life for children and young people with disabilities who live in Aberdeen. Support is provided to service users with a variety of needs. In accordance with the Social Care (Self-directed Support) (Scotland) Act 2013, service users can choose how they manage their care/support and budget and have four options as follows: direct payment for service user to manage their own budget (Option 1); budget administered by Council but service user chooses how it is spent (Option 2); Council chooses and arranges services (Option 3); or a mix of these options (Option 4).

Under the Council's agreed Powers Delegated to Officers, the Chief Officer – Integrated Children's and Family Services has the authority to make direct payments to children and young people with a disability to allow them to pay for children's services under the Social Care (Self-directed Support) (Scotland) Act 2013. In the financial year 2021/22, thirty five children and young people were paid a total of £510k through Options 1 and 2 while the Council paid eight suppliers a total of £1.11m under options 3 and 4 to deliver support and care to 76 children and young people.

Objective

The objective of this audit was to obtain assurance that care for children with disabilities via contracts and direct payments is being arranged and paid for in accordance with procedure to secure Best Value outcomes. Payments relating to out of authority placements have not been covered as these will be considered as part of a separate audit planned for 2022/23.

Assurance

In general, care for children with disabilities via contracts and direct payments is being arranged and paid for in accordance with procedure, with due consideration given to child wellbeing and the financial impact of associated care packages. However, Best Value was not always being demonstrated since the procurement of the main contract for provision of residential respite services, care at home services and short breaks, at £825k per annum for three years, with an option to extend by two years, was by direct award, without formalised competition through a tender process, contrary to the Council's Procurement Regulations. In addition, instances were identified where Council arranged provision of services to children with disabilities, was not supported by current contracts reflected on the Council's Contracts Register, as required by the Council's Procurement Regulations and Procurement Legislation.

[1] A Named Person is a single point of contact with responsibility for promoting, supporting and safeguarding the child's wellbeing.

Other areas that would benefit from enhanced controls include preparation of Child Plans and associated Action Plans; delegation of authority to authorise direct payments; retention of signed agreements for direct payments from claimants detailing their responsibilities; segregation of duties in establishing and approving care packages within the care management system; and raising of purchase orders.

Findings and Recommendations

The Council agreed a three-year contract, including an option to extend for a further two years, with a provider for the provision of residential respite services, care at home services and short breaks at £825k per annum. This contract replaces the requirement to go out to the market for each individual client's service requirements where the Council is choosing and arranging care for the child concerned. The contract was awarded by way of a direct award as agreed by the Chief Officer - Integrated Children's Services and Families. However, section 15 of the Council's Procurement Regulations does not allow for direct award of contracts above the Light Touch Regime of £664k. Such contracts per the regulations *"Must be advertised in Find a Tender Service and the light touch provisions in The Public Contracts (Scotland) Regulations 2015 apply".* A business case was prepared and submitted to the January 2020 Strategic Commissioning Committee who approved the business case. The submission of the business case did not include a specific request to put aside Section 15 of the Council's Procurement Regulations and allow the direct award to be made. Failure to advertise contracts in line with the Council's Procurement Regulations could risk legal challenge from other possible Service providers. In addition, in breach of the Council's Procurement Regulations and Procurement Legislation, contractual documentation was absent for service provision arranged by the Council, where over £50,000 spend had been incurred with the respective providers and the contracts were not reflected on the Council's Contract Register. A recommendation graded 'Major at a Service Level' was raised for Integrated Children's and Family Services to ensure contracts are procured in accordance with Procurement Legislation and the Council's Procurement Regulations.

The Council's Child's Plan template is comprehensive and covers the requirements of the C&YP (Scotland) Act 2014 for Child's Plans, with a detailed action plan attached for agreed wellbeing outcomes. Council procedure requires review of these action plans at least every six months. Of 10 cases reviewed, nine (90%) had a current completed and approved Child Plan. The remaining case (10%) had a plan completed and approved in June 2020, but due to family health circumstances a full plan had not been completed at the time of the audit. The lack of a current plan does not indicate a lack of interaction between the client and CWD professionals, with such interaction recorded on the CareFirst system. Of the four actions plans in place all had had a review within the previous six months as required to monitor delivery of action and their impact on desired wellbeing outcomes. However, six (60%) action plans were not in place. Where action plans with SMART indicators linked to wellbeing indicators are not formalised and relevant stakeholders are not consulted as required in the preparation of action plans, there is a greater risk desired wellbeing outcomes will not be achieved. A recommendation graded 'Significant within audited area' was raised with the Service for Child Plans and associated action plans to be completed as required.

Under the Council's agreed Powers Delegated to Officers, the Chief Officer – Integrated Children's and Family Services has the power to make direct payments to children and young people with a disability to allow them to pay for children's services under the Social Care (Self-directed Support) (Scotland) Act 2013. However, this authority has not been sub-delegated to the chair of the Resource Allocation Forum (RAF) who is responsible for approving care packages. In addition, it was noted at

the time of review, the chair of the RAF had not completed the necessary procurement training and was not included on the Council's Delegated Procurement Authority Register to enable approval of purchases of over £50k, despite three packages (30%) out of six reviewed exceeding this value and being procured following the chair's approval. Recommendations graded 'Significant within audited area' were raised for the Chief Officer - Integrated Children's and Family Services to review authorised signatory requirements for expenditure under the RAF's remit and if appropriate establish the necessary written sub-delegation of officer powers required to allow the RAF to approve expenditure under their remit; and for all staff undertaking any procurement process to complete the necessary Delegated Procurement Authority training to the required level.

A random sample of five direct payments was reviewed with applications dating between 2009 and 2017. While set up forms were present for each of the sample, one agreement form was absent. As the agreement form details the responsibilities of the claimant and is signed by them to confirm their agreement, it forms a fundamental part of the contract between the Council and the claimant. If the document is not retained this poses a risk should the claimant fail to uphold these responsibilities and the Council wish to take legal action. A recommendation graded 'Significant within audited area' was raised with the Service to ensure all applications and agreement forms are retained for the length of time a claimant is being supported.

Where a client has decided on a direct payment, the details of the agreed package resulting from an application or review are recorded in the care management system as a Service Agreement, which should record the number of hours of care and the rate per hour at the time of the RAF approval being given. The care management system will then generate "invoices" based on the frequency and value. It was noted that care package payment schedules were applied to the care management system by an administrator without evidence in the system of approval by a separate officer with knowledge of the client and delegated authority to approve the payments. In the absence of segregation of duties between care package application and approval, with approval by an appropriate officer within the care management system, there is a greater risk a care package will be established that is not in line with the intentions of the RAF. A recommendation graded 'Significant within audited area' was raised for care packages to be approved within the care management system by an officer with the delegated authority who is separate from the officer who entered it on the system, ensuring it matches the care package approved by the RAF.

All invoices for Option 3 care packages chosen and arranged by the Council that were reviewed had been processed directly through the Council's Integrated Financial Management system and had been approved by an appropriate officer. However, none of the payments were supported by a purchase order, as required by the Council's Procurement Regulations. Without a purchase order verification of the invoice charges cannot be easily carried out to ensure the contractors are charging for services requested and at the rate agreed. To comply with the Council's Procurement Regulations and to ensure only the approved costs are being paid, a purchase order should be raised for all packages not being processed through care management system. A recommendation graded 'Significant within audited area' was raised for the Service to raise a purchase order based on the agreed financial assistance (s23) form for all commissioned service payments not being processed through the care management system.

Management Response

The Service welcomes the learning highlighted from this audit. Several of the findings have already been actioned and completed. The findings while focused on services

provided to children with a disability also have relevance to other parts of our business and this learning has been shared and acted on.

Services to children with disabilities cover a broad spectrum of need. It includes those with sensory impairments, with learning disabilities, with neurodevelopmental needs and those with life limiting health needs. Over the last number of years the fragility of the local market has been highly apparent with four providers of community based supports making the decision to cease operating to this client group. This reflects the growing complexity of need and challenges around recruitment experienced by social care providers to children and their families.

This fragility was felt by those families receiving support from commissioned services. The service was therefore acutely aware that progressing the re-tender of our commissioned services would add to the anxieties of families and children. There was also the potential of significant reputational risk to the Council. In this context it was important to that Children's Social Work, in partnership with Procurement colleagues, gave careful thought to minimising such impact and provided clarity to families. Consequently extensive engagement was undertaken with parents, children and providers. This ensured their views fully informed the service specification. During this exercise all but one of the providers ruled themselves out from being able to deliver on the proposed specification.

While other national providers could potentially have tendered for this contract the disruption would have been significant and potentially harmful to some of the children. It would also have undermined the confidence and trusting relationships with families in receipt of the support. This context was set out in the Business Case presented to and approved by Committee; however it is acknowledged that specific reference to put aside Section 15 was omitted. This will be fully considered in future Business Cases should the context indicate the need for such.

13. INTRODUCTION

13.1 The Council has a duty under the Children's (Scotland) Act 1995 (1995 Act) to assess the needs of children with disabilities within Aberdeen to safeguard and promote their welfare, through the provision of a range of services appropriate to their needs. The 1995 Act requires the services provided by the Council to be designed to minimise the effect on children living within Aberdeen of their respective disabilities or the effect of a disabled sibling's disabilities and to give those children the opportunity to lead lives that are as normal as possible. Under the 1995 Act the Council is required to consider the views of the parent or guardian or child's carer as part of this assessment of need.

13.2 The Council provides social care and support to children and families as part of a wider Scottish Government policy and practice framework - Getting it Right for Every Child (GIRFEC), enshrined in law within the Children and Young People (C&YP) (Scotland) Act 2014. It is a requirement of the C&YP (Scotland) Act 2014 for the Council to establish a Child's Plan where a child has a wellbeing need and the need is not capable of being met, or met fully, by the taking of action other than by a targeted intervention that will address those needs. In deciding whether a Child's Plan is required the Council must consult the child's 'named person'[2], and in so far as is reasonably practicable, the child and the child's parents. Should a need for a targeted intervention be established, the Council is responsible under the C&YP (Scotland) Act 2014 of ensuring delivery of that targeted intervention.

13.3 Integrated Children's and Family Services work with NHS Grampian and the Aberdeen Health and Social Care Partnership to deliver services aimed at improving the quality of life for children and young people with learning disabilities who live in Aberdeen. Support is provided to service users with a variety of needs. When a person applies for care or support, an assessment is carried out and a Child Plan is agreed between them or their representative and a lead professional. Often but not exclusively, the lead professional will be a social worker. All the children and families whose cases were audited were open to children's social work, and all open to the Children with Disabilities Service.

13.4 In accordance with the Social Care (Self-directed Support) (Scotland) Act 2013, service users can choose how they wish to manage their care/support and budget, and have four options as follows:

- **Option 1** – **Direct Payment** – The service user chooses how their budget is used and the service user (or representative) manages the budget.
- **Option 2** – **Directing Your Support** – The service user chooses how the budget is used, but the budget is administered by the Council or and third-party Individual Service Fund (ISF).
- **Option 3** – The service user asks the council to choose and arrange their services
- **Option 4** – A mix of the three options above.

13.5 Under the Council's agreed Powers Delegated to Officers, the Chief Officer – Integrated Children's and Family Services has the authority to make direct payments to children

[2] A Named Person is a single point of contact with responsibility for promoting, supporting and safeguarding the child's wellbeing.

and young people with a disability to allow them to pay for children's services under the Social Care (Self-directed Support) (Scotland) Act 2013.

13.6 In the financial year 2021/22, thirty five children and young people were paid a total of £510k through Options 1 and 2 while the Council paid eight suppliers a total of £1.11m under options 3 and 4 to deliver support and care to 76 children and young people.

13.7 The objective of this audit was to obtain assurance that care for children with disabilities via contracts and direct payments is being arranged and paid for in accordance with procedure to secure Best Value outcomes. This involved obtaining and reviewing the relevant guidance and procedures and testing a sample of direct payments and commissioned services from the Council's Care Management System (CareFirst) to ensure they complied with the procedures. Payments relating to out of authority placements have not been covered as these will be considered as part of a separate audit planned for 2022/23.

13.8 The factual accuracy of this report and action to be taken regarding the recommendations made have been agreed with Graeme Simpson, Chief Officer – Integrated Children's and Family Services, Alison McAlpine, Lead Service Manager and Sarah Ward, Category Manager – Children's Services and Housing Manager.

14. FINDINGS AND RECOMMENDATIONS

14.1 Written Procedures & Training

14.1.1 Comprehensive written procedures that 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 that correct and consistent instructions are available to staff, important in the event of an experienced employee being absent or leaving.

14.1.2 The Service has relevant guidance in place on self-directed support, the completion of Child Plans, the use of the care management system (CareFirst) and some operational aspects of children with disabilities service delivery, such as referral to the Resource Allocation Forum (RAF). However, the Children with Disabilities Children's Social Work Service policy on service delivery was due a review in October 2019. While the review has commenced due to priorities of workload and staffing levels it has not been concluded. In addition, whilst referral to the RAF is explained there is no formal guidance on the calculation of support hours by the RAF based on Child Plan recommendations, risking inconsistencies in awarded support.

Recommendation

a) The Service should complete the review the Children with Disabilities Children's Social Work Service policy.

b) The Service should formalise the RAF procedure for the calculation of support hours.

Service Response / Action

Agreed. The service has been working to develop its new client data base D365 which will go live in September 2022. This will necessitate guidance being updated to reflect the functionality of our new system which proposes to allow recording in hours. The D365 system will require new and more efficient ways of working to be developed. The service will complete the review of the CWD Social Work service policy.

Priority at the outset of 2020 was to ensure that care packages were scrutinised further to differentiate between the provision that was in place to meet the needs of a child (activities to support the child/young person to become more independent etc.) and the provision in place to meet the needs of adult carers – usually parents, (the allocation of short breaks in recognition of the pressures on them of caring for children with more complex needs.) This shift is to ensure that intervention which is put in place via care packages is aligned to the person whose need it is meeting, i.e., whether it is to meet the needs of the child or their adult carer. This shift has required considerable additional work for children's social work professionals, especially considering resourcing pressures for the 3rd sector provider involved in undertaking adult carers support plans in Aberdeen City.

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Implementation Date	Responsible Officer	Grading
April 2023	Lead Service Manager	Important within audited area

14.2 Child's Plan

14.2.1 The Council's Child's Plan template covers the requirements of the C&YP (Scotland) Act 2014 for Child's Plans, detailing client's circumstances, historical information, partners to the plan, the outcome of specialist assessments, and strengths and wellbeing concerns evaluated under the GIRFEC eight SHANARRI wellbeing indicator headings (Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included).

Recommendations for a targeted intervention / care package are documented on the Child's Plan by the relevant Practitioner assessing needs, as well as the views of the child / young person and the parent / carer. Confirmation is also required that the options for delivery of the care under self-directed support have been discussed with the family and where appropriate an option agreed.

14.2.2 The C&YP (Scotland) Act 2014 requires local authorities responsible for delivery of a Child's Plan to keep that Child's Plan under review. While these plans are normally reviewed and updated on an annual basis, should any fundamental changes to wellbeing be identified prior to the annual review a revised plan may be completed.

14.2.3 As part of the Council's Child Plan template and in line with Council operational guidance on SMART (Specific, Measurable, Achievable, Relevant and Time Bound) indicators, a detailed action plan is attached to the Child's Plan describing for each desired outcome, the SHANARRI indicators covered, what is to be achieved, the measure of success, the action / intervention, the implementation due date and responsible officer, documenting separately any contributions from parents / carers and child / young persons. A space is also available against each action to document the outcome of reviews, including if the action resulted in improvement, no change or deterioration and the associated impact on the desired outcome. The Council's GIRFEC operational guidance requires review of action plans contained within Child Plans at least every six months.

14.2.4 A sample of four Option 1, (there were no option 2's in operation at time of the audit), five Option 3 and one Option 4 (combination direct payment and Council commissioned place) cases were chosen at random from payments processed through the Councils payments system. Of these cases reviewed nine (90%) had a current completed and approved Child Plan. The remaining case (10%) had a plan completed and approved in June 2020, but due to family health circumstances a full plan had not been completed at the time of the audit. The Children with Disabilities Service (CWD) advised a review of the plan was currently ongoing with Health partners taking the lead and it is anticipated to be submitted to the September 2022 RAF. The lack of a current plan does not indicate a lack of interaction between the client and CWD professionals, with such interaction recorded on the CareFirst system.

14.2.5 For the sample of 10 Child Plans referred to in 2.2.4 above, four (40%) had complete action plans detailing desired outcomes and measures of success with evidence of consultation with parent / carers and the child / young person or reasons why this was not possible; six (60%) did not have such an action plan. All had evidence of contributions documented on the action plan or on the main Child Plan. Of the four actions plans in place all had had a review within the previous six months as required to monitor delivery of action and their impact on desired wellbeing outcomes. Where action plans with SMART indicators linked to SHANNARI wellbeing indicators are not formalised; relevant stakeholders are not consulted as required in the preparation of action plans, there is a greater risk desired wellbeing outcomes will not be achieved.

Recommendation
Child Plans and associated action plans should be completed as required.

Service Response / Action
Agreed. The Aberdeen City partnership has developed an updated template for the Child's Plan which will be tested over the coming months. Feedback from staff and families on the accessibility and suitability of the revised plan will inform further changes that need to be made. The revised template will make it easier for intended outcomes to be recorded and tracked via reviewing processes. The updated CWD Social Work service policy will make clear expectations around the reviewing of plans. Reporting via D365 will support an auditing of this action to ensure compliance.

Implementation Date	Responsible Officer	Grading
April 2023	Lead Service Manager	Significant within audited area

14.3 Financial Assessment Form (FAF)

14.3.1 Alongside the Child Plan the CWD professional also completes a Financial Assessment Form (FAF) which details a financial breakdown based on the recommended care package recorded on the Child Plan. The FAF details any current care package being funded, a summary of any significant changes to the client's circumstances and the details of the new care package being recommended.

14.3.2 Testing of the sample of ten described in paragraph 2.2.4 above found the FAF summary was in line with the Child Plan, and where any change was being recommended it had been approved by the CWD professional's line manager.

14.4 Resource Allocation Forum (RAF)

14.4.1 The monthly Resource Allocation Forum (RAF) is a joint group made up of representatives from the Integrated Children's and Family Services, NHS, Health and Social Care Partnership and Aberlour (the Councils new contracted single source care provider for CWD). Scrutiny of planning and how requested packages will meet needs identified by multi agencies is shared by representatives from across the partnership. The final financial decision making responsibility sits with the Chief Officer – Children & Family Services (or sub delegated). The role of the RAF is to address the needs of children and young people with a disability who meet the eligibility criteria and whose needs may only be met through providing individual, tailored packages of support and intervention. The RAF consider all new packages of care and review all care packages over £100 per week. During and since the pandemic the RAF continued in a virtual format to allow continuity of service to clients. This forum required to consider the impact of lockdown restrictions, and reduced support from education settings for several children with complex health and disability challenges. A small but significant number of children required alternative bespoke adjustments either to existing packages or for new packages of support to take account of the lockdown restrictions and of fluctuating numbers of known covid 19 cases. Some of this decision making required to take place on a more regular basis than the scheduled monthly RAF panels across this period but was supported by completed paperwork endorsed by Service Manager.

14.4.2 The RAF will review the details on the Child Plan, the financial breakdown on the FAF and listen to any verbal submissions from the Team Leader or Team Manager, to support the application from e.g. Social Worker, client, parents, health care professionals. The panel can approve the recommendation in its entirety or approve only specific items, lower values or request further work is undertaken before a resubmission to panel. The panel update the FAF with exactly which package has been approved and the form is authorised by the RAF chairperson.

14.4.3 For the sample of 10 care packages referred to in paragraph 2.2.4, all FAFs had been approved by the RAF chairperson and the summary of agreed care, excluding financial details, had been accurately recorded on the RAF minutes, evidencing scrutiny of the awarded care package value.

14.4.4 Nine (90%) of the 10 cases reviewed had a current RAF approval, with the other (10%) last approved in 2019. The review process requires family/client involvement but due to mitigating circumstances during the pandemic this was not possible. The Child Plan

relation to the exceptional case last approved in 2019 is currently under review as described in paragraph 2.2.4 above.

14.4.5 Under the Council's agreed Powers Delegated to Officers, the Chief Officer – Integrated Children's and Family Services has the power to make direct payments to children and young people with a disability to allow them to pay for children's services under the Social Care (Self-directed Support) (Scotland) Act 2013. However, this authority has not been sub-delegated to the chair of the RAF.

Recommendation
The Chief Officer - Integrated Children's and Family Services should review authorised signatory requirements for expenditure under the RAF's remit and if appropriate establish the necessary written sub-delegation of officer powers required to allow the RAF to approve expenditure under their remit.

Service Response / Action
Agreed. CO – C&FS in collaboration with CO – Governance will review delegated powers to reflect the need for these to be sub-delegated as is operationally appropriate.

Implementation Date	Responsible Officer	Grading
October 2022	Chief Officer – Integrated Children's and Family Services	Significant within audited area

14.4.6 The sample of six care packages which were procured by the Council following approval by the chair of the RAF; three (50%) of these care packages exceeded £50k annually, with five (83%) care packages having exceeded £50k in the past 4 years. The Chair of the RAF had not completed the necessary procurement training and was not included on the Council's Delegated Procurement Authority Register to enable approval of purchases at this level at the time of review; this has now been resolved. It was also found the Chief Officer – Integrated Children's and Family Services has not completed the training or appear on the Register; it was advised that procurement training was completed when this was previously available under OIL

Recommendation
All staff undertaking any procurement process should complete the DPA training to the required level.

Service Response / Action
Agreed. All procuring staff will be asked to complete the necessary training.

Implementation Date	Responsible Officer	Grading
January 2023	Chief Officer – Integrated Children's and Family Services	Significant within audited area

14.5 Direct Payments

14.5.1 Direct Payment applications and the associated direct payment agreement form are completed by the relevant Social Worker with the supported person or their legal representative. The application form requires a detailed breakdown of annual costs e.g. payroll software costs, insurance costs, advertising and training as an employer of Personal Assistants; recurring payments (hours of care), and one off payments (respite costs). The application form also covers required advice, such as in relation to employment responsibilities where employing a carer which must be given to the supported person. The application and the direct payment agreement form cover the respective responsibilities of the supported person / legal representative and the Council

and require a declaration to be signed and dated by both parties that responsibilities are understood. Supported persons have fifteen responsibilities they agree to including, using the monies only to meet the assessed and agreed outcomes provide financial monitoring statements and make payments to care providers in terms with their contract whilst the Council eleven responsibilities include, carry out regular monitoring, support the supported person to meet their outcomes and make payments in line with the agreement.

14.5.2 Based on the application and agreement form CWD will complete a Direct Payment Set up Form which is populated with the details required to set up the agreement on the CareFirst system.

14.5.3 Historically payments were made into standard bank accounts set up by the claimant for the sole purpose of receiving the financial support and subsequently paying the charges received from the Service provider. Since 2020/21 claimants have been moved onto PrePaid Card accounts which is similar to online banking however Council officers can view the account directly, and the supporting invoices/expenditure records should be uploaded onto the system. Any surplus requiring to be reclaimed can be done so online by the Finance team without the need of raising an invoice. For the period of the audit only two of the direct payments were being paid into non Prepaid Card accounts.

14.5.4 A random sample of five direct payments was reviewed with applications dating between 2009 and 2017. While set up forms were present for each of the sample, one had an application form and four an agreement form. As the agreement form details the responsibilities of the claimant and is signed by them to confirm their agreement to uphold them, it forms a fundamental part of the contract between the Council and the claimant. If the document is not retained this poses a risk should the claimant fail to uphold these Responsibilities and the Council wish to take legal action.

Recommendation
The Service should ensure all applications and Agreement Forms are retained for the length of time a claimant is being supported.

Service Response / Action
Agreed. The updated CWD Social Work service policy will make clear expectations around the retention of agreement forms within the child's electronic file.

Implementation Date	Responsible Officer	Grading
April 2023	Unit Coordinator	Significant within audited area

14.5.5 Council procedures required direct payment care packages to be reviewed annually with a Direct Payment and Service Annual Review form template to document this undertaking. The supported person agrees to provide necessary evidence to facilitate these reviews when signing their application form declaration. Once the outcome of the review is documented on the form both the supported person and the Practitioner must sign the form to evidence it is accurate. Of the sample of five reviewed one had a signed form in place while two had minutes of a review meeting recorded on CareFirst.

Recommendation
The Service should undertake the annual review and complete the required documentation to evidence it.

Service Response / Action
Agreed. The updated CWD Social Work service policy will make clear expectations around the reviewing of plans/packages of care. Reporting via D365 will support an auditing of this action to ensure compliance.

Implementation Date	Responsible Officer	Grading
April 2023	Lead Service Manager	Important within audited area

14.5.6 The review includes a financial audit undertaken by Finance, which requires the supported person or their legal representative to submit a Financial Monitoring Statement detailing expenditure from the dedicated direct payment bank account transactions to ensure payments being made from the account equate to the agreed care package detailed on the set up form. Finance have confirmed that these annual reviews are only undertaken where non Prepaid Card accounts are still being used. Testing for the two clients who still used normal bank accounts found an audit was being carried out.

14.5.7 The packages approved by the RAF are based on the agreed care provision being fully provided by the external supplier engaged by the client. Due to a lack of qualified and/or suitably experienced and trained staff, along with issues caused by the pandemic, several clients have been unable to fulfil their approved package. Where some staff have been required to isolate or have been unable to work due to having covid 19 symptoms, the client may have incurred costs for payment to their personal assistant, as well as requiring funding to pay an alternative service provider. This has meant some families have required to request an enhancement to their DP package and in other instances a surplus will accumulate in the clients care bank account. On a quarterly basis the Direct Payments Finance team will review the bank balances of those receiving a direct payment and where any surplus exceeds four weeks entitlement they will contact the client informing them the surplus will be recovered by the Council. The client can discuss any reasons for the surplus with their case worker, in case there are invoices outstanding from the third party care provider. A review of the bank accounts for the five direct payment care packages sampled found this process had been correctly applied.

14.5.8 Where a client has decided on Option 1, direct payment, the details of the agreed package resulting from an application or review are recorded in CareFirst as a Service Agreement, which should record the number of hours of care and the rate per hour at the time of the RAF approval being given. The agreement will also record the frequency on which the costed package has been arrived at; for the sample of five direct payments tested, all were weekly. CareFirst will then generate “invoices” based on the frequency and value. All direct payment clients must set up a specific bank account into which all Council payments will be credited and all payments to the care providers are debited. It was noted that care packages were applied to CareFirst by an administrator without evidence in the system of approval by a separate officer with knowledge of the client and delegated authority to approve the payments. In the absence of segregation of duties between care package application and approval, with approval by an appropriate officer within the CareFirst system, there is a greater risk a care package will be established that is not in line with the intentions of the RAF. An overpayment occurred as described in paragraph 2.5.9 below which potentially could have been avoided by this system of review.

14.5.9 A sample of five clients who were receiving direct payments to allow them to commission their specific care requirements was tested to ensure payments in the Integrated Financial Management system agreed to CareFirst and the approved care package described in the FAF. One client (20%) had an overpayment caused by the incorrect set up in Carefirst of the care provided during school holidays as described in paragraph 2.5.10 below, another two (40%) had payments of £304 per annum relating to payroll software costs which had not been detailed on the approved FAF.

14.5.10 The care package incorrectly set up in Carefirst referred to in paragraph 2.5.9 above was split between normal weeks and school holiday weeks. Where the school holidays were ongoing, extra hours were required from the care providers. The FAF showed this as being

12 weeks, resulting in an additional weekly cost of £912 (approximately £11k per annum). A review of the payments through the Integrated Financial Management system these school holiday payments appeared to be ongoing throughout the whole year (52 weeks) rather than the 12 holiday weeks. The Service advised whilst original approval was for 12 weeks subsequent approval had extended the additional hours but not for the full 52 week period. The client has since moved onto a Prepaid Card account and Finance recovered the surplus balance held in the old account totalling £24k.

14.5.11 The care packages are set up in CareFirst by the practitioner who competed the S23. The set up does not currently require a review or approval prior to going "live." The lack of a check / approval to ensure the details are per the approved S23 can result in incorrect payments being made. While a surplus will accumulate in the client's bank account, provided the service provider charges based on the approved package, should any extra costs outwith the RAF approval be paid through the account this would reduce the surplus and not be detected during any subsequent review.

Recommendation
Care packages should be approved within CareFirst/D365 by an officer with the delegated authority who is separate from the officer who entered the care package in CareFirst/D365, ensuring the care package in the system matches the approved FAF / s23 form.

Service Response / Action
Agreed. The updated CWD Social Work service policy will make clear expectations around the reviewing of plans. Reporting via D365 will support an auditing of this action to ensure compliance.

Implementation Date	Responsible Officer	Grading
April 2023	Lead Service Manager	Significant within audited area

14.5.12 It was noted that agreed budgets and actual expenditure at a client care package level is not routinely monitored. Such monitoring would help ensure payments are as agreed and reduce the risk of overpayments.

Recommendation
A system of monitoring should be introduced for expenditure at a care package level.

Service Response / Action
Agreed. The updated CWD Social Work service policy will make clear expectations around the reviewing of plans. Reporting via D365 will support an auditing of this action to ensure compliance.

Implementation Date	Responsible Officer	Grading
December 2022	Team Manager CWD	Important within audited area

14.5.13 The FAF has a section for recording that the details have been updated onto CareFirst. Each Service Agreement in CareFirst has a unique ID reference; however, the Service Agreement reference is not recorded on the FAF making verification that CareFirst agrees to FAF care package decisions challenging. Where only a single change to the value of a package is applied following an annual review, the lack of a unique cross reference between the two is not an issue for reconciliation purposes. Where multiple changes result from six weekly reviews, e.g. hours of care, rates paid, additions/decreases in provision, it makes reconciliation of charges more difficult, especially where the breakdown of the package on the FAF is based on varying hours throughout the year. The recording of the

Service Agreement ID on the FAF would facilitate financial control where accuracy of payments is being verified to direct payment award decisions.

Recommendation
The Service Agreement ID on CareFirst should be recorded on the supporting FAF (s23 form).

Service Response / Action
Agreed. The updated CWD Social Work service policy will make clear expectations around the reviewing of plans. Reporting via D365 will support an auditing of this action to ensure compliance.

Implementation Date	Responsible Officer	Grading
January 2023	Unit Coordinator	Important within audited area

14.6 Option 3 – Third Party Commissioned Services

14.6.1 A sample of six clients receiving their care provision through Council commissioned care providers was tested to ensure payments being made to these external suppliers matched the approved FAF care package form. Testing found two of the six did not match the approved cost.

14.6.1.1 One invoice from the care provider Camphill showed shared night attendant charges of £104 per night for the period 22 December 2021 to 1 April 2022 totalling approximately £11k. This was not shown on the approved FAF. A recommendation has already been made at paragraph 2.5.12 above to introduce a system of monitoring of expenditure at a care package level.

14.6.1.2 One invoice from Grampian Autistic Society is based on a daily rate however the FAF shows an hourly rate, and several approved hours for the client. The current documentation does not allow an exact match of costs to be carried out. The lack of data to match invoices being paid against expected service provision has a risk of incorrect charges being paid. C&PSS advised on 12 September 2022 that the related contract has reviewed and the revised contract has been agreed with the service provider.

Recommendation
S23 rates should be based on how the charge will be invoiced.

Service Response / Action
Agreed. The updated CWD Social Work service policy will make clear expectations around the reviewing of plans. Reporting via D365 will support an auditing of this action to ensure compliance.

Implementation Date	Responsible Officer	Grading
April 2023	Lead Service Manager	Important within audited area

14.6.2 All invoices had been processed directly through the Council's Integrated Financial Management system rather than CareFirst and had been approved by an appropriate officer. However, none of the payments was supported by a purchase order, as required by the Council's Procurement Regulations. Without a purchase order verification of invoice charged cannot be easily carried out to ensure the contractors are charging for services requested and at the rate agreed. To comply with the Council's Procurement

Regulations and to ensure only the approved FAF costs are being paid, a purchase order should be raised for all packages not being processed through CareFirst.

14.6.3 All direct payments are processed through the interface between CareFirst and the Council's Integrated Financial Management system . A review of all invoices processed directly through the Council's Integrated Financial Management System for Children with Disabilities payments found 55 (39%) had a purchase order raised while 87 (61%) to a value of £969k did not. The Council's Procurement Regulation 7.1 requires a purchase order to be raised for all supplies and services. To comply with this requirement, purchase orders should be raised in advance of receipt of goods / services and prior to processing the related invoice to ensure the Council only pays for what has been ordered and received. It also helps ensure committed expenditure is recorded for budget monitoring purposes.

Recommendation
CWD should raise a purchase order based on the agreed FAF (s23 form) for all commissioned service payments not being processed through CareFirst.

Service Response / Action
Agreed. The updated CWD Social Work service policy will make clear expectations around the reviewing of plans. Reporting via D365 will support an auditing of this action to ensure compliance.

Implementation Date	Responsible Officer	Grading
January 2023	Lead Service Manager	Significant within audited area

14.7 Procurement Scheme of Governance

14.7.1 Aberdeen City Council agreed a three-year contract, including an option to extend for a further two years, with Aberlour Child Care Trust for the provision of residential respite services, care at home services and short breaks. The contract agrees year one funding of £825k, which will form the basis of subsequent year values unless a justified payment increase request is received. This contract replaces the requirement to go out to the market for each individual client's service requirements where Option 3 has been chosen by the client.

14.7.2 The contract was awarded by way of a direct award as agreed by the Chief Officer – Integrated Children's Services and Families. Section 15 of the Council's Procurement Regulations does not allow for direct award of contracts above the Light Touch Regime of £664k. Such contracts per the regulations *"Must be advertised in Find a Tender Service and the light touch provisions in The Public Contracts (Scotland) Regulations 2015 apply".*

14.7.3 A business case was prepared and submitted to the January 2020 Strategic Commissioning Committee who approved the business case. The submission of the business case did not include a specific request to put aside Section 15 of the Council's Procurement Regulations and allow the direct award to be made. The Service advised they undertook consultation with all known providers to encourage interest and to assess ability to deliver and it was determined that they were unable to increase provision as required. However, failure to formally advertise contracts in line with the Council's Procurement Regulations could risk legal challenge from Service providers, including national providers that have not had an opportunity to bid. While there is a new single provider contract, the Children with Disabilities Service are still transitioning ongoing provision already being provided by other third-party providers as mentioned in section 2.6. This transition is only being undertaken in agreement with the clients and where the provision of service will not have a detrimental effect to the client and cannot be met within

commissioned service contract – for example, for a child living out with Aberdeen City area.

14.7.4 Currently seven other providers are delivering services to clients. Testing was undertaken to ensure contracts were in place with these providers and the correct Scheme of Governance followed in their procurement. Five of the providers had no supporting documentation relating to the arrangements in place (four of these exceeded £50k in last four years). Their annual costs ranged from £7k to £53k in the financial year 2021-22. Over the four-year period ending 31 March 2021 spend with these providers ranged from £7k to £405k.

14.7.5 Another provider with annual expenditure of £51k has a letter of agreement covering the period 1 April 2020 – 31 March 2021. Service provision is ongoing currently being invoiced at £13k per quarter but there is no supporting documentation extending the agreement. The total spend over the current and previous four years is over £232k. The Service advised this provision is now being managed by the Aberdeen City Health and Social Care Partnership.

14.7.6 Another provider annual expenditure of £98k for which an interim contract was present. The contracted provision commenced on 1 April 2016 with an expiry date of 31 March 2019. However, the interim contract also had a clause extending the contract on a rolling six monthly basis unless terminated by either party. The total spend on this interim contract was over £403k at the time of review in August 2022. This has now been addressed because of Committee approval of a direct award for this provision.

14.7.7 None of the above contracts appears on the Council's contracts register and there is no documentation to provide evidence the correct Scheme of Governance had been followed when these provisions had started. The contracts register also includes no evidence the provisions were tendered for allowing open market involvement and demonstrating Best Value had been achieved, despite the requirement of the Council's Procurement Regulations and the legal requirement for all contracts of £50,000 or greater to go through such a process. If these providers are to be retained on an ongoing basis rather than the clients being transferred to the new contract, then Integrated Children's and Family Services should ensure the Council's Procurement Regulations and Procurement Legislation are adhered to.

Recommendation

Integrated Children's and Family Services should ensure contracts are procured in accordance with Procurement Legislation and the Council's Procurement Regulations.

Service Response / Action

Agreed. Over the last number of years the fragility of the local market has been highly apparent with four providers of community based supports making the decision to cease operating to this client group. This fragility was felt by those families receiving support from commissioned services. The service was therefore acutely aware that progressing the re-tender of our commissioned services would add to the anxieties of families and children. There was also the potential of significant reputational risk to the Council. Consequently, with the assistance of C&PSS, extensive engagement was undertaken with parents, children, and providers. This ensured their views fully informed the service specification. During this exercise all but one of the providers ruled themselves out from being able to deliver on the proposed specification.

While other national providers could potentially have tendered for this contract the disruption would have been significant and potentially harmful to some of the children. It would also have undermined the confidence and trusting relationships with families in receipt of the support. This context was set out in the Business Case presented to and

approved by Committee; however it is acknowledged that specific reference to put aside Section 15 was omitted.

The Service will plan future procurements to ensure compliance with the requirements of the Council's Procurement Regulations and Procurement Legislation with any future direct awards only undertaken with the necessary approvals.

Implementation Date	**Responsible Officer**	**Grading**
Implemented	Chief Officer - IC&FS	Major at a Service Level

14.8 Performance and Budget Monitoring

14.8.1 The new single contractor provision has a structured quarterly reporting process and monthly monitoring meetings between the Service, C&PSS and contractor to deal with any issues which may arise. There are 26 statistical and 10 narrative KPIs in the contract, and these were reviewed against the April – June 22 quarterly report. Testing found three statistical and three narrative KPIs which did not appear to have been reported. This was highlighted to the CPSS contract manager for raising at the next contractor meeting.

14.8.2 The older third-party provider contracts have little or no record of ongoing monitoring. However, the professional staff in the Service have regular interaction with the clients, where any issues regarding care provision can be brought up and the client's wellbeing can be monitored. In addition, there is also a written annual review of each client's Child Plan as described in section 2.2 above which is submitted to the RAF when provision and costs are reviewed.

14.8.3 The Service receive regular monitoring reports and hold meetings with Finance officers to monitor actual spend against approved budgets. For the financial year 2021/22 children and young people with learning disabilities received support and care in Aberdeen from a revenue budget of £1.44m. Net expenditure after adjustments for accruals and prepayments resulted in an overspend of £79k. This was represented by an underspend in direct payments by £156,776 but an overspend in commissioned services of £207,386 partially due to clients moving from direct payments to the new Aberlour provision. There was also increased salary costs of £28,790.

AUDITORS: J Dale
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 organisation.
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	13 December 2022
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Internal Audit Report AC2304 – Corporate Health and Safety
REPORT NUMBER	IA/AC2205
DIRECTOR	N/A
REPORT AUTHOR	Jamie Dale
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 Corporate Health and Safety

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. CURRENT SITUATION

3.1 Internal Audit has completed the attached report which relates to an audit of Corporate Health and Safety.

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. ENVIRONMENTAL IMPLICATIONS

6.1 There are no direct environmental implications arising from the recommendations of this report.

7. 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 detailed in the resultant Internal Audit reports. Recommendations, consistent with the Council's Risk Appetite Statement, 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.

8. OUTCOMES

8.1 The proposals in this report have no impact on the Council Delivery Plan.

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
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

10. BACKGROUND PAPERS

10.1 There are no relevant background papers related directly to this report.

11. APPENDICES

11.1 Internal Audit Report AC2304 – Corporate Health and Safety

12. REPORT AUTHOR CONTACT DETAILS

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Internal Audit

Assurance Review of Corporate Health and Safety

Status: Final
Date: 8 November 2022
Risk Level: Corporate

Report No: AC2304
Assurance Year: 2022-23

Net Risk Rating	Description	Assurance Assessment
Moderate	The framework of governance, risk management and control provides reasonable assurance over the achievement of objectives. Net risks to objectives are moderate in relation to Council's activities and processes.	Reasonable

Report Tracking	Planned Date	Actual Date
Scope issued	02/08/2022	02/08/2022
Scope agreed	09/08/2022	26/08/2022
Fieldwork commenced	23/08/2022	23/08/2022
Fieldwork completed	13/09/2022	28/09/2022
Draft report issued	04/10/2022	30/09/2022
Process owner response	25/10/2022	17/10/2022
Director response	01/11/2022	08/11/2022
Final report issued	08/11/2022	08/11/2022
Audit Committee	13/12/2022	

Distribution	
Document type	Assurance Report
Director	Gale Beattie, Director of Commissioning
Process Owner	Vikki Cuthbert, Interim Chief Officer, Governance
Stakeholder	Colin Leaver, Corporate Health, and Safety Lead
	Fiona Mann, Emergency Plan, Resilience and Civic Lead
	Jonathan Belford, Chief Officer - Finance*
*Final only	External Audit*
Lead auditor	Cassie Jamieson, Auditor

Contents

1 Introduction

1.1 Area subject to review

The Council has a statutory duty to manage its workplace with due regard to the health and safety of the workforce and those affected by the Council's activities.

The Health & Safety at Work etc. Act 1974 is the primary legislation covering occupational health and safety. It sets out the general duties that employers have towards employees and members of the public, and which employees have to themselves and each other.

The Management of Health & Safety at Work Regulations 1999 make more explicit what employers are required to do to manage health and safety under the Health & Safety at Work etc. Act 1974. The main requirements on employers are to carry out risk assessments and record any significant findings, plan to implement necessary measures, appoint competent people to implement the arrangements, set up emergency procedures, arrange for clear information and training of employees and work together with other employers sharing the workplace.

The Health and Safety Executive (HSE) is responsible for enforcing health and safety legislation. They ensure the Council manages the health and safety of its workforce and those affected by their work.

Non-compliance with health and safety regulations could not just damage the Council's reputation, but also result in fines of up to £20k per breach and in more serious cases where human lives are endangered this can lead to unlimited fines and imprisonment.

1.2 Rationale for the review

The objective of this audit is to provide assurance that appropriate processes are being employed in managing health and safety at a corporate level.

Compliance with health and safety legislation is a statutory requirement for the Council; failure to comply could lead to death, injury, and ill health of Council employees and those affected by the Council's work; reputational damage to the Council; and financial penalties. As such this is a high priority area subject to regular review by Internal Audit. The last Internal Audit review of the Council's corporate health and safety arrangements took place in 2018-19 as part of a Council wide audit of health and safety arrangements. This found that in general appropriate arrangements were in place however recommendations were made to update policies and procedures; formalise Function improvement plans; establish training needs and monitor completion; and to monitor risk assessment completion.

1.3 How to use this report

This report has several sections and is designed for different stakeholders. The executive summary (section 2) is designed for senior staff and is cross referenced to the more detailed narrative in later sections (3 onwards) of the report should the reader require it. Section 3 contains the detailed narrative for risks and issues we identified in our work.

2 Executive Summary

2.1 Overall opinion

The full chart of net risk and assurance assessment definitions can be found in Appendix 1 – Assurance Scope and Terms. We have assessed the net risk (risk arising after controls and risk mitigation actions have been applied) as:

Net Risk Rating	Description	Assurance Assessment
Moderate	The framework of governance, risk management and control provides reasonable assurance over the achievement of objectives. Net risks to objectives are moderate in relation to Council's activities and processes.	**Reasonable**

The organisational risk level at which this risk assessment applies is:

Risk Level	Definition
Corporate	This issue / risk level impacts the Council as a whole. Mitigating actions should be taken at the Senior Leadership level.

2.2 Assurance assessment

The level of net risk is assessed as **MODERATE**, with the control framework deemed to provide **REASONABLE** assurance over the Council's approach to corporate health and safety.

The Council has adequate control over its health and safety arrangements, including an agreed policy that clearly sets out both employee responsibilities and corporate and function governance arrangements to ensure appropriate monitoring. Health and safety related data (including accident and incident statistics) is being presented to the Staff Governance Committee and Function specific health and safety groups meet regularly, comprising the respective Director and relevant health and safety representatives (including both employee and Local Trade Union members). There is also a dedicated Health and Safety Team within Governance who provide occupational health and safety advice to members of the Council.

However, certain enhancements could be made to improve controls. The Health and Safety Team has advised that a new system is planned to be implemented in October 2022, with the plans in place for this new system addressing a number of the points that Internal Audit identified as part of this review. It would therefore be beneficial to use this opportunity to ensure the system addressed the issues noted.

Recommendations have also been made around corporate health and safety procedures, completion of mandatory training, documentation of internal procedures, reporting and, monitoring.

Whilst we recognise this as an area with many stakeholders across the Council, the central team provide oversight, second line control and have the ability and expertise to ensure an effective framework of control. As such, our recommendations have been targeted towards them, whilst recognising they will need to engage across the business to implement enhancements.

2.3 Severe or major issues/risks

No severe or major issues/risks were identified as part of this review.

2.4 Management response

The report presents a fair summary of the areas which the Corporate Health and Safety Team is currently focused on improving. The roll out of the health and safety module within Core HR presents opportunities to increase controls around the reporting of incidents and near misses, whilst the SharePoint pages currently under development are being designed in a way that improves our health and safety communications to the workforce and highlights training requirements and opportunities. This is consistent with the recently approved Corporate Health and Safety Policy which sets out the overarching approach to increasing health and safety compliance:-

1. *Policies and procedures - Set the framework and requirements to ensure compliance with H&S law and guidance, including roles, responsibilities, and governance.*
2. *Data and Digital - Ensure that the organisation is self-checking its adherence to the requirements and provides end user capability to increase compliance.*
3. *Training and communications - Provide the organisation with information on the requirements, including their roles and responsibilities and the part they must play.*

3 Issues / Risks, Recommendations, and Management Response

3.1 Issues / Risks, recommendations, and management response

Ref	Description	Risk Rating	Minor
1.1	**Corporate Health and Safety Procedures** – The Health and Safety Homepage within the Zone has links to activity related policies and procedures (i.e., asbestos, DSE, first aid, Control of hazardous substances, incident and near miss reporting guidance) as well as guides for employees to encourage / increase positive health (e.g. how to manage stress, mental health awareness etc). There was also guidance for managers outlining their health and safety responsibilities, a list of health and safety related training courses, and minutes of meetings from Function health and safety groups. Whilst the 'Incident and Near Miss Reporting Guidance' was found to be overall comprehensive, it did not define categories within the current system or give examples how each should be answered. Some of these categories were found to be confusing and unclear (i.e., risk recurrence probability, risk assessed and risk details). In light of the implementation of a new incident and near miss reporting system within Core HR, this would be an optimal time to refresh guidance.		
	IA Recommended Mitigating Actions System guidance should be updated to include classifications for each category.		
	Management Actions to Address Issues/Risks *Agreed – The Health and Safety SharePoint pages are due for publication before the end of the year and will include crossovers to the Risk Management pages. All definitions used in health and safety risk management will be fully explained.*		

Risk Agreed	Person(s)	Due Date
Yes	Corporate Health and Safety Lead	Dec-22

Ref	Description	Risk Rating	Moderate
1.2	**Mandatory Health and Safety Training** – As stated in the Corporate Health and Safety Policy, the Health and Safety Team advises services on their health and safety training requirements and deliver health and safety communications to ensure all services are clear on their responsibilities and how to meet these. Various training modules are available to staff via the Council's online learning platform. The health and safety section has eight training courses associated to it, including: DSE assessment, manual handling, counter terrorism awareness, asbestos awareness, fire marshal and warden responsibilities, food hygiene certificate, stress awareness for Managers and working at height. The mandatory training section within the platform includes an 'Introduction to Health & Safety' course and a 'Fire Safety' course. There is also a mandatory course for Managers – 'Managing Safety'. Internal Audit requested completion records for the above three training courses from People and Organisational Development to ensure mandatory training had been completed as required. The below figures are based on completions by all current employees of the Council and all relief workers currently on the Council's payroll system (except for long-term sick		

	employee's, those on parental leave and those who have just newly joined the Council in the past month). There were approximately 8,455 individuals currently employed by the Council as at March 2022. However it is recognised that not all training will be required for all staff. As at 29 August 2022: • The 'Introduction to Health and Safety' course had been completed by 2,857 'current' employees. This is based on a report made available to Internal Audit showing staff who had completed the course since 2020 due to being new starts.. Staff may have completed the training before the reporting period. • The 'Fire Safety' course had been completed by 2,281 • The Managers 'Managing Safety' course by 389 All three training courses had low levels of completion and were not being subsequently monitored. This increases the risk that staff are unaware of their health and safety duties, and do not carry these out properly.

IA Recommended Mitigating Actions

The following recommendations have been made to address the above issues:

- Relevant staff should be reminded of their responsibility to complete mandatory health and safety related training.
- Mandatory health and safety related training courses should be monitored periodically with action taken where required to encourage completion.

Management Actions to Address Issues/Risks

There is a recognition that compliance needs to be higher and this is being reviewed through Smarter Working workstream and processes. Work is also underway with People & Organisational Development to identify who requires to complete mandatory training and to monitor completion rates.

Risk Agreed	Person(s)	Due Date
Yes	Corporate Health and Safety Lead	Mar-23

Ref	Description	Risk Rating	Moderate
1.3	**Internal Procedures** – Across the corporate health and safety sphere, there are no internal procedures in place for Health and Safety Advisers, with reliance placed on their experience; all have been employed by the Council for 8+ years. More specifically, there is a lack of guidance outlining when an investigation should be conducted and examples of circumstances that would warrant this. The CHST advised however that they are not routinely responsible for investigations. Instead, RIDDOR reports are checked with managers to ensure they have conducted investigations and reached the correct conclusions. The only investigations carried out by CHST are those where senior managers request them and that can be for varied reasons. Following on from conversations with the Cluster, the Corporate Health and Safety Lead advised that they ask their team to follow-up on all HSE reportable incidents. A review of a sample of 20 incidents and near misses found that one had been subject to an investigation by the Health and Safety Team, despite six being reportable to the HSE. It is therefore not clear based on the lack of internal procedures and limited system functionality what led to the conclusion that local investigations were adequate and did not require follow up from the Health and Safety Team. The lack of comprehensive written procedures, which are easily accessible by all members of staff, can increase the risk of errors and inconsistency. It also increases the risk that there is no reference point for the training of current and new employees. This reduces		

Ref	Description	Risk Rating	Moderate
	management's assurance that correct and consistent practices are being followed, especially in the event of an experienced employee being absent or leaving.		
	IA Recommended Mitigating Actions		
	The Health and Safety Team should develop a means of documenting internal procedures covering all elements involved in managing incidents and near misses.		
	Management Actions to Address Issues/Risks		
	Agreed - A flowchart will be added to onto the SharePoint pages on the process for investigations, including RIDDOR reported incidents, and the respective roles of the Corporate Health and Safety Team and managers. This will be extracted from the recently approved Corporate Health and Safety Policy.		
	Risk Agreed	**Person(s)**	**Due Date**
	Yes	Corporate Health and Safety Lead	Dec-22

Ref	Description	Risk Rating	Moderate
1.4	**Incident and Near Miss Reporting –** The Health and Safety Team receives notifications of all incidents and near misses reported through the Council's electronic reporting system via YourHR. The Line Manager or authorised member of staff are required to input the initial details surrounding the incident / near miss within 10 working days. Once it has been established that a physical injury has been sustained or involved actions that could have resulted in damage if unchanged, an incident report should be completed via YourHR. The reporting of an incident or near miss will create an investigation form and an investigation should be undertaken promptly by the responsible Line Manager in conjunction with all parties involved. Once the investigation has taken place and the details have been recorded on the system, both the investigation report and accident form will be given a unique reference number. The accident report can be cross referenced to identify its corresponding investigation report. Once submitted, the Health and Safety Team receives notifications of reports into their shared inbox and will review accordingly. Based on reports provided by the Corporate Health and Safety Lead, there were 924 injury reports and 617 near miss reports raised between January 2022 and 21 September 2022. Findings based on the current system in use during the course of the audit were: • Two instances where incidents / near misses had not been reported timeously, i.e., within the 10-day timeframe • 14 instances where the mandatory managers' training course had not been completed by staff, four of which had been reported by non-managerial staff and 10 deemed to be managerial. A recommendation has already been made to address this in 1.2. The current system of control presents an issue where instances are not being dealt with in a timeous and proper manner, which could result in operational, compliance and financial risks for the Council, as well as the health and safety of the workforce and those affected by the Council's activities.		
	IA Recommended Mitigating Actions		

Ref	Description	Risk Rating	Moderate
	With regards to the issues noted above, we recommend these are built into the new approach being implemented for Corporate Health and Safety within Core HR.		
	Management Actions to Address Issues/Risks		
	Agreed - The reporting system for incidents and near misses will be Core HR and data on compliance will be reported through the Performance Board and Function H&S Groups, and also to Staff Governance Committee. Clusters will have the data they need to monitor themselves. Work will also be carried out with clusters to enhance their own internal monitoring and training completion.		
	Risk Agreed	**Person(s)**	**Due Date**
	Yes	Corporate Health and Safety Lead	Mar-23

Ref	Description	Risk Rating	Minor
1.5	**Risk Assessment Monitoring** – The Council has a statutory obligation to assess the risks to the health and safety of its employees to which they are exposed while at work. Corporate oversight of risk assessment completion beyond investigations, which as noted above, are not taking place often, could be enhanced. CHST advised that there are sometimes gaps in compliance with completing the risk assessments and also keeping these under review, which then impacts centrally. These tend to be in lower risk office-based roles. However, this is in the process of being addressed by the CHST, with plans in place to create a reference library within SharePoint where risk owners can upload their own risk assessments and view others, subject to controls about personal data being adhered to. Once in place, annual reminders will be sent to risk owners informing them it is time to review their risk assessments and to update where applicable. Whilst work is underway to centralise risk assessments, completion is dependent on availability of corporate resource to ensure all the relevant controls are in place but is estimated for 2023. A recommendation has been included to track progress.		
	IA Recommended Mitigating Actions		
	The Health and Safety Team should complete the planned publication of H&S risk assessments and put in place a process for Clusters to monitor their own compliance, with central oversight provided.		
	Management Actions to Address Issues/Risks		
	Agreed – CHST has been engaging with trade unions on the implementation of a document library and is working with colleagues in Digital & Technology and Data & Insights to ensure that the appropriate controls are in place..		
	Risk Agreed	**Person(s)**	**Due Date**
	Yes	Corporate Health and Safety Lead	Mar-23

4 Appendix 1 – Assurance Terms and Rating Scales

4.1 Overall report level and net risk rating definitions

The following levels and ratings will be used to assess the risk in this report:

Risk level	Definition
Corporate	This issue / risk level impacts the Council as a whole. Mitigating actions should be taken at the Senior Leadership level.
Function	This issue / risk level has implications at the functional level and the potential to impact across a range of services. They could be mitigated through the redeployment of resources or a change of policy within a given function.
Cluster	This issue / risk level impacts a particular Service or Cluster. Mitigating actions should be implemented by the responsible Chief Officer.
Programme and Project	This issue / risk level impacts the programme or project that has been reviewed. Mitigating actions should be taken at the level of the programme or project concerned.

Net Risk Rating	Description	Assurance Assessment
Minor	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.	Substantial
Moderate	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified, which may put at risk the achievement of objectives in the area audited.	Reasonable
Major	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	Limited
Severe	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	Minimal

Individual Issue / Risk Rating	Definitions
Minor	Although the element of internal control is satisfactory there is scope for improvement. Addressing this issue is considered desirable and should result in enhanced control or better value for money. Action should be taken within a 12 month period.
Moderate	An element of control is missing or only partial in nature. The existence of the weakness identified has an impact on the audited area's adequacy and effectiveness. Action should be taken within a six month period.
Major	The absence of, or failure to comply with, an appropriate internal control, which could result in, for example, a material financial loss. Action should be taken within three months.
Severe	This is an issue / risk that could significantly affect the achievement of one or many of the Council's objectives or could impact the effectiveness or efficiency of the Council's activities or processes. Action is considered imperative to ensure that the Council is not exposed to severe risks and should be taken immediately.

5 Appendix 2 – Assurance Scope and Terms of Reference

5.1 Area subject to review

The Council has a statutory duty to manage its workplace with due regard to the health and safety of the workforce and those affected by the Council's activities.

The Health & Safety at Work etc. Act 1974 is the primary legislation covering occupational health and safety. It sets out the general duties that employers have towards employees and members of the public, and which employees have to themselves and each other.

The Management of Health & Safety at Work Regulations 1999 make more explicit what employers are required to do to manage health and safety under the Health & Safety at Work etc. Act 1974. The main requirements on employers are to carry out risk assessments and record any significant findings, plan to implement necessary measures, appoint competent people to implement the arrangements, set up emergency procedures, arrange for clear information and training of employees and work together with other employers sharing the workplace.

The Health and Safety Executive (HSE) is responsible for enforcing health and safety legislation. They ensure the Council manages the health and safety of its workforce and those affected by their work.

5.2 Rationale for review

The objective of this audit is to provide assurance that appropriate processes are being employed in managing health and safety at a corporate level.

Compliance with health and safety legislation is a statutory requirement for the Council; failure to comply could lead to death, injury, and ill health of Council employees and those affected by the Council's work; reputational damage to the Council; and financial penalties. As such this is a high priority area subject to regular review by Internal Audit. The last Internal Audit review of the Council's corporate health and safety arrangements took place in 2018-19 as part of a Council wide audit of health and safety arrangements. This found that in general appropriate arrangements were in place however recommendations were made to update policies and procedures; formalise Function improvement plans; establish Function training needs analyses and monitor training completion; and to monitor risk assessment completion, particularly for activities resulting in near misses and incidents.

5.3 Scope and risk level of review

This review will offer the following judgements:

- An overall **net risk** rating at the Corporate level.
- Individual **net risk** ratings for findings.

5.3.1 Detailed scope areas

As a risk-based review this scope is not limited by the specific areas of activity listed below. Where related and other issues / risks are identified in the undertaking of this review these will be reported, as considered appropriate by IA, within the resulting report.

The specific areas to be covered by this review are:

- Health and Safety Policies, Procedures and Guidance
- Training
- Governance Arrangements and Internal Reporting
- Risk Management at Corporate Level
- Function Health and Safety Improvement Plans
- Health and Safety Team Procedures
- Accident and Incident Reporting and Follow Up
- Health and Safety Team Audits
- Risk Assessment Monitoring Arrangements

5.4 Methodology

This review will be undertaken through interviews with key staff involved in the process(es) under review and analysis and review of supporting data, documentation, and paperwork. To support our work, we will review relevant legislation, codes of practice, policies, procedures, guidance

Due to the ongoing impacts of COVID-19, this review will be undertaken remotely. We remain flexible in the face of the rapidly changing risk environment. Where our resourcing or access to the client is impacted further by COVID-19, we will adapt our audit methodology to balance the risks and assurance output and will work in co-operation with key contacts to understand the impact of the situation as it evolves.

5.5 IA outputs

The IA outputs from this review will be:

- A risk-based report with the results of the review, to be shared with the following:
    - Council Key Contacts (see 1.7 below)
    - Audit Committee (final only)
    - External Audit (final only)

5.6 IA staff

The IA staff assigned to this review are:

- Cassie Jamieson, Auditor **(audit lead)**
- Andrew Johnston, Audit Team Manager
- Jamie Dale, Chief Internal Auditor **(oversight only)**

5.7 Council key contacts

The key contacts for this review across the Council are:

- Gale Beattie, Director - Commissioning
- Fraser Bell, Chief Officer - Governance **(process owner)**
- Vikki Cuthbert, Assurance Manager
- Colin Leaver, Corporate Health and Safety Lead

5.8 Delivery plan and milestones

The key delivery plan and milestones are:

Milestone	Planned date
Scope issued	02/08/2022
Scope agreed	26/08/2022
Fieldwork commences	23/08/2022
Fieldwork completed	13/09/2022
Draft report issued	04/10/2022
Process owner response	25/10/2022

Milestone	Planned date
Director response	01/11/2022
Final report issued	08/11/2022

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