Public Document Pack

To: Councillor Malik, Convener; Councillor Houghton, Vice-Convener; and Councillors Allard, Bonsell, Bouse, Fairfull, Graham, Henrickson, McLellan, McRae, Massey, Radley and Mrs Stewart.

Town House,
ABERDEEN, 2 February 2024

AUDIT, RISK AND SCRUTINY COMMITTEE

The Members of the **AUDIT, RISK AND SCRUTINY COMMITTEE** are requested to meet in **Committee Room 2 - Town House on MONDAY, 12 FEBRUARY 2024 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 (LEGAL)

B U S I N E S S

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

3.1. Members are requested to intimate any declarations of interest

DEPUTATIONS

4.1. There are no requests at this time

MINUTE OF PREVIOUS MEETING

5.1. Minute of Previous Meeting of 23 November 2023 (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 no referrals at this time

COMMITTEE BUSINESS

Risk Management

9.1. Business Continuity Annual Report - COM/24/007 (Pages 19 - 26)

9.2. Corporate Risk Register, Cluster Assurance Maps, and Inspections Planner - COM/24/008 (Pages 27 - 78)

9.3. Risk Appetite Statement - Annual Review - COM/24/009 (Pages 79 - 90)

Governance, Accounts and Finance

9.4. Public Sector Equality Duty - COM/24/005 (Pages 91 - 98)

9.5. Assurance Reporting - COM/24/006 (Pages 99 - 104)

Legal Obligations

9.6. Use of Investigatory Powers - Annual Report 2023 - COM/24/010 (Pages 105 - 126)

Internal Audit

9.7. Internal Audit Charter - IA/24/003 (Pages 127 - 134)

9.8. Internal Audit Progress Report - IA/24/001 (Pages 135 - 160)

9.9. IJB Complaints Handling - AC2402 (Pages 161 - 178)

9.10. Attendance Management - AC2411 (Pages 179 - 196)

9.11. COVID-19 Spending - AC2409 (Pages 197 - 210)

9.12. Vehicle and Driver Compliance - AC2401 (Pages 211 - 232)

9.13. Internal Audit Plan 2024-2027 - IA/24/002 (Pages 233 - 254)

EXEMPT/CONFIDENTIAL BUSINESS

10.1. There are none at this time

Integrated Impact Assessments 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 053945 or email kfinch@aberdeencity.gov.uk

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AUDIT, RISK AND SCRUTINY COMMITTEE

ABERDEEN, 23 November 2023. Minute of Meeting of the AUDIT, RISK AND SCRUTINY COMMITTEE. Present:- Councillor Malik, Convener; Councillor Houghton, Vice-Convener; and Councillors Allard, Bonsell, Bouse, Delaney (as substitute for Councillor Bouse), Fairfull, Henrickson, Lawrence (as substitute for Councillor Graham), McLellan, McRae, Massey, Radley and Mrs Stewart.

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.

DECLARATIONS OF INTEREST OR TRANSPARENCY STATEMENTS

1. Members were requested to intimate any declarations of interest or transparency statements in respect of the items on today's agenda, thereafter the following was intimated:-

Councillor Bonsell advised that she had a connection in relation to agenda items 9.5 (Annual Effectiveness Report); 9.6 (External Quality Assessment) and 9.7 (Internal Audit Update Report) due to her being a member of CIPFA Scotland, the Chartered Institute of Public Finance and Accountancy, having applied the objective test, she did not consider that she had an interest and would not be withdrawing from the meeting for the items.

MINUTE OF PREVIOUS MEETING OF 14 SEPTEMBER 2023

2. The Committee had before it the minute of their previous meeting of 14 September 2023.

The Committee resolved:-

(i) in relation to article 8, resolution (i), to note the update provided by officers and that for future meetings, progress with the implementation of the agreed audit recommendations would be included in the Internal Audit Progress Report; and

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

COMMITTEE BUSINESS PLANNER

3. The Committee had before it the Committee Business Planner as prepared by the Interim Chief Officer – Governance (Assurance).

The Committee resolved:-

to note the content of the Committee Business Planner.

AUDIT, RISK AND SCRUTINY COMMITTEE
23 November 2023

ALEO ASSURANCE HUB UPDATE - COM/23/356

4. The Committee had before it a report by the Director of Commissioning which provided 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.

The report recommended:-
That the Committee -
(a) notes the level of assurance provided by each ALEO on governance arrangements, risk management and financial management respectively and the risk ratings applied by the ALEO Assurance Hub, as detailed in appendices B-H; and
(b) notes that the ALEO Assurance Hub would discuss any outstanding issues specified in the appendices with ALEO representatives, with a view to maintaining low/very low risk ratings and improving any medium risk ratings to low/very low.

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

USE OF INVESTIGATORY POWERS - QUARTER 4 REPORT - COM/23/355

5. With reference to article 6 of the minute of its previous meeting, the Committee had before it a report by the Director of Commissioning which was provided 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
(a) note the covert surveillance activity and the Investigatory Powers Commissioner's letter of 5th September attached to this report; and
(b) note the update on Communications Data.

In response to a question regarding the cancelled surveillance, Mr Forsyth advised that when the surveillance operation had concluded, it was good practice to cancel the request in line with the policy and procedure.

In response to a question regarding training for officers, Mr Forsyth advised that during the quarter there had not been any training provided and that when legislation was changed, the training would be amended and sessions delivered to officers.

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

AUDIT, RISK AND SCRUTINY COMMITTEE
23 November 2023

SCOTTISH PUBLIC SERVICES OMBUDSMAN DECISIONS AND INSPECTOR OF CREMATIONS COMPLAINT DECISIONS - CUS/23/357

6. With reference to article 8 of the minute of it's meeting of 27 June 2023, 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 to Committee that complaints and Scottish Welfare Fund applications were 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.

ANNUAL ACCOUNTS 2023-24 KEY DATES - RES/23/375

7. The Committee had before it a report by the Director of Resources which provided high level information and key dates in relation to the 2023/24 Annual Accounts including linkages to the plans and timetables to the Council's External Auditors.

The report recommended:-
(a) that the Committee notes the information in relation to the 2023/24 annual accounts process contained within the report; and
(b) that a special meeting of this committee is held in May 2023 to align with the reporting of the unaudited Annual Accounts.

The Committee resolved:-
(i) to note that the Convener would liaise with the Chief Officer – Finance and the Governance team regarding changing the meeting date for the Committee to accommodate the unaudited accounts 2023-24; and
(ii) to otherwise approve recommendation (a) within the report.

ANNUAL EFFECTIVENESS REPORT - COM/23/358

8. The Committee had before it a report by the Director of Commissioning which presented the annual report of the Audit, Risk and Scrutiny Committee to enable Members to provide comment on the data contained within.

The report recommended:-
that the Committee –
(a) provide comments and observations on the data contained within the annual report; and
(b) note the annual report of the Audit, Risk and Scrutiny Committee.

The Committee resolved:-
(i) to note the annual report of the Audit, Risk and Scrutiny Committee; and
(ii) to note that the management assurance report mentioned in the Convener's introduction had been missed from the planner in error and would be included.

EXTERNAL QUALITY ASSESSMENT - IA/23/010

9. The Committee had before it a report by the Chief Internal Auditor which presented the Committee with the results of the External Quality Assessment (EQA) of Internal Audit.

The report recommended:-
that the Committee consider and comment on the EQA, and note that the Internal Audit Service fully conforms with the Public Sector Internal Audit Standards (PSIAS).

In response to a question regarding the recommendations for updating the Internal Audit Charter and whether these would be achieved by the completion date, the Chief Internal Auditor advised that the Internal Audit Charter was reported annually and that the recommendations would be included in the report to Committee in February 2024.

In response to a question regarding the recommendation to review the Counter Fraud Policy, the Chief Officer – Finance advised that the changes would be included in the updated Counter Fraud Policy.

The Committee resolved:-
to approve the recommendation within the report.

INTERNAL AUDIT PROGRESS REPORT - IA/23/009

10. With reference to article 9 of the minute of it's previous meeting, 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 the Committee to be aware of.

The report recommended:-
That the Committee:
(a) note the progress of the Internal Audit Plan; and

(b) note the progress that management had made with implementing recommendations agreed in Internal Audit reports.

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

CORPORATE ASSET MANAGEMENT - AC2313

11. The Committee had before it a report by the Chief Internal Auditor which presented an audit on Corporate Asset Management which was undertaken to ensure resources were allocated appropriately and efficiently following a suitable Asset Management Plan.

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

In response to a question regarding improved governance and policy documents and the process to enable members to scrutinise them, the Chief Internal Auditor advised that where policies are reviewed, these should be reported via the Committee process to provide assurance to members that the policies were in place.

In response to a question regarding the recommendations made compared with the management agreed actions and whether Internal Audit were satisfied wit the response provided, the Chief Internal Auditor advised that Internal Audit make recommendations which management consider and make risk based decisions. Where management agree with recommendations, actions are agreed and these are what Internal Audit would follow up on and include in the Internal Audit Update report. Management have agreed to document the process for Asset Transformation Programme with updates being provided in April and August in 2024.

In response to a question regarding whether an application could be made to the Transformation Fund to assist with Asset Management, the Chief Officer – Finance advised that the fund is used for change programmes and if a business case was presented that met the criteria then funds could be released via delegated authority.

In response to a question regarding whether complete records would be kept for the Capital Board moving forward, the Director of Resources advised that the agendas and minutes were available and that he would ensure these were submitted to the Chief Internal Auditor for review.

The Committee resolved:-
(i) to note the information provided on the Transformation Programme Fund;
(ii) to note that the agendas and minutes from the Capital Board would be submitted to the Chief Internal Auditor;

(ii) to otherwise endorse the agreed recommendations for improvement as contained in the internal audit report.

PUPIL EQUITY FUND - AC2403

12. The Committee had before it a report by the Chief Internal Auditor which presented an audit on Pupil Equity Fund which was undertaken to provide assurance that schools were spending in accordance with their plans and that they were developed as required to close the poverty related attainment gap.

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

The Committee resolved:-
to endorse the agreed recommendations for improvement as contained in the internal audit report.

CARE MANAGEMENT SYSTEM - AC2405

13. The Committee had before it a report by the Chief Internal Auditor which presented an audit on the Care Management System which was undertaken to consider whether appropriate control was being exercised over the care management system, including contingency planning, disaster input and its data input that interfaced to and from other systems were accurate and properly controlled.

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

The Committee resolved:-
to endorse the agreed recommendations for improvement as contained in the internal audit report.

DATA PROTECTION - AC2406

14. The Committee had before it a report by the Chief Internal Auditor which presented an audit on Data Protection which was undertaken to ensure the Council had adequate arrangements in place, which were understood throughout the organisation, to protect the Council's information.

AUDIT, RISK AND SCRUTINY COMMITTEE
23 November 2023

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

The Committee resolved:-
to endorse the agreed recommendations for improvement as contained in the internal audit report.

- **COUNCILLOR M. TAUQEER MALIK, Convener**

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	A	B	C	D	E	F	G	H	I
1	**AUDIT, RISK AND 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	**12 February 2024**								
4	Use of Investigatory Powers Annual Report - COM/24/010	to present the quarterly use of investigatory powers report	Item 9.6 on the agenda	Jessica 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.	This is a standing item on the agenda.	Lucy McKenzie	Customer Experience	Customer	6.4	R	There have been no decisions to report since the last report to Committee.
6	Internal Audit Update Report - IA/24/001	To provide an update on progress of the Internal Audit Plan, Audit Recommendations Follow Up and other relevant information for the Committee.	Item 9.8 on the agenda	Jamie Dale	Governance	Commissioning	2.2		
7	Internal Audit Plan 2024-2027 - IA/24/002	to present the Internal Audit Plan for 2024-2027	Item 9.13 on the agenda	Jamie Dale	Governance	Commissioning	2.1		
8	Internal Audit Charter - IA/24/003	to present the Internal Audit Charter for 2024-25	Item 9.7 on the agenda	Jamie Dale	Governance	Commissioning	2.1		
9	IJB Complaints Handling - AC2402	The objective of this audit is to ensure that the complaints procedures are being complied with for all matters and that data generated is used by Management to monitor and improve performance.	item 9.9 on the agenda	Jamie Dale	Governance	Commissioning	2.2		
10	Attendance Management - AC2411	The objective of this audit is to obtain assurance that controls in this area are designed and operating effectively and to determine whether the Council's Absence Improvement Plan is having a positive impact on attendance.	item 9.10 on the agenda	Jamie Dale	Governance	Commissioning	2.2		
11	COVID-19 Spending - AC2409	The objective of this audit is to obtain assurance over the key spending decisions and financial payments in relation to COVID-19.	item 9.11 on the agenda	Jamie Dale	Governance	Commissioning	2.2		

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12	Vehicle and Driver Compliance - AC2401	The objective of this audit is to obtain assurance that adequate procedures are in place to effectively manage the Council's vehicle and driver records, to comply with licence and insurance requirements.	item 9.12 on the agenda	Jamie Dale	Governance	Commissioning	2.2		
13	External Audit Annual Report	To present the External Audit Annual Report		Anne MacDonald	Governance	Commissioning	3.1	D	This report has been delayed to other work pressures and will be submitted to Committee in April 2024.
14	Best Value Thematic Report			Anne MacDonald	Governance	Commissioning	3.1	D	This report has been delayed to other work pressures and will be submitted to Committee in April 2024.
15	ALEO Assurance Hub Workplan and Terms of Reference	To present the ALEO Assurance Hub Workplan for 2023 including the dates for reporting.		Vikki Cuthbert	Governance	Commissioning	1.3	D	This report has been delayed to other work pressures and will be submitted to Committee in April 2024.
16	Business Continuity Annual Report - COM/24/007	To present the annual review of the Council's Business Continuity arrangements.	Item 9.1 on the agenda	Ronnie McKean	Governance	Commissioning	1.2		
17	Corporate Risk Register, Assurance Maps and Inspections Planner - COM/24/008	To present the Corporate Risk Register and Assurance Maps.	Item 9.2 on the agenda	Ronnie McKean	Governance	Commissioning	1.1		
18	Public Sector Equality Duty - COM/24/005	To provide management assurance on the Council's compliance with its statutory duties under the Equality Act 2010, specifically in relation to our Public Sector Equality Duty	Item 9.4 on the agenda	Vikki Cuthbert	Governance	Commissioning	4.4		
19	Assurance Reporting - COM/24/006	To advise the committee on the non-management assurance reporting scheduled to be reported to the Committee in 2024 and to outline proposals for managing the resulting impact on officer resources	Item 9.5 on the agenda	Vikki Cuthbert	Governance	Commissioning	4.4		
20	Risk Appetite Statement - Annual Review - COM/24/009	The purpose of this report is to present the Council's updated Risk Appetite Statement.	Item 9.3 on the agenda	Ronnie McKean	Governance	Commissioning	1.1		

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21	Cyber Crime	Referred from Communities, Housing and Public Protection Committee - To agree that Cybercrime continues to rise in scale and complexity in Scotland and globally, noting the cyber-attack at Western Isles Council therefore instruct the Chief Officer –Digital and Technology to bring forward a report to the February 2024 Audit, Risk and Scrutiny Committee meeting on how the Council is currently combating Cybercrime		Steve Roud	Digital and Technology	Customer	5.2	D	This item was inadvertently omitted from the business planner, and was reinstated immediately before the agenda was due to be published, therefore this report is now deferred to the April 2024 meeting of the Committee
22	**25 April 2024**								
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	Unaudited Annual Accounts 2023-24	To present the unaudited annual accounts for 23-24 and the Charities Accounts for 23-24	Date to be confirmed	Lesley Fullerton	Finance	Resources	4.1		
28	**27 June 2024**								
29	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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30	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		
31	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		
32	Internal Audit Reports	Reports which have been finalised will be presented to the Committee.		Jamie Dale	Governance	Commissioning	2.2		
33	Internal Audit Annual Report 2023-24	To present the Internal Audit Annual Report for 2023-2024		Jamie Dale	Governance	Commissioning	2.1		
34	Audited Annual Accounts 2023-24	To present the audited Accounts for 2023-24 and the Charities Accounts 23-24	Date to be confirmed						
35	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		
36	**26 September 2024**								
37	Use of Investigatory Powers Quarter 3 Report	to present the quarterly use of investigatory powers report		Jessica Anderson	Governance	Commissioning	5.2		
38	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		

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39	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		
40	Internal Audit Reports	Reports which have been finalised will be presented to the Committee.		Jamie Dale	Governance	Commissioning	2.2		
41	Informarmation Governance Management Annual Report 2023-24	to present the annual report for the Council's Information Governance		Martin Murchie	Data Insights	Customer Services	1.4		
42	**28 November 2024**								
43	Use of Investigatory Powers Quarter 4 Report	to present the quarterly use of investigatory powers report		Jessica Anderson	Governance	Commissioning	5.2		
44	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		
45	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		
46	Internal Audit Reports	Reports which have been finalised will be presented to the Committee.		Jamie Dale	Governance	Commissioning	2.2		
47	Annual Committee Effectiveness Report	To report on the annual effectiveness of the committee		Karen Finch	Governance	Commissioning	GD 8.5		
48	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		
49	Annual Accounts 2024-25 - Key Dates	to provide Elected Members with high level information and key dates in relation to the 2024/25 Annual Accounts including linkages to the plans and timetables of the Council's External Auditors		Lesley Fullerton	Finance	Resources	4.1		

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50	**Service Updates**								

ABERDEEN CITY COUNCIL

COMMITTEE	Audit Risk and Scrutiny Committee
DATE	12 February 2024
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Business Continuity – Annual Report
REPORT NUMBER	COM/24/007
DIRECTOR	Gale Beattie
CHIEF OFFICER	Jenni Lawson/Vikki Cuthbert
REPORT AUTHOR	Ronnie McKean
TERMS OF REFERENCE	1.2

1. PURPOSE OF REPORT

1.1 To provide the annual assurance report on the Council's Business Continuity arrangements that are required to comply with the requirements of a Category 1 responder under the Civil Contingencies Act 2004.

2. RECOMMENDATION(S)

That the Committee notes the activities undertaken in 2023 and planned in 2024 to review, exercise and improve the Council's Business Continuity arrangements.

3. CURRENT SITUATION

Legislative context

3.1 The Council is required to have Business Continuity arrangements in place as a Category 1 responder, as defined by the Civil Contingencies Act 2004, specifically:

- To maintain Business Continuity Plans (BCPs)
- To promote business continuity by providing advice and assistance to businesses and voluntary organisations

3.2 The Council's Business Continuity arrangements aim to increase the Council's resilience and minimise as far as is practicable the possible risk of disruption to Council services, particularly critical services. Given the number and range of critical services which the Council delivers, the continuing threat to these must be carefully mitigated.

Disruptive events that may trigger activation of Business Continuity arrangements include:

- Loss of staff e.g., through illness, industrial action
- Loss of access to premises e.g., through power outage, flooding

- Loss if key I.T. systems/infrastructure e.g., through cyber-attacks or firewall failures
- Loss of key supplier/s e.g., through market disruption and wider economic forces.

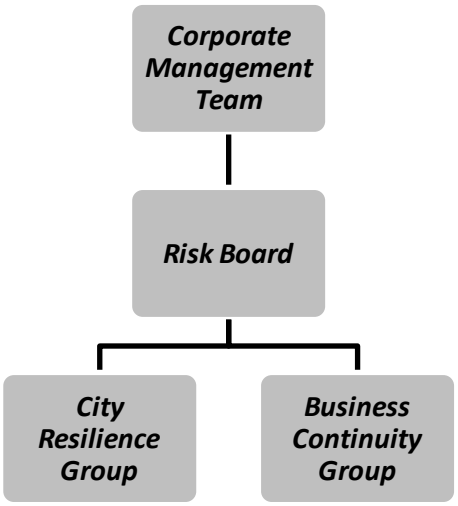
Internal Governance

3.3 The Council's Risk Management and Business Continuity arrangements are complementary, working together to identify and manage the risk of disruption. Business Continuity Plans (BCP) are control documents that are designed to respond to, and mitigate risks identified by officers within risk registers that could affect the delivery of Council services. Our plans provide a framework that supports officers to anticipate, prepare for, prevent, respond to, and recover from disruptive events within agreed timescales.

3.4 Plans and the accompanying guidance are designed to support officers to assess the impact of disruptive events in order to develop robust activation and recovery plans that account for:

- Identification of critical services/processes
- Minimum levels of service and maximum period of disruption
- Minimum resources (staff, technology)
- Key roles and responsibilities required to deliver the plan
- Actions and activities required for plan activation and recovery

3.5 The Risk Board retains oversight of the Council's preparedness and response to incidents and emergencies which are undertaken by the City Resilience Group (reported to the Communities, Housing and Public Protection Committee) and the Business Continuity Group (BCG) reported to Audit, Risk and Scrutiny Committee.



3.6 The Council's BCG is chaired by the Corporate Risk Lead (CRL) and helps to provide assurance to the Risk Board that:

- Critical services and functions have plans in place;
- Plans are maintained and reviewed;

- Plans are tested in accordance with the testing/exercise schedule; and
- Good practice and improvement activities can be shared and communicated with other plan holders across the organisation.

Summary of Activity in 2023

3.7 Quality Assurance Exercise

A Quality Assurance exercise was conducted on all of the Council's BCP's in January/February 2023. The purpose of the exercise was to review and assess the content and state of readiness for each plan to ensure that plans remain robust and fit for purpose.

The exercise identified areas for improvement to existing plans including updates required to the existing plan template which is used by officers to create their plans.

The areas for improvement included; the addition of arrangements and activities resulting from industrial action, power outage, verification and assurance of BCP arrangements in place with key suppliers and the actions required within plans to escalate plan activation and recovery activities.

3.8 BCP Template Review and Redesign

The existing BCP template has been completely redesigned and, in addition to the improvements identified from the Quality Assurance Exercise, the new template incorporates:

- Guidance to officers when creating plans including suggested mitigations and points for consideration.
- Additional sections for disruptive events including counter terror threats and extreme weather events.
- Plan activation trigger points and associated actions.
- Impacts and consequences of disruption to critical services over specified durations.

It is expected that new template will be issued to the BCG and Officers during the first Quarter of 2024.

3.9 Planned and Unplanned Power Outages

The Council's Winter Preparedness activities for 2023 included planning for the low risk of Rota Load Disconnection (RLD) and Demand Control OC-6. These are planned power outages for a 3-hour period in predefined geographical areas across the UK that are aligned with postcodes.

The BCG and officers updated existing BCP's to incorporate the actions and activities required in order to respond to planned and unplanned power outages with particular focus being placed on the Council's Critical Services.

3.10 School Business Continuity Arrangements

The Education Service continued to conduct an annual review of plans and arrangements in each school setting ahead of Term 1. These reviews provide Head Teachers and support staff with an opportunity to improve and update existing plans and for new staff to familiarise themselves with the locations of the plans and individual roles and responsibilities required for plan activation.

Updates and improvements to plans include shared best practice identified, updates to security arrangements, structural changes to account for new pupil intake accessibility requirements, updates to school contact information including staff and key suppliers. The updates provide Head Teachers and support staff with the assurance that plans are accurate, up to date and reflect completed risk assessments.

3.11 Critical Service List Annual Review

The Council's Critical Service list details the Council's services that have been assessed by officers as being the most important to continue to be delivered as far as is practicable.

The list was reviewed and updated by Chief Officers in December 2023 to ensure that it remains relevant and up to date.

Each service added to the list is allocated with one of the following categories:

Red	Critical to the Local Resilience Partnership Response	These are services that perform activities and functions that are essential to support the Council's response as a Category 1 responder.
Yellow	Critical to protect vulnerable people	These are services that perform activities and provide services that are essential for the safety and wellbeing of vulnerable people.
Green	Critical Digital Technology	These are services that digital systems and technology to support Red, Yellow and Grey Critical Services.
Grey	Organisationally Critical	These are services upon which the red, yellow and green categories depend, as well as services which ensure the Council meets statutory obligations which still need to be met during the emergency or business continuity event(s)"

3.12 Business Continuity Policy Review

The Council's Business Continuity Policy which was approved by Committee in December 2020 was fully reviewed in order to ensure that it remained relevant and up to date. No substantive changes that would require Committee approval were made. The updated policy document will be published on the Risk Safety and Resilience intranet pages.

3.13 Business Continuity Intranet Pages

Intranet pages were developed and published during the year. These pages are accessible to staff and elected members and hosts the Council's Business

Continuity related information including; policy, guidance, templates, and the Critical Service List. These pages are also linked to the Council's Risk Management Framework and Emergency Planning and Resilience pages.

3.14 Review of Plans Activated

Regional Communications Centre (RCC)

The RCC activated Business Continuity Plans during the course of 2023 in order to respond to a number of events including; I.T. system outage, BT system/network outage, fire alarm activations, technical fault (loss of sound) and weather warnings.

The service recognised that existing plans could be improved to reflect the decisions and activities undertaken during the activation period, these updates included; updates to Incident Management Team information, creation of communication templates for the Council's website and improvements to out of hours messaging.

Storm Babet

The Incident Management Team (IMT) established for Storm Babet monitored potential plan activations via the service updates provided at each IMT meeting conducted and concluded that it was not necessary to activate any of the Council's BCP's during this event.

Industrial Action

The City's school settings and Facilities Management services were affected by Industrial Action during 2023 however, this did not result in any plan activations.

Planned Activity in 2024

3.15 Development and improvement activities will continue in 2024 and will focus on the continued development of the Business Continuity Framework and plan improvement through activation debriefs/lessons learned and exercising and will include:

3.16 Plan Updates – New Template

The new plan template will be issued in the first Quarter of 2024, the BCG will be used to support Chief Officers and plan owners to transfer and update existing plans from the current template to the new template with a target to complete by end June 2024.

3.17 Exercising of Plans

A Testing/Exercise plan for 2024 will be provided to the Risk Board for review and approval to enable Table-top exercises to commence upon the completion of plan updates.

The Council's Critical Service list will be used to establish the criteria and priority for plan exercising and to inform exercise and suitable combinations of plans for exercising.

3.18 Internal Audit Recommendations

Oversight and monitoring of internal audit recommendations in 2023 that related specifically to Business Continuity arrangements included the recommendation that BCP's should be updated to reflect any lessons learned from COVID-19.

The "loss of staff (Pandemic)" section of the new plan template will be used by BCG and officers to capture the information within each plan in order to close the recommendation as required.

3.19 Business Continuity Intranet Pages

The CRL will continue to maintain and develop the Business Continuity intranet pages including updates to templates and guidance, testing plans and Critical Services.

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.

5.2 The Council's existing Business Continuity framework and arrangements support compliance with legislation including the Civil Contingencies Act 2004.

6. ENVIRONMENTAL IMPLICATIONS

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

7. RISK

7.1 The Council's Business Continuity plans and supporting activities contribute to the Council's overall system of risk management.

7.2 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	*Does Target Risk Level Match

			controls/control actions	Appetite Set?
Strategic Risk	None			
Compliance	Non-compliance with legislation.	Effective Business Continuity plans and arrangements in place will support compliance with legislation as required.	L	Yes
Operational	Disruptive events may affect service delivery	Effective Business Continuity plans are designed to mitigate disruption to service delivery as far as is practicable.	L	Yes
Financial	None			
Reputational	Negative publicity in media/social media platforms to Council's response to a disruptive event.	Effective Business Continuity plans and arrangements are designed to support minimum levels of service as far as is practical including communication and information sharing with citizens.	L	Yes
Environment / Climate	Severe weather events may affect delivery of Council services.	Effective Business Continuity plans are designed to respond to and minimise disruption resulting from weather related events as far as is practicable.	L	Yes

8. OUTCOMES

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

9. IMPACT ASSESSMENTS

Assessment	Outcome
Integrated Impact Assessment	It is confirmed by the Interim Chief Officer – Governance (Assurance) that no Integrated Impact Assessment is required.
Data Protection Impact Assessment	Not required.
Other	Not applicable.

10. BACKGROUND PAPERS

10.1 None.

11. APPENDICES

11.1 Not applicable.

12. REPORT AUTHOR CONTACT DETAILS

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ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	12 February 2024
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Corporate Risk Register, Cluster Assurance Maps, and Inspections Planner
REPORT NUMBER	COM/24/008
DIRECTOR	Gale Beattie
CHIEF OFFICER	Jenni Lawson/Vikki Cuthbert
REPORT AUTHOR	Ronnie McKean
TERMS OF REFERENCE	Remit 1.1

1. PURPOSE OF REPORT

1.1 To present the Corporate Risk Register, Cluster Assurance Maps and Inspections Planner and to provide assurance on the Council's overall system of risk management.

2. RECOMMENDATION(S)

That the Committee:-

2.1 note the Corporate Risk Register set out in Appendix A and the summary of movements in risk scores set out in table at section 3.6;

2.2 note the Cluster Assurance Maps provided at Appendix B; and

2.3 note the Inspections Planner provided at Appendix C, note that this is unlikely to include all external scrutiny requirements for 2024 for the reasons explained in item 9.5 and note that this limits the Council's visibility on the balance of management, internal and external assurance required to manage our risk environment.

3. CURRENT SITUATION

3.1 The Audit, Risk and Scrutiny Committee is responsible for overseeing the system of risk management on behalf of the Council and for receiving assurance that the Extended Corporate Management Team (ECMT) are effectively identifying and managing risks. Reviewing the strength and effectiveness of the Council's system of risk management as a whole is a key role for the Committee. It is the role of the Council's service Committees to scrutinise the Cluster Risk Registers that are relative to each Committee remit to receive assurance of the controls in place and the Committee's role to scrutinise the corporate risk register.

3.2 The Council's Corporate Risk Register (CRR) provides a high level overview of the Council's operational risk environment and captures the risks which, at this time, pose the most significant threat to the achievement of our organisational outcomes and which have the potential to cause failure of service delivery. Risks which will face us in the next 12 months are identified through broader horizon scanning, using resources such as the government publications, the National Risk Register, inspection and audit reports (of our own authority as well as others') and the corporate risk registers of our peers in local government. The impact of financial uncertainty, geo-political events and risks being managed by UK and Scottish governments, all help to inform this risk profile for the council. At local authority level, the corporate level risks are very similar when compared amongst councils

3.3 The CRR is scrutinised by the officer Risk Board after being updated by risk managers and owners. The CRR was last reported to the Committee in March 2023. An updated version is attached to the report at Appendix A.

3.4 The CRR provides the organisation with the detailed information and assessment for each risk identified including:

- **Current risk score** – this is current assessment of the risk by the risk owner and reflects the progress percentage of control actions required in order to achieve the target risk score.
- **Target risk score** – this is the assessment of the risk by the risk owner after the application of the control actions.
- **Control Actions** – these are the activities and items that will mitigate the effect of the risk event on the organisation.
- **Risk score** – each risk is assessed using a 4x6 risk matrix as detailed below.

The 4 scale represents the impact of the risk and the 6 scale represents the likelihood of the risk event.

Impact	**Score**						
Very Serious	**4**	**4**	**8**	**12**	**16**	**20**	**24**
Serious	**3**	**3**	**6**	**9**	**12**	**15**	**18**
Material	**2**	**2**	**4**	**6**	**8**	**10**	**12**
Negligible	**1**	**1**	**2**	**3**	**4**	**5**	**6**
Score		**1**	**2**	**3**	**4**	**5**	**6**
Likelihood		**Almost Impossible**	**Very Low**	**Low**	**Significant**	**High**	**Very High**

3.5 The risks contained within the Corporate Risk Register are grouped below by risk category and show the Council's corresponding risk appetite for the category as set within the Council's Risk Appetite Statement (RAS) which are

accurate at time of writing. A separate report contains proposals to amend the existing RAS. Clusters are working towards a target risk score which aligns with the risk appetite.

Risk Category	Risk Title	Target Risk Appetite	Aligned with RAS?
Strategic	Workforce Capacity and Organisational Resilience	Averse	Yes
Compliance	Civil Contingencies Compliance	Averse	Yes
	Health & Safety Compliance	Averse	Yes
Operational	Reinforced Autoclaved Aerated Concrete Panels and Planks (RAAC)	Cautious	Yes
	Cyber Security	Cautious	Yes
	Excessive resettlement and asylum demand and risk of harm	Averse	Yes
Financial	Supply Chain - Commodity Risks	Averse	Yes
	Financial Sustainability	Averse	Yes
Environment/Climate	Climate Change (Place)	Cautious	Yes

3.6 Committee is asked to note that the risks contained in the CRR are those which ECMT and the Risk Board consider the most significant at the time of writing. These must be read alongside the Assurance Maps for each risk, where the completed control actions for these risks are documented – in each case, there are controls already in place, and those yet to be completed.

3.7 Risks are also monitored and managed through Cluster Risk Registers and may be escalated to the CRR if deemed necessary. When the Risk Board receives the required assurance that significant risks are being managed, they will agree to de-escalate them back to Cluster level. This will generally be the case when the target risk score is achieved, and the residual risk is aligned with the Risk Appetite Statement.

3.8 Below is a comparison with the corporate risks reported to Committee in March 2023:

<u>De-escalated to Cluster level</u>:

1. Industrial Action – Pay Negotiations - The risk has now been closed as the Pay Award for 2023/24 has been implemented.

Escalated to Corporate level:

1. Reinforced Autoclaved Aerated Concrete Panels and Planks (RAAC) - to reflect the risk that (RAAC) presents to the Council and to allow higher level monitoring and reporting of the mitigation activities and response workplans developed by the Officer Working Group set up by the Risk Board.

Remaining on Corporate Risk Register:

	Current Risk Score 2023	Current Risk Score 2024	Movement
Financial Sustainability	9	16	
Workforce Resilience	12	12	
Cyber Security	12	12	
Resettlement and Asylum	9	12	
Supply Chain (Commodities)	12	12	
Climate Change (Place)	12	12	
Civil Contingencies	9	9	
Health and Safety Compliance	12	9	

Risk Overview

3.9 The movement in these risks is explained in some further detail below by risk owners:

Financial Sustainability

3.9.1 The Scottish Government published its latest Medium Term Financial Strategy in May 2023. This indicates that while the Scottish Resource Budget is increasing up to 2027-28, in both cash and real terms, it is not expected to rise at the same rate as the spending bill, creating a growing funding gap over time.

The Local Government position of priority in the Scottish Budget is exemplified by the 2024/25 Financial Settlement, outlined on 21 December 2023. COSLA, in their budget reality calculations, show that there is a cash reduction in the overall revenue and capital settlements. This cash reduction takes no account of inflation, including wage inflation and demand pressures that Councils are actually experiencing.

Financial settlements that cover a single year and cash reductions only make the financial environment for Councils more challenging, and reinforce the constant need for financial savings to be made to balance the books.

Workforce Resilience

3.9.2 There has been progress on control actions related to the workforce risk over the last 12 months - including delivery of the Workforce Delivery Plan in January 2023, and review and revision of Service Standards being proposed to elected members as part of the budget process - and some of these have moved over to the assurance map as strong controls. However, uncertainty about how budget decisions may impact on workforce resilience, the potential impact of known and unknown external factors which may impact on our workforce at any time, and the expected impact of the other corporate risks we are managing on workforce (eg RAAC), it is anticipated that workforce and organisational resilience will remain a corporate risk for the foreseeable future. For this reason, the risk score has been determined to remain at the same level as last year.

Cyber Security

3.9.3 The UK is experiencing a period of heightened cyber security threat due to the current global geopolitical situation. This is reflected in the risk remaining at a corporate level and maintaining its risk score, despite Digital and Technology's significant ongoing work towards completing the identified control actions.

Resettlement and Asylum Demand

3.9.4 The risk in this area has remained high due to the on-going pressures of both increased and continuous levels of inward migration and it is anticipated that will continue to create demand for housing support and homelessness services. The mitigating control actions on-going and completed are viewed as being sufficiently robust to mitigate against the risk and it is anticipated that these in addition to regular monitoring of the risk will facilitate an overall reduction in the risk score.

Supply Chain

3.9.5 Progress has been made in relation to implementation of control actions which has supported the mitigation of a proportion of cost pressures to the Council. The target date, risk score and percentage complete is reflective of progress, market developments, inflation and indices affecting supply chain in 2023, however we would expect to see the risk level reduce into the next financial year as inflation is coming under control and interest rates are stabilising. Market developments, inflation and indices will continue to be monitored and the risk updated as appropriate based on the monitoring and resultant level of risk. Through regular monitoring and review of the risk and control actions we would hope to reduce/mitigate the risk and as appropriate amend or add further controls.

Climate Change (Place)

3.9.6 A number of key controls covering climate related strategy, governance, monitoring and reporting are in place to mitigate this risk. Regular review, monitoring and updates to the risk and remaining control actions takes place and there has been continued progress. The risk scoring has been maintained

and reflects related external factors including changes to legislation and climate projections.

Civil Contingencies

3.9.7 There has been significant progress in a number of our key business areas over the past 12 months, most notably in growing the number of community resilience groups and strengthening our response to weather-related emergencies. Community-led resilience plans are in place for areas most vulnerable to flooding. Officers annually provide information, advice and guidance on overall resilience planning, such as winter preparedness and power outages to individuals, communities and businesses. We continue to progress our National Power Outage Plan and Persons at Risk Database to the next stages. These are complex corporate projects for the city which also cross over into regional plans. The risk score reflects the assessments of likelihood of civil contingency events from various sources of surveillance data shared with the Local Resilience Partnership (of which the Council is a member), combined with the strong progress which officers have made on managing the impact of such events.

Health and Safety Compliance

3.9.8 There has been positive movement in our risk score over the past 12 months, with remaining control actions relating to the automation of reporting and compliance monitoring. The risk rating has reduced because the systems in place, whilst manual, do not increase the likelihood or impact of a non-compliance event, they simply lengthen the process for officers to analyse and report on reduced or non-compliance. Training, internal communications, procedures, governance and the overarching Corporate Health and Safety Policy are the key controls and are complete (whilst remaining under review through continuous improvement) and act as our main line of defence.

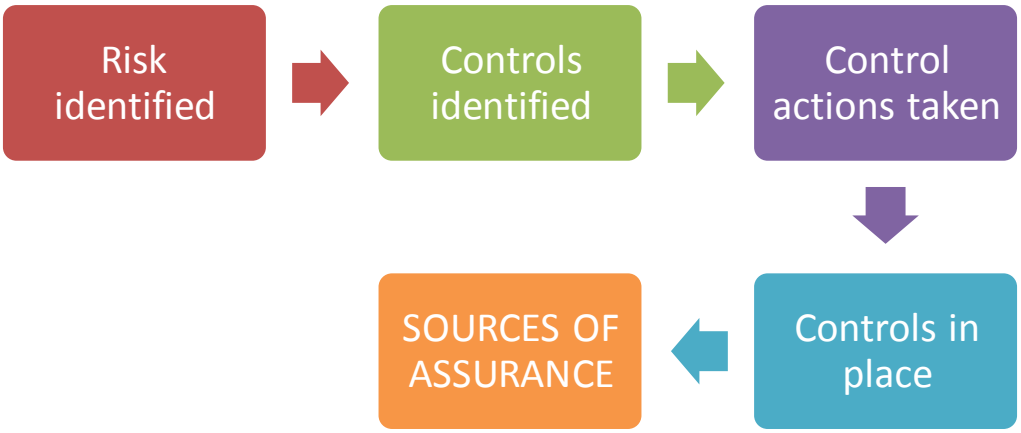
3.10 Development and improvement of the CRR and the associated processes has continued since the CRR was last reported to the Committee:

- The Council's Risk Appetite Statement (RAS) has been reviewed and updated and is before the Committee for approval today.
- Regular review and updates to "Managing Risk" pages published on the Council's intranet pages. These pages contain information and links for officers and elected members on the Council's RAS, Risk Management Policy, Guidance and Training.
- Review of the Council's Risk Management Policy
- Risk owners and leads continue to review and update risk registers to improve monitoring and reporting across the organisation. These are mechanisms which reflect the day to day business of assessing and mitigating the risks and opportunities inherent in delivering public services.

Assurance Maps

3.11 The risk registers which are reviewed by the Council's service Committees detail the risks identified within each of the relevant Functions and Clusters and

provide detail of the risk, the potential impact and consequence of the risk materialising and the control actions and activities required to manage and mitigate the risk. Assurance Maps provide a visual representation of the sources of assurance associated with each Cluster so that the Committee can consider where these are sufficient. Sources of assurance are controls which are in place following the completion of control actions Presentation of each Cluster's assurance map provides full sight of the defences we have in place as an organisation to manage the risks facing local government.



3.12 Each Assurance Map provides a breakdown of the sources of assurance within "three lines of defence", the different levels at which risk is managed. Within a large and complex organisation like the Council, risk management takes place in many ways. The Assurance Map is a way of capturing the sources of assurance and categorising them, thus ensuring that any gaps in sources of assurance are identifiable and can be addressed:

First Line of Defence "Do-ers"	Second Line of Defence "Helpers"	Third Line of Defence "Checkers"
The control environment; business operations performing day to day risk management activity; owning and managing risk as part of business as usual; these are the business owners, referred to as the "do-ers" of risk management	Oversight of risk management and ensuring compliance with standards, in our case including ARSC as well as CMT and management teams; setting the policies and procedures against which risk is managed by the do-ers, referred to as the "helpers" of risk management.	Internal and external audit, inspection and regulation, thereby offering independent assurance of the first and second lines of defence, the "do-ers" and "helpers", referred to as the "checkers" of risk management.

3.13 Clusters will continue to review and update assurance maps to support their Risk Registers, and these will be reported to the operational committees over the course of the year. In addition, the assurance rating presented in Internal Audit reports, relative to the risk rating, assists us in fully defining the controls in place and the extent to which they are acting as a defence against a risk manifesting.

Inspections Planner

3.14 The Inspections Planner provides Committee with a timetable of known external/internal audits and third-party regulatory inspections and compliance audits that are specified within the "Third Line of Defence" on each Assurance Map. These audits and inspections provide the Council with independent assurance of regulatory compliance and best practice to achieve and maintain accreditation. Where relevant, the improvement recommendations and actions arising from these audits and inspections will continue to be reported to the relevant Committees for review.

3.15 The Inspections Planner, together with the Assurance Maps, will continue to be kept under review throughout the year in light of any changes to the risk environment of the council. In 2023, a number of unnotified inspections and audits were completed, for which minimal notice was provided. For instance, Audit Scotland completed an audit of Housing Benefit in Q3, reported in December 2023. This was not notified until 6 weeks prior to the audit fieldwork. Previously, external scrutiny was coordinated through the Local Area Network which was reported to this committee. This is no longer available and as explained in item 9.5. To date, we have responded to these scrutiny requirements in spite of the additional pressures they place on services, however there is risk in this approach. Committee is asked to note that we will endeavour to respond to external scrutiny requirements at short notice but that these are often onerous and would benefit from being included in the Inspection Planner. Agenda item 9.5 proposes that action be taken to write to the Strategic Scrutiny Group seeking a schedule of external scrutiny for 2024/25.

4. FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from the recommendations of this report. The report deals with the highest level of risk and this process serves to identify controls and assurances that finances are being properly managed

5. LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from the recommendations of this report. The Corporate Risk Register serves to manage many risks with implications for the legal position and statutory responsibilities of the Council.

6. ENVIRONMENTAL IMPLICATIONS

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

7. RISK

7.1 There are no risks arising from the recommendations in this report. The report provides information on the Council's system of risk management and the improvements designed to make the system robust and fit for the changing social, political and economic environment in which we operate. The system

ensures that all risks attaching to the Council's business and strategic priorities are identified, appropriately managed and are compliant its statutory duties.

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	The council is required to have a management system in place to identify and mitigate its risks.	The council's risk management system requires that risks are identified, listed and managed via Risk Registers.	L	Yes
Compliance	As above.	As above.	L	Yes
Operational	As above.	As above.	L	Yes
Financial	As above.	As above.	L	Yes
Reputational	As above.	As above.	L	Yes
Environment / Climate	As above.	As above.	L	Yes

8. OUTCOMES

8.1 The recommendations within this report have no direct impact on the Council Delivery Plan however, the risks contained within the Council's risk registers could impact on the delivery of organisational outcomes.

9. IMPACT ASSESSMENTS

Assessment	Outcome
Integrated Impact Assessment	It is confirmed by the Interim Chief Officer – Governance (Assurance) that no Integrated Impact Assessment is required.
Data Protection Impact Assessment	Not required
Other	Not applicable

10. BACKGROUND PAPERS

10.1 None

11. APPENDICES

11.1 Appendix A – Corporate Risk Register
11.2 Appendix B – Cluster Assurance Maps
11.3 Appendix C – Inspections Planner

12. REPORT AUTHOR CONTACT DETAILS

Name	Ronnie McKean
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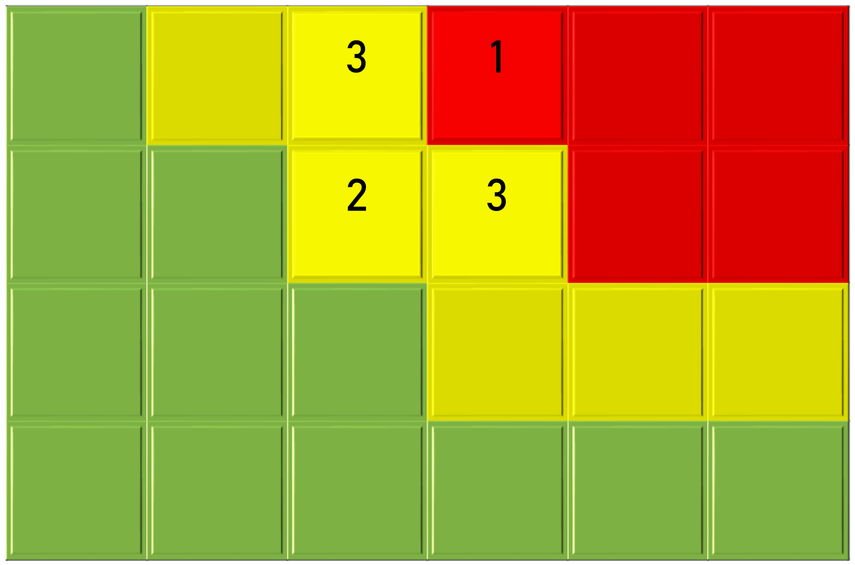
Corporate Risk Register

Current Corporate Risks	CURRENT RISK SCORE
Civil Contingencies	9
Climate Change (Place)	12
Cyber Security	12
Excessive resettlement and asylum demand and risk of harm.	12
Financial Sustainability	16
Health & Safety Compliance	9
Reinforced Autoclaved Aerated Concrete Panels and Planks (RAAC)	12
Supply Chain - Commodity Risks	12
Workforce Capacity and Organisational Resilience	12

Number of Corporate Risks

9

Risk Matrix by Likelihood (6) and Impact (4)



FUNCTION	CLUSTER	RISK OWNER	RISK LEAD
Commissioning	Governance	Vikki Cuthbert	Fiona Mann

RISK TITLE	RISK DESCRIPTION	CONTROL ACTIONS	TARGET RISK SCORE	CURRENT RISK SCORE	CURRENT LIKELIHOOD	CURRENT IMPACT	TARGET COMPLETION DATE
Civil Contingencies	Risk of non-compliance with the Council's responsibilities as a Category 1 responder under the civil contingencies legislation and guidance	1. Develop a CONTEST delivery plan (to include all four strands Prevent, Protect, Prepare and Pursue) based on the national delivery framework by 31st July 2024 2. Move to Critical and Lockdown plans alongside completion of CONTEST Delivery Plan - 31st July 2024 3. Complete National Power Outage Plan. Next draft to be complete by 31st March 24. 4. Creation of a City Persons at Risk Database. Next iteration/phase to be complete by 31st March 24. 5. Community Resilience - increase number of Community Resilience Groups in 2023 - moving target date to continue growth - 1st Dec 24	6	9	3	3	01 December 2024

FUNCTION	CLUSTER	RISK OWNER	RISK LEAD
Commissioning	Strategic Place Planning	David Dunne	Alison Leslie

RISK TITLE	RISK DESCRIPTION	CONTROL ACTIONS	TARGET RISK SCORE	CURRENT RISK SCORE	CURRENT LIKELIHOOD	CURRENT IMPACT	TARGET COMPLETION DATE
Climate Change (Place)	Failure (where ACC has scope to influence), to contribute to a reduction in city-wide emissions and to address strategic climate risks for the city. These include heavy winter rainfall, flooding, a rise in sea level, reduction summer rainfall, higher temperatures.	1. Establish a 2024/25 work plan for city climate change partnership governance, by March 2024, appropriate for delivery of the Net Zero Aberdeen Route-Map and Aberdeen Adapts Framework. 2. Roll out the processes for the monitoring and analysis of city wide emissions data, being established for local authorities in Scotland to support place based climate action, by November 2024. 3. Complete officer training on use of and analysis of area wide emissions data sets for local authorities in Scotland, by November 2024. 4. Development of collaborative delivery and monitoring mechanisms and programmes for the Net Zero Aberdeen Routemap and Aberdeen Adapts, by March 2025. 5. Identify appropriate funding mechanisms, relevant to project priorities, including opportunities for economies of scale (ongoing).	8	12	3	4	30 March 2025

FUNCTION	CLUSTER	RISK OWNER	RISK LEAD
Customer	Digital & Technology	Steve Roud	Lita Greenwell

RISK TITLE	RISK DESCRIPTION	CONTROL ACTIONS	TARGET RISK SCORE	CURRENT RISK SCORE	CURRENT LIKELIHOOD	CURRENT IMPACT	TARGET COMPLETION DATE
Cyber Security	There is a risk that the council's services are significantly impacted by a cyber attack	1. Cyber hygiene is maintained through regular patching and equipment refresh - 31/03/24 2. Application estate is modernised and technical debt is removed or re-factored - 31/03/24 3. Adoption of public cloud (IaaS and SaaS) is used to spread risk -31/03/24 4. Move towards zero trust infrastructure - 30/06/24 5. Compliance with PSN (Complete) and Cyber essentials (Complete). Cycle beginning again - 31/05/2024	8	12	3	4	29 June 2024

FUNCTION	CLUSTER	RISK OWNER	RISK LEAD
Customer	Early Int. & Community Emp.	Jacqui McKenzie	Gill Strachan

RISK TITLE	RISK DESCRIPTION	CONTROL ACTIONS	TARGET RISK SCORE	CURRENT RISK SCORE	CURRENT LIKELIHOOD	CURRENT IMPACT	TARGET COMPLETION DATE
Excessive resettlement and asylum demand and risk of harm.	Risk that Aberdeen City Council and partners are unable to provide appropriate levels of support to people arriving in the city as refugees or asylum seekers. Increased homelessness presentations and sustained demand for core services including; housing support services, education, community learning and development, children and families social work and resettlement support arising from external factors including arrivals of displaced people from other Scottish cities who can present as homeless due to the removal of "local connection" and the potential requirement for RAAC decants.	1) Monitoring with partner organisations of impact on services of Asylum and Resettlement Strategic Partnership, the risk and control actions will be reviewed by this group going further - On-going monthly. 2) Development of Pathways and Support for Asylum seekers who are granted leave to remain has been drafted to gain access to basic services. If a person is given leave to remain they will be given a 28 days notice to quit, and there is an expectation that they will present as homeless, the Resettlement team at ACC will provide integration support - On-going. 3) Public Health Scotland have joined the group to address concerns around infectious diseases - Complete. 4) There is an emerging risk that people transferred to Aberdeen through the Asylum scheme are claiming to be younger, and therefore could place further pressures on Children and Families Social Work Services. Pathways for this are being developed along with additional training on age assessments sourced by Children and Families Social work - On-going. 5) There is a business case being developed to increase the capacity of the Resettlement Team, this will be short term and based on current funding arrangements - Complete 6) A proposed Joint Assurance Board will be set up between the Scottish Government and Aberdeen City Council which will meet monthly and monitor and review actions to support remaining Ukrainian Displaced People move from Hotels into other accommodation in Scotland - Complete/On-going. 7) Representation at COSLA and Home Office meetings to continue to push the message that Aberdeen cannot accept asylum seeking families, and to keep the focus on single adult males - Complete. 8) Review and assess existing and future commitments to establish Safe and Legal Routes Cap - On-going. 9) Monitoring relevant budget lines and apply for all funding options that are available- On-going. 10) Develop strategic approach to resettlement and asylum for the City - Target date March 2024.	8	12	4	3	31 Decembe 2024

FUNCTION	CLUSTER	RISK OWNER	RISK LEAD
Resources	Finance	Jonathan Belford	Helen Sherrit

RISK TITLE	RISK DESCRIPTION	CONTROL ACTIONS	TARGET RISK SCORE	CURRENT RISK SCORE	CURRENT LIKELIHOOD	CURRENT IMPACT	TARGET COMPLETION DATE
Financial Sustainability	Failure to deliver financial sustainability due to: Failure to align resources to commissioning intentions and service standards Inadequate financial reporting and planning Failure to respond to external factors Failure of partners, businesses or the 3rd sector Failure of transformation plans, projects or service redesigns Inadequate financial stewardship or capability	1. Achieve going concern status encompassing medium- and long-term planning assumptions and valuations in 23-24 accounts audit. 2. The Medium-Term Finance Strategy was refreshed in August 23 taking account of the Scottish Government Resource Spending Review announced at the end of May 23 and the key Council strategic policies and priorities, work is being undertaken to achieve a balanced budget for 24-25 in March 24. 3. Refresh the risk-based approach to the Counter Fraud Policy focussing on clusters where significant risk could exist has been completed by 30 September 24, and is ongoing for all other clusters. 4. Complete a self-evaluation of the FM code criteria and reflected in AGS for March 24. 5. Scrutinise on a project by project basis the cost estimates at key stages of the delivery. 6. Contract Managers are to complete a template which will allow them to test and challenge contract cost increases which will ensure they are achieving best value from the supply chain - on-going when required by contract managers. 7. On-going assessment of impacts to ACC staff, assets and finances resulting from National Care Service 8. Budget Protocol approved at Council in June 23 this identifies the key stages in the preparation of the medium term financial strategy and annual budget. 9. Regular meetings of the Budget Strategy group which includes Directors, Partnership and relevant officers. 10. Ongoing monitoring during the financial year - Q1/2/3/4, reported to Finance & Resources Committee	6	16	4	4	29 March 2024

FUNCTION	CLUSTER	RISK OWNER	RISK LEAD
Commissioning	Governance	Vikki Cuthbert	Colin Leaver

RISK TITLE	RISK DESCRIPTION	CONTROL ACTIONS	TARGET RISK SCORE	CURRENT RISK SCORE	CURRENT LIKELIHOOD	CURRENT IMPACT	TARGET COMPLETION DATE
Health & Safety Compliance	Risk of non-compliance with Health and Safety legislation and practices resulting in harm to the workforce and/or members of the public	1. Roll out H&S module of Core HR and link to the Assurance dashboard of the Managers' Portal and implement across SMTs, H&S Function Groups and ECMT by 31st July 2024. 2. Completion of post-COVID H&S Action Plan to embed good practices from the pandemic in BAU by 31st July 2024.	6	9	3	3	31 December 2024

FUNCTION	CLUSTER	RISK OWNER	RISK LEAD
Resources	Corporate Landlord	Stephen Booth	Alastair Reid / Scott Whitelaw

RISK TITLE	RISK DESCRIPTION	CONTROL ACTIONS	TARGET RISK SCORE	CURRENT RISK SCORE	CURRENT LIKELIHOOD	CURRENT IMPACT	TARGET COMPLETION DATE
Reinforced Autoclaved Aerated Concrete Panels and Planks (RAAC)	RAAC was a commonly used material in the 50's 60's, 70's and early 80's. There have a small number of incidents where roof planks have failed leading to the collapse to elements of the roof. RAAC has been confirmed as present in 5 non housing buildings. With RAAC present in 362 Council Houses and 142 former Council houses. Investigations are ongoing.	Non Housing: 1. Desktop assessment completed to identify shortlist for inspection - Complete. 2. Initial structural inspection of shortlisted public buildings - Complete 3. Structural Engineer carrying out invasive testing on buildings with RAAC. ACC officers to consider recommendations - Complete 4. Business continuity plans in place - Complete 5. Second review of non-housing buildings - Target Date - 31/03/24 Housing: 6. Desktop assessment completed to identify shortlist for inspection - Complete 7. Initial structural inspections of those shortlisted to date - Target completion 29/02/24 8. Structural Engineer carrying out invasive testing on housing with RAAC. ACC officers to consider recommendations - Programme on-going.	8	12	3	4	31 December 2024

FUNCTION	CLUSTER	RISK OWNER	RISK LEAD
Commissioning	Commercial & Procurement	Craig Innes	Melanie McKenzie

RISK TITLE	RISK DESCRIPTION	CONTROL ACTIONS	TARGET RISK SCORE	CURRENT RISK SCORE	CURRENT LIKELIHOOD	CURRENT IMPACT	TARGET COMPLETION DATE
Supply Chain - Commodity Risks	1. Impacts on Supply Chain due to ongoing market impacts/volatility from Brexit/Covid/Invasion of the Ukraine and inflation continuing to affect key commodities such as Utilities, Construction & Construction Materials, Food, Waste, Transport, Fuel, and Manufacturing i.e. Vehicle Purchase	1. Monitor price increases and continue to challenge (Track & Report on Increases at each quarterly Strategic Procurement Board) along with reports on market trends - Ongoing 2. Regular review of products (Core Lists) with services & suppliers/Work with Scotland Excel & Framework Suppliers to look at alternatives where shortages/increased pricing are indicated - Ongoing 3. Capital teams to continue to monitor Construction Sector Market volatility and assess the associated impact on procurement strategies including timing and approach - Ongoing. 4. Energy Management teams to continue to monitor and report on the situation with energy markets and pricing - Ongoing.	6	12	4	3	31 December 2024

FUNCTION	CLUSTER	RISK OWNER	RISK LEAD
Customer	People & Organisational Development	Isla Newcombe	Lindsay MacInnes

RISK TITLE	RISK DESCRIPTION	CONTROL ACTIONS	TARGET RISK SCORE	CURRENT RISK SCORE	CURRENT LIKELIHOOD	CURRENT IMPACT	TARGET COMPLETION DATE
Workforce Capacity and Organisational Resilience	Risk that changes to and within the workforce, caused by external factors and pressures eg budgetary restrictions, population reduction and changes including availability of required skills significantly impact on our capacity and ability to deliver services and on the resilience of our workforce. Risk that this impacts as follows: dips in individual performance, increase in staff absences, increase in number of conduct investigations, fewer managers and staff to conduct staff investigations, strain on labour relations, deterioration in mental wellbeing and reduced goodwill of employees which in turn impacts on service delivery	1. Delivery of year one workforce capacity aspects of Tom 1.2 including Workforce Strategy and Workforce Delivery Plan - by 31st March 2024. 2. Completion of VSER process 23/24 including capture of knowledge and requirements of each role being removed, including mandatory training, approvals and delegations attached to these roles, in order to mitigate internal control failures resulting from loss of key staff – by 31st March 2024 3. Agree and implement an escalation process for services to identify gaps in service delivery – to be owned by ECMT - by 30th April 2024 4. Redesign of teams around Organisational Design Principles to ensure teams are resilient to any reduction in capacity and loss of capability - 31st March 2024 5. Revise Council Delivery Plan, specifically Commissioning Intentions and Service Standards to recognise the increasing demand on a reduced workforce in order to manage expectations as to what we can deliver– 31st March 2024 7. Review of statutory service provision to identify opportunities for transfer or legislative reform. – 31st March 2024 8. Delivery of actions contained within the Mental Health Action Plan and ongoing review of the Plan through the PDSA model for improvement cycle. – 31st March 2024 9.Continued roll out of Mental Health First Aider Training - – 31st March 2024 10. Continued roll out of Health and Wellbeing Roadshows for frontline staff – 31st March 2024 11. Early engagement with Trade Unions via Director/Union Engagement weekly meetings, informal weekly meetings between Employee Relations and Wellbeing Manager and Trade Unions- ongoing 12. Continued and expanded use of temp movement of staff process to cover risks to our capacity for emergency response due to reduced/compressed operational teams. - ongoing 13. Continued implementation of the workstreams within the Absence Improvement Project - – 31st March 2024 14. Monitoring and management of workflow peaks via the Establishment Control Board and enabling creative and sustainable use of resource as appropriate- ongoing. 15. Monitoring of Workforce data to allow trends and hotspot areas to be highlighted for interventions- ongoing. 16. Continued use of external communications campaigns and expectation-setting with citizens in terms of financial situation, any areas of reduction in line with this, and promotion of positive, proactive activity - ongoing. 17. Work alongside employability team in engaging young workforce (schools, colleges, universities) and other untapped pools around our opportunities (foundation/modern apprenticeships, placements, ABZ campus etc) in particular around our shortage occupations – ongoing. 18. Utilising digital technology to support flexible and agile working, reduce travel costs and emissions,	6	12	4	3	29 June 2024

Assurance Map
Cluster – Commercial & Procurement Services

Corporate Risk Register Risks:

1. Supply Chain - Commodity Risks
1. Impacts on Supply Chain due to ongoing market impacts/volatility from Brexit/Covid/Invasion of the Ukraine and inflation continuing to affect key commodities such as Utilities, Construction & Construction Materials, Food, Waste, Transport, Fuel, and Manufacturing i.e. Vehicle Purchase

Cluster Risk Register Risks:

1. Non-Compliance with Procurement Regulations
1. Contract Management - Risk that Strategic & Critical contracts and associated supplier relationships are not managed effectively, which can have a detrimental impact on the achievement of required outcomes to support commissioning intentions/delivery of LOIP outcomes/achievement of best value.
2. Non-Compliance - Governance Arrangements are not fully complied with by Delegated Procurers including seeking approval to go out to market, provision of Annual Procurement Workplans and ensuring contracts are recorded on the Contract Register, which could lead to the Council being in breach of Procurement Legislation.

2. Shared Service - Service Level Agreement - Delivery of KPI's - Risk that Commercial & Procurement Shared Service are unable to deliver against agreed KPI's within Service Level Agreement:
1. Local Supplier Spend (Aberdeenshire)
2. Community Benefits/Fair Work (Highland)
3. Climate Change (3 Councils)

3. Shared Procurement Service Partner Withdrawal - Partner to the Shared Service decides to withdraw.

4. Scotland Excel - Membership does not deliver anticipated benefits - The ability of Scotland Excel to deliver against their objectives in relation to Financial Savings/Delivery of Community Benefits & Sustainable Procurement on behalf of the Shared Service Partner Authorities

5. Climate Change and severe weather affect the costs and availability of goods and services.
1. Failure to embed climate change procurement policy, processes and to consider climate risks in the design life of procurements.
2. Production or supply chain disruptions impact critical services
3. Increase in flooding, heavy rainfall, storms, higher temperatures, a rise in sea level and drought cause damage to supplier s tock, result in delivery disruptions and cause depletion of resources, affecting the price of products and the availability of goods.

6. Procurement Fraud - Public procurement is vulnerable to fraud and corruption because of the level of expenditure, the volume of transactions, the complexity of the process and the number of stakeholders involved, these vulnerabilities can also make public procurement a target for Serious & Organised Crime.

First Line of Defence (Do-ers)	Second Line of Defence (Helpers)	Third Line of Defence (Checkers)

• Online Staff Training & Development
• Operational procedures and guidance including Procurement Manual, Contract Management Guidance and Procurement Regulations
• Procedures to implement contract management policies
• CPSS Communication Plan – Regular communication with CO's/Service Managers/DPA's with updates/guidance
• Procurement Fraud Risk Assessment
• Price Increase Review Process/Tracker
• Inflation Monitoring/Tracker
• Scotland Excel Supply Chain Reports (Quarterly)
	• CMT Boards
	• Council Committees
	• Senior Management Team (SMT) undertakes review of Cluster Operational Risk Register
	• Procurement/Contract review by Demand Management Board
	• Strategic Procurement Board (Senior management representation from other Shared Service Partners)
	• Joint Procurement Strategy 2023-2026
	• Policy documentation including Sustainable Procurement and Community Benefits Policy
		• Internal Audits on Procurement
		  ○ Contract Management – 21/04/23
		  ○ Procurement Compliance (End 2023/Early 2024)
		• Annual External Audit and report
		• External reports from Scotland Excel including
		  ○ Procurement Capability and Improvement Plans (PCIP)
		• Scottish Government performance review and reports (Annual Procurement Report)

Assurance Map Governance		
Corporate Risk Register Risks:		
1. **Civil Contingencies** - Risk of non-compliance with the Council's responsibilities as a Category 1 responder under the civil contingencies legislation and guidance 2. **Health & Safety Compliance** - Risk of non-compliance with Health and Safety legislation and practices resulting in harm to the workforce and/or members of the public		
First Line of Defence (Do-ers)	**Second Line of Defence (Helpers)**	**Third Line of Defence (Checkers)**
• Mandatory health and safety training requirements included in training needs analyses for Clusters • Trained and qualified staff • Training and exercising plan for DERCs, Tactical Leads, ALEOs and operational staff on the components of emergency response. • Risk assessments and project risk registers • RIDDOR reporting (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) • Investigations into incidents and breaches of H&S policy or legislation. • Protocols, Plans & Guidance to implement policies • Protest Management Plan • Duty Emergency Response Coordinators (DERCs) • Tactical Leads to support DERCs with emergency response • Housing and Flooding rotas to support emergency response • RCC, with Page One process to support emergency activation of DERC.	• CMT Boards • Council Committees • Corporate Management Team • Scheme of Governance • Local Code of Corporate Governance • Annual Governance Statement • Risk Appetite Statement • Risk Registers • Legislation and Consultation Trackers • Risk Horizon Scanning Tracker • Generic Emergency Plan and Activation Packs • Fulltime EPR&C Lead and Officer post • DERC, UDERC and Tactical Lead rota • Resilience Hub including DERC Handbook and Materials and regular updates, including for UNICORN • DERC, UDERC and Tactical Lead Training Materials • Resilience huddles across three Grampian local authorities including Scottish Govt rep. • Reception Centre Handbook including ALEO support	• Health and Safety Executive • Scottish Fire and Rescue Service Audits • Care Inspectorate inspections • Education Scotland inspections • Traffic Commissioner Scotland • External Audit • North Regional Resilience Partnership • Grampian Local Resilience Partnership (GLRP) and GLRP Working Group • GLRP P&J Liaison Group • Local Authority Resilience Group Scotland (LARGS) • North East CONTEST Multi-Agency Group • Information Commissioner's Office (regarding data protection) • Office of the Scottish Information Commissioner (regarding freedom of information) • Investigatory Powers Commissioner's Office • Credit Rating Agency

• Additional Tactical Leads matching DERC numbers (11 of each) • Tactical Lead buddy system • Business Continuity Plan for Governance • Civil Contingency Incident De-Briefs • Corporate Procedure: CCTV • Bond Governance Protocol • Implementation of a Radio system across City Centre ACC buildings for managing security incidents and response. • Representation from across ACC emergency response team members at the monthly Bridge Calls arranged by Police Scotland Crime and Counter Terrorism Unit. Covering all CONTEST strands updates, training opportunities and awareness raising • Community Resilience Groups (Bridge of Don/Danestone, Culter, Cults, Milltimber & Bieldside)	• SCORDS Training Hub (Scottish Resilience Development Service • Community Resilience Framework • ALEO Assurance Hub • Committee Effectiveness Reports • Revised Corporate H&S Policy approved by Staff Governance Committee including inventory of H&S procedures. • Process for approval of H&S procedures (CO-G approves corporate, relevant CO approves Cluster specific). • H&S Management System setting out roles and responsibilities • Document management system detailing corporate and local H&S procedures and documents, including review dates and responsible officers. • First Aid training and E-Learning including: Intro to health and safety, Fire safety, Managing Safety, Manual Handling, asbestos awareness, Fire Marshall and warden responsibilities, working at height, display screen equipment. • Face to face H&S training sessions on: risk assessment, lone working, COSHH risk assessment, Investigation, Incident reporting • Guidance on incident and near miss reporting. • Asbestos Working Group Terms of Reference, to monitor actions arising from breaches or HSE interventions. • Reporting to external bodies (HSE, Scottish Fire and Rescue Service and the Care Inspectorate) • Risk Assessment Guidance and templates (including COVID-19) • Compliance checks for COVID-19 risk assessments • Process for COVID-19 individual risk assessments • Guidance on homeworking during COVID-19 • Process for review of Scottish Government guidance on COVID-19 to update internal guidance • Trades Union/Director Group • Health and Safety Trade Union meeting	• Accounts Commission • Audit Scotland • CIPFA • Standards Commission for Scotland • Commission for Ethical Standards in Public Life in Scotland • Law Society of Scotland • Office of the Scottish Charity Regulator (relevant where ACC itself is a charity trustee) • Financial Conduct Authority (regarding Stock Exchange bonds) • External competent bodies (regarding statutory inspection of plant and equipment) • Electoral Commission • Electoral Management Board for Scotland

	• Commissioning, Customer, Resources and Trades Unions Health and Safety Group • Operations and Trade Unions Health and Safety Group • Information Governance Group • Public Protection Committee • Risk Management Policy • Business Continuity Policy • International Twinning Grant Criteria Policy • Appointment of Elected Members to Outside Bodies Policy • Licensing Policies • Licensing Committee • Licensing Board • Organisational Resilience Group • Business Continuity Sub-Group • Policy Group • Occupational Health Provider	

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Assurance Map

Strategic Place Planning

Corporate Risk Register Risks:

1. **Climate Change (Place**) - Failure (where ACC has scope to influence), to contribute to a reduction in city-wide emissions and to address strategic climate risks for the city. These include heavy winter rainfall, flooding, a rise in sea level, reduction summer rainfall, higher temperatures.

Cluster Risk Register Risk:

1. **Climate Duties - Council Compliance -** Risk of non-compliance with public bodies duties under the Climate Change (Scotland) Act 2009.
2. **Strategic Plan Delivery – SPP** - Failure to deliver key strategic plans – staff and process restructuring risks

First Line of Defence (Do-ers)	Second Line of Defence (Helpers)	Third Line of Defence (Checkers)
• Trained and qualified staff. • Team Managers oversight of finances for teams. • All staff involved in risk assessment process. • Team Business Continuity Plans in place. • Operational plans and guidance including surveys, monitoring, committee reporting. • Contract Management Guidance, policies and Procurement Regulations. • Environmental risks/ implications (including climate) incorporated in project plans, business cases, policy templates, committee reporting and guidance. • Emergency plans. • Community involvement. • Agreed health and safety procedures – all staff supported to familiarise as part of induction. • Cross Service protocols and training. • Joint working with internal/external resources and services. • Internal/ external communication and networking. • Committee reporting. • LOIP objectives. • Maintain an awareness of current statutory requirements. • Respond to internal and external consultation.	• CMT Boards. • Council Committees. • Council Climate Change Plan: Towards a Net Zero and Climate Resilient Council in place. • Council Climate Change Plan dashboard in place for monitoring. • Oversight Group for the Council Climate Change Plan meets monthly. • Carbon budget and monitoring in place. • Updated Aberdeen Adapts: Climate Adaptation Framework in place. • Net Zero Aberdeen Routemap: Towards becoming a net zero emissions city by 2045 in place. • 6 Net Zero (Place) enabling strategies: Mobility, Buildings & Heat, Circular Economy, Energy Supply, Natural Environment, Empowerment in place. • Net Zero (Place) Governance with approved Terms of Reference. • Senior Management Team review of Cluster Operational Risk Register and monthly budget and contract management. • Oversight on service KPIs. • Contract review by Demand Management Board. • Plans, programmes, strategies including those for flooding, Aberdeen Local Development Plan, Local Transport Strategy, Local Housing Strategy, Aberdeen Open Space Strategy, Aberdeen Food Growing Strategy. • Customer Service Excellence accreditation. • Local Resilience Partnership undertaking resilience planning and preparedness across all partners. • Climate on the agenda for the City Resilience Group. • Emergency plans eg flooding and storms. • Climate and Nature Pledge in place, microsite established.	• Annual Climate Change report (Public Bodies Climate Change Duties) submitted to Scottish Government. • Regional and National reports from Scottish Government, UK Government and SEPA. • Scottish Government performance review and reports. • Environmental Standard Scotland reports. • Monitoring of current/ future climate risks affecting Aberdeen, in line with UK Climate Projections, UK Climate Risk Assessment. • Annual review against the Public Sector Adaptation Capability Framework. • Audit Scotland and National Audit reports. • Community Planning Aberdeen Board. • Local Outcome Improvement Plan (LOIP). • Participation in external quality system inspection programme Customer Service Excellence. • Annual reporting of Risk Registers to Committee. • Economic Policy Panel. • APSE benchmarking.

Assurance Map

City Growth

Cluster Risk Register Risk:

Perception of Place: There is a risk that Aberdeen's image as an attractive place to live or relocate may be negatively impacted due to the influence of concurrent economic events in recent years. This unfavourable perception has the potential to hinder the region's ability to achieve inclusive economic growth.
Protecting our people from Terrorism - Hostile Vehicle Mitigation: Mass gatherings, including Aberdeen City Council's events, are soft targets and, therefore, vulnerable targets for terrorism.

First Line of Defence (Do-ers)	Second Line of Defence (Helpers)	Third Line of Defence (Checkers)
Programme Management • Establishment of a Programme Management Office to oversee the successful delivery of the Regional Economic Strategy • Governance of the Regional Economic Strategy via a Regional Economic Partnership including terms of references for Boards and delegated authority • Execution of an agreed regional Investment plan • Data capture and analysis to measure progress and inform decision making. • Alignment with relevant policies and procedures **Stakeholders** • Collaboration with internal and external teams to achieve shared outcomes and benefits. • Engaging with communities to empower positive change. **Communications** • Development of communication plans and protocols in coordination with regional partners and ACC teams, including advocacy of the region.	**ACC Management Boards** • ACC Risk Monitoring and Assurance • ACC Strategies and Plans • ACC Service Plans • ACC Personal Objectives through CR&D **ACC Committees** • Political Priorities • Committee Remits **Observers/ members on Partners Boards** • Alignment to governments strategies and plans • Coordination with partners organisations strategies and plans **Networks** • Utilising national and regional networks to develop innovative programmes and optimise resources for shared objectives.	**Report progress to**: • UK and SG • Committees • Partners • Management Teams **Reviewing progress and process** • Audit • Economic Policy Panel • Health & Safety **Provide Economic Data and Analysis to**: • Community Planning Aberdeen (LOIP) • Funders • Inform future strategies. • National Networks including alliances, partners, and collaborators. **Best Practice** - Recognition through awards, ranking tables and achieving status.

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Assurance Map Cluster – Customer Experience		
Cluster Risk Register Risk:		
1. **Customer Experience Service Delivery** - Risk to delivery of key front-line services in the event of failures of systems, processes, significant increase in demand (e.g., pandemic; rise in cost of living), or in the event of an incident, e.g., climate event.		
First Line of Defence (Do-ers)	**Second Line of Defence (Helpers)**	**Third Line of Defence (Checkers)**
• Trained and qualified staff with knowledge captured and shared to ensure business continuity • Operational Procedures, Guidance Documents and videos captured for future training requirements and business continuity • Use of technology (e.g., Robotic Process engineering) to provide enhanced resource and resilience to processes • Staff training and development • Operational Risk Assessments • Operational procedures and guidance including those set out in the Business Continuity Plans in the event of a system or process failure. • Operational Test Schedules for Business Continuity Plans • Disaster Recovery plan for Regional Contact Centre • Analysis following activation of business continuity arrangements / tests and improvement plans identified.	• CMT Boards • Council Committees • Customer Function Senior Management Team (undertakes review of Cluster Operational Risk Register) • Customer Experience Cluster Senior Management Team (undertakes review of Cluster Operational Risk Register) • Policy Documentation • Assurance Team • Business Continuity Sub-Group	• Internal Audit – Benefits Quality Assurance Process – 27/02/23 • Annual External Audit • DWP Subsidy Audit • DWP Housing Benefit Review • Non-Domestic Rates NDRI – External Audit • Internal Audit - IJB Complaints Handling • Internal Audit – Data Protection • Scottish Public Services Ombudsman scrutiny of complaint handling • Information Commissioners Officer scrutiny of protection right request handling

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Assurance Map

Cluster – Early Intervention and Community Empowerment

Corporate Risk Register Risk:

1. **Excessive resettlement and asylum demand and risk of harm** - There is a risk that Aberdeen City Council and partners are unable to provide appropriate levels of support to people arriving in the city as refugees or asylum seekers.

   There is a risk of increased homelessness presentations and sustained demand for core services including; housing support services, education, community learning and development, children and families social work and resettlement support arising from external factors including arrivals of displaced people from other Scottish cities who can present as homeless due to the removal of "local connection" and the potential requirement for RAAC decants.

   There is a financial risk to the Council that increased demand and supporting activities required in this area are not fully funded.

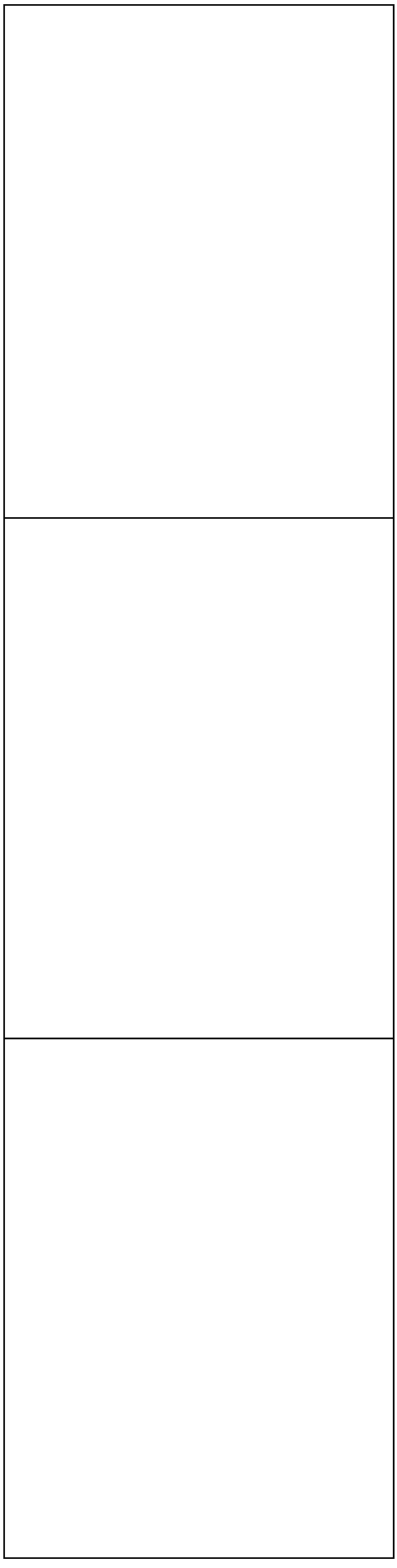
Cluster Risk Register Risks:

1. **Inability to meet the Unsuitable Accommodation Order** - There is a risk to the Council of not being compliant with the Homeless Persons (Unsuitable Accommodation) (Scotland) Order
2. **Risk to the welfare of children, young people and families due to the increase in the cost of living, and the long-term impact of Covid-19**
3. **Safeguarding amongst refugee communities** - There is a risk that safeguarding issues for children and adults become prevalent and cannot be assessed as refugee communities move from hotel accommodation to settled accommodation.
4. **Void Property Management -** There is a risk that the level of void properties leaves ACC unable to house applicants appropriately or timeously, affecting quality of life, increasing spend on hotels and reducing rental income.

First Line of Defence (Do-ers)	Second Line of Defence (Helpers)	Third Line of Defence (Checkers)
• Trained and qualified staff • Operational procedures and guidance documentation	• CMT Boards • Council Committees • Policy Documentation • Senior Management Team (SMT) undertakes review of Cluster Operational Risk Register • Full Council • Organisational Resilience Group • Strategic Partnership Group	• Annual External Audit and report • Community Planning Aberdeen • Education Scotland - CLD Strategy and performance (HGIOCLD) • Scottish Housing Regulator - Annual return on housing performance; annual risk assessment

	• Warm Scottish Welcome Delivery Board • Resettlement Strategic Partnership Group • Home Office Afghan Resettlement Meetings • Scottish Government Better Homes Division • Joint Assurance Board (Ukrainian Displaced People)	• Scottish Social Services Council - Registered Housing Support Services • Care Inspectorate for Registered Housing Support Services • Scotland and Scottish Library & Information Council - Ambition & Opportunity: National Strategy for Public Library Services, and performance framework (HGIOPLS) • Scotland and Scottish Library & Information Council and Education Scotland -Vibrant Libraries thriving schools : Strategy for School Libraries -and performance HGIOSL • Financial Inclusion Team - Scottish National Standards for Advice and Information Providers Scottish Legal Aid Board • Scottish Government - Child Poverty Action Plan • Scottish Government Homelessness reporting and Rapid rehousing Transition Plan scrutiny

Assurance Map Digital & Technology		
Corporate Risk Register Risk:		
1. **Cyber Security** - Risk that Cyber security threats are not sufficiently mitigated against to protect the Council, its essential functions and customer data		
Cluster Risk Register Risks:		
1. **Climate Change - Digital Infrastructure** - Digital infrastructure will be impacted by adverse incidents caused by climate change (flooding, extreme weather) resulting in disruption to the delivery of council services. 2. **Sustainability of support services**- On premise infrastructure and networks are not supportable due to the availability of replacement components.		
First Line of Defence (Do-ers)	**Second Line of Defence (Helpers)**	**Third Line of Defence (Checkers)**
• Trained and qualified staff • IT Security Technologies – devices to filter traffic and protect network, virus control software and domain access rules e.g. Conditional Access and Encryption • Proactive Monitoring & Alerting • Operational procedures and guidance notes • Mandatory Information Governance Staff Training and IT Security Staff Training • Investigation into incidents and breaches • Patch Management • System Change Management process via Change Advisory Board • Threat Hunting	• CMT Boards • Council Committees • D&T Senior Management Team (SMT) undertakes review of Cluster Operational Risk Register • Information Governance Group • ICT System Risk Assessments • Data Privacy Impact Assessments • Vendor Management • Policy documentation including, Information and Communication Technology (ICT) Acceptable Use Policy and ICT Access Control Policy, Protective Monitoring Policy • Annual review against Public Sector Cyber Security Framework • Participation in the North of Scotland Cyber Resilience Group	• Independent IT Health Checks for PSN Accreditation by Surecloud. Surecloud are National Cyber Security Centre and Check approved. • Independent Penetration testing on internet facing services by Surecloud. Surecloud are National Cyber Security Centre (NCSC) and Check approved. • Public Services Network (PSN) assurance review annually • Registered for NCSC proactive notifications service • Cyber Essentials Plus assurance • Completed Scottish Government Cyber Assurance audit • Internal Audit –Care Management System – 17/10/23



Assurance Map Data & Insights		
Cluster Risk Register Risk:		
1. **Information Governance** - Risk that the Council's Information Governance Framework (people and behaviour, process and system, adapting and learning) is not sufficiently robust to ensure that council information and data is processed in a way which: i. mitigates potential harm to the rights and freedoms of data subjects arising from data processing ii. meets the Council's operational, strategic and accountability requirements (business and statutory); iii. demonstrates proper stewardship to deliver outcomes for our people, place and economy.		
First Line of Defence (Do-ers)	**Second Line of Defence (Helpers)**	**Third Line of Defence (Checkers)**
• Trained and qualified staff • Operational procedures and guidance notes, including consistent corporate processes for: - Data Protection Impact Assessment - Privacy notices - Data Protection Rights Requests - Incident reporting and handling - Information Sharing Agreement and contractual arrangements - Maintaining the Council's records of processing activities (Information Asset Register) • Records Retention and Disposal Schedule • Mandatory Information Governance Staff Training • Clear and consistent roles and responsibilities in relation to data and information in Corporate Policy and supporting Handbooks of procedures	• CMT Boards • Council Committees • Effective Information Governance / DPO advice and support • Information Governance Group led by Senior Information Risk Owner (SIRO) reviews Quarterly Information Governance Assurance reports • Corporate Information Policy • Data Forums • Governance including annual Information Governance Assurance Statement • Internal Information Assets Assurance Cycle • CCTV Assurance Framework	• External scrutiny of Council's arrangements in relation to DP and PRSA in the form of Reports, inspections, and audits from the Information Commissioners Office and the Keeper of the National Records of Scotland • Internal Audit – Data Protection – 17/10/23

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Assurance Map

Cluster – Children & Families Services (Children's Social Work)

Cluster Risk Register Risks:

1. **Child Migration including unaccompanied asylum seeking children and young people (UASC) and all families requiring resettlement or with no recourse to public funds (NRPF)**
2. **Service Standards/ Performance** - Risk that service standards and performance are not achieved, and risk of budget overspend on external services and resource.
3. **External factors** – increase in service demand and impact of National Care Service (NCS)
4. **Budget Constraints/Pressures** - Risk that budget reductions and budget allocation within the Cluster for service delivery, staff training and development and CPD impacts capacity of services and income.
5. **Workforce – Children's Services** - Risk that staff recruitment/retention challenges within Social Work and Social Care reduce staff capacity and resilience whilst service demand continues to increase. Staff training requirements increase in complexity and budgets are under pressure.
6. **Scottish Child Abuse Inquiry (SCAI)**

First Line of Defence (Do-ers)	Second Line of Defence (Helpers)	Third Line of Defence (Checkers)
• Trained and qualified staff • Professional Supervision in place for all CSW staff ensuring day to day service delivery. • Team Managers/SM's oversight of finances for teams • Agreed health and safety procedures – all staff supported to familiarise as part of induction. • All staff involved in risk assessment process • Team Business Continuity Plans in place • Tracking and monitoring arrangements in place in all schools to track performance and delivery of statutory duties. • Learning from case reviews considered on single and multi-agency basis and embedded at practitioner level. • Voice of children and young people at the heart of service planning and improvement.	• CMT Boards • Council Committees • Health and Safety guidance for services, including Lone Working • Identified health and safety team link for all teams • Child protection and safeguarding guidance and professional learning available • Range of policies/procedures for schools to support consistent practice • SM QA activity within teams and through professional supervision. • Multi-agency Quality Improvement activity • Service Business Continuity Plan • Improvement groups comprising central Officers and school staff identify and address emerging risks	• Care Inspectorate Inspections • HSE Covid-19 inspections • Health and Safety Team compliance visits to work settings • ECMT data reviews • Performance reports to Committee • Annual reporting of Risk Registers to Committee • Regular contact with Scottish Government OCSA Team • External Audit • Monthly budget print outs • Annual External Audit and report • Annual Internal Audit Plan approved and overseen by Audit, Risk and Scrutiny Committee • Audit Scotland and National Audit reports

• Regular analysis of CSW data to improvement planning on both single and multi-agency basis. • Staff supported to fulfil registration requirements to ensure continuous professional development.	• Data dashboard and Risk Register discussed fortnightly by SMT • Regular finance meetings with Senior Leadership Team • Assurance Team • Committee reports • Regular contact with SWS and COSLA	

Assurance Map

Cluster – Education Service

Cluster Risk Register Risks:

1. **Removal of Scottish Attainment Challenge funding** - If the Scottish Attainment Challenge Funding is removed schools will be unable to continue to afford interventions in place to support young people
2. **Risk of poor external inspection by HMIE or Care Inspectorate for schools with self-evaluation scores of weak or satisfactory**.
3. **Risk that rising numbers of COVID infections impact on staffing**.
4. **Risk that the number of Senior Leadership vacancies leads to staff in posts that are not of required quality**
5. **Education - Demographic demands** - Growing demographic demands result in service delivery pressures

First Line of Defence (Do-ers)	Second Line of Defence (Helpers)	Third Line of Defence (Checkers)
• Trained and qualified staff • School Leadership Team oversight and quality assurance of day to day operations and finances in school • School health and safety procedures agreed annually • All staff involved in school risk assessment process • Designated school Health and Safety Reps • Risk assessments shared with all staff including Trade Union reps • School risk registers in place in all schools with effective mechanisms in place for review and escalation • School Business Continuity Plans in place • Tracking and monitoring arrangements in place in all schools to track attainment • School positive behaviour management procedure agreed yearly	• CMT Boards • Council Committees • Health and Safety guidance for schools • Identified health and safety team link for all schools • Child protection and safeguarding guidance and professional learning available to schools • Range of policies/procedures for schools to support consistent practice • Quality Improvement Framework setting expectations around accountability • Quality Improvement Visits to schools and Early Learning and Childcare provision • Quality Improvement Team monitoring of live data • Service Business Continuity Plan • Monitoring of complaints • Improvement groups comprising central Officers and school staff identify and address emerging risks	• Education Scotland inspections • Care Inspectorate Inspections • HSE inspections • Health and Safety Team compliance visits to schools • ECMT data reviews • External Audit • Monthly budget print outs • Annual Internal Audit Plan • Audit Scotland and National Audit reports • Internal Audit – Scottish Milk & Healthy Snack Scheme – April 2023 • Internal Audit – Pupil Equity Fund – 27/09/23

• School child protection and safeguarding procedures agreed yearly • Yearly analysis of school community data to inform the school improvement plan • Regular review of applications for school placements in order to identify emerging trends • Regular meetings with Higher Education to understand demand for school placements from international students • Calendar of data gathering around the health and wellbeing needs of pupils • Monitoring of levels of vacancy in schools and ELC provisions • In-service days and staff meetings to address any identified vulnerabilities	• Weekly Trade Union meetings • Engagement with Parents and Carers • Data dashboard and Risk Register discussed fortnightly by Senior Leadership Team • Regular finance meetings with Senior Leadership Team • Assurance Team • Regular contact with ADES and COSLA	

Assurance Map

Operations and Protective Services

Cluster Risk Register Risks:

1. **Substance Misuse** - Risk to services as a result of substance misuse issues in the operational workforce – causing both increased absence (and related cost) and potential risks to service provision and related health and safety concerns.
2. **Non-Compliance - Interventions / Food Law Code of Practice** - Risk of non-compliance with Interventions/Food Law code of practice due to lack of qualitied officers.
3. **Climate change – Tree Disease** - Risk to public safety, increased service demand, and staff H&S operational risks within Operations & Protective Services due to tree pest and diseases such as Ash Dieback and Dutch Elm.
4. **Loss of UKAS Accreditation** - The Laboratory losing, temporarily, its external UKAS accreditation following findings raised at either an annual, or unannou nced UKAS visit
5. **Sea Defence Failure** -Failure of Sea Defences
6. **Loss of Operator's Licence** - Effect of services inability to use goods vehicles through loss of operator's licence.
7. **Waste Disposal Failure** - Risk of waste disposal failure - loss of markets for materials or waste management contract failure

First Line of Defence (Do-ers)	Second Line of Defence (Helpers)	Third Line of Defence (Checkers)
• Trained and qualified staff • Operational plans and guidance including surveys, monitoring of existing infrastructure, committee reporting and guidance • Contract Management Guidance and Procurement Regulations • Procedures to implement contract management policies • Operational procedures • Climate risk Assessments & Guidance • Environmental risks (including climate risks) incorporated in business cases, committee reporting and guidance • Weather impact Assessments • Regular monitoring and Infrastructure Assessments • Budget planning for anticipated impacts/ budget requirements • Emergency plans, Operational response procedures	• CMT Boards • Senior Management Team (SMT) undertakes review of Cluster Operational Risk Register • Corporate Policy Documentation • Council Committees • Contract review by Demand Management Board • Strategic plans including North East Flood Risk Management Plan and Strategy; and development of Climate Adaptation Framework (Aberdeen Adapts) • Strategic Commissioning Committee • Inclusion in plans, programmes, strategies including those for planning, transport & housing • Local Resilience Partnership undertaking resilience planning and preparedness across all partners • Public protection committee oversight of resilience arrangements • Local Outcome Improvement Plan (LOIP) • APSE benchmarking	• Internal Audit – Vehicle Usage • Internal Audit -Vehicle Replacement Policy and Procurement • Internal Audit - H&S in Operations and Protective Services • Annual Climate Change report (Public Bodies Climate Change Duties) submitted to Scottish Government • Regional and National reports from Scottish Government, UK Government and SEPA • North Regional Resilience Partnership • Grampian Local Resilience Partnership • Scottish Government performance review and reports • Testing of emergency plans at partner level

• Investigation with other LA's / SCOTS and our Legal teams whether we can refuse to sign up to the legal agreement • Service Business Continuity Plans • Roads Winter Maintenance Plans • Flood Risk Management Plans • Community involvement • Cross Service training events • Joint working with internal/external resources and Environmental Services • Park Management Plans • Internal / external communication and networking • Committee reporting • LOIP Improvement projects 11.3, 13.2 • Maintaining an awareness of current accreditation requirements through receiving regular updates from UKAS • UKAS included as a main topic in team meetings and as an objective in PR&Ds • Fleet Service Users • Drivers / Operators • Fleet Workshop Managers and Operatives • Waste Service Policies	• Aberdeen Open Space Strategy • Aberdeen Food Growing Strategy • Partnership working through Northern Roads Collaboration Group / Committee • Comprehensive in-house quality system audit programme to cover all aspects of current quality systems. • Union partnership (safety representatives) • Planning works as per CDM regulations 2015 • Risk assessment Method Statements and procedures established and reviewed • Coordination of works by team leaders • Team Leader supervision • Internal inspection regimes • Fleet Management / Compliance Team • Procurement Team • Operational management team, Contract managers, Team leaders, Risk control team • Customer feedback management system • KPI's management systems established • Service User's	• Adaptation Capability Framework Benchmarking Tool • North Regional Resilience Partnership • Community Planning Aberdeen Board (CPA Board) • Local Outcome Improvement Plan (LOIP) Residual • Participation in external quality system audit programme to cover all aspects of current quality system • Participation in external quality system inspection programme to cover all aspects of current quality system • External Audit provider UK Logistics (FTA) • DVSA • Police Scotland • Inspection of Crematoria • Catering Service Quality Management System, BSI 9001 • CITB (Industrial Training Board) inspection/ audit • Skills development Scotland (Managing agency Tullos Training) Inspection/ audit • Gas Safe Register risk-based audit • Scottish Electrical Charitable Training Trust (Managing agency NICEIC) periodic audit • External fuel providers (contingency plan) • Scottish Road Works Commissioner – Annual Performance Review Report • Waste Data Flow Report to SEPA

Assurance Map

Finance

Corporate Risk Register Risk:

1. **Financial Sustainability** - Failure to deliver financial sustainability due to:
   - Failure to align resources to commissioning intentions and service standards
   - Inadequate financial reporting and planning
   - Failure to respond to external factors
   - Failure of partners, businesses or the 3rd sector
   - Failure of transformation plans, projects or service redesigns
   - Inadequate financial stewardship or capability

Cluster Risk Register Risk:

1. **Failure to deliver key financial services in the event of the failure of plans, capabilities, systems and processes**
   - Failure to deliver statutory monitoring
   - Failure to administer NESPF
   - Failure to provide business advice and financial implications of change
   - Inability to deliver key service standards and customer service
   - System failure
   - Failure of financial policies and controls, loss of income, poor management of council finances
   - Failure to make benefits of technology and best practice
   - Reputational damage and poor relationship management

First Line of Defence (Do-ers)	Second Line of Defence (Helpers)	Third Line of Defence (Checkers)
• Annual statements of accounts and quarterly reporting including valuations and balance sheet • Medium Term Financial Strategy, Budget Protocol and Budget setting • Monthly and Quarterly monitoring and reporting of budget including contingent liabilities	• Finance and Resources Committee scrutiny of all financial decisions • Pensions Committee scrutiny of pensions decisions • Audit, Risk and Scrutiny Committee oversight of risk management system • Audit Risk and Scrutiny oversight of Internal and External Audit reports	• Annual External Audit and report of ACC Accounts, Pension Funds and Group Accounts • Annual Internal Audit Plan based on risk and approved and overseen by Audit, Risk and Scrutiny Committee • Internal Audit – Lease Financing – 03/02/23 • Internal Audit – Following the Public Pound – 13/02/23

• Financial protocols in Scheme of Governance, Financial Regulations and associated financial procedures and practices • Financial policies and procedures including Counter Fraud, Following the Public Pound and Service Income • Finance Business Continuity Plan • Financial Implications review of all committee reports • Treasury Management reviews with our treasury consultants • Monitoring of Finance Cluster and Institutional risks • FM Code Self Assessment • Pension fund management protocols and procedures • Task plans, CR&D and Succession Plans • Horizon Scanning reviews • Embedding new impacts into BAU e.g. refugee costs, Monitoring and grant claims • Budget holder training	• Council and specific Charitable Trust Boards • Other Committees as applicable • Finance SMT • CMT and ECMT • Risk Board • Strategy Board • Transformation Board • Performance Board • ALEO assurance hub • IJB Risk Audit and Performance Board	• Internal Audit – Revenue Budget Setting and Financial Strategy - 2024 • Annual credit rating review • London Stock Exchange compliance checks • National Audit reports and Best Value Audit • His Majesty's Revenue and Customs Inspections • Treasury, Directors of Finance and other bodies reports and advice • Charities Commission (OSCR) reports and advice and reports on Trust Accounts • Scottish Government Returns e.g. budget and out-turn data, grant claim criteria • Data required by other grant funders and stakeholders of ACC • ICAS and CIPFA trainer accreditations • The Pensions Regulator • Bond Trustee

Assurance Map

Capital

Cluster Risk Register Risks:

1. **Capital Project**: Budget Allocations - Budget allocations within approved Outline Business Cases of projects are insufficient for project development/construction and any associated future maintenance obligations.
2. **Capital Projects**: Developer Obligations Income - The income from Developer Obligations is less than expected.
3. **Capital Projects**: Financial Stewardship - Risk that management failures / slippage in the delivery of capital projects /failure to secure and or retain funding from external sources, impacts negatively on the Council's financial stewardship.
4. **Capital Projects**: Resource – Lack of staff resources, which impacts negatively on the delivery of capital projects.
5. **Concurrent Risks**: External Impacts (Covid, Brexit, War, etc) - External factors such as Covid - 19 pandemic, Brexit, Ukraine (war), having a direct impact on the deliverability of projects/programmes contained within the approved Capital Programme.
6. **Construction delays due to interruption to supplies of materials**: Construction projects delayed due to interruptions to supplies of construction materials due to Covid, Brexit, climate events or industrial action.

First Line of Defence (Do-ers)	Second Line of Defence (Helpers)	Third Line of Defence (Checkers)
• Trained and qualified staff. • Follow Project Management protocols for project delivery. • Ensure project/programme risk register review meetings include consideration of any financial impact on the wider capital portfolio and any implications this may have across the Council. • Ensure key/sensitive projects allocated to managers with appropriate skills. • Review risk management training programme for key staff. • Seek guidance from Project Management Office. • Plan for good communication across Clusters. • Consider availability to utilise ACC staff with appropriate skill out with the Capital team to deliver the capital programme of projects.	• CMT Boards. • Council Committees. • Resources Function Senior Management Team (SMT) undertakes review of Cluster Operational Risk Register. • Review by Chief Officer Capital and provide any key updates to Director of Resources and other Chief Officers. • Review by Capital Board. • Report any issues by exception to the Performance Board. • Policy Documentation.	• External Audit.

• Consider availability of using consultant/contractor frameworks to facilitate the delivery of the capital programme of projects. • Ensure consultation with other key Chief Officers. • Cost estimates for key projects to be reviewed at key stages of delivery. • For significant/key projects ensure an independent cost estimate review check is carried out, prior to approving OBC. • Regular progress meetings. • Where appropriate maintain close collaboration with other Chief Officers throughout delivery. • Regular reporting to Finance Officers, monthly.		

Assurance Map

Corporate Landlord

Corporate Risk Register Risk:

1. **Reinforced Autoclaved Aerated Concrete Panels and Planks (RAAC**) - RAAC was a commonly used material in the 50's 60's, 70's and early 80's. There have a small number of incidents where roof planks have failed leading to the collapse to elements of the roof. RAAC has been confirmed as present in 5 non housing buildings. With RAAC present in 362 Council Houses and 142 former Council houses. Investigations are ongoing.

Cluster Risk Register Risks:

1. **Declining condition of operational property estate**
2. **Failure to deliver asset valuations** - Risk of failure to complete the asset valuation which is required for the council financial accounts.
3. **Inadequate Asset Management Planning** - Risk that resources will not be allocated appropriately and efficiently if asset management plan is not in place and is not robust.
4. **Risk of non-compliance with Statutory Compliance with Council Properties** - The Council is required to safeguard its employees and members of the public to ensure their health and safety through effective implementation of statutory maintenance and compliance checks such as asbestos management plans, gas safety certification, legionella testing etc.
5. **Risk to the delivery of Capital and Revenue Income** - The Cluster has income targets for capital and revenue income.

First Line of Defence (Do-ers)	Second Line of Defence (Helpers)	Third Line of Defence (Checkers)
• Trained and qualified staff • Operational procedures and guidance including those set out in the Business Continuity Plans in the event of a system or process failure. • Risk Assessments. • Staff training and development on business continuity arrangements. • Analysis following activation of Customer Experience Cluster Senior.	• CMT Boards • Council Committees • Policy Documentation. • Resources Senior Management Team (SMT) undertakes review of Cluster Operational Risk Register. • Executive Board Structure • Assurance Team. • Business Continuity Group Sub-Group.	• External Audit. • RICS Registration. • Internal Audit – Corporate Asset Management – 13/09/23

• Management Team (SMT) undertakes review of Cluster Operational Risk Register. • Staff have appropriate training, qualifications and engage with market and like professionals. • Regular marketing and income meetings. • Use of external property consultants, management agreements and managing agents as appropriate. • Resource plan developed. • Use of external advisors in specialised areas. • Participation in national networks (CIPFA/ ACES/ RICS/ SHoPs etc.) • Programmes of inspections for property portfolio. • Contract management meetings.	• Annual reporting of Function / Cluster Risk Register to Operational Delivery Committee • Monthly budget print outs. • Capital Board – post project reviews and post occupancy evaluations.	

Function	Cluster	Category	Inspection/Audit Activity Title	Focus Area	Year	Date
Commissioning	Commercial & Procurement	External Inspection or Audit	PCIP (Procurement Commercial Improvement Programme)	Commercial Procurement	2024	March
Commissioning	Governance	External Finance	Annual Credit Rating Assessment	Credit Rating	2024	November
Commissioning	Governance	External Inspection or Audit	External Audit Annual Report	Financial Controls/Annual Accounts	2024	August
Commissioning	Governance	External Inspection or Audit	Audit Scotland - Thematic Review "Leadership in the development of the council's strategic priorities"	Compliance	2024	January
Commissioning	Governance	External Inspection or Audit	Use of Investigatory Powers	Compliance	2026	TBC
Commissioning	Governance	External Inspection or Audit	SFRS - Audit of Care Homes and Children's Homes	Compliance	2024	Annual
Commissioning	Governance	External Inspection or Audit	SFRS - Visit/Inspection City Centre Tower Blocks (safety/access for fire service)	Compliance	2024	6 Monthly
Commissioning	City Growth	External Inspection or Audit	AAGM Firearms license inspection undertaken by Police Scotland	Compliance	2026	March
Commissioning	City Growth	Internal Process	AAGM & Mairtime Museum Environmental Health - catering outlets	Compliance	2024	Annual
Customer	Digital & Technology	Internal Process	PCI Technical Assessment	Security	Continuous	Quarterly
Customer	Digital & Technology	Internal Process	External Network Penetration Assessment	Security	Continuous	Annual
Customer	Digital & Technology	Internal Process	Internal IT Health Check	Security	Continuous	Annual
Customer	Digital & Technology	Internal Process	Cyber Resilience Self Assessment	Security	Continuous	Continuous
Customer	People & Organisational Development	External Inspection or Audit	Equally Safe at Work Accreditation	Equality and Diversity	2024	September
Customer	Customer Experience	External Inspection or Audit	DWP Housing Benefit Review	Compliance	2024	Nov
Customer	Customer Experience	External Inspection or Audit	Non-Domestic Rates NDRI – External Audit	Compliance	2024	January
Customer	Customer Experience	External Inspection or Audit	DWP Housing Benefit Subsidy Audit	Compliance	2024	November
Resources	Finance	External Finance	Stock Exchange Reporting and Compliance	Finance	Continuous	Continuous
Resources	Finance	External Finance	Charities Commission Accounts and Reports - Annual	Finance	Annual	December
Resources	Finance	External Finance	SG Returns - LFR/POBE	Finance	Annual	Nov/April
Resources	Operations & Protective Services	External Inspection or Audit	UK Logistics (FTA)	Gate Inspections (depots) and Vehicle Inspections (Vehicle Depots)	2024	Monthly
Resources	Operations & Protective Services	External Inspection or Audit	UK Logistics (FTA)	Fleet - Vehicle Records - vehicles within the scope of ACC's Operator's Licence	2024	June
Resources	Operations & Protective Services	External	Road Works Commissioners Office	Roadworks Register Annual performance figures	Annual	December
Resources	Operations & Protective Services	External Inspection or Audit	Quality Management System, BSI 9001:2015	FM Catering	2024	6 Monthly
Resources	Operations & Protective Services	External Inspection or Audit	SECT (Managing Agency NICEIC) Approved Contractor Scheme Perodic Audit	Building Services	2024	Periodic
Resources	Operations & Protective Services	External Inspection or Audit	Gas Safety Register (Gas Safe Register) Staff Registration	Building Services	2024	August
Resources	Operations & Protective Services	External Inspection or Audit	Skills Development Scotland (Managing Agency CITB)	Building Services	Continuous	Continuous
Resources	Operations & Protective Services	External Inspection or Audit	Scottish, Northern Ireland Employers Federation (Tullos Training)	Building Services	Continuous	Continuous
Resources	Operations & Protective Services	External Inspection or Audit	Inspection of Crematoria	Compliance - Regulations and record keeping (Inspectors Inspection)	2024	TBC
Resources	Operations & Protective Services	External Inspection or Audit	UKAS Accreditation	Compliance, systems and processes	2024	February
Resources	Operations & Protective Services	External Inspection or Audit	BSI - ISO 9001 - Roads Operations - Tullos	BSI - ISO 9001 - Roads Operations - Tullos	2023	6 Monthly
Children's & Family Services	Children's & Family Services	External Inspection	Children's Social Work	Chlidren's Care Home Inspections	2024	Continuous
Children's & Family Services	Children's & Family Services	External Inspection	Experiences of Disabled Children and Young People	Compliance with Standards	2024	May (Concludes May 2024)
Children's & Family Services	Education	External Inspection or Audit	Education Scotland Inspections of Schools	Compliance	2024	Continuous
Children's & Family Services	Education	External Inspection or Audit	CLD Progress Visits	Compliance/Progress	2024	September
Children's & Family Services	Education	External Inspection or Audit	Care Insectorate Inspections of ELC	ELC and National Standards	2024	Continuous
Children's & Family Services	Education	Internal Process	Health and Safety team compliance visits to schools	H&S Compliance	2024	Continuous
Children's & Family Services	Education	Internal Process	Performance reports to Committee	Attainment data	2024	Triannual

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ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	12 February 2024
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Annual Review - Risk Appetite Statement
REPORT NUMBER	COM/24/009
DIRECTOR	Gale Beattie
CHIEF OFFICER	Jenni Lawson/Vikki Cuthbert
REPORT AUTHOR	Ronnie McKean
TERMS OF REFERENCE	Remit 1.1

1. PURPOSE OF REPORT

1.1 The purpose of this report is to present the Council's updated Risk Appetite Statement to Committee for approval.

2. RECOMMENDATION(S)

It is recommended that the Committee:

2.1 Approve the updated Risk Appetite Statement, attached at Appendix A; and

2.2 Note the progress made towards embedding the RAS during 2023 and the training and engagement activities planned for 2024.

3. CURRENT SITUATION

3.1 The Council's Risk Appetite Statement (RAS) sets out the categories of risk recognised by the Council and the amount (extent) of risk that the Council is/is not prepared to tolerate in pursuit of its strategic outcomes. The RAS balances the relationship between acceptance of risk in one area to achieve the benefits or outcomes required in another area and recognises that there are both threats and opportunities in the management of risk.

3.2 The RAS was last reviewed by Committee in March 2023 and is a key element in the Council's risk management framework as illustrated below:

3.3 When the Council's RAS was originally approved by Committee in December 2020, it was agreed by Committee to undertake an annual review to ensure the levels of risk appetite are appropriate and reflect any changes in our risk environment.

3.4 The process of embedding the RAS within the Council has continued to progress during 2023 and it continues to be used by officers when exercising delegated powers and to guide strategic/operational proposals and decision making as demonstrated by the examples below:

- **Corporate Management Team (CMT)/Extended Corporate Management Team (ECMT)** – RAS has been integrated into the budget process to support the assessment of any options to be considered by officers and Elected Members.
- **Executive Boards and Committees –** Capital Project Business Case Template risk section has been updated to reflect RAS to ensure that risk appetite is considered in planning for capital projects.
- **"Managing Risk" Intranet Pages –** these pages contain links accessible to officers and Elected Members on the Council's RAS, Risk Management Policy, Guidance and Training.
- **Internal Audit -**
    - Council's risk register and RAS were used in the formation of the 2024-27 Audit Plan, also presented to this committee for approval.
    - Audit recommendations consider the level of risk appetite in the area audited to ensure they are proportionate to the level of risk appetite.

3.5 Further improvement activities will be conducted during 2024. These activities will include:

- Incorporate RAS into the Council's Integrated Impact Assessment (IIAs) supporting processes.

- Update of the Council's Budget Protocol to incorporate RAS to enable assessment and alignment of proposals against the RAS.
- Further development of "Managing Risk" intranet pages.
- Elected Member training on scrutiny.

3.6 The existing RAS was considered and reviewed by ECMT and CMT in November 2023 and by the Risk Board in December 2023. The revisions agreed and proposed are included in the updated RAS attached in Appendix A and are summarised below.

The updates proposed reflect the Council's current operating environment which includes the on-going recovery from the pandemic, current and future economic challenges, inflationary pressures and increased demand for Council services. If approved, the revisions will take effect from 1st April 2024.

- **Strategic Risk** – the appetite level within this category remains unchanged however, the text has been updated to reflect that changes in strategic direction may be required in order to respond to threats emerging from external factors. In recent years, local authorities have reacted to significant change in the world's economy, geo-political events and the pandemic. In expectation of some these turbulent events continuing, it is recommended that we reflect this in our appetite for strategic risks.
- **Compliance Risk** – the appetite level within this category remains unchanged however, the text has been updated to provide assurance that any deviation from Council's duties would require the appropriate approvals to be in place. This provides additional assurance and a safeguard against non-compliance.
- **Operational Risk** – the appetite level within this category remains unchanged however, the text has been updated to reflect the increase in demand for the Council's services and the impact this may have on our operational performance. By aligning our appetite level to the Council's agreed service standards and statutory duties, we ensure that we have a shared clarity on the risks we are willing to take.
- **Reputational Risk** – the appetite level in this area remains unchanged however, the text has been updated to make clear that there is a need to balance a number of factors when we make decisions which affect our reputation. This relates to the possibility of the Council making strategic and operational decisions in response to increased demand for our services whilst under budget pressures. Service improvement and performance, strategic outcomes and commissioning intentions would ideally be aligned with one another, but there may be occasions where this is a balancing act.

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 There are no risks arising from the recommendations from the report. The RAS is a supporting document which forms part of the Council's overall system of risk management. The risk management system ensures that all risks attaching to the Council's business and strategic priorities are identified, appropriately managed and that the Council's activities are compliant with its statutory duties.

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	The council is required to have a management system in place to identify and mitigate its risks.	The council's risk management system requires that risks are identified, listed and managed via Risk Registers.	L	Yes
Compliance	As above.	As above.	L	Yes
Operational	As above.	As above.	L	Yes
Financial	As above.	As above.	L	Yes
Reputational	As above.	As above.	L	Yes
Environment / Climate	As above.	As above.	L	Yes

8. OUTCOMES

8.1 The recommendations within this report have no direct impact on the Council Delivery Plan however, the risks contained within the Council's risk registers could impact on the delivery of organisational outcomes.

9. IMPACT ASSESSMENTS

Assessment	Outcome

Integrated Impact Assessment	It is confirmed by the Interim Chief Officer – Governance (Assurance) that no Integrated Impact Assessment is required.
Data Protection Impact Assessment	Not required
Other	Not applicable

10. BACKGROUND PAPERS

10.1 None

11. APPENDICES

11.1 Appendix A – Annual Risk Appetite Statement – Proposed Changes

12. REPORT AUTHOR CONTACT DETAILS

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Risk Appetite Statement

April 2024~~3~~

Contents

1. Purpose

The Council's risk appetite statement sets out how the Council balances the risks and opportunities in pursuit of delivering the outcomes set out within the Local Outcome Improvement Plan and associated strategies.

The risk appetite statement is a key element that supports our Scheme of Governance and should provide guidance when decisions are made by Full Council, committees and sub-committees within their Terms of Reference, and officers under the Powers Delegated to Officers.

The statement will assist Council Officers and Elected members in considering their response to findings and recommendations arising from external audits and inspections.

There may be occasions where there are competing risks to which the Council has a competing risks and appetites. In such instances, the decision maker and/or the officer making a recommendation, will be expected to consider and manage those competing risks and appetites and exercise careful judgement.

From time to time, the Council may deviate from its agreed risk appetite. When this is case, it will be important to exercise judgement whilst assessing the potential impacts across the organisation.

The statement is reviewed annually by the Risk Board and the Corporate Management Team which will submit any proposals for revision to the Audit Risk and Scrutiny Committee.

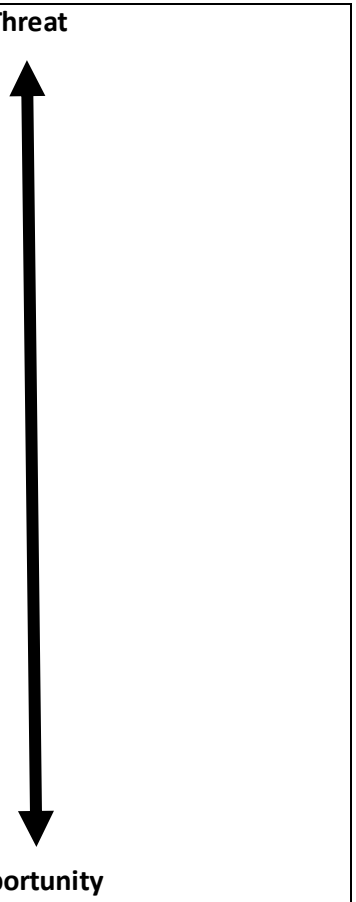
2. Risk Categories

The Council recognises the following categories of risk:

- Strategic
- Compliance
- Operational
- Financial
- Reputational
- Environment/Climate

3. Risk Appetite Definitions

Appetite Level (determined by risk category)	Approximate Target Risk Score Equivalent	Description
Averse	**1-6 (Low)**	Avoidance of risk. Uncertainty in achievement of strategic objectives and delivery of outcomes is critical. Activities undertaken will only be those considered to carry virtually no risk
Cautious	**8-9 (Medium)**	Willing to accept/tolerate a degree of risk when selecting which activities to undertake in order to achieve a significant reward and to achieve delivery of strategic outcomes and objectives. The activities may carry a high degree of risk that will be mitigated and controlled.
Open	**10-12 (Medium)**	Undertakes activities by seeking to achieve a balance between a high likelihood of successful delivery and a high degree of reward and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Hungry	**15-24 (High)**	Eager to be innovative and choose activities that focus on maximising opportunities (additional benefits and goals) and offering potentially very high reward, even if these activities carry a very high residual risk.



4. Overarching Statement

Aberdeen City Council delivers a wide range of services to the citizens of Aberdeen. Risk management forms a fundamental part of its operations, and the Council recognises that whilst it may be desirable to avoid risks it must also accept risks in order for the Council to evolve and achieve its ambitions for the people and the place.

Strategic

The Council is **cautious** to risks which may threaten the delivery of critical services, our outcomes and commissioning intentions.

The Council is **open** to taking well managed risks when opportunities provide clear benefits allowing for improvement, innovation, and transformation **or when the threat from external factors necessitates a change in strategic direction.**

The Council has an **open** appetite for risks that provide and contribute to the economic prosperity of the City.

Compliance

The Council is **averse** to any risks that will result in non-compliance or breaches in statutory obligations, regulations, and law. **Any deviation from our duties will require the appropriate approvals in place.**

The Council is **cautious** when giving legal advice and considers the likelihood of any legal challenge and the likely success of any legal challenge.

Operational

The Council is **cautious** to any risks that may have a negative effect on the health and safety, diversity and equality of its staff, elected members and members of the public.

The Council has an **open** appetite to the risks that allows it to **deliver** ~~manage~~ service**s in the face of growing** demand **including from external factors, provided these risks are assessed in light of our statutory duties and our agreed service standards.** ~~continuously improve service delivery and performance.~~

Financial

The Council is **averse** to risks associated with impairing financial stewardship, internal controls, and financial sustainability.

The Council has an **open** appetite for short-term risks that support financial performance and mitigate negative external factors. It has a~~n~~ **cautious** appetite for longer term capital and financial investments provided that the risks are well managed and demonstrate realisable future benefits for delivering the Council's outcomes and commissioning intention

Reputational

The Council relies on its reputation to ensure engagement with communities, partner organisations and stakeholders in order to deliver its strategic outcomes.

The Council has a **cautious** appetite to reputational risk **but** ~~and~~ will accept opposition when its activities and projects **are on balance designed to secure** ~~will provide~~ longer-term benefits and improvements to service delivery, performance, outcomes and commissioning intentions **or all of the above**.

Environment/Climate

The Council has an **averse** appetite for any risks that may have a long-term detrimental impact ~~up~~on the environment but is **hungry** for well managed risks in order to contribute to **a** net zero **City and target of net zero Council** ~~corporate~~ ~~carbon~~ emission~~s~~ ~~targets in the City~~ by 2045.

The Council is **cautious** to any risks relating to the impact of climate change which may threaten the delivery of critical services, our outcomes and commissioning intentions.

ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	12 February 2024
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Public Sector Equality Duty
REPORT NUMBER	COM/24/005
DIRECTOR	Gale Beattie
CHIEF OFFICER	Vikki Cuthbert
REPORT AUTHOR	Vikki Cuthbert
TERMS OF REFERENCE	4.4

1. PURPOSE OF REPORT

To provide management assurance on the Council's compliance with its statutory duties under the Equality Act 2010, specifically in relation to our Public Sector Equality Duty.

2. RECOMMENDATION(S)

That the Committee –

2.1 note the management assurance on the controls in place for managing the Council's compliance with the Public Sector Equality Duty; and

2.2 note that the Annual Governance Statement, reported to this Committee as part of the annual accounts audited by Audit Scotland, will assess the effectiveness of our controls in this area, any residual risk and how we manage it, and that this will be reported here in April.

3. CURRENT SITUATION

3.1 This report responds to the following Convener statement in the Annual Effectiveness Report for this Committee in November 2023:

> "I have instructed a management assurance report to the February meeting of the Committee on the Council's compliance with the requirements under the Equalities Act 2010 to meet our Public Sector Equality Duty. It is then the role of our auditors to undertake their own scrutiny through internal and external reports. Together, these will help us to understand the extent of any control weaknesses in relation to the closing of libraries and Bucksburn pool, and provide assurance to that we are transparent about lessons to be learned as a result."

3.2 Local authorities have legal obligations under the Equality Act 2010 relating to the Public Sector Equality Duty (PSED), as part of which they must give due regard to the need to eliminate unlawful discrimination, victimisation and harassment, advance equal opportunity and foster good relations in respect of protected characteristics. They must also assess the equality impact of proposed and revised policies and practices.

3.3 For a number of years now, this duty, in regard to decision making, has been evidenced by the Council through the use of Integrated Impact Assessments (IIA). These accompany committee reports which recommend a decision requiring the "due regard" referred to above to be taken into account. Equality impacts, as well as impacts of the UN Convention on the Rights of the Child, Human Rights impacts and socio-economic impacts are all captured with the IIA, although the only requirement with a legislative duty is the equality duty and the socio-economic duty.

3.4 More recently, officers have reviewed the measures in place to support members to consider the possible impacts of recommendations on protected characteristics. This has been partly in response to the judicial review of Council decisions following the closure of libraries and Bucksburn Swimming Pool in the 2023 budget process, and ensures that we are satisfied that we are fully compliant with the Public Sector Equality Duty. In addition, it is clear that the financial challenges faced by local authorities place considerable pressure on our ability to deliver the services we are responsible for, the impacts of which must be understood and mitigated for in future annual budget decision making processes.

3.5 The Accounts Commission's 2023 report *Local Government in Scotland: An Overview*, recommends that there is a need to "be open and clear with communities and staff about the need for change, what that means for future service delivery and involve communities in making difficult decisions". Also, councils "should have a clear plan for strengthening their use of data to understand needs, make decisions and direct resources. This includes equalities data and learning from those with lived experience". This has sharpened the focus of local authorities in refining the processes which support compliance with the Public Sector Equality Duty.

3.6 Guidance for public authorities has recently been updated by UK Government and replaces guidance from 2010. As well as providing practical advice on how to comply with the duty and how to demonstrate compliance, the guidance provides useful balance on when the duty should be met – including some operational decisions, strategic decisions – and when it is not likely to be required.

3.7 A Steering Group was established in July 2023 and chaired by the Interim Chief Officer – Governance (Assurance) to oversee an improvement plan, the primary purpose of which was to ensure that the full impacts of officer recommendations are clear to members at the point of decisions being taken. This would include the mitigations which officers propose to manage any risk of discrimination, victimisation or harassment.

3.8 As a Council that adopts a continuous improvement methodology, work to further improve our processes and ensure compliance with our Public Sector Equality Duty is both **structural** - having the right policies, templates and processes in place; and **cultural** – having the right mindsets, training, support and social pressure/expectations for our workforce. So to embed IIA compliance, improve quality of consultation and engagement and improve proposals/decision making, we are following our approved change management methodology.

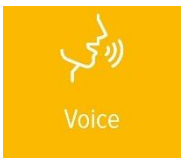
3.9 Following this approach, and accompanying gap analysis, a comprehensive and holistic action plan has been developed and progress has been made at pace since July 2023. The main improvements already put in place over recent months are listed below, amongst others which are planned in the first quarter of 2024:

Cultural Improvements:

- Chief Officers have been trained in Public Sector Equality Duty by external legal specialists so that they understand the Equality, Diversity & Inclusion agenda and current best practice – and actively champion this within their own cluster and across the organisation.
- A Director hosted the Leadership Forum event for 120 senior leaders across the council to demonstrate corporate leadership of Public Sector Equality Duty.

- New Sharepoint site (Equality, Diversity and Inclusion Hub) has been established for officers and members including resources such as FAQs, worked case studies and guidance on how to engage with people with protected characteristics.
- Improved accessibility to online IIAs for elected members and the public.

- A Leadership Forum event delivered on the importance of the Public Sector Equality Duty and tools and guidance available for officers when developing proposals requiring an IIA.
- Committee Business Planners will prompt report authors well in advance of the drafting of reports as to the requirements for IIAs.



- A Budget Protocol was approved by Council in June 2023 which incorporates the need for stakeholder engagement on budget options as they are developed, with a clear requirement for these to be equality impact assessed from the very outset and updated throughout their development. External legal specialists were consulted in the development of the Protocol.
- Engagement sessions held with stakeholder groups to understand impact of budget options, and possible mitigations.

- Self-learning resources developed and available through SharePoint site.
- Equality Ambassadors are identified to support the organisation in learning about protected characteristics groups and the Public Sector Equality Duty.
- Pitstop sessions scheduled for officers to learn more about the importance of and process for, assessing impacts and putting mitigations in place.
- Training for elected members on their responsibilities with PSED.
- We will continue the journey of improvement through training and comms to staff and members, to embed our understanding of these duties in our day-to-day approach to developing policies
- Using digital technology to transform the Integrated Impact Assessment process and governance, using design thinking methodology and co-design approaches.

- Workshops delivered with managers to understand current experience of IIA process. As a result a revised IIA template combining stage 1 and 2 and providing additional links to authors to support them with their assessment, has been effective since 1st January 2024. This will mean that officers need to identify mitigations at the same time as any impacts are identified.

- It is intended to introduce a service standard for approval as part of the Council Delivery Plan and this will be monitored by the Performance Board and through the relevant Committee.
- An Equality, Diversity and Inclusion Policy will be presented to Staff Governance Committee in the first half of 2024, including measures for performance.

3.10 The Council was subject to four petitions for judicial reviews in 2023 relative to budget decisions on the closure of six libraries and Bucksburn swimming pool. These petitions have now been withdrawn following on from the consultation exercises undertaken and updated IIAs presented to Council in December. The process of legal challenge has provided valuable learning for us as a Council, and the improvements outlined above address the gaps which led us to judicial review. We will of course continue to monitor our journey. The Council's Annual Governance Statement, being reported as part of the annual accounts, will also assess the effectiveness of our controls in this area and any residual risk and how we manage it. This is scheduled to be reported to this Committee in April, and to a subsequent meeting, at the conclusion of the external audit process carried out by Audit Scotland and presentation of their Annual Audit Report for financial year 2023/24.

4. FINANCIAL IMPLICATIONS

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

4.2 The cost of defending the recent Judicial Reviews in relation to the libraries and Bucksburn Swimming Pool was £30,784 which includes external legal fees,

counsel fees, court outlays, met from contingencies for Council legal costs. Training fees were £624 plus VAT, met from the corporate training budget.

5. LEGAL IMPLICATIONS

5.1 The Public Sector Equality duty requires decision-makers to understand and take account of the consequences of their choices, having due regard to the aim of eliminating conduct prohibited by the act, advancing equality of opportunity and fostering good relations. At the same time, the duty is not a rubber stamp. It is a legal requirement. Making decisions without having due regard to the duty can be unlawful.

5.2 Responsibility for complying with the general duty falls on the decision-maker. It is therefore essential that the decision-maker is made aware of any work that others have done to comply with the duty.

5.3 The activities outlined should mitigate the risk of successful legal challenge against the authority. Provided the Council meets the requirement of "due regard", including consideration of mitigations, it does not prevent members from making decisions which may impact negatively on some groups with protected characteristic. The Council has other legal duties that need to be met, and a decision that has some impacts can be proportionate, with appropriate mitigations, when balanced against the Councils other legitimate aims such as the duty to balance the budget each year.

6. ENVIRONMENTAL IMPLICATIONS

6.1 There are no environmental implications arising from the recommendations in 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	None.			**Yes**
Compliance	Risk that Equalities and Human Rights Commission can take enforcement action	Improvement plan to improve internal compliance.		**Yes**

	against the Council.			
Operational	None.			**Yes**
Financial	Risk that Council will be subject to further Judicial Reviews which incur additional costs.	Improvement plan to ensure robust IIAs are available to inform decision makers.		**Yes**
Reputational	Risk that the Council is not perceived as undertaking due diligence.	Improvement plan to ensure due diligence.		**Yes**
Environment / Climate	None.			**Yes**

8. OUTCOMES

COUNCIL DELIVERY PLAN 2023-2024	
	Impact of Report
Aberdeen City Council Policy Statement **Working in Partnership for Aberdeen**	The proposals within this report support the delivery of the following aspects of the policy statement:- • Recognise that citizens and communities – rather than the City Council - are best placed to say what services they require and how these are provided and seek to give greater control over appropriate services and facilities to local communities.

9. IMPACT ASSESSMENTS

Assessment	Outcome
Integrated Impact Assessment	It is confirmed by the Interim Chief Officer – Governance (Assurance) that no Integrated Impact Assessment is required.

Data Protection Impact Assessment	Not required.
Other	None.

10. BACKGROUND PAPERS

10.1 Public Sector Equality Duty: Guidance for Public Authorities – 18th December 2023

10.2 Public Sector Equality Duty: specific duties in Scotland | EHRC (equalityhumanrights.com)

11. APPENDICES

None.

12. REPORT AUTHOR CONTACT DETAILS

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ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	12 February 2024
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Assurance Reporting
REPORT NUMBER	COM/24/006
DIRECTOR	Gale Beattie
CHIEF OFFICER	Vikki Cuthbert
REPORT AUTHOR	Vikki Cuthbert
TERMS OF REFERENCE	4.4

1. PURPOSE OF REPORT

To advise Committee of the requirements for audit and scrutiny activities in 2024 and of the associated pressures on Council resources.

2. RECOMMENDATION(S)

That the Committee:

2.1 Instruct the Interim Chief Officer – Governance (Assurance) to seek a schedule of external audit reporting in 2024/25 from Audit Scotland by 31st March 2024, including dates for reporting the audited annual accounts and Best Value reports, in order that officers can plan for resourcing these activities, update committee business planners and ensure the requirements to notify the London Stock Exchange are fully met;

2.2 Instruct the Interim Chief Officer – Governance (Assurance) to write to the chair of the Strategic Scrutiny Group, comprising Scotland's main public sector scrutiny bodies, to seek a schedule of external scrutiny in 2024/25 to allow Council resources to be allocated accordingly; and

2.3 Note the management proposals on the Internal Audit Plan 2024/25 and seek the views of the Chief Internal Auditor on these proposals when considering the Plan at a later point in this agenda.

3. CURRENT SITUATION

3.1 The Committee will be familiar with the three lines of defence model as an approach to risk management. This is referenced throughout other reports on this agenda, the basic principle being that we defend against the risks to the Council through 1) management actions day-to-day 2) internal control systems, policies and frameworks which regulate those management actions and 3) risk-based independent assurance – this comes from internal audit, which provides assurance on the effectiveness of our governance, risk management and internal controls, and from external audit and external inspection bodies.

3.2 Management assurance is reported to the committee in the form of reports such as our use of investigatory powers, risk appetite, risk registers and business continuity. Internal audit present their Internal Audit Plan and review reports, Internal Audit Progress Reports, the Internal Audit Charter and Annual Reports. External Audit present an Annual Audit Plan, Best Value Audit reports, audit opinions on the Council's Annual Accounts and those of its charities, and an Annual Audit Report. Until relatively recently, the Local Area Network produced a report on the external inspections which are planned for us however as reported to Committee in May 2023 (COM/023/128), this scrutiny activity is no longer reported as part of the external audit process. Audit Scotland, through their published Scrutiny Programme, notify local authorities of intended scrutiny, however this has not proved to be reflective of our experience of audit work completed in 2023/24.

3.4 An effective audit and inspection regime is an essential part of the council's end of year Annual Governance Statement, which is in turn required for sign-off of our Annual Accounts under statute. Notwithstanding, management must spend considerable time resourcing the response to audit and scrutiny activities and effective scheduling is essential if management are to manage all the demands on the limited resource available.

3.5 Agenda item 9.2 details our corporate risks, those presenting us with the most significant threat to achievement of our strategic outcomes. In the past year, members will note that we are now managing the risk around Reinforced Autoclaved Aerated Concrete (RAAC), the impacts of which will may be far-reaching. Furthermore, the risk scores relating to Financial Sustainability and Resettlement/Asylum Demand have increased since last reported to committee. Much officer time is being spent managing these risks. For that reason, the demands placed on us by delayed external audits, unexpected inspections and non-essential internal audits need to be reduced.

3.6 In 2023, the Council held 4 adjourned meetings and 3 requisitioned meetings, in addition to the scheduled 7 meetings. Officer preparation and time spent on these additional Council meetings is significant and clearly requires resourcing.

External Scrutiny

3.7 In 2016/17, Aberdeen City Council obtained a credit rating and issued bonds of £370 million on the London Stock Exchange (LSE). This brought with it reporting and governance requirements from the LSE. To comply, the Council's Annual Accounts are now prepared to earlier deadlines as there is a requirement for Annual Reports to be published within four months of their year-end. As the Council's year end is 31st March this means that the Annual Accounts must be audited and approved by Committee by 31st July, each year. This deadline has not been met in recent years. In 2022/23, Audit Scotland intended to conclude the audit on 20 July 2023 but following the Council's need to reschedule the meeting, the 2022/23 Accounts were approved at this Committee on 15 August 2023. While an improvement on the previous year, this was 15 days after the required deadline.

3.8 In addition and as previously reported, the Best Value reporting regime has been modified by Audit Scotland, resulting in increased check-in points. As well as the annual financial audit report, Committee is due to receive a Best Value Thematic Report once a year. During the five year audit appointment, the Accounts Commission will consider each council's best value arrangements at least once. The report considered by the Commission will essentially be that year's annual audit report and best value thematic report. Audit Scotland, as our appointed auditor, are in the first year of implementing this schedule and expect the thematic report to be submitted in April, rather than last September as originally anticipated. There is a risk this will impact on the above requirement for early close of accounts.

3.9 Committee is referred to the item on this agenda "Corporate Risk Register, Assurance Maps and Inspections Planner". The Inspections Planner supports officers in preparing for external scrutiny, both from a scheduling and a readiness perspective. Unfortunately, the lack of an external scrutiny plan from the Local Area Network means that there are some gaps in this planner, and the report notes that some services are not currently sighted on all the areas of service likely to be subject to inspection. This will create in-year pressure when such inspections do come to fruition. The Strategic Scrutiny Group publishes the planned scrutiny activity for each local authority, however this has not aligned with the actual scrutiny activity undertaken in recent years. The committee is therefore recommended to formally seek confirmation of the planned external scrutiny activity in 2024/25 to allow council resources to be allocated accordingly.

Internal Audit Plan

3.10 Agenda item 9.13 is the proposed Internal Audit Plan from the Chief Internal Auditor. This includes a total of 21 internal audits in the coming financial year 2024/25, two of which are audits of the Integration Joint Board and one of the North East of Scotland Pension Fund. This means there are 18 audits of Council service areas.

3.11 The Chief Internal Auditor requires a minimum number of internal audits to be completed in a year to inform the annual opinion on the effectiveness of our internal controls and governance. This is then included in the end of year assurance within the Annual Governance Statement, informing external auditor opinion when they complete their audit of annual accounts.

3.12 In light of the pressures outlined above – emergence of new corporate risks and the escalation of existing risks, lack of visibility on the content and scheduling of external scrutiny and additional demand from committee governance – management view is that there is not sufficient capacity within our system to support 18 internal audits in 2024/25 unless additional resource is made available through the budget process. Committee will be asked to consider reducing the number of audits by six and to remove the audits listed below from the plan, when agreeing this at item 9.13. These audits are in areas which support our broader governance arrangements rather than internal financial controls and systems which are a priority for supporting the year end opinions of both the chief internal auditor and the external auditor. If agreed,

the Chief Internal Auditor, following consultation with the corporate management team, will advise the committee through his cyclical update report whether capacity has become available based on the progress of the remaining audits. This may include moving forward audits from the remainder of the three year plan, if these can be more easily managed and officer capacity released. Some service areas will be under particular pressure in the year ahead, as described in paragraphs 3.5 and 3.6, and external scrutiny is an unconfirmed pressure at this point in time. If there is no decision to reduce the number of internal audits, the Committee will be asked to note that limited capacity will impact on our ability to close off audit recommendation and therefore extended timelines will be proposed for the implementation of recommendations..

3.13 Audits recommended for removal from 2024/25 plan:

	Audit Title	**Cluster**
1.	Risk Management	Governance
2.	Right to Work in UK	People and Organisational Development
3.	Freedom of Information and Subject Access Requests	Customer Experience
4.	SEEMIS	Education
5.	Trusts/Common Good Funds	Finance
6.	Corporate Landlord Responsibilities	Corporate Landlord

4. FINANCIAL IMPLICATIONS

4.1 There are no financial implications arising from the recommendations in this report. Any additional hours freed up by the Chief Internal Auditor through a reduction to twelve Council audits will be invested in additional consultancy work, which is less onerous on officers than core assurance audits. There will be no saving to the Council from a reduction of internal audit activity.

5. LEGAL IMPLICATIONS

5.1 Aberdeen City Council is required to keep accounts of all transactions relating to all funds of the Council. These accounts must be audited annually by a professional accountant. The Council's external auditor is Audit Scotland. This duty is found in Part VII of the Local Government (Scotland) Act 1973.

5.2 Aberdeen City Council has a duty to secure Best Value. This duty was introduced by the Local Government in Scotland Act 2003. This piece of legislation also introduced best value audits. It requires that the auditor of a local authority's accounts be satisfied that the local authority has made proper arrangements for securing best value.

5.3 The Financial Conduct Authority requires through Disclosure Transparency Rule 4 that the Council, as a bond issuer, must make public its annual financial report at the latest four months after the end of each financial year.

6. ENVIRONMENTAL IMPLICATIONS

6.1 There are no environmental implications arising from the recommendations in 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	Risk that control failures impact of delivery of strategic outcomes.	Best Value audits, annual audit and external scrutiny will be completed.	L	**Yes**
Compliance	Risk of internal control failures through lack of scrutiny.	Remaining internal audits will focus on internal financial controls. Those proposed for removal are assessed to be low risk.	L	**Yes**
Operational	Risk of a lack of scrutiny on operations.	Remaining audits are spread equally across operational areas.	L	**Yes**
Financial	Risk of internal control failures through lack of scrutiny.	Remaining internal audits will focus on internal financial controls. Those proposed for removal are assessed to be low risk.	L	**Yes**
Reputational	None.			
Environment / Climate	None.			

8. OUTCOMES

The recommendations have no impact on the delivery of our outcomes.

9. IMPACT ASSESSMENTS

Assessment	Outcome

Integrated Impact Assessment	It is confirmed by the Interim Chief Officer – Governance (Assurance) that no Integrated Impact Assessment is required
Data Protection Impact Assessment	Not required.
Other	None.

10. BACKGROUND PAPERS

Best Value in Scotland (audit-scotland.gov.uk)
Local government in Scotland: Overview 2023 | Audit Scotland (audit-scotland.gov.uk)

11. APPENDICES

None.

12. REPORT AUTHOR CONTACT DETAILS

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ABERDEEN CITY COUNCIL

COMMITTEE	Audit Risk and Scrutiny Committee
DATE	12 February 2024
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Use of Investigatory Powers - Annual Report 2023
REPORT NUMBER	COM/24/010
DIRECTOR	Gale Beattie
CHIEF OFFICER	Jenni Lawson- Interim Chief Officer - Governance
REPORT AUTHOR	Vicki Johnstone - Regulatory and Compliance, Legal Services
TERMS OF REFERENCE	5.2

1. PURPOSE OF REPORT

1.1 To provide Elected Members with an overview of the Council's use of investigatory powers during 2023, particularly focussing on the Committee's role in respect of assurance. Further, Committee is being asked to confirm that the Use of Investigatory Powers Policy is fit for purpose.

2. RECOMMENDATION(S)

That the Committee:-

2.1 Notes the overview of the Council's use of investigatory powers during the calendar year 2023, as set out in this report; and

2.2 Agrees that the Use of Investigatory Powers Policy remains fit for purpose.

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 worked together to put in place operational procedures to ensure compliance with the requirements of the IPA. The operational procedure in respect of Communications data was approved on 27 April 2023.

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 September 2023 and Committee was verbally updated on 14 September 2023. The IPCO undertook an inspection of Aberdeen City Council's compliance with RIPSA and the IPA and concluded that they were "*satisfied that [the Council's] reply provided assurance that ongoing compliance with RIP(S)A 2000 and the Investigatory Powers Act 2016 will be maintained. As such your Council will not require further inspection this year*". The IPCO will next inspect the Council in 2026.

3.4 The Council approved the Use of Investigatory Powers Policy in December 2021[1]. This policy governs compliance with both RIPSA and the IPA. It remains a mandatory requirement that all members of staff wishing to use investigatory powers must undertake training prior to being able to make an application to use such investigatory powers.

3.5 Committee is asked every year to confirm that the Use of Investigatory Powers Policy remains fit for purpose. Accordingly, Committee is being asked to agree that the Use of Investigatory Powers Policy remains fit for purpose. There have been no substantive changes to the Use of Investigatory Powers Policy since the Policy was reviewed last year. The IPCO are also content with the Use of

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

Investigatory Powers Policy. Further, Committee is being asked to note the overview of the Council's use of investigatory powers during 2023.

Use of Investigatory Powers Policy

3.6 The Policy was approved by this Committee in December 2021. The Team Leader, Regulatory and Compliance, Legal Services, as the Council's RIPSA Co-Ordinator has reviewed the Policy and confirms that the Policy still remains fit for purpose.

3.7 Committee is asked to note that the Policy is supported by operational procedures. One of these operational procedures has been renamed and is now called Aberdeen City Council - Corporate Procedure on Communications Data. The Covert Surveillance Procedure has also been reviewed and no further changes are required.

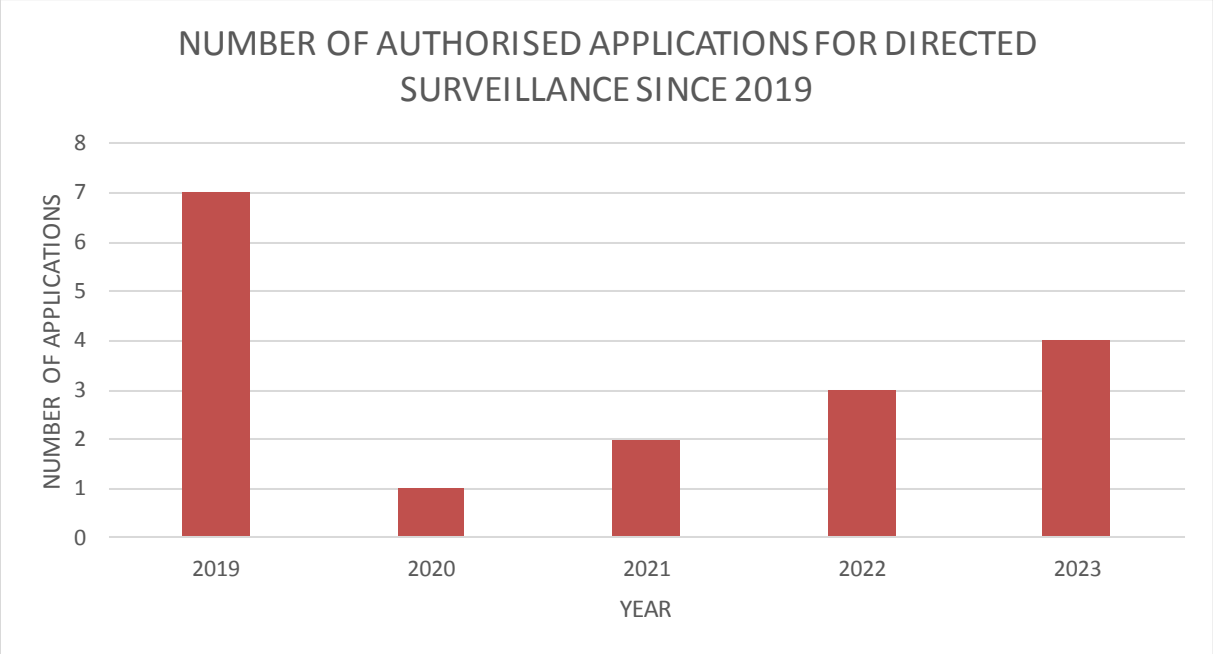
Communications data - operational procedure

3.8 As noted above, the Chief Officer - Governance approved the operational procedure in respect of Communications data on 27 April 2023. Arrangements have been made with the National Anti Fraud Network (NAFN) to provide services to the Council required by the IPA. The operational procedure in respect of Communications data has also been reviewed and no further changes are required.

Applications for covert surveillance

3.9 During 2023, there were four Directed Surveillance authorisations (two in Q2, one in Q3 and one in Q4). As reported throughout the year, these were in relation to the sale of Age Restricted goods, in particular, test purchases of Tobacco and Nicotine Vapour products. All four applications came from the Operations and Protective Services Cluster. There were no further authorisations under RIPSA in 2023. One application was refused by the Authorising Officer on proportionality grounds in Q2 as the Authorising Officer did not feel that the applicant had been clear about the period of surveillance. A further application (relating to the same matter as the application which was refused),was subsequently authorised in Q2.

3.10 The graph below shows the numbers of applications authorised by year, since 2019. Members will note that surveillance powers were utilised in 2020 and 2021 albeit, not frequently. This was due to the Coronavirus pandemic and Services prioritising supporting that legislation to ensure safe practices were being adhered to across the city.



Applications for Communications Data

3.11 During 2023, there were four applications requested for Communications Data. These applications were submitted but not progressed as there was a technical issue with the application system. The matter is being looked into by NAFN and ACC IT.

Authorising Officers (AO)

3.12 At the start of 2023 there were two AOs in post. During 2023, two addition AOs were obtained. Legal Services have trained these two new AOs, which means that the Council now has four AOs in operation. It is hoped that the additional AOs will allow more flexibility and availability for officers. The AO rota has been amended accordingly.

Training

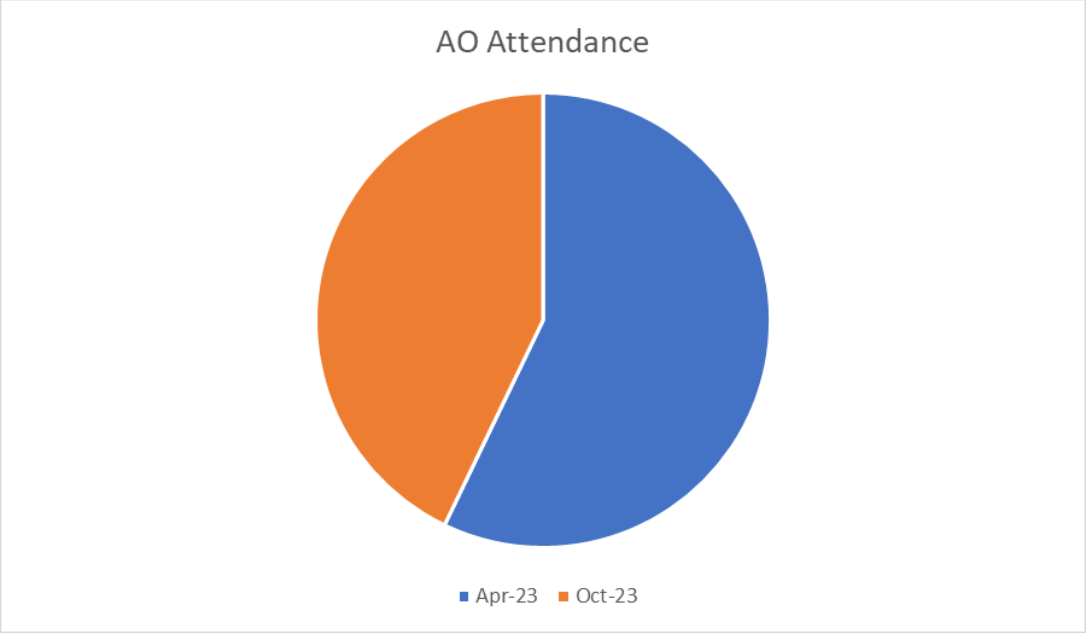
3.13 Two one on one training sessions took place on 21 April and 11 August 2023 with each of the new AOs. This training is mandatory for all officers involved with covert surveillance. Further, the new AOs have been added to the online restricted portal and Teams sites so that they have access to all the guidance available to other officers, including AOs.

3.14 Three training sessions on Communications Data were provided by Legal Services to Officers in Protective Services in July 2023. The training took place on Teams and included interactive elements. The training focused on the Council's procedure and complemented extensive training modules provided by NAFN. Out of 33 officers in Protective Services invited to attend, 27 attended. Those officers are now able to utilise Communications Data where it is necessary and proportionate to do so.

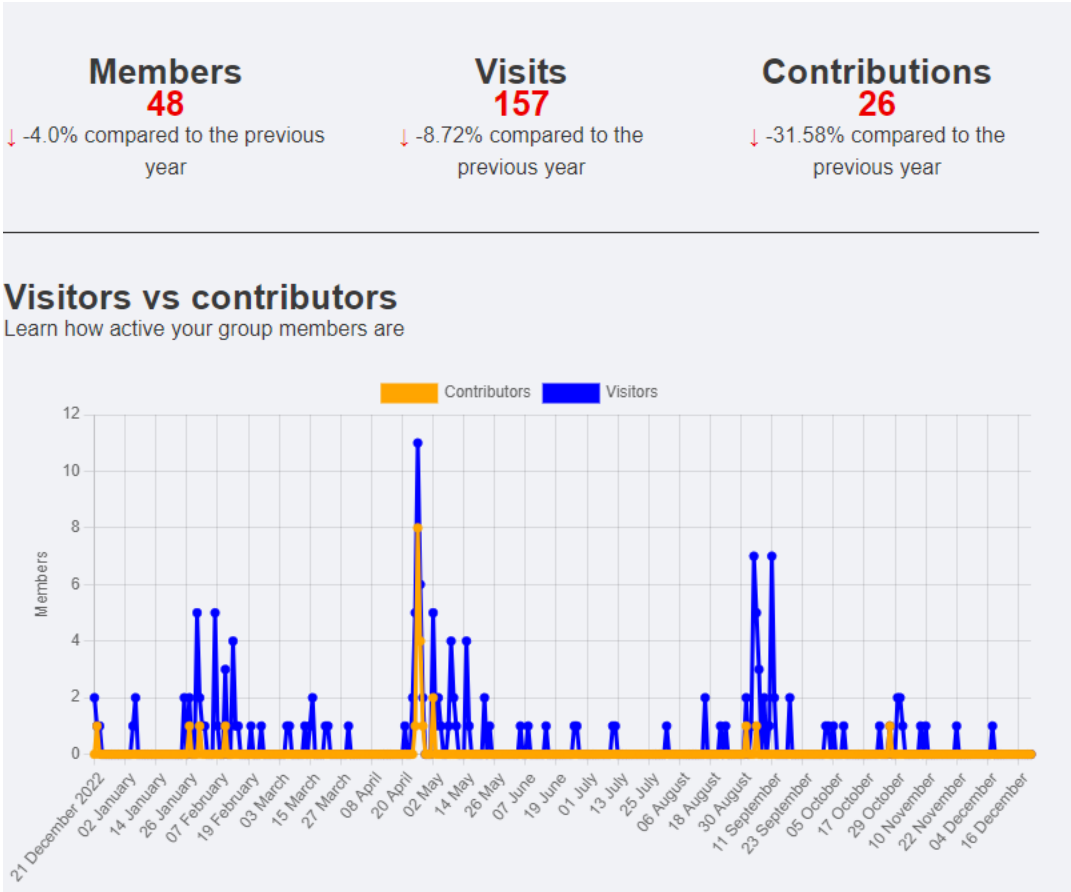
3.15 The Council's RIPSA Co-Ordinator was asked to speak at the in-house Society of Advocates and Lawyers Association (SOLAR) Annual Conference on 10 November 2023 on RIPSA. This was aimed at the Legal Service and its role in RIPSA compliance.

Awareness Raising

3.16 The AO's meetings take place after the Directors' Deadline for the committee reporting cycle. This is so that AO's can be made aware of any matters which will be raised in the upcoming quarterly report to Committee. As such, we've had 2 AO meetings throughout 2023. The attendance rate is shown below.

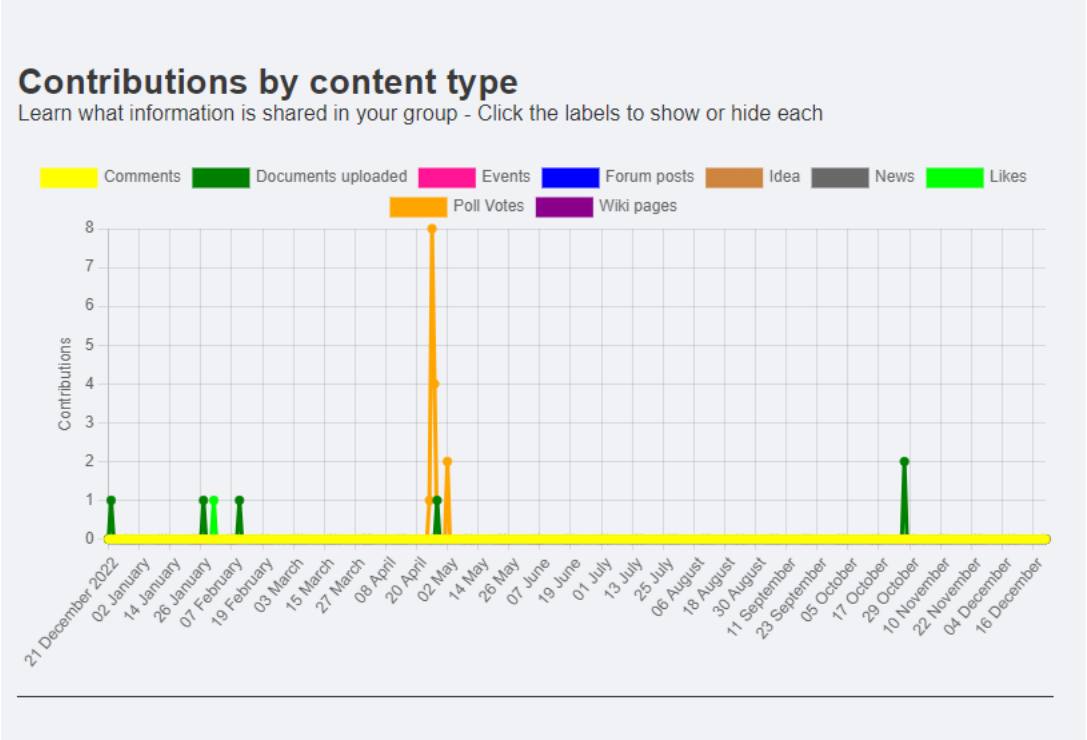


3.17 In addition to AO meetings, Legal Services have been keeping the restricted online portal updated throughout the year. There are 48 members. During 2023, there were 157 visits to the restricted online portal with 26 contributions being made. Reports show that there were 8.72% less visits in 2023 compared to 2022. The graph below shows when staff accessed the system in 2023.



3.18 It should be noted whilst there are 48 members of the online portal, not all will have used covert surveillance powers. It is a mandatory requirement of the Use of Investigatory Powers Policy that all staff MUST have been trained in order to be able to apply for covert surveillance, however, many have had no need to apply to use such powers. It is within this context that members are asked to consider the statistics referred to in this report.

3.19 There were 26 contributions to the portal throughout the year. These are shown in the graph below. Members will see that these relate to documents uploaded and polls posted on the site. The documents uploaded related to IPCO newsletters and the Aberdeen City Council - Corporate Procedure on Communications Data. There were 38 contributions to the restricted online portal throughout 2022. Although there were 12 more contributions to the portal in 2022 compared to 2023, there were more poll votes submitted by members of the online portal in 2022 than in 2023. This is due to the fact that there were two polls posted on the restricted online portal in 2022 compared to one poll in 2023.



Workplan 2024

3.20 The focus this year is to encourage members to visit and interact with the online portal. Legal Services will aim to generate more interactive posts, online discussions about topics of interest (where this is appropriate) and updates from the AO meetings. This is building on areas of good practice currently in place but perhaps focusing it in a more targeted way.

3.21 Further, we will look to continue to invite officers from other parts of the Council to attend AO meetings to inform AO's of the investigatory/ enforcement work they undertake. These sessions help to develop an AO's knowledge of the work of the Council but also broadens their understanding of overt investigatory powers and what options might be expected to be utilised before covert surveillance is required.

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 Annual and 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 It is recommended as good practice, under paragraph 4.43 of the Scottish Government's Code of Practice for Covert Surveillance and Property interference, that elected members consider a statement on the Council's Regulation of Investigatory Powers (Scotland) Act 2000 (RIPSA) policy and statistical information on relevant activity on an annual basis.

5.5 The management, knowledge and awareness of those involved with RIPSA activity was something which was commended by the IPCO in the 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	This report sets out the Use of investigatory Powers Annual Report, which fulfils the requirements placed upon the Council under paragraph 4.43 of the Scottish	L	**Yes**

	data does not comply with the Home Office Code of Practice.	Government's Code of Practice for Covert Surveillance and Property interference. Further, 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.		
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 reputational damage when	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 no requirement to report	L	**Yes**

	this is raised by the IPCO in their inspection.	to Committee about the Council's use of Communication Data, the broader reporting of both demonstrates the Council's wish to be transparent about its 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 **Working in Partnership for Aberdeen**	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	It is confirmed by Chief Officer Jenni Lawson (Interim Chief Officer – Governance) that no Integrated Impact Assessment is required.
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, (v.2 February 2024) (attached)

11. REPORT AUTHOR CONTACT DETAILS

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The Use of Investigatory Powers Policy

Approved by Audit, Risk and Scrutiny Committee on 2 December 2021 with an implementation date of 2 December 2021

ABERDEEN CITY COUNCIL

Document Control

Approval Date	2 December 2021
Implementation Date	2 December 2021
Policy Number	POL-G-0005
Policy Author(s) and Owner	Jess Anderson, Fraser Bell
Approval Authority	Audit, Risk and Scrutiny Committee
Scheduled Review	12 months
Date and Changes: 28 Sept 2021 – Policy Group Review 5 Oct 2021- Risk Board Review and approval Dec 2021- Committee approved policy Feb 2023- No changes made- Committee approved policy Feb 2024- Operational Procedure name change- Committee approved Policy	

Table of Contents

1 Why does the Council need this Policy?

1.1 There are a range of situations in which Council officers in the course of their duties have to carry out investigations and activities for legitimate purposes and it's deemed necessary and proportionate to use investigatory powers to acquire information about a person, either in their personal capacity, or about their trade or business.

1.2 The Council's policy documents are control documents designed to mitigate risks. Policies are key controls in the Council's Risk Management Framework. This policy sets out the monitoring and assurance framework (such as a robust application/ authorisation process, audits, training and awareness raising provided by Legal Services) around the Council's use of specific investigatory techniques and powers by trained officers to enforce statutory duties the Council is tasked with discharging. By doing so, this policy mitigates any potential risks in relation to an unlawful interference with a person's right to a private and family life under the Human Rights Act 1998 (HRA)[1], and ensures that the Council and its officers have clarity on the reporting arrangements in respect of this type of activity.

1.2 In particular, this policy ensures the Council complies with the requirement in the Scottish Government's "Covert Surveillance and Property Interference Code of Practice" and "Covert Human Intelligence Sources Code of Practice" that elected members set the policy for covert surveillance activity on an annual basis and ensure it remains fit for purpose. Additionally, this policy harmonises the assurance and monitoring in place for covert surveillance and extends that to situations where authority to acquire Communications data is sought and obtained.

1.3 In setting policy each year, members are giving that formal endorsement that the arrangements in place and monitored by the Chief Officer- Governance as Senior Responsible Officer (SRO), comply with the relevant legislation through practical application of the operational procedures, training and awareness raising.

2 Application and Scope Statement

2.1 The Council does, and shall, continue to use the powers available to it under the Investigatory Powers Act 2016 (IPA) and the Regulation of Investigatory Powers (Scotland) Act 2000 (RIPSA) respectively, as key investigation tools where it has a lawful purpose to do so. This policy relates to the Council's use of covert surveillance and the acquisition of Communications data and defines the control environment and principles around the use of such investigatory powers. This policy does not extend to officers who do not have an investigatory or enforcement role whereby this type of activity is a real likelihood, nor does it apply to any external or partner organisations.

[1] Article 8 of the HRA.

2.2 The Council has specific powers under RIPSA to conduct Directed Surveillance and it's officers may authorise the use of a Covert Human Intelligence Source (CHIS) (where it is deemed necessary and proportionate). Directed Surveillance is surveillance for a specific investigation or operation, is covert, and is likely to result in the obtaining of private information about an individual. A CHIS is essentially an undercover officer. The purpose of a CHIS is to establish or maintain a false personal relationship with others to obtain or access information covertly. Covert Surveillance is covert where it is carried out in such a way that anyone subject to it is unaware that the surveillance is taking place. An example of when the Council may use surveillance is to covertly record Trading Standards test purchasing.

2.3 The acquisition of Communications data is permitted by the IPA. Communications data is the way in which, and by what method, a person or thing communicates with another person or thing. It excludes anything within a communication including text, audio and video that reveals the meaning, other than inferred meaning, of the communication.

2.4 Any officer requiring to use investigatory powers for a lawful purpose must be trained to do so, prior to applying for, using, and/ or authorising the use of investigatory powers. The operational procedures, referred to at section 4 of this policy, set out the training plan for covert surveillance and the acquisition of Communications data. Further, Authorising Officers are required to attend the same training prior to authorising an application for the use of investigatory powers and attend/ participate in quarterly meetings. Sections 1.3 and 1.4 of this policy set out the role which Elected Members play in setting policy.

2.5 The Council has entered into a contract with the National Anti-Fraud Network (NAFN) who provide assurance and advice to council officers where there is a lawful purpose to access Communications data. It is a requirement of the IPA that the Council has a person/ organisation in place to undertake this role. NAFN is the only provider approved by the Home Office to carry out these services.

3 Responsibilities

3.1 The Chief Officer - Governance as SRO is responsible for this policy. The SRO is the main point of contact for the Council with the Investigatory Powers Commissioner (IPC), the Office for Communications Data Authorisations, and the Home Office. The SRO is responsible and answerable to the IPC for the Council's compliance in respect of the use of these investigatory powers. The SRO has delegated powers to appoint

Authorising Officers for covert surveillance and Approved Rank Officers for the acquisition of Communications Data. The SRO shall continue to report to the Audit Risk and Scrutiny Committee on a quarterly basis on covert surveillance activity, and the SRO shall also report on Communications data activity in so far as it does not impact on operational matters.

3.2 A willful breach of this policy by any Council officer shall be considered a disciplinary matter and will be dealt with under the Council's agreed disciplinary procedures or as a contractual dispute where the breach was caused by a third party engaged by the Council in the acquiring of Communications data. Further, a breach of this policy and supporting procedures may also be a breach of Data Protection Legislation and be reported and investigated internally having regard to the Corporate Information Policy and supporting Information Handbook of procedures. These responsibilities are highlighted in the training provided on the use of these investigatory powers.

3.4 As noted at 2.6 above, the Council contracts with NAFN to carry out the role of a Single Point of Contact (SPoC). The SPoC is there to ensure that any applications for the acquisition of Communications data are practical and lawful. The SPoC also provides objective judgement and advice to the Council and the Protective Services Manager on the application.

3.5 The Regulatory and Compliance (R&C) Team, Legal Services monitor compliance regarding covert surveillance activity and Communications data requests. Primarily this is done by maintaining a central record for covert surveillance and Communications data activity. Access to this record is restricted to the R&C Team and this record includes every application, authorisation or refusal made by the Council. The R&C Team also provides regular awareness raising, on the quality of applications/ authorisations (in respect of covert surveillance only), and training to officers.

4 Supporting Procedures & Documentation

4.1 This policy is supported by two operational procedures**: namely Covert Surveillance and Communications Data.** These procedures govern how applications and authorisations for the use of investigatory powers shall be made, reviewed and cancelled. They also set out how any data obtained shall be used, kept, accessed and destroyed, having particular regard to Data Protection Legislation and Data Assurance. They are available on the restricted online portal which all trained officers have access to, along with this policy. A copy of this policy is available on the Council's intranet.

4.2 Officers who have received training on **Covert Surveillance** and/or the acquisition and retention of **Communications Data** will be provided with access to an online restricted portal where these procedures, guidance, news/updates and application/ authorisation forms (for covert surveillance only) will be accessible. This online resource was developed and is maintained by the R&C Team.

4.3 The Chief Officer – Governance has the power under the Council's Scheme of Governance to approve any necessary changes to the procedures referred to in 4.1 above. At all times, the procedures will be consistent with the terms of this Policy.

4.4 Any changes to process, or law shall be notified to officers through the online portal (referred to at 4.2 above), and amendments to this policy or the procedures shall be uploaded after approval, so that the information available on that portal is up to date and accurate at all times.

5 About this Policy

5.1 This policy demonstrates the Council's intention to exercise the powers available to it under the IPA and RIPSA and provides a framework to ensure that the powers are exercised in accordance with the law.

6 Risk

6.1 This policy and its supporting procedures will manage the following risks:

- **Compliance Risks** - The policy and supporting documentation will reduce the risk of non-compliance with the Human Rights Act 1998, IPA and RIPSA, by setting out the standards and behaviours required in order to ensure compliance. This policy sets out how routine monitoring is in place to ensure continued compliance with these documents and the relevant legislation.

- **Reputational Risks** – The policy and supporting documentation sets out the standards required when considering and applying to use these investigatory powers. Failure to report to committee on covert surveillance activity and follow procedure could lead to reputational damage when this is identified by the IPC at their inspection. This risk is mitigated by reporting to the Audit, Risk and Scrutiny Committee on a quarterly basis. Further, any IPC inspection report is shared with Committee and any resultant action plan is endorsed by Committee.

- **Operational Risks** – the policy and supporting documentation sets out the process all Council officers must follow when they wish to use investigatory powers under the IPA and RIPSA. Further, it is a requirement of this policy that officers receive training prior to applying to use investigatory powers. Officers who have not been trained shall not be permitted to use the investigatory powers referred to under this policy. This risk is managed by managers highlighting which staff require

training due to their enforcement/ investigatory roles. Awareness-raising in this regard and the wider impact of surveillance work is done on a biennial basis.

7 Environmental Considerations

7.1 This policy does not relate to, nor have an impact on, any environmental factors. As such an Environmental Assessment was not undertaken.

8 Policy Performance

8.1 Setting policy is a requirement under the Code of Practice on Covert Surveillance and Property Interference. Assurance that the policy is effective when conducting covert surveillance falls to the Audit, Risk and Scrutiny Committee. Covert surveillance activity has been reported regularly to this committee since Autumn 2017 and it is considered prudent to extend that oversight role to the acquisition of Communications data, albeit such extension is not a statutory requirement. The effectiveness of this policy will be demonstrated by the feedback during inspections undertaken by the IPC but also in the quarterly reporting on the use of these powers to this Committee and compliance with this policy and its operational procedures. Committee will continue to receive updates on the use of investigatory powers on a quarterly basis.

8.2 The R&C Team, Legal Services undertake audits of all authorisations of covert surveillance applications and feedback is provided to council officers. Additionally, the R&C Team will maintain a record of all applications where these are refused or authorised, reviewed, renewed and/or cancelled in respect of both covert surveillance and the acquisition of Communications data. Additionally, any errors made by the Council under the IPA are reported to the Chief Officer- Governance. Collectively, this gives assurances that the policy is performing well, as there is a framework to mitigate and manage non- compliance.

8.3 The Investigatory Powers Commissioner (IPCO) has oversight of the Council's use of investigatory powers under the IPA and RIPSA by way of an inspection every 3 or 4 years. The IPC focuses on the Council's compliance under those legislative regimes. As a matter of course, the IPC reviews the Council's policy and any feedback on its performance, clarity or meaning would be reflected in the IPC inspection report which this Committee will be sighted on.

9 Design and Delivery

9.1 This policy links to the Aberdeen City Local Outcome Improvement Plan (LOIP), particularly the stretch outcomes; Prosperous Economy and Prosperous Place. The LOIP states that "All people in Aberdeen are entitled to live within our community in a manner in which they feel safe and protected from harm", and "promote wellbeing and good health choices/ to nurture our physical health". The use of investigatory powers, where this is appropriate, in tackling offences such as the selling of counterfeit goods or routine test purchases of tobacco related products to ensure they are being sold in accordance with the law, demonstrates the Council's commitment to these outcomes and that it will act, where it is empowered to do so.

9.2 Council's Statutory Obligations - this policy links to the Council's statutory obligation not to act in a way which is incompatible with a human right, under section 6 of the HRA.

10 Housekeeping and Maintenance

10.1 This policy shall be reviewed annually by the Audit, Risk and Scrutiny Committee. The procedures which support this policy shall follow the same review timeline, so that changes or amendments to policy flow through to the procedures, where this is necessary.

10.2 The SRO as Chief Officer - Governance has delegated powers under the Council's Scheme of Governance, Powers Delegated to Officers [2] to create and amend procedures, protocols and guidance. Any changes or amendments required will be referred to the SRO for approval.

11 Communication and Distribution

11.1 This policy will be uploaded to the Covert Surveillance page on the intranet, with a link provided from the Leadership Forum, and it will also be available on a restricted online portal. Access to this portal has been given to all staff who have completed the training.

11.2 Further, specific training will also be provided for any officer who requires to work with this policy, and guidance and support shall be provided on an ongoing basis.

[2] PDO

12 Information Management

12.1 Any personal information gathered as a result of an officer using investigatory powers shall be processed in compliance with the Data Assurance practices and Data Protection Legislation, as set out in the supporting procedures.

Definitions

Communications data	means the way in which, and by what method, a person or thing communicates with another person or thing. It excludes anything within a communication including text, audio and video that reveals the meaning, other than inferred meaning, of the communication;
Data Protection Legislation	means the (i) "UKGDPR" being the retained EU law version of the General Data Protection Regulation ((EU) 2016/679) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018 and as amended by Schedule 1 to the Data Protection, Privacy and the Electronic Communications (Amendments etc) (EU Exit) Regulations 2019 (SI 2019/419) and any applicable national implementing Laws as amended from time to time; and (ii) the Data Protection Act 2018 to the extent that it relates to the processing of personal data and privacy;
Covert Surveillance	means surveillance by way of either Directed Surveillance or a Covert Human Intelligence Source undertaken for a specific purpose or investigation and in a manner that is likely to result in the obtaining of private information about any person.
Data Assurance	means the way in which the Council, officers and elected members understand and have clarity about what happens to information about, and obtained as a result of, using investigatory techniques.

ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	12 February 2024
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Internal Audit Charter
REPORT NUMBER	IA/24/003
DIRECTOR	N/A
REPORT AUTHOR	Jamie Dale, Chief Internal Auditor
TERMS OF REFERENCE	2.1

1. PURPOSE OF REPORT

1.1 The purpose of this report is to seek agreement for continuing use of the current Internal Audit Charter.

2. RECOMMENDATION

2.1 It is recommended that the Committee approve the attached Internal Audit Charter. Minor changes, noted in red, have been suggested to the previous Internal Audit Charter to satisfy recommendations made as part of the recent External Quality Assessment.

3. CURRENT SITUATION

3.1 The Public Sector Internal Audit Standards (PSIAS) require that Internal Audit sections have an Internal Audit Charter which includes specific requirements contained within the Standards. The Standards require that the organisation's Board (for the Council, the Audit, Risk and Scrutiny Committee) approves the Internal Audit Charter.

3.2 The Standards define the Charter as follows:

"The internal audit charter is a formal document that defines the internal audit activity's purpose, authority, and responsibility. The internal audit charter establishes the internal audit activity's position within the organisation, including the nature of the chief audit executive's functional reporting relationship with the board; authorises access to records, personnel, and physical properties relevant to the performance of engagements; and defines the scope of internal audit activities. Final approval of the internal audit charter resides with the board".

3.3 In relation to the public sector, it must:

- Define the terms 'board' and 'senior management' for the purposes of internal audit activity.
- Cover the arrangements for appropriate resourcing.
- Define the role of internal audit in any fraud-related work.
- Include arrangements for avoiding conflicts of interest if internal audit undertakes non-audit activities.

3.4 The current Internal Audit Charter was approved by the Audit, Risk and Scrutiny Committee in February 2023. There is a requirement that the Internal Audit Charter be reviewed annually. Such a review was completed by the Chief internal Auditor, and the Charter was considered to still be relevant and as such is presented to the Committee with no proposed amendments.

3.5 The Internal Audit Charter, which is attached as an appendix to this report, is based on the requirements of the PSIAS, the main requirements of which are:

- Relationships between the chief audit executive (Chief Internal Auditor), Chief Financial Officer, Chief Executive, the Audit Committee, and other key officers are defined.
- The purpose, authority and responsibility of Internal Audit must be formally defined in the Charter which must be consistent with the Definition of Internal Audit, the Code of Ethics, and the Standards.
- The nature of assurance services provided to the organisation must be defined.
- The mandatory nature of the *Definition of Internal Auditing,* the *Code of Ethics* and the *Standards* must be recognised in the internal audit charter.

3.6 Other important considerations include establishing Internal Audit's independence and ensuring that it is free from interference in determining the scope of internal auditing, performing work, and communicating results. This includes the reporting of any impairment to that independence (either in fact or appearance), scope limitations, and restrictions on access to records, etc to appropriate parties.

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 are made to address the identified risks and Internal Audit follows up progress with implementing those that are agreed with management. Where planned progress is not maintained, there is a risk that sufficient work will not have been completed by the end of the financial year for Internal Audit to complete its annual opinion on the Council's control environment.

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, because 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 – Aberdeen City Council Internal Audit Charter.

12. REPORT AUTHOR DETAILS

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Appendix A

ABERDEEN CITY COUNCIL
INTERNAL AUDIT CHARTER

INTRODUCTION

The Public Sector Internal Audit Standards (PSIAS) require that an Internal Audit Charter be in place to detail the purpose, authority, and responsibility of Internal Audit. The Charter should also establish Internal Audit's position within the organisation, including the Chief Internal Auditor's functional reporting relationship with the "Board", authorise Internal Audit's access to records, personnel, and physical properties relevant to the performance of its activity, and define the scope of such activity.

It is a requirement of PSIAS that the Charter be approved by the "Board". Within Aberdeen City Council, the Board is the Audit, Risk and Scrutiny Committee.

DEFINITION OF INTERNAL AUDITING

PSIAS defines Internal Auditing as follows:

"Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes".

ROLE

Internal Audit's primary role is to provide independent and objective assurance on the Council's risk management, control, and governance processes. This involves a continuous rolling review and appraisal of the internal controls of the Council involving the examination and evaluation of the adequacy of the 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 Committee, except where they relate to the Pension Fund, in which case the report is provided to the Pensions Committee. Along with other evidence, these reports are used in forming an annual opinion on the adequacy of risk management, control, and governance processes.

Internal Audit is also responsible for carrying out ad-hoc investigations into potential irregularities involving cash, stores, equipment, or other property of the Council, and for providing advice as and when required in relation to control and compliance issues.

PROFESSIONALISM

Internal Audit will govern itself by adherence to the requirements of the Public Sector Internal Audit Standards. This mandatory guidance constitutes principles of the

fundamental requirements for the professional practice of internal auditing and for evaluating the effectiveness of the internal audit activity's performance.

AUTHORITY

Internal Audit, with strict accountability for confidentiality and safeguarding records and information, has authority, through the Council's Financial Regulations, to:

(a) Enter at all reasonable times any Council premises or land.
(b) Have access to all records, documents and correspondence relating to any financial and other transactions of the Council.
(c) Require and receive such explanations as are necessary concerning any matter under examination.
(d) Require any employee of the Council to produce cash, stores, equipment, or any other Council property under their control.

The Chief Internal Auditor has free and unfettered access to the Council's Chief Executive, and Convener of the Board. The Chief Internal Auditor has the right to report direct to Council in any instance where they deem it inappropriate to report direct to the Chief Officer – Governance, Chief Executive, or Audit, Risk and Scrutiny Committee.

ORGANISATION

The Chief Internal Auditor will report functionally to the Audit, Risk and Scrutiny Committee and administratively (i.e., day to day operations) to the Chief Officer – Governance.

In this context functional reporting means the Audit, Risk and Scrutiny Committee will:

(a) Approve the Internal Audit Charter.
(b) Be consulted on and approve the annual Internal Audit Plan.
(c) Receive reports from the Chief Internal Auditor on the results of Internal Audit activity or other matters the Chief Internal Auditor determines necessary.
(d) Make enquiries of management to ensure that Internal Audit is adequately resourced to meet assurance and other key responsibilities.
(e) Make enquiries of management to ensure that Internal Audit is operating in an independent manner and that it is receiving the necessary co-operation from Council management in undertaking its duties.

The Chief Internal Auditor's annual review will be undertaken by the Director of Business Services in Aberdeenshire Council.

INDEPENDENCE AND OBJECTIVITY

To satisfy the requirements of the Public Sector Internal Audit Standards, Internal Audit must be independent and objective.

Internal Audit will remain free from interference by any element in the organisation in the matter of audit selection (including scope, procedures, frequency, and timing), and

content of reports thereon to permit maintenance of a necessary independent and objective mental attitude. Notwithstanding this, Internal Audit will consult with management regarding the scope, timing, and outcome of each assignment.

Internal auditors will have no direct operational responsibility or authority over any of the activities audited. Accordingly, they will not implement internal controls, develop procedures, install systems, prepare records, or engage in any other activity that may impair an internal auditor's judgment. However, Internal Audit may be consulted on the implementation of new systems to ensure that, as far as possible, all considerations are considered during their implementation. Such involvement shall not preclude Internal Audit from reviewing that area and reporting thereon.

Internal auditors must exhibit the highest level of professional objectivity in gathering, evaluating, and communicating information about the activity or process being examined. Internal auditors must make a balanced assessment of all the relevant circumstances and not be unduly influenced by their own interests or by others in forming judgments.

Internal Audit staff will complete an annual declaration confirming compliance with rules on independence, any conflicts of interest, and the offer and / or acceptance of inducements. Where Internal Audit staff have had operational responsibility for any activity whilst working in a previous or seconded role, they will not be involved in the audit of that area for at least one year following the end of any such responsibility.

The Chief Internal Auditor will confirm to the Audit, Risk and Scrutiny Committee, at least annually, the organisational independence of the Internal Audit function.

RESPONSIBILITY

It shall be the responsibility of Internal Audit to complete sufficient assurance work to support the annual opinion detailed in Internal Audit's Annual Report. All work shall be undertaken in accordance with the requirements of the Public Sector Internal Audit Standards. All Internal Audit staff will complete an annual declaration confirming that they have read and understood these requirements.

It shall be the responsibility of Council management to ensure that adequate and appropriate systems of internal control are in operation which help ensure that the Council's objectives are fulfilled in a manner which complies with the Council's policies and procedures and in accordance with the law. Council management will ensure that access is provided to records, personnel and assets of the Council as required by Internal Audit, and that responses are provided to Internal Audit as required by the Council's Financial Regulations.

The CIPFA *Statement on the Role of the Chief Financial Officer in Local Government* states that the chief financial officer (Chief Officer – Finance) must:

(a) ensure an effective internal audit function is resourced and maintained
(b) ensure that the authority has put in place effective arrangements for internal audit of the control environment
(c) support the authority's internal audit arrangements, and

(d) ensure that the audit committee receives the necessary advice and information, so that both functions can operate effectively.

The Council's Financial Regulations require that Chief Officers immediately notify the Chief Officer – Finance and Chief Officer – Governance of any circumstances which may suggest an irregularity affecting the finances, property, services, or policy of the Council and that the Chief Officer – Finance or Chief Officer – Governance may investigate such incidents as they consider appropriate. The Council's Counter Fraud Policy extends this requirement for reporting to the Chief Internal Auditor.

Internal Audit will consider the outcome of such investigations in its future work programme and in forming its opinion on the control environment of the Council.

INTERNAL AUDIT PLAN

On an annual basis, the Chief Internal Auditor will consult with senior management in developing an Internal Audit plan for submission to the Council's Corporate Management Team (in terms of PSIAS "senior management") and Audit, Risk and Scrutiny Committee for review, comment, and approval by the latter. The Internal Audit plan will consist of a work schedule as well as budget and resource requirements for the period covered by the plan.

The Internal Audit plan will be developed based on a prioritisation of the audit universe using a risk-based methodology, including input from the Council's Corporate Management Team and Audit, Risk and Scrutiny Committee. Any significant deviation from the Internal Audit plan will be communicated to the Council's Corporate Management Team and Audit, Risk and Scrutiny Committee through periodic activity reports.

The Chief Internal Auditor will ensure appropriate arrangements for resourcing the Service to deliver the planned work. Any issues with regards to resourcing will be discussed with the Chief Officer – Governance as appropriate.

REPORTING AND MONITORING

A written report will be prepared and issued by the Chief Internal Auditor or designee following the conclusion of each audit and this shall be distributed as appropriate. Internal Audit results will be reported to the Audit, Risk and Scrutiny Committee and, where they relate to Health and Social Care Integration (Adult Social Care), the Aberdeen City Integration Joint Board Risk, Audit and Performance Committee. Reports relating to the Pension Fund will be reported to the Pensions Committee. Where reports relate to consultancy requested by management for operational purposes, the results will be reported to the Audit, Risk and Scrutiny Committee where they relate to governance or control issues.

The Internal Audit report will include management's response and corrective action taken or to be taken regarding the specific findings and recommendations. Management's response will include a timetable for anticipated completion of action to be taken and an explanation for any corrective action that will not be implemented.

Internal Audit will monitor action taken by management to implement agreed recommendations and will provide this information to the Audit, Risk and Scrutiny Committee / Pensions Committee.

PERIODIC ASSESSMENT

The Chief Internal Auditor will periodically report to the Council's Corporate Management Team and Audit, Risk and Scrutiny Committee on Internal Audit's purpose, authority, and responsibility, as well as performance relative to its plan. Reporting will also include significant risk exposures and control issues, including ; risks, governance issues, and other matters needed or requested by the Council's Corporate Management Team and Audit, Risk and Scrutiny Committee.

In addition, the Chief Internal Auditor will communicate to the Council's Corporate Management Team and Audit, Risk and Scrutiny Committee regarding Internal Audit's quality assurance and improvement programme, including results of ongoing internal assessments and external assessments which must be conducted at least every five years.

Approved by the Audit, Risk and Scrutiny Committee on TBC.

ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	12 February 2024
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Internal Audit Update Report
REPORT NUMBER	IA/24/001
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
February 2024

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 2023/24 Internal Audit Plan, 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:

- Four reviews have been completed.
- Work is underway with regards to delivery of the 2023/24 Internal Audit Plan.
- 10 audit recommendations have been closed.

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 2023/24 Audits

Service	Audit Area	Position
Children and Family Services	Secondary School Visits	**Review in progress**
Commissioning	Procurement Compliance	**Review in progress**
Commissioning	City Region Deal	**Review in progress**
Commissioning	Environmental Action	**Review in progress**
Council Led HSCP Services	Social Care Financial Assessments	**Review in progress**
Customer	Volunteer Arrangements	**Review in progress**
Customer	Recruitment	**Review Scheduled**
Customer	PREVENT	**Review in progress**
Customer	Attendance Management	**Final Report Issued**
Customer	Cyber Controls	**Review in progress**
IJB	IJB Hosted Services	**Review in progress**
IJB	IJB Complaints Handling	**Final Report Issued**
NESPF	Pensions Investment Strategy	**Review in progress**
Resources	Vehicle and Driver Compliance	**Final Report Issued**
Resources	Stores Stock Controls	**Review in progress**
Resources	Revenue Budget Setting and Financial Strategy	**Review in progress**
Resources	Creditors System	**Review in progress**
Resources	COVID-19 Spend	**Final Report Issued**
Resources	Private Sector Housing	**Review Scheduled**

2.2 Audit reports presented to this Committee

Report Title	Assurance Year	Conclusion
AC2402 – IJB Complaints Handling	2023/24	The level of net risk is assessed as **MODERATE**, with the control framework deemed to provide **REASONABLE** assurance over the IJB's approach to complaint handling. The following governance, risk management and control measures were generally fit for purpose: Governance Arrangements, Written Procedures, Guidance and Training, Complaint Handling, and Annual Performance Reporting. However, the review identified some areas of weakness where enhancements could be made to strengthen the framework of control, specifically: Early Resolution, Management Monitoring, Public Reporting, and System Data and Dashboard Report. It is acknowledged that there are challenges; requirements to capture complaints information across three different organisations, that use different systems, meaning the task of coordination and presenting data can be more onerous. However, the above issues increase the risk of continued complaint handling delays, and poor service delivery where reasons for complaints are not addressed. This increases the risk of repeat complaints, complainant

Report Title	Assurance Year	Conclusion
		dissatisfaction and escalation to the SPSO, with resulting reputational damage for the H&SCP where complaints are publicly upheld by the SPSO. Recommendations have been made to address these matters including establishing senior management complaints reporting that covers SPSO requirements as a minimum; publishing necessary complaint outcome and actions taken reports; reviewing mandatory reporting requirements for complaints handling systems to ensure lessons learned and necessary corrective action are captured; and establishing senior management H&SCP complaints handling dashboard reporting.
AC2411 – Attendance Management	2023/24	The level of net risk is assessed as **MODERATE**, with the control framework deemed to provide **REASONABLE** assurance over the Council's approach to Attendance Management. The Council operates a supporting Attendance and Wellbeing Policy; approved by the Staff Governance Committee in November 2018 and implemented in January 2019. The Policy, although comprehensive and still relevant, is meant to be reviewed every three years. No formal review has been concluded, and as such, no formal consultation arrangements or reporting to Committee on the Policy has taken place since 2018. Management has advised that this is because of the wider work ongoing with regards to the Absence Improvement Project. There was however no workstream identified to review the Policy as part of plans. This Project began in September 2023, under the revised project charter, and is due to finish in April 2024, but review of the current Draft Project Plan indicates limited results being achieved or tasks being completed to date. The Project Charter only contains timescales across August 2023 and September 2023, with two elements of the work (implementing and sustaining changes that demonstrate improvement and spreading change) having no identified timescale. This aligned with the Draft Project Plan that only saw one workstream complete (Review of Manager Training) and all others as either in progress or not started. The audit identified issues with regards to demonstrating compliance with key elements of the Policy: lack of records on the HR system of Return to Work (RTW) discussions taking place; no RTW forms, a mandatory aspect of the Policy, being completed; an instance of an employee returning to work but the absence still being open on the system; and instances where individual line managers across the Council did not respond to the requests of Internal Audit with regards to evidence and as such no assurance can be taken over these. These results highlight that whilst the controls are generally designed effectively, there are inconsistencies in their application. Management advised that in addition to the overall Policy, guides are available for using CoreHR

Report Title	Assurance Year	Conclusion
		and an Outcomes for Supporting Attendance Online Course is available. However, since its introduction in 2020, it has only been completed 129 times. There may therefore be a lack of understanding and awareness of responsibilities and requirements. In addition to the results, a general review of the HR system and discussions with individual line managers highlighted varying approaches with regards to updating the system, retention of documentation, a lack of understanding if the Policy was applicable, and an instance where Management advised an absence was not being managed through the Supporting Attendance and Wellbeing Policy and that this decision had been made at a local level. General issues with the quality of data available through the HR system were also noted, including: historical issues with regards to absence logging and reporting errors following restructuring, and individuals moving roles or having more than one position. These will have an impact on the accuracy of reporting across Management and to Committee. Management advised they were aware of these data issues and would be working on remedial action. Recommendations have been made to address the noted points, specifically: reviewing the Policy, either as a standalone task or as part of the Absence Improvement Project; reviewing the Project Charter and Draft Project Plan to ensure they are as accurate, complete and realistic as possible; and strengthening the understanding of the Policy at an operational level, including the establishment of a minimum standard to which individual line managers should be held to account. A final recommendation has been made for Management to develop stronger second line oversight of Attendance Management across the Council and a means of gaining feedback from managers and those employees who have been through the Attendance Management process.
AC2412 – COVID-19 Spend	2023/24	The level of net risk is assessed as **MINOR**, with control framework deemed to provide **SUBSTANTIAL** assurance over the Council's key spending decisions and financial payments in relation to COVID-19. Substantial assurance has been taken over the following aspects of the Council's COVID-19 spending decisions and payment control: Grant Governance and Administration, Applications and Grant Award, Payment Control, Budget Monitoring and Reporting, and Civil Contingencies. However, the review identified some areas of weakness where enhancements could be made to strengthen the framework of control, specifically: Record Retention and Supporting Documentation, Written Procedures, Bulk Grant Payment Approval, and Business Continuity Planning. Recommendations were made for record keeping arrangements to be reviewed to ensure data is stored and

Report Title	Assurance Year	Conclusion
		retained appropriately, for grant bank account evidence requirements and bulk grant payment approval controls to be formalised, and to ensure BCPs are complete and where necessary reflect on the impact of COVID-19.
AC2401 – Vehicle and Driver Compliance	2023/24	The level of net risk is assessed as **MODERATE**, with the control framework deemed to provide **REASONABLE** assurance over the Council's approach to Vehicle and Driver Compliance. Driver and Vehicle Standards Agency (DVSA) categorises Fleets by Operator Compliance Risk Score. This grading calculates the operator risk of not following the rules on roadworthiness. ACC Fleet have been graded the highest score band achievable: green (low risk) with points given for defects or infringements. The more serious these are the more points awarded. ACC score was 1.96 in 2022 and 1.705 in 2023, demonstrating the Fleet is a lower risk in 2023 compared to 2022. This is well within the threshold of 10 for green. Vehicle maintenance systems compliance is also reviewed periodically on a sample basis by a third party assessor, and also subject to unannounced DVSA compliance checks. There are regular checks on compliance including gate checks, depot audits, tachograph analysis, and investigations into non-compliance. However, there are limited resources to complete these checks, which have been exacerbated by vacancies, and there is limited data to demonstrate these are being scheduled and targeted efficiently to maximise assurance. Ongoing implementation of the Fleet Management System provides opportunities for improvement and there may be scope for further process automation and more efficient practice. Fleet, whilst responsible for overall management of council vehicles and maintaining the Operators licence, has limited power to hold individual drivers or services to account. Although there is guidance to encourage good practice and compliance, there is no corporate policy covering employees driving Council-provided vehicles and the implications of non-compliance. Non-adherence to guidance is flagged to line managers within drivers' employing Services, who must balance this with other operational demands. Guidance would also benefit from more regular updates, clarifications, and regular refresher training. Non-compliance could present a corporate risk: 23% of incidents and notifiable defects investigated by the Fleet Compliance Team in 2022/23 and 2023/24 to date were not reported to Fleet at the point they should have been identified as part of drivers' daily first use vehicle checks. Delays in reporting defects can present risks to vehicles, drivers, and road users' safety, as well as increased maintenance costs and down-time in the event of subsequent vehicle / parts failure. Fleet has a system for maintaining records of vehicles and their maintenance, providing a comprehensive record to

Report Title	Assurance Year	Conclusion
		demonstrate compliance with Operators Licence and safety requirements. However, due to continuing development and implementation of the system, elements of some processes (e.g. scheduling of maintenance) requires manual intervention., The system flags any missed events, however there is limited management information currently reported on performance against set maintenance and inspection timescales. Performance of Services operating vehicles and acting on identified compliance risks is also not regularly reported to provide assurance over their activities. Key contracts including tyres and HGV parts and servicing, are not recorded as being up to date on the Councils contracts register system. The Council continues to obtain these services, but not having formal recorded contracts presents a risk to continuity of supply. It is also a breach of the Council's Financial Regulations, procurement regulations, and national procurement rules, which require competitive tendering at the levels of expenditure incurred.

2.3 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 November 2023 (the baseline for our exercise), 19 audit recommendations were due and outstanding:

- Two rated as Major
- 14 rated as Moderate
- Three rated as Minor

As part of the audit recommendations follow up exercise, 10 recommendations were closed:

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

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 outstanding audit recommendations that will be taken forward and followed up as part of the next cycle. For one, Management did not provide an update on the status of implementation.

2.3.1 AC2314 - Assurance Review of Adults with Incapacity – Follow Up

At the September Audit, Risk and Scrutiny Committee, in response to a question relating to how the Committee would get assurance that the Service was on track between now and June 2024 with implementation of the recommendations of this Major risk report, it was agreed that progress updates would be presented to each Committee going forward. Internal Audit reached out on the recommendations in advance of Committee and the response from Management is included at Appendix 3 – Audit Recommendations Follow Up – AC2314 – Adults with Incapacity. It should be noted that these updates are Management assurance and have not been reviewed by Internal Audit; Internal Audit will follow up on recommendations as they fall due as part of the standard update process.

3 Appendix 1 – 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.

4 Appendix 2 – Audit Recommendations Follow Up – Outstanding Actions

Report	Grading	Ref	Recommendation	Original Due Date	Current Due Date	Committee Update	Status
AC2017 – Industrial & Commercial Properties	**Minor**	2.2.14	The Service should consider whether different approaches to property management could be applied across parts of the Investment Portfolio which might increase Portfolio income and deliver Portfolio objectives more efficiently and effectively.	Nov-23	Nov-23	No update provided.	**No update provided**
AC2111 – Consilium System	**Moderate**	2.6.12	The Service should ensure system access is aligned with service requirements, and that use of generic users is limited and monitored. The technical reasons requiring such users will be raised with the software supplier as part of the system upgrade.	Sep-23	Mar-24	The upgrade to the Total system has not proceeded at this time due to certain factors, service redesigns and the move to hopefully rationalise systems, both of which align with TOM 1.2, which has prevented us moving forward and closing off the outstanding recommendations. Meetings are however being held to push for ideas or to find possible work arounds to comply with our outstanding with updates to follow.	**In Progress**

Report	Grading	Ref	Recommendation	Original Due Date	Current Due Date	Committee Update	Status
AC2111 – Consilium System	**Moderate**	2.6.4	The Service should explore options to lock users after a set period of inactivity with the software provider as part of the system upgrade. The Business & Systems Support Manager will raise this with the software provider to ascertain if this can be applied in the current system. It will also be looked to be addressed as part of the system upgrade.	Sep-23	Mar-24	The upgrade to the Total system has not proceeded at this time due to certain factors, service redesigns and the move to hopefully rationalise systems, both of which align with TOM 1.2, which has prevented us moving forward and closing off the outstanding recommendations. Meetings are however being held to push for ideas or to find possible work arounds to comply with our outstanding with updates to follow.	**In Progress**
AC2111 – Consilium System	**Moderate**	2.6.8	The System Team should ensure the system enforces compliance with the Councils password standard. Current system does not provide this functionality, but it will be raised as part of the system upgrade.	Sep-23	Mar-24	The upgrade to the Total system has not proceeded at this time due to certain factors, service redesigns and the move to hopefully rationalise systems, both of which align with TOM 1.2, which has prevented us moving forward and closing off the outstanding recommendations. Meetings are however being held to push for ideas or to find possible work arounds to	**In Progress**

Report	Grading	Ref	Recommendation	Original Due Date	Current Due Date	Committee Update	Status
						comply with our outstanding with updates to follow.	
AC2111 – Consilium System	**Moderate**	2.6.6	The system team should raise the issue of transactional processes only being available under an administrator profile as part of the system upgrade.	Sep-23	Mar-24	The upgrade to the Total system has not proceeded at this time due to certain factors, service redesigns and the move to hopefully rationalise systems, both of which align with TOM 1.2, which has prevented us moving forward and closing off the outstanding recommendations. Meetings are however being held to push for ideas or to find possible work arounds to comply with our outstanding with updates to follow.	**In Progress**

Report	Grading	Ref	Recommendation	Original Due Date	Current Due Date	Committee Update	Status
AC2201 – IT Infrastructure Resilience	**Major**	2.4.7 a	The Service should establish Cyber Essentials PLUS accreditation for the Council.	Oct-23	Mar-24	We are still working with our security partner to achieve the '+' element of the certification. This maps to the current assurance work of the PSN assurance that is currently being renewed through the Digital Cabinet Office.	**In Progress**
AC2302 – IJB Data Sharing	**Moderate**	1.3a	Management should ensure the IJB receives periodic assurance that policy and procedure for data sharing is robust within each Partner.	Sep-23	Mar-24	This is actively being worked on by Management who are considering the assurances in place, balanced with the fact that staff are across both NHS and Council.	**In progress**
AC2302 – IJB Data Sharing	**Moderate**	1.2c	Management should establish mechanisms which provide assurance that data protection training is up to date.	Sep-23	Mar-24	Management are proposing to ask ACC and NHSG to send us an annual report around the % of compliance of staff undertaking the mandatory training.	**In progress**

Report	Grading	Ref	Recommendation	Original Due Date	Current Due Date	Committee Update	Status
AC2302 – IJB Dara Sharing	**Moderate**	1.2b	Management should establish reporting mechanisms which ensure the Business and Resilience Manager receives assurance regarding information sharing and provides this assurance to the IJB.	Sep-23	Mar-24	This is actively being worked on by Management who are considering the assurances in place, balanced with the fact that staff are across both NHS and Council.	**In progress**

5 Appendix 3 – Audit Recommendations Follow Up – AC2314 – Adults with Incapacity

Report	Grading	Ref	Recommendation	Due Date	Management Update
AC2314 - Adults with Incapacity - management of funds	**Major**	1.1.a	The Service should document and implement procedures in respect of DWP appointeeship, Intervention Orders, Access to funds, guardianship and POA in dealing with Adults with Incapacity. The Service should ensure these are clear, efficient, provide practical guidance on day-to-day management of funds, and are subject to periodic recorded reviews. Staff required to apply the procedures should be adequately trained in their application.	Jan-24	A comprehensive AWI Training Plan is in the process of being created. The training will take place between January 2024 and July 2024. Mandatory training will be delivered to all Adult SW staff (350). Additional staff from NESS and other parts of the partnership will also be invited to attend these training sessions. Dates, times, and venues are still being confirmed. An AWI Teams channel is being created to store all of the AWI related documents/policies/guidance notes etc. This will be accessible to all Adult SW staff.
AC2314 - Adults with Incapacity - management of funds	**Major**	1.1.b	The Service should develop AWI staff training and procedures for key systems, D365, the corporate appointee database, access to funds process, DWP website to provide adequate cover so that key information required can be accessed and audit trails completed for client information stored.	Jan-24	A comprehensive AWI Training Plan is in the process of being created. The training will take place between January 2024 and July 2024. Mandatory training will be delivered to all Adult SW staff (350). Additional staff from NESS and other parts of the partnership will also be invited to attend these training sessions. Dates, times, and venues are still being confirmed. An AWI Teams channel is being created to store all of the AWI related documents/policies/guidance notes etc. This will be accessible to all Adult SW staff.

Report	Grading	Ref	Recommendation	Due Date	Management Update
AC2314 - Adults with Incapacity - management of funds	**Major**	1.2.a	The Service should implement processes and controls to ensure consistent and complete AWI records are held in line with the GDPR accuracy principle, and these are accessible to relevant officers to avoid the risk of duplication and misalignment.	Apr-24	All new policies and guidance notes will highlight all new processes and controls to ensure AWI records and CA accounts are in line with GDPR. Legal members/ FIT members of the group will scrutinise new policies and guidance notes to make sure these meet the accuracy principle.
AC2314 - Adults with Incapacity - management of funds	**Major**	1.2.b	A reconciliation of existing file records against new system records should be undertaken, and corrections applied where necessary.	Apr-24	Reconciliation of existing file records is ongoing by the payment control team. There are over 500 Corporate Appointeeship accounts. The SLWG receive updates from finance staff regarding the reconciliation cases.
AC2314 - Adults with Incapacity - management of funds	**Major**	1.2.c	A system of review should be developed and implemented to obtain regular periodic assurance over the content and accuracy of AWI funds management records	Apr-24	The use of share point or D365 to trigger reminders set for financial review is being explored. QA checks will also be introduced. Annual review paperwork will trigger staff to carry out annual reviews of client's financial matters (AWI Records)

Report	Grading	Ref	Recommendation	Due Date	Management Update
AC2314 - Adults with Incapacity - management of funds	**Major**	1.3	The Service should review the appointeeship process to ensure it reflects the requirements of the scheme, and minimises intervention where possible. As part of the review the Service should ensure all interventions are subject to secondary review to ensure they are appropriate in line with policy and procedure in advance of their implementation.	Mar-24	This has been covered by previous action points. Review processes are being developed to capture all financial interventions. Financial Quality Assurance checks to be introduced to all adult services.
AC2314 - Adults with Incapacity - management of funds	**Major**	1.4.a	All requests for funds and payments should have clearly documented review and approval before funds are released. Segregation of duties should be in place for each stage	May-24	Process in which CA money is requested, released, and documented is being explored by the group.
AC2314 - Adults with Incapacity - management of funds	**Major**	1.4.b	The identity of funds recipients should be verified and documented. Variations should be subject to approval.	May-24	This point has been discussed but it was felt further exploration was required by our finance colleagues within the SLWG. However, it was felt this point would be covered by the new Corporate Appointee Ship (CA) Policy. For example, in the future we are keen for all CA keyworkers to record, document and verify every transaction. How we physically do this is being explored but it will form part of the CA policy.

Report	Grading	Ref	Recommendation	Due Date	Management Update
AC2314 - Adults with Incapacity - management of funds	**Major**	1.4.c	All funds movements and transfers should be documented and countersigned at the point such movements take place, with such documentation held separately from the physical funds	May-24	Handling Cash policies are being explored. D365 processes are being explored. Fund movements will be detailed in the new CA guidance note which is still being written.
AC2314 - Adults with Incapacity - management of funds	**Major**	1.4.d	Consideration should be given to whether collecting and distributing cash remains the most appropriate means of providing support to individuals.	May-24	Collecting and distributing cash will continue to remain as this is the wish of the clients in Aberdeen. Ways to switch or encourage clients to move away from cash will be supported. However, overhauling the procedure is being looked at. Inhouse services have policies where are being looked at to adapt.
AC2314 - Adults with Incapacity - management of funds	**Major**	1.4.e	The bank reconciliation to the corporate appointee database should be regularly completed, reviewed, and actions approved and monitored to conclusion.	May-24	This is being looked at by finance colleagues within the SLWG. Detailed feedback on this point still needs clarified.

Report	Grading	Ref	Recommendation	Due Date	Management Update
AC2314 - Adults with Incapacity - management of funds	**Major**	1.4.f	Accounts of deceased clients that are still active should be reviewed for necessary actions to close.	May-24	This has been completed by the Payment Control team. Actions on each individual case is being explored.
AC2314 - Adults with Incapacity - management of funds	**Major**	1.5	The Service should ensure there is a clear and consistent audit trail for all instances where funds are managed on behalf of service users. This should be subject to periodic reconciliation against other records (e.g. bank statements, cash balances, inventories, DWP data and other source documentation), and potential discrepancies escalated and the results and actions recorded.	Feb-24	The process of carrying out an audit trail is still being looked at by the group. SharePoint is being considered as an option. Alternative financial packages for D365 are also being considered which will aid any audit trail. Review paperwork is being updated to incorporate financial reviews in cases where ACC hold financial responsibility. A process for escalation is being developed. D365 recording process is being reviewed. This will form part of any new guidance notes.
AC2314 - Adults with Incapacity - management of funds	**Moderate**	1.6	The Service should ensure client accounts with balances in excess of specified thresholds are reviewed to ensure they are managed appropriately.	Jan-24	Review process for Corporate Appointeeship accounts is being developed and will be incorporated into the new Corporate Appointee ship Policy which is still being worked on by the group. An annual review mechanism is also being considered by the group. This is likely to be incorporated into the Care management yearly review paperwork.

ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	12 February 2024
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Internal Audit Report AC2402 – IJB Complaints Handling
REPORT NUMBER	IA/AC2402
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 the IJB Complaints Handling.

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 the IJB Complaints Handling.

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 There are no direct impacts, as a result of this report, in relation to the Council Delivery Plan, or the Local Outcome Improvement Plan Themes of Prosperous Economy, People or Place.

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 AC2402 – IJB Complaints Handling

12. REPORT AUTHOR CONTACT DETAILS

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Aberdeen City Health & Social Care Partnership
A caring partnership

Internal Audit

Assurance Review of IJB Complaints Handling

Status: Final
Date: 15 November 2023
Risk Level: Corporate

Report No: AC2402
Assurance Year: 2023/24

Net Risk Rating	Description	Assurance Assessment
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**

Report Tracking	Planned Date	Actual Date
Scope issued	12-May-23	15-May-23
Scope agreed	26-May-23	25-May-23
Fieldwork commenced	8-June-23	8-June-23
Fieldwork completed	28-July-23	22-Sep-23
Draft report issued	11-Aug-23	22-Sep-23
Process owner response	1-Sep-23	18-Oct-23
Director response	8-Sep-23	15-Nov-23
Final report issued	15-Sep-23	15-Nov-23
Audit Committee	1-Feb-24	

Distribution	
Document type	Assurance Report
Director	Sandra MacLeod, Chief Officer (ACHSCP)
Process Owner	Fraser Bell, Chief Operating Officer (ACHSCP)
Stakeholder	Martin Allan, Business and Resilience Manager (ACHSCP)
	Paul Mitchell, Chief Finance Officer (ACHSCP)
	Alison Macleod, Strategy and Transformation Lead
	Caroline Howarth, Clinical Director (ACHSCP)
	Lucy McKenzie, Interim Chief Officer People & Organisational Development and Customer Experience (ACC)
	Alice Goodrum, Customer Feedback & Access to Information Ops Lead (ACC)
	Michelle Grant, Transformation Programme Manager – Digital and Data (ACHSCP)
	Linda Lever, Team Leader Adverse Events & Feedback (NHS Grampian)
	Isla Gray, Feedback Quality Improvement & Assurance Advisor (NHS Grampian)
	Heather Sheen, Quality Infomatics Facilitator (NHS Grampian)
	Catriona Sim, Data Protection Officer (ACC)*
	Alan Bell, Data Protection Officer (NHS Grampian)*
	Dr June Brown, Executive Nurse Director (NHS Grampian)*
	Vikki Cuthbert, Interim Chief Officer – Governance (ACC)*
***Final only**	Ronnie McKean, Corporate Risk Lead (ACC)*
	External Audit*
Lead auditor	Andrew Johnston, Audit Team Manager

1 Introduction

1.1 Area subject to review

Under the Scottish Public Services Ombudsman (SPSO) Act 2002, Scottish public sector organisations are required to establish a complaints procedure that complies with the SPSO's statement of complaints handling principles. This statement states, an effective complaints handling procedure is:

- **User-focused** – It puts the complainant at the heart of the process.
- **Accessible** – It is appropriately and clearly communicated, easily understood and available to all.
- **Simple and timely** – It has as few steps as necessary within an agreed and transparent timeframe.
- **Thorough, proportionate, and consistent** – It should provide quality outcomes in all complaints through robust but proportionate investigation and the use of clear quality standards.
- **Objective, impartial and fair** – It should be objective and evidence-based and driven by the facts and established circumstances, not assumptions, and this should be clearly demonstrated.
- **Seeks early resolution** – It aims to resolve complaints at the earliest opportunity, to the service user's satisfaction wherever possible and appropriate.
- **Delivers improvement** – It is driven by a search for improvement, using analysis of outcomes to support service delivery and drive service quality improvements.

To help ensure the above principles are achieved, the SPSO has published various sector specific model complaints handling procedures (MCHPs), which include:

- A shared definition of what is and is not a complaint.
- A two-stage process where complaints are resolved, with the customer's agreement, as close to the frontline as possible.
- Frontline response to complaints within five working days.
- An investigation stage of 20 working days, which provides the organisation's final decision.
- Recording of all complaints.
- Active learning from complaints through reporting and publicising complaint information.

The SPSO Local Authority MCHP implementation guidance requires health and social care partnerships (HSCPs) to adapt and adopt this procedure for complaints relating to adult social care services delivered by a HSCP. In addition, under the NHS MCHP, NHS staff are required to work with health and social care partnership staff to resolve complaints raised with the NHS that relate to integrated health and social care services. Furthermore, for complaints relating to the actions and processes of the IJB itself, IJBs are expected to adopt the MCHP for Scottish Government, Scottish Parliament, and Associated Public Authorities.

In 2022/23 the Aberdeen City Health and Social Care Partnership received 199 complaints[1] (153 health, 46 social care) relating to delivery of health and social care services (249 2021/22 – 207 health, 42 social care). No complaints were received in 2022/23 or 2021/22 relating to the actions of the IJB itself.

1.2 Rationale for the review

The audit objective is to ensure that the complaints procedures are being complied with for all matters and that data generated is used by Management to monitor and improve performance.

The area has not been subject to review previously by Internal Audit. It has been included in the 2023/24 Internal Audit plan following consultation with Senior Management due to the risk of reputational damage and potential financial loss, should complaints be mismanaged and / or associated control weaknesses addressed.

1.3 How to use this report

[1] Complaint numbers are based on complaints recorded in the respective complaints handling systems.

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	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**

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

Risk Level	Definition
Corporate	This issue / risk level impacts the IJB 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 IJB's approach to complaint handling.

The following governance, risk management and control measures were generally fit for purpose:

- **Governance arrangements** – Delegated authority for complaint handling is formalised and the NHS and Council Feedback teams maintain good oversight of complaints, with systems in place for progressing complaint investigations and responses with relevant lead officers. In addition, regular monitoring of complaints takes place by the Health and Social Care Partnership (H&SCP) Clinical and Care Governance Group and the H&SCP Clinical and Care Governance Committee.
- **Written procedures, guidance, and training** – Written procedures and guidance for staff are comprehensive and comply with the relevant SPSO model complaints handling procedures. In addition, online training, shared learning events and regular staff newsletters covering complaints handling are in place. Furthermore, complaints handling procedures and reporting arrangements are adequately advertised to members of the public.
- **Complaint handling** – Complaints are generally being well handled based on a sample of 20 H&SCP complaints reviewed (nine NHS patient, eight social care service users, three directly to the Chief Officer) reviewed. Correspondence with complainants was generally of a good standard and lessons had been learned and improvement action taken where complaints were upheld.
- **Annual performance reporting** – Mandatory annual reporting on complaints key performance indicators was in line with SPSO requirements for all Council and NHS Grampian complaints, which cover Aberdeen City H&SCP complaints.

However, the review identified some areas of weakness where enhancements could be made to strengthen the framework of control, specifically:

- **Early resolution** – Complaints in general could be resolved quicker. In 2022/23, of 160 H&SCP complaints received (145 NHS and 15 Social Care) deemed suitable[2] for early resolution within five working days, only 46 (29%) (41 NHS and 5 Social Care) achieved early

[2] Complaints are classified within the NHS complaint handling system (Datix) by the Feedback team and service complaint lead, according to customer severity and complexity. This determines if suitable for early resolution within five working days of receipt or if investigation is instead required over a 20-working day period where more complex / higher risk. A similar process is adopted by the Council's Feedback team with complaints suitable for early resolution which have taken longer specifically identified as 'S2-Esc'.

resolution, with the remainder taking longer, with an average complaint receipt to closure duration of 40 days (NHS average 45 days, Social Care average 21 days).

- **Management monitoring** – The SPSO mandated quarterly key performance indicator (KPI) on average response times by complaint stage is not being reported at all to senior management as required, despite complaint handling timeliness needing improvement. Also, whilst some lessons learned are being reported for some services to the Aberdeen City H&SCP Clinical and Care Governance Group, this reporting was not observed to the H&SCP Clinical and Care Governance Committee nor the H&SCP Senior Leadership Team (SLT). The H&SCP SLT identified the need for complaints and enquiries performance reports to be reported to the monthly SLT meetings in November 2022. Prior to the commencement of this audit, work to collate this data from across NHS Grampian, Aberdeen City Council and the Integration Joint Board is underway and scheduled for completion during 2023/24.
- **Public reporting** – The SPSO requires anonymised quarterly external reporting on complaints outcomes and actions taken to improve services however this is not taking place. This is qualitative in nature and can be addressed for social care complaints by 'You Said, We Did' notifications or case studies. Similar reporting is required for health complaints with an additional requirement to report on complaints 'trends' e.g., overall number of complaints received by quarter. The April 2023 Aberdeen City H&SCP Clinical and Care Governance Committee complaint report reviewed covered the required content to some extent with a case study example of action taken to address a complaint. However, these Committee reports are unavailable to the public.
- **System data and dashboard reporting** – Lessons learned, and improvement actions are not always recorded in the Council complaints handling systems despite being captured in the related correspondence with complainants. In addition, multiple systems are in use to handle complaints as described at Appendix 3, some of which are spreadsheet based. These issues mean system data available to H&SCP SLT members is incomplete for dashboard reporting purposes.

It is acknowledged that there are challenges; requirements to capture complaints information across three different organisations, that use different systems, meaning the task of coordination and presenting data can be more onerous. However, the above issues increase the risk of continued complaint handling delays, and poor service delivery where reasons for complaints are not addressed. This increases the risk of repeat complaints, complainant dissatisfaction and escalation to the SPSO, with resulting reputational damage for the H&SCP where complaints are publicly upheld by the SPSO.

Recommendations have been made to address these matters including establishing senior management complaints reporting that covers SPSO requirements as a minimum; publishing necessary complaint outcome and actions taken reports; reviewing mandatory reporting requirements for complaints handling systems to ensure lessons learned and necessary corrective action are captured; and establishing senior management H&SCP complaints handling dashboard reporting.

Severe or major issues / risks

Issues and risks identified are categorised according to their impact on the Board. The following are summaries of higher rated issues / risks that have been identified as part of this review:

Ref	Severe or Major Issues / Risks	Risk Agreed	Risk Rating	Page No.
1.1	**Management monitoring** – It is a mandatory requirement of SPSO model complaints procedures for complaints key performance indicators (KPIs) to be reported to senior management on a quarterly basis. However, performance needs improvement, since in 2022/23, of 160 H&SCP complaints received (145 NHS and 15 Social Care) deemed suitable for early resolution within five working days, only 46 (29%) (41 NHS and 5	Yes	**Major**	9

Ref	Severe or Major Issues / Risks	Risk Agreed	Risk Rating	Page No.
	Social Care) achieved early resolution, with the remainder taking longer, with an average complaint receipt to closure duration of 40 days (NHS average 45 days, Social Care average 21 days). Regular performance reporting intended to cover all Aberdeen City H&SCP complaints, is taking place through the H&SCP Clinical and Care Governance Group and H&SCP Clinical and Care Governance Committee. However, reporting does not include the SPSO mandated quarterly key performance indicator (KPI) on average response times by complaint stage, which needs addressed. Also, whilst some lessons learned are being reported for some services to the Aberdeen City H&SCP Clinical and Care Governance Group, this reporting was not observed to the Clinical and Care Governance Committee nor H&SCP Senior Leadership Team (SLT). Where Senior Management complaints key performance reporting is incomplete there is a greater risk complaint resolution will continue to be delayed, lessons will not be learned, and that complaints will be escalated to the SPSO, resulting in reputational damage to the H&SCP where upheld.			

2.3 Management response

The Senior Leadership Team (SLT) welcome the findings of the audit. SLT are currently working on a governance dashboard which will include data on complaints (including the quarterly SPSO data outlined in this audit). This dashboard will allow SLT to be sighted on key data sets on a regular basis. SLT will also work with colleagues in Aberdeen City Council (ACC) and NHS Grampian to ensure consistency across templates, response letters etc.

3 Issues / Risks, Recommendations, and Management Response

3.1 Issues / Risks, recommendations, and management response

Ref	Description	Risk Rating	Major
1.1	**Management monitoring** – It is a mandatory requirement of SPSO model complaints procedures for complaints key performance indicators (KPIs) to be reported to Senior Management on a quarterly basis. Required KPIs cover complaint volume and average time at the various stages of resolution, investigation, and conclusion. Regular performance reporting intended to cover all Aberdeen City H&SCP complaints, is taking place through the H&SCP Clinical and Care Governance Group and H&SCP Clinical and Care Governance Committee. However, performance needs improvement, since in 2022/23, of 160 H&SCP complaints received (145 NHS and 15 Social Care) deemed suitable for early resolution within five working days, only 46 (29%) (41 NHS and 5 Social Care) achieved early resolution, with the remainder taking longer, with an average complaint receipt to closure duration of 40 days (NHS average 45 days, Social Care average 21 days). The H&SCP C&CG Group receive 'Sector Reports' from each service area with the H&SCP, with the Sector Report template covering various matters, including complaints. However, the level of detail reported varied by service area, based on the February 2023 meeting papers reviewed, with some blank returns without explanation, and some without actions taken / lessons learned. This could in part be due to the reporting template lacking guidance on required information. The H&SCP C&CG Group is aware that all necessary information is not always being received and the Sector Reports are under review as a result. Whilst the H&SCP C&CG Committee reporting is generally comprehensive, it was noted that it does not include the SPSO mandated quarterly key performance indicator (KPI) on average response times by complaint stage, an area which needs improvement as detailed above. In addition, it was noted there was no reporting on lessons learned and improvement actions at the April H&SCP C&CG Committee meeting. At the time of review, there was no separate Council, NHS Grampian, or H&SCP Senior Leadership Team (SLT) quarterly reporting covering H&SCP complaints KPIs. However, SLT identified the need for this reporting in November 2022 and work has commenced to address this. Where senior management complaints key performance reporting is incomplete there is a greater risk complaint resolution will be delayed or not achieved, lessons will not be learned, and that complaints will be escalated to the SPSO, resulting in reputational damage to the H&SCP where upheld. **IA Recommended Mitigating Actions** a) Mandatory quarterly SPSO complaints KPIs should be reported as required. b) Sector Reports for the H&SCP Clinical and Care Governance Group should be standardised to capture all necessary information including lessons learned and improvement actions. **Management Actions to Address Issues/Risks** *a) Agreed. The development of the Senior Leadership Team governance dashboard will include the mandatory SPSO details moving forward.* *b) Agreed.*		

Risk Agreed	Person(s)	Due Date

Ref	Description		Risk Rating	Major
	a) Yes b) Yes	a) Business and Resilience Manager and Strategy and Transformation Lead b) Business and Resilience Manager	a) 30 June 2024 b) 30 June 2024	

Ref	Description	Risk Rating	Moderate
1.2	**Systems and dashboard reporting** – Complaints handling systems should facilitate management oversight, to ensure complaints are being handled in a timely manner in accordance with procedure and any necessary improvements are addressed. Complaints are handled using multiple systems as described in Appendix 3. Relevant officers within the H&SCP SLT have access to complaints recorded in the NHS complaints handling system Datix, and the spreadsheet-based logs used to handle H&SCP complaints received directly by the H&SCP Chief Officer. However, H&SCP SLT officers do not have access to the Council's complaints handling system for monitoring progress with social care complaints, since this is recorded in spreadsheets, with access restricted to the Customer Feedback and Access to Information (Feedback) team, who lead on investigating and responding to social care complaints. In addition, lessons learned, and improvement actions are not always recorded in the spreadsheet-based log used by the Council's Feedback team, as detailed at 1.3 below. These data recording and access issues act as a barrier to H&SCP SLT dashboard reporting, reducing senior management oversight of complaints, which risks wider lessons not being learned and addressed, poor service delivery, complaint resolution delays, and escalation of mishandled complaints to the SPSO.		

IA Recommended Mitigating Actions

a) Mandatory fields within the Council's social care complaints handling system should be reviewed to ensure all necessary complaint handling data is captured.

b) Dashboard reporting covering relevant complaints KPIs should be established for H&SCP SLT members.

Management Actions to Address Issues/Risks

a) Agreed. ACHSCP will work with ACC and NHSG to capture all necessary complaint handling data. Manual updates will be maintained of lessons learned and improvement actions which will be systematically shared on a regular basis with necessary stakeholders.

b) Agreed. The development of the Senior Leadership Team governance dashboard is ongoing and will capture complaints KPI's. The dashboard is intended to be reported to SLT on a quarterly basis.

Risk Agreed	Person(s)	Due Date
a) Yes b) Yes	a) Business and Resilience Manager and Customer Service Manager, ACC b) Business and Resilience Manager and Strategy and Transformation Lead	a) 30 June 2024 b) 30 June 2024

Ref	Description	Risk Rating	Minor
1.3	**Complaint handling** – SPSO model complaints handling procedures describe how the NHS and local authorities should handle complaints, including means and timing of acknowledgement, early resolution, investigation, and associated correspondence requirements. A sample of 20 complaints (nine NHS Datix, eight Council Feedback team social care log, three Chief Officer spreadsheet log) were reviewed. In general, complaints had been well handled, with complaint issues identified at the acknowledgement stage and responses to complainants covering reasons for outcomes, and where upheld, complaint causes, lessons learned, and action taken. However, whilst lessons learned, and improvement actions had been reported as required to complainants these were not captured for three of six (50%) upheld social care complaints reviewed in the related Feedback team spreadsheet log. This data recording risk has already been covered at 1.2 above. It is an SPSO requirement to acknowledge complaints requiring investigation within three working days of receipt. Complainants were generally kept informed of any delays, However, two (13%) of 15 complaints reviewed at the investigation stage were formally acknowledged in line with SPSO requirements late risking reputational damage. The Service advised that due to the complex nature of complaints such as these it can take longer than anticipated to establish the basis of the complaint and if indeed it is a complaint. A general acknowledgement was issued for one of these prior to the three day SPSO deadline whilst conducting this process. Whilst all responses to complainants at the investigation stage had been approved by a relevant manager, eight (40%) (four social care, four NHS) had not been approved by an H&SCP SLT service lead with the necessary delegated authority. This is contrary to Council complaints handling procedure and reduces H&SCP SLT oversight and control over complaints handling. Correspondence with complainants was generally of a good standard and complied with most SPSO requirements, However, one (13%) of eight NHS acknowledgment letters for complaints that reached the investigation stage did not include reference to the role and contact details for the SPSO nor did they include details of advice and support available, including Professional Advocacy Advice and Support Service Scotland (PASS).The Feedback team advised this was due to the respective service responding by email without Feedback team involvement and the use of a standard pro-forma acknowledgement template. In addition, it was noted one (13%) NHS response omitted an apology for the complaint despite the complaint being fully upheld and the letter also being issued a day late. Whilst reasons for one (33%) of three delayed complaint investigations were not explained in the related correspondence acknowledging delays as required. The Feedback team advised that this was due to no explanation being provided by the related service when requested. The NHS Feedback team have a helpful checklist for staff to follow when preparing a written response to complaints following investigation. This includes the need for an apology where appropriate. It may further help staff if examples of when it is appropriate to apologies are included on the checklist, such as when a complaint is upheld. Finally, Council complaint responses were of a good standard, but it was noted they omitted the SPSO requirement to notify complainants that a member of staff is available to clarify any aspect of the letter. These matters, whilst relatively minor, increase the risk complainants will refer a response they are dissatisfied with directly to the SPSO.		

Ref	Description	Risk Rating	Minor

IA Recommended Mitigating Actions

a) Delegated authority should be adhered to or reviewed.

b) The Council's acknowledgement process should be reviewed to ensure timely response.

c) Council template complaint response letters should be reviewed to ensure they cover all SPSO requirements.

d) NHS services should be reminded of complaint handling requirements (including acknowledgement requirements and reasons for delays), and the Feedback team's complaint response sign off checklist requirements should be reviewed and reissued.

Management Actions to Address Issues/Risks

a) Agreed.

b) Agreed. ACH&SP will work with ACC on a review of the acknowledgement process.

c) Agreed.

d) Agreed

Risk Agreed	Person(s)	Due Date
Yes	a) Business and Resilience Manager	a) and c) 30 June 24
	b) Customer Service Manager, ACC	b) December 2023
	c) Customer Service Manager, ACC	c) December 2023
	d) Business and Resilience Manager & Team Leader Adverse Events & Feedback (NHS Grampian)	d) 30 June 24

Ref	Description	Risk Rating	Moderate
1.4	**Public reporting** – It is a mandatory SPSO requirement for quarterly publishing of complaints outcomes and actions taken to improve services, with a focus on positive communication with customers on the value of complaints.		

This can be addressed by case study examples of how complaints have helped improve services or 'You Said We Did' notifications. The April 2023 Aberdeen City H&SCP Clinical and Care Governance Committee complaint report reviewed covered this to some extent, with a case study example of action taken to address a complaint. However, these reports are unavailable to the public.

Furthermore, there is no equivalent NHS Grampian or Council reporting which is covering this for the H&SCP complaints.

IA Recommended Mitigating Actions

SPSO mandatory public reporting should take place as required for the H&SCP.

Management Actions to Address Issues/Risks

	Agreed.		
	Risk Agreed	**Person(s)**	**Due Date**
	Yes	Business and Resilience Manager and Strategy and Transformation Lead	30 June 24

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 IJB 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 IJB's objectives or could impact the effectiveness or efficiency of the IJB's activities or processes. Action is considered imperative to ensure that the IJB is not exposed to severe risks and should be taken immediately.

5 Appendix 2 – Assurance review scoping document

5.1 Area subject to review

Under the Scottish Public Services Ombudsman (SPSO) Act 2002, Scottish public sector organisations are required to establish a complaints procedure that complies with the SPSO's statement of complaints handling principles. This statement states, an effective complaints handling procedure is:

- **User-focused** – It puts the complainant at the heart of the process.
- **Accessible** – It is appropriately and clearly communicated, easily understood and available to all.
- **Simple and timely** – It has as few steps as necessary within an agreed and transparent timeframe.
- **Thorough, proportionate, and consistent** – It should provide quality outcomes in all complaints through robust but proportionate investigation and the use of clear quality standards.
- **Objective, impartial and fair** – It should be objective and evidence-based and driven by the facts and established circumstances, not assumptions, and this should be clearly demonstrated.
- **Seeks early resolution** – It aims to resolve complaints at the earliest opportunity, to the service user's satisfaction wherever possible and appropriate.
- **Delivers improvement** – It is driven by a search for improvement, using analysis of outcomes to support service delivery and drive service quality improvements.

To help ensure the above principles are achieved, the SPSO has published various sector specific model complaints handling procedures (MCHPs), which include:

- A shared definition of what is and is not a complaint.
- A two-stage process where complaints are resolved, with the customer's agreement, as close to the frontline as possible.
- Frontline response to complaints within five working days.
- An investigation stage of 20 working days, which provides the organisation's final decision.
- Recording of all complaints.
- Active learning from complaints through reporting and publicising complaint information.

The SPSO Local Authority MCHP implementation guidance requires health and social care partnerships (HSCPs) to adapt and adopt this procedure for complaints relating to adult social care services delivered by a HSCP. In addition, under the NHS MCHP, NHS staff are required to work with health and social care partnership staff to resolve complaints raised with the NHS that relate to integrated health and social care services. Furthermore, for complaints relating to the actions and processes of the IJB itself, IJBs are expected to adopt the MCHP for Scottish Government, Scottish Parliament, and Associated Public Authorities.

In 2022/23 the Aberdeen City Health and Social Care Partnership received 199 complaints[3] (153 health, 46 social care) relating to delivery of health and social care services (249 2021/22 – 207 health, 42 social care). No complaints were received in 2022/23 or 2021/22 relating to the actions of the IJB itself.

5.2 Rationale for review

The audit objective is to ensure that the complaints procedures are being complied with for all matters and that data generated is used by Management to monitor and improve performance.

The area has not been subject to review previously by Internal Audit. It has been included in the 2023/24 Internal Audit plan following consultation with Senior Management due to the risk of reputational damage and potential financial loss, should complaints be mismanaged and / or associated control weaknesses addressed.

5.3 Scope and risk level of review

[3] Complaint numbers are based on complaints recorded in the respective complaints handling systems.

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:

- Written Policies and Procedures
- Training
- Systems and Record Keeping
- Data Sharing
- Complaint Management
- Monitoring and Reporting
- Lessons Learned and Improvements

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 hybrid working across the Council, this review will be undertaken primarily remotely.

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:

- Andy Johnston, Audit Team Manager **(audit lead)**
- Jamie Dale, Chief Internal Auditor

5.7 Partnership key contacts

The key contacts for this review across the Partnership are:

- Sandra MacLeod, Chief Officer
- Fraser Bell, Chief Operating Officer **(process owner)**
- Paul Mitchell, Chief Finance Officer
- Martin Allan, Business Manager

5.8 Delivery plan and milestones

The key delivery plan and milestones are:

Milestone	Planned date
Scope issued	12/05/2023

Milestone	Planned date
Scope agreed	26/05/2023
Fieldwork commences	08/06/2023
Fieldwork completed	28/07/2023
Draft report issued	11/08/2023
Process owner response	01/09/2023
Director response	08/09/2023
Final report issued	15/09/2023

6 Appendix 3 – Complaints Handling Systems

	NHS Patients	Social Care Service Users	Chief Officer Complaints
Complaint Handling System	Datix	Spreadsheet Logs and GovService (for reference number)	Spreadsheet Logs
Complainants / Complaint Enquiry Source	Service Users or representatives, Patient Advice and Support Service (PASS), Advocacy Service, MPs, MSPs, Councillors, Care Opinion	Service Users or representatives, Advocacy Service, MPs, MSPs, Councillors	NHS Grampian Chief Executive (non-patient related complaints) MPs, MSPs, Councillors, Scottish Government, SPSO, Service Users
Nature of Complaints	Service User Specific	Service User Specific	Various - Service User Specific Redirected to Feedback Team
Complaint Route to Feedback Team	Email, Letter, Telephone, Freepost Feedback Card, Patient Advice and Support Service (PASS), Advocacy Service	Email, Letter, Telephone, GovService webform	Email, Letter
Investigating Officer	Service Manager	Feedback Team	PA to Chief Officer
Authorised Signatory Complaint Response	H&SCP SLT Service Lead	Chief Officer - Social Work (Adults)	Chief Operating Officer

ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	12 February 2024
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Internal Audit Report AC2411 – Attendance Management
REPORT NUMBER	IA/AC2411
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. RECOMMENDATIONS

2.1 It is recommended that the Committee review, discuss and comment on the issues raised within this report and the attached appendix.

2.2 Committee notes that the activities required to review and update the Supporting Attendance Management and Wellbeing Policy are well underway. People and Organisational Development will submit the updated policy to the Policy Group and Risk Board meetings in April 2024 with submission to Staff Governance Committee for approval thereafter.

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 There are no direct impacts, as a result of this report, in relation to the Council Delivery Plan, or the Local Outcome Improvement Plan Themes of Prosperous Economy, People or Place.

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 AC2411 – Attendance Management

12. REPORT AUTHOR CONTACT DETAILS

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Internal Audit

Assurance Review of Attendance Management

Status: Final
Date: 22 November 2023
Risk Level: Corporate

Report No: AC2411
Assurance Year: 2023/24

Net Risk Rating	Description	Assurance Assessment
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**

Report Tracking	Planned Date	Actual Date
Scope issued	08/09/2023	08/09/2023
Scope agreed	15/09/2023	14/09/2023
Fieldwork commenced	02/10/2023	02/10/2023
Fieldwork completed	13/10/2023	13/10/2023
Draft report issued	03/11/2023	25/10/2023
Process owner response	24/11/2023	15/11/2023
Director response	01/12/2023	22/11/2023
Final report issued	08/12/2023	22/11/2023
Committee	01/02/2024	

Distribution	
Document type	Assurance Report
Director	Andy MacDonald, Director of Customer
Process Owner	Kirsten Foley, Employee Relations and Wellbeing Manager
Stakeholder	Lindsay MacInnes, Interim Chief Officer, People & Organisational Development and Customer Experience
	Sharon Robb, Employee Relations Casework Lead
***Final only**	Vikki Cuthbert, Interim Chief Officer – Governance*
	Jonathan Belford, Chief Officer - Finance*
	External Audit*
Lead auditor	Jamie Dale, Chief Internal Auditor

1 Introduction

1.1 Area subject to review

Attendance Management is important to the Council because staff absence affects the ability to deliver. The success of Aberdeen City Council is dependent upon employees maintaining the required standards of attendance in order to deliver services effectively.

Based on the current available figures, absence across the Council, including comparisons, is as follows:

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
2020/21	10.32	9.71	4.16	4.16
2019/20	11.30	11.90	5.37	6.35
2018/19	11.87	11.49	4.87	6.23

Where the responsibility for individual Attendance Management cases is the responsibility of line management, within the Council, the People & Organisational Development Cluster has responsibility for second line oversight.

Reporting is facilitated through PowerBI reports made available to Management, with six monthly updates being presented to the Staff Governance Committee, and performance reports also being presented to other relevant committees.

1.2 Rationale for the review

The objective of this audit is to obtain assurance that controls in this area are designed and operating effectively and to determine whether the Council's Absence Improvement Plan is having a positive impact on attendance.

In December 2022, the Audit, Risk and Scrutiny Committee reviewed an Internal Audit Report on Attendance Management. This report set out how assurance had been obtained over compliance and reporting for Attendance Management, however, following consultation with Management, it was recognised that improvement work was ongoing to address absence levels across the Council, which according to the most recently available data was 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. This work included a full review of the Supporting Attendance Policy. It was determined that the best use of resources was to gain the assurance over compliance and reporting and then collaborate with People & Organisational Development going forward, with a full review to be included in the 2023/24 Internal Audit Plan.

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	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**

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 Attendance Management.

The Council operates a supporting Attendance and Wellbeing Policy; approved by the Staff Governance Committee in November 2018 and implemented in January 2019. The Policy applies to all Council employees and covers any sickness absence, regardless of the reason(s). The Policy sets out the responsibilities of different stakeholders and sets out the procedures across areas such as: Reporting and Recording Sickness Absence, Return to Work, Medical Referrals, Absence Triggers and Procedural Changes. Recording and monitoring of attendance and application of the Policy is through CoreHR

The Policy, although comprehensive and still relevant, is meant to be reviewed every three years. No formal review has been concluded, and as such, no formal consultation arrangements or reporting to Committee on the Policy has taken place since 2018. Management has advised that this is because of the wider work ongoing with regards to the Absence Improvement Project. There was however no workstream identified to review the Policy as part of plans.

This Project began in September 2023, under the revised project charter, and is due to finish in April 2024, but review of the current Draft Project Plan indicates limited results being achieved or tasks being completed to date. The Project Charter only contains timescales across August 2023 and September 2023, with two elements of the work (implementing and sustaining changes that demonstrate improvement and spreading change) having no identified timescale. This aligned with the Draft Project Plan that only saw one workstream complete (Review of Manager Training) and all others as either in progress or not started.

The audit identified issues with regards to demonstrating compliance with key elements of the Policy: lack of records on the HR system of Return to Work (RTW) discussions taking place; no RTW forms, a mandatory aspect of the Policy, being completed; an instance of an employee returning to work but the absence still being open on the system; and instances where individual line managers across the Council did not respond to the requests of Internal Audit with regards to evidence and as such no assurance can be taken over these.

These results highlight that whilst the controls are generally designed effectively, there are inconsistencies in their application. Management advised that in addition to the overall Policy, guides are available for using CoreHR and an Outcomes for Supporting Attendance Online Course is available.

However, since its introduction in 2020, it has only been completed 129 times. There may therefore be a lack of understanding and awareness of responsibilities and requirements.

In addition to the results, a general review of the HR system and discussions with individual line managers highlighted varying approaches with regards to updating the system, retention of documentation, a lack of understanding if the Policy was applicable, and an instance where Management advised an absence was not being managed through the Supporting Attendance and Wellbeing Policy and that this decision had been made at a local level. General issues with the quality of data available through the HR system were also noted, including: historical issues with regards to absence logging and reporting errors following restructuring, and individuals moving roles or having more than one position. These will have an impact on the accuracy of reporting across Management and to Committee. Management advised they were aware of these data issues and would be working on remedial action.

Flexibility is necessary within the bounds of the Policy given the varying types of sicknesses and periods, but there is a risk that current application of the Policy is inconsistent, with the potential for absent employees not to be given the support they need, and a resulting impact on service delivery. It is vital that all absences are treated and recorded to a minimum standard, for the benefit of supporting employees returning to work, to facilitate accurate reporting, and also to provide an evidence base should there be challenge to how an instance was managed.

Recommendations have been made to address the noted points, specifically: reviewing the Policy, either as a standalone task or as part of the Absence Improvement Project; reviewing the Project Charter and Draft Project Plan to ensure they are as accurate, complete and realistic as possible; and strengthening the understanding of the Policy at an operational level, including the establishment of a minimum standard to which individual line managers should be held to account. A final recommendation has been made for Management to develop stronger second line oversight of Attendance Management across the Council and a means of gaining feedback from managers and those employees who have been through the Attendance Management process.

2.3 Severe or major issues / risks

Issues and risks identified are categorised according to their impact on the Council. The following are summaries of higher rated issues / risks that have been identified as part of this review:

Ref	Severe or Major Issues / Risks	Risk Agreed	Risk Rating	Page No.
1.2	**Policy Application and Recording** – The Council has in place a Supporting Attendance and Wellbeing Policy. Testing of key elements identified issues with regards to: • No records on the CoreHR system of Return to Work (RTW) discussions taking place. • No RTW form, a mandatory aspect of the Policy, being completed. • An instance of an employee returning to work but the absence still being open on the system. • Instances where individual line managers did not respond to the requests of Internal Audit with regards to evidence and as such no assurance can be taken over these. The above results highlight inconsistencies in approach. Management advised that in addition to the overall Policy, guides are	Yes	**Major**	10

Ref	Severe or Major Issues / Risks	Risk Agreed	Risk Rating	Page No.
	available for using CoreHR and an Outcomes for Supporting Attendance Online Course is available. However, since its introduction in 2020, it has only been completed 129 times. There may therefore be a lack of understanding and awareness of responsibilities and requirements. In addition to the results noted above, a general review of the HR system and discussions with individual line managers highlighted varying approaches with regards to updating the system, retention of documentation, a lack of understanding if the Policy was applicable, and one instance where Management advised an absence was not being managed through the Supporting Attendance and Wellbeing Policy and that this decision had been made at a local level. General issues with the quality of data available through the HR system were also noted, including: historical issues with regards to absence logging and reporting errors following restructuring, or individuals moving roles or having more than one position. Management advised they were aware of these data issues and would be working on remedial action. Although it is inevitable that the Policy may be applied differently given the varying types of sicknesses and periods, there is a risk that the current application of the Policy is inconsistent, with the potential for absent employees not to be given the support they need, and a resulting impact on service delivery. It is vital that all absences are treated and recorded to a minimum standard, for the benefit of supporting employees returning to work but also to provide an evidence base should there be challenge to how an instance was managed.			

2.4 Management response

The Absence Improvement Project, which started in September 2023 following a revision of the Project charter and is due to end in April 2024, should address the issues identified.

Manager training is being reviewed with an increased emphasis on the importance of compliance with the policy provisions and absence recording.

The issue with regard to the accuracy of the absence data has been recognised and work is underway to complete a full data cleanse.

3 Issues / Risks, Recommendations, and Management Response

3.1 Issues / Risks, recommendations, and management response

Ref	Description	Risk Rating	Moderate
1.1	**Supporting Attendance Management and Wellbeing Policy and Wider Absence Improvement** – The Council has in place a Supporting Attendance and Wellbeing Policy; approved by the Staff Governance Committee in November 2018 and implemented in January 2019. The policy applies to all Council employees and covers any sickness absence, regardless of the reason(s). The Policy sets out the responsibilities of different stakeholders and sets out the procedures across areas such as: Reporting and Recording Sickness Absence, Return to Work, Medical Referrals, Absence Triggers and Procedural Changes. The Policy includes a requirement that it should be reviewed every three years. No formal review has been concluded, and as such, no formal consultation or reporting to Committee on the Policy has taken place since 2018. Management has advised that this is because of the wider work ongoing with regards to the Absence Improvement Project. The aim of this work is: • *"To reduce the number of absences extending beyond six months through supporting employees back into the workplace or progress through ill health retirement/capability".* • *"To reduce the number of employees hitting short term absence triggers (three occasions or more in 12 months)".* • *"To improve overall employee mental health and wellbeing in the workplace, creating a sense of belonging and inclusion, alongside fair work practices".* This Project began in September 2023, under the revised project charter, but review of the current Draft Project Plan shows limited results being achieved or tasks being completed to date. The Project Charter only contains timescales across August 2023 and September 2023, with some elements of the work (implementing and sustaining changes that demonstrate improvement and spreading change) having no identified timescale. This aligned with the Draft Project Plan that only saw one workstream complete (Review of Manager Training) and all others as either in progress or not started. There was also no workstream identified to review the Supporting Attendance and Wellbeing Policy, which Management advised was a part of the work. Similarly no workstream was included to cover the work on data. Where this was included heavily in the Project Charter and Management advised of known issues e.g. data cleansing requirements for older absences and reporting classifications, it would be expected for dedicated workstreams to be in place. There is a risk that the current approach to the Absence Improvement Project may not yield the desired results or meet the established aims. Where Management has advised they will be progressing the Project, a recommendation has been made to track implementation, specifically around the review of the Policy, working on the known data issues, and any other workstreams that Management may wish to feed in as a result of the recommendations of this audit. **IA Recommended Mitigating Actions** Management should review the Supporting Attendance and Wellbeing Policy, either as a standalone task or as part of a dedicated workstream within the Absence Improvement Project. Management should review the Absence Improvement Project Charter and Draft Project Plan to ensure it is as accurate and complete as possible. The review should ensure that realistic		

Ref	Description	Risk Rating	Moderate
	timescales are in place for all workstreams and that these are monitored and reported throughout the lifecycle of the Project.		

Management Actions to Address Issues/Risks

Policy review was an area of work which was put on hold during the COVID pandemic, thus resulting in a backlog of policies requiring review, and work is underway to clear this backlog. The review of the Supporting Attendance Policy is scheduled for the summer of 2024, with the revised policy being on the agenda for Staff Governance Committee in November 2024.

There have been a number of unavoidable delays in progressing the Absence Improvement Project, however the actions are now being progressed and recorded against the Project Plan, with progress being reported in through the Performance Board. The actions that are being trialled through the project should address the issues identified within the audit report.

Risk Agreed	Person(s)	Due Date
Yes	Employee Relations & Wellbeing Manager	April 2024

Ref	Description	Risk Rating	Major
1.2	**Policy Application and Recording** – As noted at 1.1 above, the Council has in place a Supporting Attendance and Wellbeing Policy. The key elements of this process that were tested are as follows: • Line managers must record every absence on the HR/Payroll system with the start date and sickness reason as soon as they are informed of an employee's absence. • Upon return to work, the employee's absence must be closed on the HR/Payroll system. • On each occasion an employee returns to work following a sickness absence, their Line Manager must arrange to discuss that absence with them, including completion of a Return to Work (RTW) form. • In order to manage absence there are triggers levels that, if met, place the employee into the formal Supporting Attendance and Wellbeing procedure. The triggers are as follows: 10 days or more of absence in any 12-month period, or three occasions or more of absence in any 12-month period. Results of this work identified: • From a sample of 25 absences to ensure they were recorded timeously: o All were either recorded on the day of the absence or within a few days the instance. • From a sample of 25 absences to ensure that RTW discussions had taken place: o 16 (64%) - No record on the system of a RTW discussion taking place. Management advised it is possible that these may have taken place and not been marked on the system by individual line managers, however there is no assurance over this. o 9 (36%) - The HR system had been updated to record that a RTW discussion had taken place, however: ▪ Only one (12%) Line Manager was able to provide a completed RTW form. ▪ Four (44%) - Management confirmed they did not have the required completed form and that they had either input notes on the system or that the RTW was informal. Where informality is allowed under the Policy, it is mandatory that a RTW form be completed. Discussions with Management highlighted ambiguity where some		

Ref	Description	Risk Rating	Major

individual managers will use the notes function instead of the required form. Management advised they will review the Policy in relation to this reporting to ensure clarity, with the notes function being seen as proportionate going forward.

- Four (44%) - Individual line managers did not respond when asked to provide the completed RTW form and as such no assurance can be taken that these actually took place. Please note that this was individual managers across the Council and not within P&OD; the Cluster responded to all requests, made their staff available throughout the review and also supported with obtaining responses from individuals.

- From a sample of 10 absences that were still active on the HR system i.e. the person has not been recorded as returning to work:
  - Two (20%) - Enquiries of Management identified that the individual had returned to work but this had not been closed on the system.
  - Eight (80%) - Enquires of Management identified that the individual had not returned to work and this was a valid absence.
    - In each of the eight cases, discussions were held with Management and evidence obtained that the Supporting Attendance and Wellbeing Policy was being followed e.g. discussions with individuals, Occupational Health Referrals etc.
- From a sample of 10 absences that would meet the triggers for appropriate action under the Attendance and Wellbeing Procedures (10 days or more absence in any 12 month period or three occasions or more of absence in any 12 month period):
  - Four (40%) - Enquiries of Management highlighted that the Supporting Attendance and Wellbeing Policy was being followed.
  - Six (60%) - Management did not respond to enquiries and as such no assurance can be taken over compliance with the Supporting Attendance and Wellbeing Policy.

The above results highlight inconsistencies in application of the Policy. This could possibly be the result of a lack of understanding and awareness of the responsibilities. Management advised that in addition to the overall Policy, guides are available for using CoreHR and an Outcomes for Supporting Attendance Online Course is available. However, since its introduction in 2020, it has only been completed 129 times. These errors could also be prevented if the system did not allow an absence to be closed without the requisite actions being evidenced as concluded.

In addition to the results noted above, a general review of the HR system and discussions with individual line managers highlighted varying approaches with regards to updating the system, retention of documentation, a lack of understanding if the Policy was applicable, and one instance where Management advised an absence was not being managed through the Supporting Attendance and Wellbeing Policy and that this decision had been made at a local level. General issues with the quality of data available through the HR system were also noted, including historical issues with regards to absence logging and reporting errors following restructuring, or individuals moving roles or having more than one position. Management advised they were aware of these data issues and would be working on remedial action.

Although it is inevitable that the Policy may be applied differently given the varying types of sicknesses and periods, there is a risk that the current application of the Policy is inconsistent and there is the potential for absent employees not to be given the support they need, with a resulting impact on service delivery. It is vital that all absences are treated and recorded to a minimum standard, for the benefit of supporting employees returning to work, reporting to Management and Committee, and also to provide an evidence base should there be challenge to how an instance was managed.

Ref	Description	Risk Rating	Major
	IA Recommended Mitigating Actions		
	Management should strengthen the understanding of the Policy at an operational level, including the establishment of a minimum standard. This work should focus on updated guidance, promotion of available training (including monitoring completion), and other forums whereby individual line managers can be made aware of their responsibilities and the process to be followed. Management should also explore the system functionality to not allow an absence to be closed without a completed return to work and any other automations or limitations that would support recording and compliance. This should also work on ensuring data accuracy and remedial historical issues as recommended in 1.1 above.		
	Management Actions to Address Issues/Risks		
	A range of guidance documents are available to managers; these will be reviewed and relaunched as part of the Absence Improvement Project, and work is already underway on this review. *The revised management training will be launched, emphasising the importance of compliance.* *Work is being undertaken to identify additional stages of the supporting attendance process at which it would be beneficial for managers to received automatic alerts, for example re the completion of the return to work interview and when an employee might be expected to move to the next stage of the procedure.* *Discussions will take place with the system provider to check whether there are options to limit progress through the stages of the absence recording system if certain stages have not been completed, however this also needs to be balanced against the importance of closing absences timeously to ensure accurate recording and pay.*		
	Risk Agreed	**Person(s)**	**Due Date**
	Yes	Employee Relations & Wellbeing Manager	February 2024

Ref	Description	Risk Rating	Moderate
1.3	**Central Governance and Oversight** – The Supporting Attendance and Wellbeing Policy sets out the responsibilities of the three key stakeholders: • **Employees** – The Policy gives employees the responsibility to maintain their attendance at work and to comply with all aspects, including attending meetings and health assessments. It is expected that employees will identify measures to look after their general health and wellbeing and seek medical advice, where appropriate, to maximise their attendance at work. • **Line Managers** – The Policy gives line managers specific responsibilities in relation to recording and monitoring absence levels and for implementing the Policy fairly and consistently. This has been tested and discussed at 1.2 above. The third set of stakeholders identified by the Policy is Senior Management, stating they: *"Are responsible for overseeing the implementation of this Policy, leading strategic initiatives to reduce sickness absence and promoting a positive health, safety and wellbeing culture".* There is a need for stronger second line (People & Organisational Development) (P&OD) oversight of Attendance Management across the Council. Where the audit has identified some initiatives e.g. PowerBI reporting and meetings on request with HR Representatives to		

Ref	Description	Risk Rating	Moderate

provide support, this still puts the onus on individual first line managers. The audit identified limited proactive work on the part of P&OD to ensure application of the Policy at an operational level e.g. absences were being closed off, RTWs were being completed, and the procedural stages were being applied.

User Feedback

Individual line managers provided feedback as part of the audit, with regards to the Supporting Attendance Wellbeing Policy, the HR system, and the approach across the Council in general. This included concerns around the Policy's ability to be applied, the lack of communication, managers applying it in some cases drastically differently, and the HR system not being user friendly. A consistent view was also expressed about the length of time the process took when Occupational Health input was required, however it is recognised that Management are limited in their ability to influence this. Routine engagement with a wider population of Management and users would help to support future reviews. A lack of engagement and understanding, as discussed at 1.2 above, can impact on the consistency of approach to actioning and recording application of the Policy requirements.

There is a risk that if Management does not have effective oversight of the operational application of the Policy, errors in application and recording, as identified in 1.2 above, will continue and go uncorrected. This may result in employees not being supported with their Attendance Management and leave the council vulnerable to challenge. This could also have a negative impact on service delivery.

IA Recommended Mitigating Actions

Management should develop stronger second line oversight of Attendance Management across the Council. This should involve regular review of absences, ensuring that RTWs are being completed, long term absences are still indeed valid, and where this is the case, the proper support is being given to individuals, whilst also supporting line managers. Depending on the available resource, this could be on a sample basis, recreating the tests of Internal Audit, with reporting on results shared with CMT and eCMT.

Management should reflect on feedback from managers and employees who have been through the Attendance Management process. This could be used to strengthen the process, and be built in to the wider Absence Improvement Project.

Management Actions to Address Issues/Risks

Work is underway to produce monthly reports showing the top 50 longest open absences within each Cluster; these will be provided to SMTs, alongside absence trend and absence reason data, to allow a discussion to be held once a month at Cluster SMT level around the absence levels.

Cluster SMT meetings will be attended by a People & Organisational Development Adviser on a quarterly basis as a minimum (more frequently if requested by the Cluster) to undertake a "deep dive" into the absence data for the cluster.

Risk Agreed	Person(s)	Due Date
Yes	Employee Relations & Wellbeing Manager	January 2024

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

Attendance Management is important to the Council because staff absence affects the ability deliver. The success of Aberdeen City Council is dependent upon employees maintaining the required standards of attendance in order to deliver services effectively.

Based on the current available figures, absence across the Council, including comparisons, is as follows:

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
2020/21	10.32	9.71	4.16	4.16
2019/20	11.30	11.90	5.37	6.35
2018/19	11.87	11.49	4.87	6.23

Where the responsibility for individual Attendance Management cases is the responsibility of line management, within the Council, the People & Organisational Development Cluster has responsibility for second line oversight.

Reporting is facilitated through PowerBI reports made available to Management, with six monthly updates being presented to the Staff Governance Committee, and performance reports also being presented to other relevant committees.

5.2 Rationale for review

The objective of this audit is to obtain assurance that controls in this area are designed and operating effectively and to determine whether the Council's Absence Improvement Plan is having a positive impact on attendance.

In December 2022, the Audit, Risk and Scrutiny Committee reviewed an Internal Audit Report on Attendance Management. This report set out how assurance had been obtained over compliance and reporting for Attendance Management, however, following consultation with Management, it was recognised that improvement work was ongoing to address absence levels across the Council, which according to the most recently available data was 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. This work included a full review of the Supporting Attendance Policy. It was determined that the best use of resources was to gain the assurance over compliance and reporting and then collaborate with People & Organisational Development going forward, with a full reviewed to be included in the 2023/24 Internal Audit Plan.

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:

- **Governance** – including the overall Policy, training, and guidance available to those who have responsibility for monitoring and managing attendance.

- **Management** – including the actions taken by Management and support given to staff at appropriate stages of sickness absence.
- **Recording** – including the systems used and completeness of records.
- **Oversight and Reporting** – including the second line responsibilities of People & Organisational Development, and reporting within Management and to Committee.

Where this review will look at Attendance Management across the Council, focus will be given to cases of sickness absence. Additionally, where it is recognised that Attendance Management is the responsibility of many stakeholders, recommendations will be focused on Management centrally to help ensure improvement across the entirety of the Council.

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 hybrid working across the Council, this review will be undertaken primarily remotely.

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 5.7 below)
  - Audit Committee (final only)
  - External Audit (final only)

5.6 IA staff

The IA staff assigned to this review are:

- Jamie Dale, Chief Internal Auditor **(audit lead)**

5.7 Council key contacts

The key contacts for this review across the Council are:

- Andy MacDonald, Director of Customer
- Lindsay MacInnes, Interim Chief Officer – **People & Organisational Development** and Customer Experience
- Kirsten Foley, Employee Relations and Wellbeing Manager **(process owner)**
- Vikki Cuthbert, Interim Chief Officer – Governance
- Jonathan Belford, Chief Officer – Finance
- External Audit

5.8 Delivery plan and milestones

The key delivery plan and milestones are:

Milestone	Planned date
Scope issued	8 Sep 2023
Scope agreed	15 Sep 2023
Fieldwork commences	2 Oct 2023
Fieldwork completed	13 Oct 2023

Milestone	Planned date
Draft report issued	3 Nov 2023
Process owner response	24 Nov 2023
Director response	1 Dec 2023
Final report issued	8 Dec 2023

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ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	12 February 2024
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Internal Audit Report AC2412 – COVID-19 Spend
REPORT NUMBER	IA/AC2412
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 COVID-19 Spend.

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 the COVID-19 Spend.

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 There are no direct impacts, as a result of this report, in relation to the Council Delivery Plan, or the Local Outcome Improvement Plan Themes of Prosperous Economy, People or Place.

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 AC2412 – COVID-19 Spend

12. REPORT AUTHOR CONTACT DETAILS

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Tel	(01467) 530 988

Internal Audit

Assurance Review of COVID-19 Spend

Status: Final
Date: 24 November 2023
Risk Level: Corporate

Report No: AC2412
Assurance Year: 2023/24

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

Report Tracking	Planned Date	Actual Date
Scope issued	04-Sep-23	04-Sep-23
Scope agreed	11-Sep-23	06-Sep-23
Fieldwork commenced	18-Sep-23	18-Sep-23
Fieldwork completed	06-Oct-23	05-Oct-23
Draft report issued	27-Oct-23	19-Oct-23
Process owner response	17-Nov-23	7-Nov-23
Director response	24-Nov-23	23-Nov-23
Final report issued	01-Dec-23	24-Nov-23
Audit Committee	01-Feb-24	

Distribution	
Document type	Assurance Report
Director	Steven Whyte, Director – Resources
Process Owner	Jonathan Belford, Chief Officer – Finance
Stakeholder	Julie Richards, Wood, Service Manager External Partnerships
	Mark Bremner, Cultural Policy and Partner Team Leader
	Helen Sherrit, Finance Partner
	Wayne Connell, Revenues and Benefit Manager
	Richard Burnett, Senior Accountant
***Final only**	Vikki Cuthbert, Interim Chief Officer – Governance*
	External Audit*
Lead auditor	Agne McDonald, Auditor

1 Introduction

1.1 Area subject to review

On 23rd March 2020, the UK Prime Minister announced a nationwide lockdown to curb a widening outbreak of COVID-19, closing many sectors and ordering the public to stay at home. Subsequently restrictions were lifted incrementally by the Scottish First Minister, before being re-introduced in late 2020 and early 2021 as infections rose. The various restrictions had a significant financial impact on businesses and individuals, and grants schemes were established in response, with the Council acting as an agent for the Scottish Government to administer these.

£143.934m of COVID-19 related funding was received by the Council from the Scottish Government. Of this, £83.816m was for businesses and the self-employed, and the remainder £60.118m was to off-set additional COVID-19 related expenditure and income lost by the Council, where services were paused because of the pandemic.

1.2 Rationale for review

The objective of this audit is to obtain assurance over the key spending decisions and financial payments in relation to COVID-19.

Significant grants were received from the Scottish Government and distributed to businesses and individuals over the course of the pandemic. In addition, the pandemic had a significant impact on procurement processes where scarce resources required to be procured at short notice.

This is the first time that the Council has had to respond to a large-scale pandemic. This review will focus on how associated spending decisions were handled, any lessons that have been learnt, and improvements made, for any similar future emergency response. Any findings and recommendations will be focused on future readiness as this review is not looking to critique or change any historical actions carried out during the pandemic.

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
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

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 **MINOR**, with control framework deemed to provide **SUBSTANTIAL** assurance over the Council's key spending decisions and financial payments in relation to COVID-19.

Substantial assurance[1] has been taken over the following aspects of the Council's COVID-19 spending decisions and payment control.

- **Grant Governance and Administration** – Suitable lead officers were allocated to oversee the administration of all grants. In addition, regular meetings took place, including with other local authorities, to ensure grant eligibility and administration requirements were interpreted correctly, suitable controls were in place, and grant payments were being appropriately progressed. Furthermore, grant administration was facilitated through the use of a COVID-19 Business Response Hub Teams site, grant application tracking spreadsheets and relevant written procedures.
- **Applications and Grant Award** – Where a complete audit trail was available (see Records Retention and Supporting Documentation exception below) grant awards were to eligible applicants for the correct amount.
- **Payment Control** – Fraud risks increased nationally when COVID-19 grants were being administered due to the large number of new grant schemes introduced. Finance helped mitigate this risk by monitoring relevant national fraud updates and analysing payment files prior to payment for fraudulent bank accounts or duplicate payments. In addition, where records were complete (see Records Retention exception below), payments processed through the Creditors system were to the correct bank accounts for the correct amount.
- **Budget Monitoring and Reporting** – Regular updates were provided to Urgent Business Committee on the financial impact of COVID-19.
- **Civil Contingencies** – The Council's General Emergency Plan was activated in response to the first lockdown and this specifies delegated authority for incurring emergency spend.

However, the review identified some areas of weakness where enhancements could be made to strengthen the framework of control, specifically:

[1] Finance advised that COVID-19 emergency purchases were made by Building Services. From the creditors report provided and the way items are coded we were unable to determine which expenditure related to COVID-19 emergency purchases and as such this area has not been tested in detail as part of this review.

- **Record Retention and Supporting Documentation** – It is a requirement of the COVID-19 grant schemes for the Council to *'keep and maintain for a period of six years after the expenditure occurs, adequate and proper records and books of account recording all receipts and expenditure of monies paid to it by the Scottish Ministers'*. Records were unavailable for one (7%) payment reviewed. Whilst it is recognised the circumstances presented COVID-19 were exceptional, where grant payment records are not adequately maintained this is a breach of grant funding conditions and risks recovery of unsupported payments by the Scottish Government. In addition, it presents data protection risks where personal data is not held in accordance with grant application privacy notices, risking enforcement action by the Information Commissioner and reputational damage. Also, where grant payments are made in the absence of bank account supporting details, this increases the risk of fraud and payment error.
- **Written Procedures** – Whilst the Council's Following the Public Pound policy provides detailed guidance on appropriate checks prior to grant awards and payments, it does not currently indicate what is acceptable evidence for bank account details to be used for grant payments, increasing the risk of payment error and fraud for future grant payments.
- **Bulk Grant Payment Approval** – Due to the volume of new suppliers requiring COVID-19 grant payments and the urgency of those payments, Finance established a new grant payment process involving bulk upload of new suppliers and associated grant payments to the Creditors system. This is based on spreadsheets of grant payments maintained by the respective Council Clusters responsible for assessing grant eligibility, where the relevant spreadsheet indicates a payment is approved. Whilst approving Clusters can review grant payment batch totals (value and number of grants) prior to payment to confirm totals are as expected, a risk remains that an officer without delegated authority could indicate a payment is ready for approval, risking inappropriate grant payments, since authorisation is by typed updates to a shared spreadsheet.
- **Business Continuity Planning** – A critical service list was developed in 2020 in response to the pandemic and this is reviewed annually by ECMT. This list has been used to prioritise business continuity plan review and testing with a Teams channel in place for storing all business continuity plans. However, two (66%) of three business continuity plans reviewed for service areas relevant to the administration of COVID-19 grants were incomplete. The Finance BCP did not reflect on the impact of the pandemic on service delivery like the other two BCPs did and the External Partnerships (City Growth) BCP was missing details of necessary procedures and staffing requirements to ensure business continuity.

Recommendations were made for record keeping arrangements to be reviewed to ensure data is stored and retained appropriately, for grant bank account evidence requirements and bulk grant payment approval controls to be formalised, and to ensure BCPs are complete and where necessary reflect on the impact of COVID-19.

2.3 Severe or major issues / risks

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

2.4 Management response

Finance – It is reassuring that in general this has shown our processes and procedures to be sound and to be relied on during what was a rapidly and frequently changing period of time, where a large amount of the public money was being handled to support businesses. The recommendations that have been identified are accepted and action is being taken to address those in full. I note the comment about BCP for Finance and the lessons of COVID-19 pandemic will be included in the further work done with the Corporate Risk Lead.

City Growth – We welcome this audit that provides an assurance review of COVID-19 spend, and note the net risk is described as minor. The recommendations that have been identified are accepted and action is being taken to address those in full. We will continue to work with the Corporate Risk Lead to ensure Business Continuity Plans are reviewed to ensure they are complete and reflect on lessons learned from COVID-19 where necessary.

Governance - Emergency Plans were well tested by the pandemic, as were business continuity plans. It is however, important to ensure we continually refresh these, particularly as the organisation continues to transform and our ways of working develop.

Education - It is reassuring that substantial reassurance has been taken from the actions around spending and payment control in relation to COVID-19 grants. The recommendation that has been identified is accepted and action is being taken to address in full. The service will review the arrangements for retention of grant payments.

3 Issues / Risks, Recommendations, and Management Response

3.1 Issues / Risks, recommendations, and management response

<table>
<tr><th>Ref</th><th>Description</th><th>Risk Rating</th><th>Moderate</th></tr>
<tr><td>1.1</td><td colspan="3">
Supporting Documentation and Record Retention – It is a requirement of the COVID-19 grant schemes for the Council to:

“Keep and maintain for a period of six years after the expenditure occurs, adequate and proper records and books of account recording all receipts and expenditure of monies paid to it by the Scottish Ministers”.

In addition, privacy notices to grant applicants indicated personal data supplied as part of the grant application process would be held in line with the Council’s corporate retention schedule, which is set in line with the Scottish Council of Archives Retention Schedules (SCARRS), which sets the retention of funding application documentation at six years plus the current financial year.

13 (87%) of 15 payments reviewed were to eligible applicants for the correct amount to the correct bank account, meaning payments were fully supported. However, records were unavailable for one (7%) payment (Temporary Restrictions Fund grant £4,800). In addition, the bank account used for another (7%) (Business Contingency grant £69,500) was different to that supplied by the applicant and based on an Advice of Wrongly Account for Credit Service (AWACS). Whist the change in bank account was supported by this report, procedures are not formalised to make changes to payee bank account details based on AWACS reports.

The Council’s Following the Public Pound policy provides detailed guidance on appropriate checks prior to grant awards and payments. However, it does not currently indicate what is acceptable evidence for bank account details to be used for grant payments, increasing the risk of payment error and fraud.

Whilst it is recognised the circumstances presented by COVID-19 were exceptional, where grant payment records are not adequately maintained this is a breach of grant funding conditions and risks recovery of unsupported payments by the Scottish Government. In addition, it presents data protection risks where personal data is not held in accordance with grant application privacy notices, risking enforcement action by the Information Commissioner and reputational damage for the Council.

IA Recommended Mitigating Actions

a) Record retention arrangements in support of grant payments should be reviewed to ensure they are fit for purpose in future.

b) Finance should formalise bank account evidence requirements for grant applications.

Management Actions to Address Issues/Risks

a) Agreed. There will be a review of the record retention arrangements around grant payments and guidance will be updated.

b) Agreed. The bank account evidence requirements by grant type will be reviewed and guidance formalised within the FPP Policy.
<table>
<tr><th>Risk Agreed</th><th>Person(s)</th><th>Due Date</th></tr>
<tr><td>a) Yes

b) Yes</td><td>a) Chief Education Officer

b) Finance Operations Manager</td><td>a) March 2024

b) August 2024</td></tr>
</table>
</td></tr>
</table>

Ref	Description	Risk Rating	Moderate
1.2	**Bulk Grant Payment Processing** – A good system of payment control requires segregation of duties between payment preparation, approval and processing, and a similar level of segregation for establishing new suppliers or changes to supplier standing data. Under normal circumstances a generally good system of control is in place for establishing new suppliers via forms and for making grant payments to those suppliers via a workflow-based payment voucher approval process (InfoSmart) or exceptionally via email. However, due to the volume of new suppliers requiring COVID-19 grant payments and the urgency of those payments, Finance established a new grant payment process involving bulk upload of new suppliers and associated grant payments to the Creditors system. This was based on uplifting spreadsheets of grant payments maintained by the respective Council Clusters responsible for assessing grant eligibility, with payments processed based on the relevant lines with recorded approval. These files are uploaded to the Creditors system by the Finance Controls team with batch total values and payment numbers emailed to the ACC Development team and relevant Cluster leads, for top level checking purposes. Whilst review of payment total and number of payments is possible based on batch totals shared the risk of payment error and any potential fraudulent payment would be further reduced if payment approval could be better attributed to the relevant authorised signatory since presently there is a risk a non-authorised signatory could indicate a payment is approved and Clusters do not have access to the payment file processed by Finance.		
	IA Recommended Mitigating Actions Finance should review the bulk grant payment authorisation process and ensure authorised signatory review and approval requirements are robust.		
	Management Actions to Address Issues/Risks *Agreed. Any files created by Finance based on information / requests received from services will be shared back with the service for approval. Furthermore, any payment files received from services will be checked for appropriate approval. A procedure will be formalised on the bulk grant payment process which will cover these requirements.*		
	Risk Agreed / Yes	**Person(s)** / Senior Accountant	**Due Date** / January 2024

Ref	Description	Risk Rating	Moderate
1.3	**Business Continuity Plans** – The Council's Business Continuity Policy states *"The Business Continuity Group is responsible for supporting the Corporate Risk Lead in order to provide the Organisational Resilience Working Group and the Risk Board with the assurance that the Council's Business Continuity plans are implemented, maintained and tested….Each Function must ensure that these Plans are reviewed, maintained and tested in accordance with the testing schedule provided by the Business Continuity Group."* The business continuity plans (BCPs) for three service areas (Finance, Revenues and Benefits, and City Growth) relevant to COVID-19 spend had all been reviewed recently in September 2023. However, the External Partnerships (City Growth) BCP did not include details of documents, including procedures essential to support recovery (BCP Appendix C) nor did it include details of staffing requirements (BCP Appendix D) as required. In addition,		

Ref	Description	Risk Rating	Moderate
	whilst the City Growth and Revenues and Benefits BCPs made reference to the impact of the pandemic on service delivery, this was not covered in the Finance BCP. Where business continuity plans are incomplete or do not fully reflect on significant events impacting service delivery, there is a greater risk a future emergency will cause service disruption.		
	IA Recommended Mitigating Actions Business Continuity Plans should be reviewed to ensure they are complete and reflect on lessons learned from COVID-19 where necessary.		
	Management Actions to Address Issues/Risks *Agreed. The Business Continuity Group is in the process of redesigning the existing BCP template. The new template contains a "loss of staff section" which includes a specific section on 'Loss of staff (Pandemic)' where the expectation would be for plan owners to add any lessons learned. The intention is to issue this to the BCG and other plan owners with a requirement to update their BCPs in line with the new template.*		
	Risk Agreed: Yes	**Person(s)**: Corporate Risk Lead	**Due Date**: June 2024

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

On 23rd March 2020, the UK Prime Minister announced a nationwide lockdown to curb a widening outbreak of COVID-19, closing many sectors and ordering the public to stay at home. Subsequently restrictions were lifted incrementally by the Scottish First Minister, before being re-introduced in late 2020 and early 2021 as infections rose. The various restrictions had a significant financial impact on businesses and individuals, and grants schemes were established in response, with the Council acting as an agent for the Scottish Government to administer these.

£143.934m of COVID-19 related funding was received by the Council from the Scottish Government. Of this, £83.816m was for businesses and the self-employed, and the remainder £60.118m was to off-set additional COVID-19 related expenditure and income lost by the Council, where services were paused because of the pandemic.

5.2 Rationale for review

The objective of this audit is to obtain assurance over the key spending decisions and financial payments in relation to COVID-19.

Significant grants were received from the Scottish Government and distributed to businesses and individuals over the course of the pandemic. In addition, the pandemic had a significant impact on procurement processes where scarce resources required to be procured at short notice.

This is the first time that the Council has had to respond to a large-scale pandemic. This review will focus on how associated spending decisions were handled, any lessons that have been learnt, and improvements made, for any similar future emergency response. Any findings and recommendations will be focused on future readiness as this review is not looking to critique or change any historical actions carried out during the pandemic.

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:

- Written Policies and Procedures
- Applications
- Procurement and Payments
- Grant Award, Budget Monitoring and Reporting
- Lessons Learned and Improvements

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, and guidance.

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, Risk and Scrutiny Committee (final only)
  - External Audit (final only)

5.6 IA staff

The IA staff assigned to this review are:

- Agne McDonald, 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:

- Jonathan Belford, Chief Officer – Finance
- Julie Richards-Wood, Service Manager External Partnerships
- Mark Bremner, Cultural Policy and Partner Team Leader

5.8 Delivery plan and milestones

The key delivery plan and milestones are:

Milestone	Planned date
Scope issued	04-Sep-23
Scope agreed	11-Sep-23
Fieldwork commences	18-Sep-23
Fieldwork completed	06-Oct-23
Draft report issued	27-Oct-23
Process owner response	17-Nov-23
Director response	24-Nov-23
Final report issued	01-Dec-23

6 Appendix 3 – COVID-19 Grants Administered by the Council

Grant	Lead Team
Business Support Grants	City Growth
Self Employed Hardship Fund	City Growth
Strategic Framework Grants	City Growth
Support for Nightclubs and Soft Play Centres	City Growth
Taxi and Private Hire Support Fund	City Growth
Strategic Framework - Hospitality, Retail & Leisure	City Growth
Covid Restrictions Fund	City Growth
Brewers, Travel Agents & Football Centres	City Growth
Bed and Breakfast	City Growth
Self-Catering Accommodation	City Growth
Strategic Framework Business Fund Transition Payment and Scottish Business Restart Grants	City Growth
Restrictions Extension	City Growth
Soft Play Restrictions Top Up Grant	City Growth
Top Up Hospitality Funding – December 2021 / January 2022	City Growth
Top Up Business Support Funding - Hospitality & Leisure – January 2021	City Growth
Ventilation Fund	City Growth
Public House Table Service Fund	City Growth
Self-Isolation Support Grants	Customer Experience
Hardship Payments	Customer Experience
Low Income Pandemic Payments	Customer Experience
Scottish Child Bridging Payments/Family Pandemic Payments	Children's and Family Services
Temporary Restrictions Fund - Early Years and Childcare	Children's and Family Services
Childcare Providers Support Grants	Children's and Family Services
Childcare Sector Omicron Impact Fund	Children's and Family Services
£500 Thank You Payments for Social Care Staff	People & Organisational Development
£400 Thank You Payments for Teachers	Children's and Family Services

ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	12 February 2024
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Internal Audit Report AC2401 – Vehicle and Driver Compliance
REPORT NUMBER	IA/AC2401
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 the Vehicle and Driver Compliance.

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 Vehicle and Driver Compliance.

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 There are no direct impacts, as a result of this report, in relation to the Council Delivery Plan, or the Local Outcome Improvement Plan Themes of Prosperous Economy, People or Place.

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 AC2401 – Vehicle and Driver Compliance

12. REPORT AUTHOR CONTACT DETAILS

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Internal Audit

Assurance Review of Vehicle and Driver Compliance

Status: Final
Date: 29 November 2023
Risk Level: Function

Report No: AC2401
Assurance Year: 2023/24

Net Risk Rating	Description	Assurance Assessment
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**

Report Tracking	Planned Date	Actual Date
Scope issued	21-06-2023	23-06-2023
Scope agreed	28-06-2023	05-07-2023
Fieldwork commenced	03-07-2023	05-07-2023
Fieldwork completed	14-07-2023	02-10-2023
Draft report issued	04-08-2023	10-10-2023
Process owner response	25-08-2023	01-11-2023
Director response	01-09-2023	29-11-2023
Final report issued	08-09-2023	29-11-2023
Audit Committee	01-02-2024	

Distribution	
Document type	Assurance Report
Director	Steven Whyte, Director, Resources
Process Owner	John Weir, Fleet Manager
Stakeholder	Mark Reilly, Chief Officer, Resources.
	Derek Jamieson, Fleet Integration Manager
	Vikki Cuthbert, Interim Chief Officer - Governance*
	Jonathan Belford, Chief Officer - Finance*
***Final only**	External Audit*
Lead auditor	Debbie Steele, Auditor

1 Introduction

1.1 Area subject to review

Aberdeen City Council's Fleet provide vehicles and plant to all services within the Council including but not limited to: Waste and Recycling services; Environmental services; Building services; PTU and Roads. Fleet assets range from snowploughs through to smaller fuel powered items such as grass maintenance equipment.

Under the Goods Vehicles (Licensing of Operators) Act 1995, the Council requires to hold a "Vehicle Operators Licensing System" to operate goods vehicles (or a combination of vehicles and trailers) over the defined weight of 3.5 tonnes to ensure the vehicles are roadworthy, used properly and responsibly. Retaining the licence is conditional on appropriate fleet management practices and adherence to specified rules.

Fleet have permission for up to 111 vehicles under the "Vehicle Operators Licensing System" (Operators Licence"). Currently there are 94 vehicles and 3 trailers on the Operators licence (31/05/2023). There are a total of 523 vehicles (31/05/2023) which includes those declared on the Operators licence (O-Licence vehicles). This figure excludes hired vehicles comprising long and short-term hire. Fleet have a responsibility to maintain vehicles in a safe and roadworthy condition whilst being compliant with legislation. Individual services and drivers have a responsibility to comply with corporate policy and driving regulations in respect of their use of vehicles provided by Fleet.

The Secretary of State for Transport appoints Traffic Commissioners, who act independently of government, as regulators to the Road Transport Industry. They ensure that those granted an Operators licence are operating in a safe, reliable manner and fully comply with the Goods Vehicle Act 1995. The Traffic Commissioner may revoke; suspend; curtail or refuse to extend the Operators licence if the licence requirements are not met by the holder of the Operator licence. Such an occurrence would impact on all the services that Fleet supply vehicles to and ultimately restrict the ability of the Council to deliver its functions.

The Driver and Vehicle Standards Agency (DVSA) is the Government's enforcement agency responsible for ensuring Fleet Services are complying with the legislation in the areas concerned with vehicle roadworthiness; driver hours; facility inspections; safe vehicle loads and Operator licensing.

To ensure best practice and that vehicles are safe and in a roadworthy condition there is a requirement to have an effective management system in place which has a robust maintenance schedule and appropriate lines of supervision.

The DVSA set out that:

"To ensure best practice, you will need to combine good quality maintenance practices and skills with supervision and effective management"[1].

At any point in time a DVSA officer may visit a premises and inspect the facility to determine that the premises are suitable as an operating centre and that the Operator Licence holder is complying with the Operator Licence requirements. DVSA calculate the risks of an Operator by using the "Operator Compliance Risk Score" system.

The DVSA officer may access any large goods vehicle to inspect it and the goods it carries. Under the terms of the license the operator requires to specify the number of vehicles it holds and the maximum weights that each vehicle carries. DVSA or the Police may carry out random roadside checks to ensure

[1] DVSA Guide to maintaining road worthiness. Commercial goods and public services vehicles. Crown copyright 2023.

compliance with vehicle weight restrictions specified in the Operator licence both on motor vehicles and trailers.

Fleet are responsible for ensuring the vehicles are in a "fit and serviceable" condition. Various vehicle inspections/checks require to be carried out by both Fleet and the vehicle operator to ensure the vehicles are safe and roadworthy for public highways:

1. Safety inspections.
2. First use inspections
3. Intermediate safety checks
4. Daily walkaround checks.

It is the legal responsibility of the vehicle driver to ensure that the vehicle is safe to use on public highways. Drivers are trained to identify defects or issues prior to using a vehicle to reduce the risk to themselves; the public and the vehicle asset. In addition, drivers responsible for vehicles itemised under the Operator's licence have their drivers' licences checked regularly for infringement or licence issues.

Drivers of heavy goods vehicles, buses or coaches are required to hold a Certificate of Professional Competence (CPC), except where they are exempt as advised by DVSA guidelines. There is a periodic training requirement to complete 35 hours of training every 5 years. Penalties can be imposed if these measures are not met.

1.2 Rationale for the review

The objective of this audit is to obtain assurance that adequate procedures are in place to effectively manage the Council's vehicle and driver records, to comply with licence and insurance requirements.

Following actions implemented by the Council to address points raised by the Traffic Commissioner in 2014, Internal Audit carried out a review in 2017 to determine whether these were working as intended. On completion the 2017 internal audit identified issues regarding timely reporting by services of accidents and incidents; completion of repairs by external contractors; vehicle maintenance records; staff recruitment; tyre replacements and condition of tyres when performing vehicle first daily checks; tachograph infringements; review of the reported statistics for the statutory performance indicators on driver license issues and the centralisation of Certificate of Professional Competence (CPC) training records.

It was determined that Fleet could not make the changes in isolation and were reliant upon services and their drivers to operate their vehicles in adherence with corporate policy. New procedures had been implemented and following the recruitment of a Fleet Compliance Officer the frequency of compliance audits would be increased with an escalation process implemented to identify and address any further issues promptly. There were plans for a further two Fleet Compliance Assistants, Workshop Manager and Workshop Supervisor to be recruited in the future.

There need to be appropriate and proportionate controls, and checks over compliance, to address potential risks to the continued and effective operation of services which rely on vehicles for their delivery or support.

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	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**

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

Risk Level	Definition
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.

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 Vehicle and Driver Compliance.

Driver and Vehicle Standards Agency (DVSA) categorises Fleets by Operator Compliance Risk Score. This grading calculates the operator risk of not following the rules on roadworthiness. ACC Fleet have been graded the highest score band achievable: green (low risk) with points given for defects or infringements. The more serious these are the more points awarded. ACC score was 1.96 in 2022 and 1.705 in 2023, demonstrating the Fleet is a lower risk in 2023 compared to 2022. This is well within the threshold of 10 for green. Vehicle maintenance systems compliance is also reviewed periodically on a sample basis by a third party assessor, and also subject to unannounced DVSA compliance checks.

There are regular checks on compliance including gate checks, depot audits, tachograph analysis, and investigations into non-compliance. However, there are limited resources to complete these checks, which have been exacerbated by vacancies, and there is limited data to demonstrate these are being scheduled and targeted efficiently to maximise assurance. Ongoing implementation of the Fleet Management System provides opportunities for improvement and there may be scope for further process automation and more efficient practice.

Fleet, whilst responsible for overall management of council vehicles and maintaining the Operators licence, has limited power to hold individual drivers or services to account. Although there is guidance to encourage good practice and compliance, there is no corporate policy covering employees driving Council-provided vehicles and the implications of non-compliance. Non-adherence to guidance is flagged to line managers within drivers' employing Services, who must balance this with other operational demands. Guidance would also benefit from more regular updates, clarifications, and regular refresher training. Non-compliance could present a corporate risk: 23% of incidents and notifiable defects investigated by the Fleet Compliance Team in 2022/23 and 2023/24 to date were not reported to Fleet at the point they should have been identified as part of drivers' daily first use vehicle checks. Delays in reporting defects can present risks to vehicles, drivers, and road users' safety, as well as increased maintenance costs and down-time in the event of subsequent vehicle / parts failure.

Fleet has a system for maintaining records of vehicles and their maintenance, providing a comprehensive record to demonstrate compliance with Operators Licence and safety requirements. However, due to continuing development and implementation of the system, elements of some

processes (e.g. scheduling of maintenance) requires manual intervention., The system flags any missed events, however there is limited management information currently reported on performance against set maintenance and inspection timescales. Performance of Services operating vehicles and acting on identified compliance risks is also not regularly reported to provide assurance over their activities.

Key contracts including tyres and HGV parts and servicing, are not recorded as being up to date on the Councils contracts register system. The Council continues to obtain these services, but not having formal recorded contracts presents a risk to continuity of supply. It is also a breach of the Council's Financial Regulations, procurement regulations, and national procurement rules, which require competitive tendering at the levels of expenditure incurred.

2.3 Severe or major issues / risks

Issues and risks identified are categorised according to their impact on the Council. The following are summaries of higher rated issues / risks that have been identified as part of this review:

Ref	Severe or Major Issues / Risks	Risk Agreed	Risk Rating	Page No.
1.3	**Operator Licence Compliance and Contracts** – Fleet utilises the services of a tyre management company, which provides a 24-hour year-round service for tyre repairs and replacements. However, the contract for these services was entered into in October 2019 for two years (£234k), formally extended for six months, and expired in April 2022. The Scotland Excel framework from which the contract was derived, expired in 2021. No replacement contract has been registered on the Council's contracts register system, yet expenditure continues to be incurred (£240k since contract expiry). Similarly, there are no current contracts registered for HGV vehicle parts and services obtained from a specific supplier (£258k 2022/23, £67k 2023/24 year to date). Whilst the Council continues to utilise the services, not having formal recorded contracts presents a risk to continuity of supply. It is also a breach of the Council's Financial Regulations, procurement regulations, and national procurement rules, which require competitive tendering at these levels of expenditure.	Y	**Major**	11
1.5	**Vehicle Records (Defects)** – First Use Vehicle Checks must be completed every day or whenever another driver takes control of a vehicle, and are recorded in a Driver's / Operator's Check List and Vehicle Defect Report book held with every vehicle. When a book is completed it is returned to the Fleet depot for retention and a replacement issued. The Fleet Compliance Team regularly identifies and investigates instances of	Y	**Major**	12

Ref	Severe or Major Issues / Risks	Risk Agreed	Risk Rating	Page No.
	defects that have been picked up as part of routine Fleet workshop inspection and maintenance activity, rather than by services at the point in time they were, or should have been, first identified by drivers as part of their daily first use vehicle checks. In 2022/23, 23% of 154 incidents investigated by the Fleet Compliance Team had not been reported to Fleet in advance. For April to August 2023, 22% of 58 incidents were unreported. 19% of these related to tyres, brakes or steering faults. Defect books are not otherwise regularly reviewed. From a sample of 197 entries from books for 12 vehicles operated by various Services: 100 (51%) had omissions in mandatory sections. 42 (21%) had not confirmed the driver was fit to drive. 15 (8%) reported defects. Whilst in most cases faults were not repeated, indicating action had been taken, this action was not generally logged in the books themselves. In two cases faults were re-stated or re-occurred at a later date. Delays in reporting defects can present risks to vehicles, drivers, and road users' safety, as well as increased maintenance costs and down-time in the event of subsequent vehicle / parts failure.			

2.4 Management response

Operations welcomes this report and its acknowledgement that there is generally a sound system of governance and control over vehicle and driver compliance. The recently implemented Fleet Management System, and ongoing Fleet Transformation Programme provide opportunities, subject to available resource, to explore opportunities for efficiencies and automation as recommended in the audit report.

As highlighted in the report, Fleet is reliant on drivers and individual operating services to adhere to the processes and guidance set out, to ensure routine vehicle checks are completed, and potential defects recorded and passed to Fleet for review and appropriate action. The Fleet Compliance team carries out regular reviews and investigations to maintain assurance this is taking place. Recent vacancies within the Fleet Compliance team have impacted on the level and scope of work which can be completed, pending conclusion of ongoing recruitment. It is vital that suitable capacity and capability remains available within the service to address compliance risks. Options for further encouraging good practice and compliance at the driver level will be explored with People & Organisational Development, and at cluster level through review of performance information.

Agreements are in place to ensure continuity of supply of key goods and services used in fleet operations, however it is acknowledged that procurement records need to be updated – this will be progressed in conjunction with the Commercial and Procurement Shared Service.

3 Issues / Risks, Recommendations, and Management Response

3.1 Issues / Risks, recommendations, and management response

Ref	Description	Risk Rating	Moderate
1.1	**Procedures and Corporate Responsibilities** – Although there is a Staff Travel Policy, this is focused on use of private vehicles ('grey fleet') for Council business, rather than use of Fleet vehicles. There is a policy on Use of Locating Systems in Vehicles and Devices, but there is no "Driving at Work Policy" covering the standards and expectations required for users of Fleet vehicles. There is "Driving at Work Guidance - Council Vehicles" available from Fleet, and "Guidance Handbooks" for drivers of Light and Heavy Goods Vehicles, and Minibuses. These are focused on compliance with licence and insurance requirements. However, as 'guidance' documents it may be more difficult to hold employees to account in their application. i.e., failure to adhere to guidance may be considered less serious than non-compliance with corporate policy. Reference is made in these documents to a "Driving at Work Policy" that is not currently in place. Fleet, whilst responsible for overall management of council vehicles and maintaining the Operators licence, has limited power to hold individual drivers and services to account. Non-adherence to guidance is flagged to line managers within the employing Services, who must balance this with other operational demands. However, non-compliance could present a corporate risk. The Handbooks are issued in paper copy, and have no date or version control information, making them uncontrolled once printed. Drivers relying on these could have out of date information. Although there are details of some regulations e.g. EU Drivers Hours Regulations EC561/2006 and Working Time Regulations, it would be beneficial to drivers to insert links to legislation and Council policies and procedures (e.g. the Locating Systems policy) within the document to ensure they have access to the current edition and reduce the risk of non-compliance due to lack of up to date information. Fleet separately communicates legislation changes to Services (e.g. changes to the Highway Code) to mitigate the risks of non-compliance. An electronic version would ensure legislation amendments can be done more efficiently and with document control the electronic copy is the most up to date version available to all Services. **IA Recommended Mitigating Actions** Fleet in conjunction with P&OD should develop and implement driving at work policy to promote compliance and accountability. Fleet should review driver guidance documentation to ensure it remains up to date, and can be updated efficiently in the event of required changes. **Management Actions to Address Issues/Risks** *Agreed.* *The Fleet Manager can insist that if an individual driver is presenting a risk to the Council of non-compliance then they can be removed from driving any Council fleet vehicle until the user service has dealt appropriately with the non-compliance. Fleet will work with People & Organisational Development to review and develop driving at work policy (Fleet Vehicles) and supporting guidance for further encouraging good practice and compliance at the driver level.*		

Ref	Description	Risk Rating	Moderate
	Guidance will be reviewed and updated to ensure it remains current and consistent across documents, with consideration given to moving information online where appropriate.		

Risk Agreed	Person(s)	Due Date
Yes	Fleet Manager	December 2024

Ref	Description	Risk Rating	Moderate
1.2	**Management Information and KPI Reporting** – Up to date information on all Fleet assets (vehicles and plant) is available on the Fleet Management System. When an asset is added to the system a recurring maintenance regime is scheduled, including first use inspections, safety inspections, planned maintenance, MOT's and pre-checks, and vehicle excise duty renewals. This information is reviewed regularly, with the system highlighting upcoming and overdue activities in respect of individual vehicles. The accuracy of system information is vital, as reliance is placed on it to ensure e.g. compliance with safety inspection intervals. If records have not been set up correctly in the first place, the system will not highlight them for action at the appropriate time. The Service confirmed that there are regular manual reviews of event scheduling, however, routine checks on system/record accuracy are not currently documented in a procedure. A variety of plant items (powered saws, leaf-blowers, hedge-trimmers) had been recorded on the system with a vehicle make and model. Whilst this does not impact on their operation, it highlights potential issues with data accuracy. Fleet reports regularly to the Operations and Protective Services Management Team on a variety of drivers' information including licence checks and gate checks. Except for tachograph compliance, where further analysis is presented, the performance information generally focuses on the number of checks, rather than compliance, action, and resolution. With the exception of MOT pass rates, these reports do not include Fleet performance information e.g. inspections completed within scheduled time, or fleet availability / up-time. Review of fleet management system records demonstrated that maintenance schedules are in place for vehicles, and the system flags where these are upcoming, due, or overdue, and when they have been completed. Pre-MOT inspections are being carried out to ensure first-pass rates are maintained. In line with DVSA guidance on maintaining roadworthiness, and the safety inspection interval logged on the Vehicle Operator Licensing System, O-Licence vehicles are inspected every eight weeks, within the relevant ISO week it falls due. However, a recent external review of vehicle maintenance systems compliance commissioned by Fleet identified that one out of six vehicles selected had missed its scheduled safety inspection. Although maintenance is being planned appropriately, and completion can be evidenced at a vehicle level, management information is not currently being reported at a fleet level to demonstrate it is being carried out in line with the schedule. The Service noted that workshop scheduling, to meet demand for planned and un-planned activities, is currently a manual intensive process. There is therefore a risk of inadvertent delay due to prioritisation and resourcing. Regularly reported Fleet performance information would provide assurance over compliance, and highlight areas for management focus, or where data accuracy may require further review.		

IA Recommended Mitigating Actions

Ref	Description	Risk Rating	Moderate
	Fleet should regularly review, report, and investigate any issues with performance in respect of meeting scheduled maintenance intervals. Consideration should be given by Operations management to monitoring further Fleet and Service performance and compliance data. Fleet should periodically review system data for accuracy and completeness.		
	Management Actions to Address Issues/Risks *Agreed. Greater use of the system reporting tools will be developed to demonstrate performance and compliance, and support targeted intervention as appropriate.*		
	Risk Agreed: Yes	**Person(s)**: Fleet Manager	**Due Date**: December 2024

Ref	Description	Risk Rating	Major
1.3	**Operator Licence Compliance and Contracts** – Systems, records, and procedures (subject to addressing the areas of risk highlighted in this Internal Audit report) provide assurance over the level of compliance with the requirements of the Operator's Licence. However, the Goods Vehicles (Licencing of Operators) Act 1995 also requires: *"13C (4) There must be satisfactory facilities and arrangements for maintaining the vehicles used under the licence in a fit and serviceable condition".* Schedule 3 further sets out a requirement to maintain: *"core business documents'* including *'contracts relating to the transport service"*. Fleet utilises the services of a tyre management company, which provides a 24-hour year-round service for tyre repairs and replacements. However, the contract for these services was entered into in October 2019 for two years (£234k), formally extended for six months, and expired in April 2022. The Scotland Excel framework from which the contract was derived, expired in 2021. No replacement contract has been registered on the Council's contracts register system, yet expenditure continues to be incurred (£240k since contract expiry). Similarly, there are no current contracts registered for HGV vehicle parts and services obtained from a specific supplier (£258k 2022/23, £67k 2023/24 year to date). This includes MOT testing, for which there are limited local options for dedicated DVSA operated HGV test centres, and a nationally set price is paid. Whilst the Council continues to utilise the services, not having formal recorded contracts presents a risk to continuity of supply. It is also a breach of the Council's Financial Regulations, Procurement Regulations, and national Procurement Rules, which require competitive tendering at these levels of expenditure.		
	IA Recommended Mitigating Actions Fleet should ensure contracts relating to the transport service have been competitively tendered and are recorded on the contracts register in line with the Council's procurement governance rules.		
	Management Actions to Address Issues/Risks *Agreed. The Service will work with Commercial and Procurement to ensure contracts are in place and correctly recorded.*		
	Risk Agreed	**Person(s)**	**Due Date**

Ref	Description		Risk Rating	Major
	Yes	Fleet Manager	December 2024	

Ref	Description		Risk Rating	Moderate
1.4	**Workshop Records** – Post delivery inspections are carried out before a newly obtained vehicle is allowed to go into service. There is a standard form, and details are recorded on the fleet management system, however there is no written procedure. If there are any defects, these are reported back to the supplier and followed up on the warranty. However, in six of ten cases reviewed (60%), commissioning information was not available as it pre-dated implementation of the current fleet management system. One vehicle (10%) delivered after system implementation had no available record. Two of the remaining three vehicles' records (20%) indicated defects had been identified, but there was no record of their satisfactory resolution. For vehicles taken out of service, there is also no formal written procedure. Temporary withdrawal of vehicles, or those awaiting sale or disposal, are physically segregated from the rest of the fleet and marked accordingly. There is a vehicle decommissioning form with a tick box exercise on all the stages that require to be completed prior to the vehicle being fully decommissioned. The process is completed by two signatories (decommissioning and closing the file). System records are then updated to show the vehicle has been taken out of service.			
	IA Recommended Mitigating Actions			
	Fleet should develop and implement clear written procedures covering vehicles being taken into and out of service.			
	Management Actions to Address Issues/Risks			
	Agreed.			
	Risk Agreed	**Person(s)**	**Due Date**	
	Yes	Fleet Integration Manager	December 2024	

Ref	Description		Risk Rating	Major
1.5	**Vehicle Records (Defects)** – First Use Vehicle Checks must be completed every day or whenever another driver takes control of a vehicle, and are recorded in a Driver's / Operator's Check List and Vehicle Defect Report book held with every vehicle. When a book is completed it is returned to the Fleet depot for retention and a replacement issued. The checklist comprises: vehicle and driver details, dates and times, and mileage. There are 18 separate checks to be completed or marked not applicable, a further 13 checks for vans, pickups and LGV's, and 13 for mini buses. Drivers are also required to sign and confirm the checks have been completed and that they are fit to drive. If a fault or defect is identified it should be recorded. The printed handbooks for LGV/HGV and minibus drivers state: *"If any defects are identified, the driver must contact the Fleet Services workshop immediately and seek advice".*			

Ref	Description	Risk Rating	Major
	However, this conflicts with the information in the Check List and Vehicle Defect Report book – which will be the driver's first point of reference when logging a defect. The front cover of the book states: *"defects must be reported to supervisor or other appropriate person, and name of that person plus time defect reported recorded"*; and *"ANY DEFECT MUST BE REPORTED IMMEDIATELY"*; and *"for further advice, call Kittybrewster Workshop on [telephone number]"* Out of hours arrangements are also in place for tyre services (however see 1.3 above regarding contracts), but these are not documented in the guidance or defect books. The requirements are therefore unclear, particularly in the event of an incident or uncertainty over the impact of a particular incident or defect on vehicle operation. Supervisors/line managers within Services will need to be aware of any issues with the potential to impact on service delivery, but might prioritise operational demands over fleet management requirements. There is no written procedure to provide clarity over the requirements, and to offer protection and justification for officers or drivers making these decisions. As the experts in the field, and the responsible officers named in the Operators Licence, Fleet should make all decisions as to roadworthiness of vehicles with identified potential defects. The handbooks also state: *"Drivers must record what action is agreed and with whom on the Drivers First Use Check Form".* However, there is no field on the current form to record this information. The Fleet Compliance Team regularly identifies and investigates instances of defects that have been picked up as part of routine Fleet workshop inspection and maintenance activity, rather than by services at the point in time they were, or should have been, first identified by drivers as part of their daily first use vehicle checks. In 2022/23, 23% of 154 incidents investigated by the Fleet Compliance Team had not been reported in advance. For April to August 2023, 22% of 58 incidents were unreported. 19% of these related to tyres, brakes or steering faults. Delays in reporting defects can present risks to vehicles, drivers, and road users' safety, as well as increased maintenance costs and down-time in the event of subsequent vehicle / parts failure. Services carry out their own periodic gate checks on a proportion of the fleet, and should be reviewing defect books to ensure they are completed correctly, however there is no periodic training on their use. Whilst there will be regular feedback via Compliance Team investigations and reports, clearer guidance and training would promote more consistent practice. Defect books are not otherwise regularly reviewed. From a sample of 197 entries from books for 12 vehicles operated by various Services: 100 (51%) had omissions in mandatory sections. 42 (21%) had not confirmed the driver was fit to drive. 15 (8%) reported defects. Whilst in most cases faults were not repeated, indicating action had been taken, this action was not generally logged in the books themselves. In two cases faults were re-stated or re-occurred at a later date. The current manual process presents a variety of risks, including variations in understanding, completion, quality and content of records, and actions. These are mitigated by additional second line of defence controls – internal fleet compliance monitoring, after the event, and after the risk has been accepted / incurred by the first line. There may be scope to digitise		

Ref	Description	Risk Rating	Major
	the process to improve the availability and timely recording of management information, reducing the risks and cost of control incurred through the current paper-based process.		

IA Recommended Mitigating Actions

Fleet should ensure all documentation and guidance clearly states drivers' responsibility to contact Fleet in the event of any and all defects, prior to driving a Council vehicle.

Fleet in conjunction with P&OD should explore options for holding drivers to account for failure to report defects timeously. This could be reflected in a driving at work policy (see 1.1).

Fleet should ensure Services have appropriate guidance and training in the completion of vehicle first use checks, and gate checks.

Fleet should explore options for digitising first use checks.

Management Actions to Address Issues/Risks

Agreed. Fleet will work with People & Organisational Development and user services to explore options for further encouraging good practice and compliance at the driver level (e.g. policy and training development as appropriate). The requirement to report all defects to Fleet at the point they are identified will be reiterated. Options available on the fleet management system for digitising first use checks will be explored with a view to improving accuracy and efficiency of their completion, and supporting management action.

Risk Agreed	Person(s)	Due Date
Yes	Fleet Manager	December 2024

Ref	Description	Risk Rating	Minor
1.6	**Driver Records** – Reliance is placed on recruitment processes and Service Line Management to periodically undertake driving licence checks for employees driving as part of their work. Services maintain their own records of this activity.		

Fleet monitors licences for drivers of O-Licence vehicles and those using tachograph systems, using an online licence bureau system that regularly reviews licences for changes. The system is also used to monitor drivers' Certificate of Professional Competence, for which 35 hours of training must be logged every five years, and a qualification card held by the driver.

Digital tachograph data is uploaded, analysed, and reported within set timescales. There are regular breaches of requirements, the majority of which are attributable to driver absences not being correctly recorded (41% of 146 infringements over nine months of data). Other regular items included drivers failing to set the system correctly, or not removing cards from vehicles after driving. System records also indicate that drivers' cards may not always be renewed in advance of expiry. Infringements are all reported to line management, reviewed with and acknowledged by drivers, and relevant actions are recorded.

Although the Fleet Compliance Team monitors infringements to ensure drivers are being debriefed timeously, there is no current training for supervisors acting on infringements. Whilst there are few recurring infringements at an individual level, there are common themes. Training at a Service level could raise the profile and help reduce avoidable infringements in the future, and the resulting requirement for non-compliance action.

IA Recommended Mitigating Actions

Ref	Description	Risk Rating	Minor
	Fleet should identify recurring tachograph infringement types and provide training to Services in avoiding them.		
	Management Actions to Address Issues/Risks		
	Agreed. As agreed above Fleet will develop further management information from systems data, and will work with P&OD and user services to explore options for further encouraging good practice and compliance at the driver level.		
	Risk Agreed	**Person(s)**	**Due Date**
	Yes	Fleet Manager	December 2024

Ref	Description	Risk Rating	Moderate
1.7	**Management Assurance** – Access to the fleet management system is restricted to key individuals within Fleet. It must be updated daily to ensure work is planned effectively and actions recorded, to demonstrate an appropriate and compliant level of vehicle maintenance management. Assurance and resilience (e.g. in the event of key staff absences) would benefit from increased numbers of users with the relevant training and system access. Outside of the system there are manual processes including workshop scheduling, and vehicle excise duty renewals, which require time and resource, and present risks in the event of absences. These could benefit from automation. The Fleet Compliance team establishment includes a Team Manager and two assistants. There are currently vacancies in the team for which recruitment is ongoing. While these vacancies persist there is a risk to capacity to identify and address potential compliance issues. This risk is compounded by limited advance planning, and potential process inefficiencies – though it is recognised capacity is also required to address these. The Team formerly maintained a compliance diary to schedule planned activity e.g. gate checks, depot audits etc. This is no longer used. Whilst 'unannounced' visits can be a useful tool to observe normal practice, if the team is not scheduling its own work in advance there is a risk it will not obtain the intended level of assurance over the required period. However, there is evidence of compliance monitoring activities taking place. Where areas for improvement are identified, these are advised to Services for action, although there is limited follow-up activity to confirm implementation. There are periodic gate checks completed by both the Compliance Team and services, covering a proportion of the fleet (minimum of 10% per month but regularly covering 25-30%). Management information in this respect focuses on the number and proportion of checks, rather than compliance and coverage. Repeat checks of the same locations, vehicles, and drivers would count towards the target but may not add as much value. A more targeted approach could yield efficiency and compliance benefits. The Compliance Team investigates all incidents and accidents reported by the Workshop. As noted at 1.5 above, a substantial proportion of defects are not being reported in advance. Investigation reports require responses from services to confirm they have reviewed the incident / evidence provided and taken appropriate action, including highlighting the issue to the driver and reinforcing the requirements. Services do not always respond promptly, which causes additional work following up responses. Similarly, the Compliance Team had to follow up with services to obtain responses to 21% of 151 tachograph compliance reports between November 2022 and August 2023. Without these responses, the team has less assurance that compliance issues are being addressed.		

Ref	Description	Risk Rating	Moderate

If the requirements were underlined by Policy (see 1.1 and 1.5 above), or if Service performance information included compliance levels and response rates (particularly given the main Fleet users are also within Operations) (see 1.2 above), Services could be more effectively held to account, reducing the impact on the compliance team's workload.

The current reporting and follow up process is a largely manual exercise. There are standard forms which effectively delineate the process, and there are written procedures – though these contained inactive links and no document control, reducing assurance over their current status. There are standard formats for reporting the outcome of checks, however these would benefit from clearer and more concise content on the specific issues, actions, and timescales for resolution. If actions could be recorded on a system there may also be scope for automation of reporting and follow up.

IA Recommended Mitigating Actions

Fleet should ensure sufficient members of the team have access and training for the fleet management system.

Fleet should review opportunities for automation of recurring tasks.

Fleet compliance activity should be scheduled to ensure an appropriate level of coverage, including a targeted approach based on relevant management information.

Compliance reporting should clearly identify the relevant issues, requirements, and timescales for action.

Management Actions to Address Issues/Risks

Agreed.

All Fleet staff have appropriate access to the system as per their access requirements, however consideration will be given to resilience in the event of absences. Opportunities to further exploit system and data potential are welcome and will be reviewed.

Compliance activity will be scheduled but will include unannounced visits as we seek to ensure compliance is embedded in service culture. The team will review options for review and follow up activity, which is currently limited as a result of ongoing vacancies.

Risk Agreed	Person(s)	Due Date
Yes	Fleet Manager	December 2024

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

Aberdeen City Council's Fleet provide vehicles to services within the Council including e.g. Environmental services; Building services; Grounds maintenance; Schools and Roads. Fleet assets range from snowploughs through to smaller fuel powered items such as grass maintenance equipment.

Under the Goods Vehicles (Licensing of Operators) Act 1995, the Council requires to hold a "Vehicle Operators Licensing System" to operate goods vehicles (or a combination of vehicles and trailers) over the defined weight of 3.5 tonnes to ensure the vehicles are roadworthy, used properly and responsibly. Retaining the licence is conditional on appropriate fleet management practices and adherence to specified rules.

Fleet have permission for up to 111 vehicles under the "Vehicle Operators Licensing System" (Operators Licence"). Currently there are 94 vehicles and 3 trailers on the Operators licence (31/05/2023). There are a total of 523 vehicles (31/05/2023) which includes those declared on the Operators licence. This figure excludes hired vehicles comprising long and short-term hire. Fleet have a responsibility to maintain vehicles in a safe and roadworthy condition whilst being compliant with legislation. Individual services and drivers have a responsibility to comply with corporate policy and driving regulations in respect of their use of vehicles provided by Fleet.

The Secretary of State for Transport appoints Traffic Commissioners, who act independently of government, as regulators to the Road Transport Industry. They ensure that those granted an Operators licence are operating in a safe, reliable manner and fully comply with the Goods Vehicle Act 1995. The Traffic Commissioner may revoke; suspend; curtail or refuse to extend the Operators licence if the licence requirements are not met by the holder of the Operator licence. Such an occurrence would impact on all the services that Fleet supply vehicles to and ultimately restrict the ability of the Council to deliver its functions.

The Driver and Vehicle Standards Agency (DVSA) is the Government's enforcement agency responsible for ensuring Fleet Services are complying with the legislation in the areas concerned with vehicle roadworthiness; driver hours; facility inspections; safe vehicle loads and Operator licensing.

To ensure best practice and that vehicles are safe and in a roadworthy condition there is a requirement to have an effective management system in place which has a robust maintenance schedule and appropriate lines of supervision.

The DVSA set out that:

"To ensure best practice, you will need to combine good quality maintenance practices and skills with supervision and effective management"[2].

At any point in time a DVSA officer may visit a premises and inspect the facility to determine that the premises are suitable as an operating centre and that the Operator Licence holder is complying with the Operator Licence requirements. DVSA calculate the risks of an Operator by using the "Operator Compliance Risk Score" system.

The DVSA officer may access any large goods vehicle to inspect it and the goods it carries. Under the terms of the license the operator requires to specify the number of vehicles it holds and the maximum weights that each vehicle carries. DVSA or the Police may carry out random roadside checks to ensure

[2] DVSA Guide to maintaining road worthiness. Commercial goods and public services vehicles. Crown copyright 2023.

compliance with vehicle weight restrictions specified in the Operator licence both on motor vehicles and trailers.

Fleet are responsible for ensuring the vehicles are in a "fit and serviceable" condition. Various vehicle inspections/checks require to be carried out by both Fleet and the vehicle operator to ensure the vehicles are safe and roadworthy for public highways:

5. Safety inspections.
6. First use inspections
7. Intermediate safety checks
8. Daily walkaround checks.

It is the legal responsibility of the vehicle driver to ensure that the vehicle is safe to use on public highways. Drivers are trained to identify defects or issues prior to using a vehicle to reduce the risk to themselves; the public and the vehicle asset. In addition, drivers responsible for vehicles itemised under the Operator's licence have their drivers' licences checked regularly for infringement or licence issues.

Drivers of heavy goods vehicles, buses or coaches require to hold a Certificate of Professional Competence (CPC). There is a periodic training requirement to complete 35 hours of training every 5 years. Penalties can be imposed if these measures are not met.

5.2 Rationale for review

The objective of this audit is to obtain assurance that adequate procedures are in place to effectively manage the Councils vehicle and driver records, to comply with licence and insurance requirements.

Following concerns raised by the Traffic Commissioner, Internal Audit carried out a review in 2017 to determine whether the actions put in place to remedy these concerns were working as intended. On completion the 2017 internal audit identified issues regarding timely reporting by services of accidents and incidents; completion of repairs by external contractors; vehicle maintenance records; staff recruitment; tyre replacements and condition of tyres when performing vehicle first daily checks; tachograph infringements; review of the reported statistics for the statutory performance indicators on driver license issues and the centralisation of Certificate of Professional Competence (CPC) training records.

It was determined that Fleet could not make the changes in isolation and were reliant upon services and their drivers to operate their vehicles in adherence with corporate policy. New procedures had been implemented and following the recruitment of a Fleet Compliance Officer the frequency of compliance audits would be increased with an escalation process implemented to identify and address any further issues promptly. There were plans for a further two Fleet Compliance Assistants, Workshop Manager and Workshop Supervisor to be recruited in the future.

There need to be suitable controls, and checks over compliance, to address potential risks to the continued and effective operation of services which rely on vehicles for their delivery or support.

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:

- Procedures and corporate responsibilities
- Management information
- Operator licence compliance & KPI reporting
- Workshop records
- Vehicle records
- Tyre management
- Driver records
- CPC training records
- Staffing
- Tachograph compliance
- Insurance

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. The audit will include examination of vehicle and driver records, random spot checks of vehicles and associated Driver first use check sheets to obtain assurance of the audit objective.

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:

- Debbie Steele **(audit lead)**
- Colin Harvey, 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:

- Steven Whyte, Director, Resources, Resources – Director cluster
- Mark Reilly, Chief Officer, Resources – Operations & Protective Services
- John Weir, Fleet Manager, Resources – Operations & Protective Services. **(process owner)**
- Agnes Aitken, Fleet Compliance Manager, Resources – Operations & Protective Services

5.8 Delivery plan and milestones

The key delivery plan and milestones are:

Milestone	Planned date
Scope issued	23-06-2023
Scope agreed	30-06-2023
Fieldwork commences	03-07-2023

Milestone	Planned date
Fieldwork completed	21-07-2023
Draft report issued	04-08-2023
Process owner response	25-08-2023
Director response	01-09-2023
Final report issued	08-09-2023

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ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	12 February 2024
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Internal Audit Plan 2024-2027
REPORT NUMBER	IA/24/002
DIRECTOR	N/A
REPORT AUTHOR	Jamie Dale, Chief Internal Auditor
TERMS OF REFERENCE	2.1

1. PURPOSE OF REPORT

1.1 The purpose of this report is to seek approval of the attached Internal Audit plan for 2024-2027.

2. RECOMMENDATION

It is recommended that the Committee:

2.1 Approve the attached Internal Audit Plan for 2024-2027.

3. CURRENT SITUATION

3.1 It is one of the functions of the Audit, Risk and Scrutiny Committee to review the activities of the Internal Audit function, including the approval of the Internal Audit Plan. The proposed plan for 2024-2027 is attached at Appendix A, along with the plans for Aberdeen City Integration Joint Board and North East of Scotland Pension Fund for information.

3.2 All audits included in the attached plan, as well as those in future plans, will help inform Internal Audit's opinion on the adequacy and effectiveness of the Council's framework of governance, risk management and control, which is expressed in an annual report, and provide assurance to the Audit, Risk and Scrutiny Committee. Where opportunities for improvement in controls and their application, or improvements in value for money, are identified these will be reported along with recommendations for management to consider.

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 that are agreed with management. Those not implemented by their agreed due date are detailed in the attached appendices.	M	**Yes**
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	L	**Yes**

		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.		
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 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**
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	L	**Yes**

		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.		
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 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**
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	L	**Yes**

		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 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 – Aberdeen City Council - Internal Audit Plan - 2024-27

12. REPORT AUTHOR DETAILS

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Internal Audit

Aberdeen City Council
Internal Audit Plan
2024-27

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.

The purpose of this report is to seek approval of the attached Internal Audit plan for 2024-2027.

All audits included in the attached plan, as well as those in future plans, will help inform Internal Audit's opinion on the adequacy and effectiveness of the Council's framework of governance, risk management and control, which is expressed in an annual report, and provide assurance to the Audit, Risk and Scrutiny Committee. Where opportunities for improvement in controls and their application, or improvements in value for money, are identified these will be reported along with recommendations for Management to consider.

1.2 Management Commentary

Management welcomes this Internal Audit Plan, setting our internal audit activities over a three-year period. It is likely that, during this period, the risk environment and financial backdrop will continue to develop, and that the Council will face significant challenges in the delivery of critical services. The Committee will welcome the opportunity to revisit the Plan annually to ensure that it reflects our risk environment and appetite and delivers the required assurance on the priority areas for the Council. Management welcomes Internal Audit's engagement with officers on audit scoping, fieldwork, and the finalising and closing off of audit recommendations.

2 Internal Audit Plan

2.1 Plan development

In previous years, as agreed with the Audit, Risk and Scrutiny Committee on 26 June 2018, a single-year Plan has been set out for the Committee's approval. This provided clarity over planned work during each financial year, as changes in the risk environment were often less pronounced over a shorter period. However, this provided less opportunity for the Committee to gain an understanding of the wider context or 'audit universe'. In addition, the Plan was regularly not concluded in full during the financial year to which it originally referred – due to changes in priority, risks, and resources.

There was therefore scope to develop and extend planning to provide a clearer picture of Internal Audit's work and priorities, and to provide flexibility in timing of elements of that work, over an extended period. Therefore, from 2022, the Committee approved a rolling three year plan, with the recognition that this would still be assessed each year and updates made as required.

The Plan for 2024-27 is set out at Appendix 1. The planned work with the Aberdeen City Integration Joint Board and North East Scotland Pension Fund has also been included.

In formation of the plan, Internal Audit:

- **Reviewed historic audit outputs** – The initial planning stage involved a review of completed work from across the previous years. This looked to gauge the assurance that had been obtained recently and develop a baseline that could be built upon with the current plan. Where it is hoped that the greatest coverage can be obtained in a single year, this is not always possible, so instead it will be ensured that there has been coverage over a number of years, both previously and forward looking.
- **Reviewed the agreed Plan for 2023-26** – In addition to the review of previous assurance work, the agreed plans for 2024/25 and 2025/26, approved as part of the 2023-2026 Plan overall, were reviewed. This is the starting position for the current plan; however this has changed based on developments in year and the changing risk profile of the Council.
- **Reviewed Management's progress in implementing agreed audit recommendations** – A review of the work of Management to implement audit recommendations . This looked to identify any areas where Management has struggled to implement agreed actions, and where the risks remain, for these to be factored into the audit plan.
- **Reviewed different sources of information** – A suite of information, primarily Committee reporting, was reviewed to further develop Internal Audit's understanding of the operations and issues of the Council.
- **Reviewed information from other assurance providers** – Discussions were held and reports reviewed from other assurance providers, primarily External

Audit. This looked to ensure minimal overlap, whilst also recognising that Internal Audit is required to gain its own assurances year on year.

- **Held discussion with key stakeholders** – Discussions were held with key stakeholders across the Council, including but not limited to directors, chief officers, and councillors. These discussions focused on three key areas:
    - Key risks within the auditable area.
    - Any recent or upcoming developments.
    - Suggestions for assurance reviews, including value adding pieces of work.
- **Benchmarked against other Scottish Local Authorities** – A review of the Internal Audit plans for other Local Authorities as per their Committee reporting available online. This looked to gain an understanding of issues being faced by other Local Authorities and identify any auditable areas for Aberdeen City Council.
- **Mapped to the Council's functional structure** – The proposed Internal audit Plan, for 2024-25, has been mapped to the Council's functional structure to ensure the maximum possible coverage of Council's operations. Please see Appendix 2.
- **Mapped to the Council's risk register** – A review of the Council's risk register was carried out, focusing on the Corporate and Cluster levels, and those risks that are currently outwith appetite. This resulted in the identification of eight key risk themes that have been used for ensuring appropriate coverage of different areas across Council operations. Please see Appendix 3.

The plan details what Internal Audit anticipates being able to review in the year, assuming stability in resources available to the Service. The plan is flexible and can be amended to reflect changes in priority or because of new risks being introduced or identified, although consideration needs to be given to the requirement for Internal Audit to complete sufficient work to provide an evidence based annual opinion. Internal Audit will continue to review the Council's risk registers and update its own risk assessments based on audit findings, throughout the Plan's term.

All audits included in the attached plan are part of a rolling programme of work, each element of which will help inform Internal Audit regarding the adequacy and effectiveness of the Council's framework of governance, risk management and control, allowing assurance to be provided regarding those arrangements. Where opportunities for improvement in controls and their application, or improvements in value for money, are identified these will be reported along with recommendations for Management to consider. This is the priority of the work however where there are opportunities to provide value adding work, this has been factored into the plan.

The time allocation for all audits assumes that systems to be reviewed are adequately documented, detailing the controls put in place by Management, and that testing identifies that these controls are being complied with. If this is not the case, there will be an impact on the time taken to review planned areas and on the plan's achievability.

The Plan also includes time set aside to assist services in developing their controls and approach to improving compliance. This reflects continuing development of a more proactive value-added approach by Internal Audit, to supplement the more traditional core compliance-oriented audit work. For these elements of the Plan there will not be a separate Internal Audit report to the Audit Risk and Scrutiny Committee. Highlights from this work will however be provided as part of the regular Internal Audit progress reports provided to the Committee.

With approval of the plan, we will work with individual directorates and services to schedule the audit work for the year. This will look to match our internal resourcing but also ensure that it is suitable for those relevant stakeholders across the Council. We will look to ensure that management are not inundated with consecutive audits and that fieldwork, where most input is required, is at a time which does not clash with other priorities or commitments.

2.2 Undertaking planned work

When commencing each planned audit, Internal Audit contacts the Director and Chief Officer responsible for the area to be reviewed along with any other nominated contact officer. They are reminded of the objective and scope of the review and of how Internal Audit intends to achieve the level of assurance required. Officers are invited to identify any specific aspects of the area to be reviewed that are of particular concern. Officers are also asked about their risk appetite for the areas under review. All of this is factored into the agreed scoping document. Once fieldwork has been completed, a draft report is issued to the Director and Chief Officer responsible for the area to be reviewed along with any other nominated contact officer. Officers will be asked to provide a response to individual findings and to the report overall. This response should address the points raised and either agree to address the risks or set out why no action will be taken e.g. within appetite or other priorities for available resource. At the request of Management, Internal Audit will also work with officers to ensure their agreed actions recognise the impacts on resource and where possible seek to ensure automation of processes is considered. Prior to issuing the final report, Internal Audit seeks confirmation from the Director involved that they are satisfied with the report and actions agreed to address any identified issues.

Whilst undertaking planned work, it is possible that Internal Audit may identify governance issues that are not within the stated scope of the review being undertaken. Public Sector Internal Audit Standards require that Internal Audit report such instances to those charged with governance. In this respect, Internal Audit's reports may contain issues that appear to be "outwith scope".

2.3 Resources

To undertake the attached plan, Internal Audit has an establishment of thirteen posts. It is anticipated that this will be split between Aberdeenshire and Aberdeen City councils on a 2:1 ratio. Where not presented in this document underlying the Plan is detailed calculations based on the number of audits days available, which provides assurance on the level of resource available to deliver the work.

3 Appendix 1 – 2024-27 Internal Audit Plan

The below table sets out the Internal Audit Plan for 2024-27. The Plan should be read with the following considerations:

- Where each audit has been mapped to a Function (and a Cluster at Appendix 2), some audits will cut across many different areas of the Council's operations. During the scoping, fieldwork and reporting stages, Internal Audit will engage all officers as relevant regardless of the area the review has been assigned to.
- The same is applicable for the mapping to the Council's risk categories. This is to show that consideration has been given to ensuring the Plan addresses the myriad of risks across the Council's operations but individual audits will cut across many different risk categories; the principal risk has been shown below for ease of review.
- Core assurance audits are the typically traditional compliance based reviews that are the foundation for the annual opinion provided by the Chief Internal Auditor and, where not exclusive, will typically focus on the internal financial controls and systems. Wider assurance audits are reviews that will focus more on value adding work and the broader governance framework. Whilst mapping has been provided to show a split in the Plan for the year, the type of review is not exclusive and Internal Audit will ensure that all work contributes to the annual opinion, whilst also adding value where possible. It is considered that a mix of both core and wider assurance reviews is required to provide an evidence base on which the Chief Internal Auditor's annual opinion can be given.

The planned work with the Aberdeen City Integration Joint Board and North East Scotland Pension Fund for 2024-27 is also presented.

Function	Auditable Area	Objective	Principal Risk	Assurance
2024/25				
Commissioning	Procurement Fraud Controls	To ensure there are robust procedures in place to prevent, detect, and address potential fraud in the procurement process.	Financial	Core
Commissioning	Group Structure Assurance	To ensure the Council's approach to its Group structure provides appropriate assurance and the necessary control framework is in place, both overall and for individual bodies.	Strategic	Wider
Commissioning	Risk Management	To provide assurance over the Council's risk management arrangements at each level and how risk appetite are utilised across the delivery of operations.	Strategic	Core

Function	Auditable Area	Objective	Principal Risk	Assurance
Customer	Housing Allocations and Choice Based Letting	To provide assurance that the Housing Waiting List is maintained efficiently, and allocations are made in accordance with policy, including the choice based letting process. This review will also incorporate tenant participation and satisfaction.	Operational	Wider
Customer	Right to Work in the UK	To ensure adequate arrangements are in place to ensure staff have the right to work in the UK	Operational	Core
Customer	Resettlement Governance	To ensure that procedures regarding the Council's responsibilities in relation to the resettlement of refugees, specifically the financial costs, are operating effectively, and any wider impacts on other services delivered by the Council.	Operational	Wider
Customer	Freedom of Information and Subject Access Requests	To obtain assurance that the Council's procedures for dealing with FOI and SARs are appropriate.	Compliance	Wider
Customer	Allowances	To consider whether appropriate control is being exercised over assessing entitlement and other relevant factors for allowances, and to assess controls over making payments. This review will focus on areas such as Education Maintenance Allowance, Clothing, Free School Meals etc.	Operational	Core
Customer	Councillors Governance	To obtain assurance over the processes in place for onboarding and ongoing support and training of Councillors, including the role of Group leaders.	Operational	Wider
Children's and Family Services	SEEMiS	To provide assurance that appropriate control is being exercised over the schools and education management information system in view of the perceived criticality of the system and the significant volume of sensitive personal data held.	Operational	Core
Children's and Family Services	Pre-School Commissioned Places	To ensure pre-school commissioned places requirements are being delivered and that adequate control is exercised over expenditure.	Operational	Core
Children's and Family Services	Family Placement Services	To obtain assurance that adequate procedures are in place to control the calculation, award, and payment of allowances for Fostering, Adoption and Kinship Care.	Operational	Wider
Resources	Trusts / Common Good Funds	To consider whether appropriate governance and controls are being applied over the use of Trusts and Common Good Funds.	Financial	Core
Customer	National Fraud Initiative	To review the Council's engagement and controls for actioning outputs of the National Fraud Initiative, specifically looking at the utilisation of information to gain assurance over areas such as Council Tax and Business Rates.	Financial	Wider
Resources	Prevention of Fraud, Bribery and Corruption	To provide assurance that the Council's arrangements for the prevention of fraud, bribery and corruption are adequate and proportionate.	Financial	Core

Function	Auditable Area	Objective	Principal Risk	Assurance
Resources	Corporate Landlord Responsibilities	To ensure that the Council has systems in place that provide assurance over compliance with the legal requirements in relation to its Corporate Landlord role for these properties.	Compliance	Core
Resources	Creditors Sub-System Payments	To provide assurance that there are adequate controls over payments originating from creditors sub-systems.	Financial	Core
Council Led HSCP Services	HSCP Commissioning	To review plans and progress with commissioning across the Health and Social Care Partnership.	Operational	Core
Various	Consulting Opportunities	To support various opportunities for change, including providing appropriate checks and challenges to ensure risks, governance and internal controls are given timely consideration as part of key change programmes and systems development.	Various	Wider
2025/26				
Commissioning	Procurement Processes	To provide assurance over the procurement processes across the Council's operations.	Strategic	Core
Commissioning	Carbon Budgeting	To ensure that appropriate arrangements are in place regarding carbon budget setting, monitoring, and reporting.	Compliance	Wider
Commissioning	City Region Deal	To provide assurance over the governance and financial spend of the City Region Deal.	Operational	Core
Commissioning	Agency Costs	To ensure that appointments are made from appropriately tendered contracts and that individual appointments are adequately managed.	Financial	Core
Customer	Voluntary Severance	To provide assurance that the terms of the VSER scheme are complied with and that payments made / enhancements to pensions are accurate.	Operational	Wider
Customer	Mandatory Training Compliance	To obtain assurance over the governance arrangements in place to monitor and deliver compliance with mandatory training.	Compliance	Core
Customer	Housing Voids	To provide assurance regarding the process for re-letting void properties and compliance therewith	Operational	Wider
Customer	Digital and Technology Demand	To review the current approach across the Council regarding digital and technology and the resources in place to meet the demand.	Strategic	Wider
Customer	Bus Gates Enforcement and Appeals	To provide assurance regarding the control framework in place regarding Bus Gates.	Operational	Wider

Function	Auditable Area	Objective	Principal Risk	Assurance
Customer	Complaints Handling	To ensure that the Council's complaints procedure is being complied with and that data generated is used by services to monitor and improve performance.	Operational	Core
Customer	Cyber Security Review	To obtain assurance over the implemented control framework in relation to the Council's cyber resilience.	Operational	Core
Children's and Family Services	Out of Authority Placements Follow Up	To ensure the system for commencing and reviewing out of authority placements is adequate effective, and consistently applied, and that since our last review the control framework has been strengthened	Operational	Wider
Children's and Family Services	Nursery Visits	To ensure establishments have adequate procedures in place to manage the financial aspects of the establishment and comply with the Council's Financial Regulations.	Operational	Core
Children's and Family Services	Devolved Schools Management	To provide assurance that the devolved school management (DSM) scheme in place is adequate and that the decision making process is appropriate based on delegations in place.	Operational	Wider
Resources	Bond Governance	To obtain assurance over the governance arrangements in relation to the Aberdeen City Council bonds.	Financial	Core
Resources	Statutory Compliance	To provide assurance over the Council's control framework in relation to statutory compliance obligations for the provision of services.	Compliance	Core
Resources	Property Maintenance	To review the controls in place regarding property maintenance across the Council estate.	Operational	Core
Resources	Crematorium	To ensure that Crematorium income, expenditure and record management procedures are adequate and effective.	Operational	Wider
Council Led HSCP Services	Income Controls	To review the controls in place regarding income for the provision of Health and Social Care Partnership services.	Financial	Core
Various	Consulting Opportunities	To support various opportunities for change, including providing appropriate checks and challenges to ensure risks, governance and internal controls are given timely consideration as part of key change programmes and systems development.	Various	Wider
2026/27				
Commissioning	Information Governance	To obtain assurance over the Council's approach to information governance, and specific compliance with GDPR legislation.	Strategic	Core
Commissioning	Committee Services	To obtain assurance over the operations of Committee Services and the support function.	Operational	Wider

Function	Auditable Area	Objective	Principal Risk	Assurance
Commissioning	PROTECT	To ensure the Council's compliance with PROTECT requirements.	Strategic	Core
Customer	Income Management System	To consider whether appropriate control is being exercised over the income management system, including contingency planning and disaster recovery, and that interfaces to and from other systems are accurate and properly controlled.	Operational	Core
Customer	Payroll Data	To review the controls in place to ensure accurate data is used in the Council's payroll processes.	Operational	Core
Customer	First Line Management Development	To review the controls in place to ensure first line Management are aware of their corporate responsibilities and are discharging these effectively.	Operational	Wider
Customer	IT Procurement	To provide assurance on the effectiveness of internal controls, governance and risk management processes related to goods and services procurement in relation to IT.	Financial	Core
Children's and Family Services	Demand for School Places	To obtain assurance over the Council's approach meeting the demand for school places across the authority.	Operational	Wider
Children's and Family Services	Primary Visits	To ensure establishments have adequate procedures in place to manage the financial aspects of the establishment and comply with the Council's Financial Regulations.	Operational	Core
Children's and Family Services	Self-Directed Support Payments	To obtain assurance over the processes in place for administering self-directed support payments[1].	Financial	Core
Children's and Family Services	Health and Safety in Schools	To provide assurance that arrangements in place adequately manage health and safety risks in the classroom particularly in relation to science and technical classes.	Operational	Core
Resources	Revenue Collection	To ensure that collection arrangements are robust and adequately applied.	Financial	Core
Resources	Fixed Asset Register	To consider whether procedures for ensuring timely recording of the acquisition/disposal of assets are adequate, revaluations are undertaken in accordance with recognised best practice, that a sample of recorded assets exist and those assets that should be recorded are done so.	Financial	Core

[1] Where this has been included as a Children's and Family review, the audit will focus on both children and adults, incorporating the work of the Health and Social Care Partnership.

Function	Auditable Area	Objective	Principal Risk	Assurance
Resources	Capital Delivery Arrangements	To ensure appropriate arrangements are in place to facilitate delivery of the Council's Capital Programme and linkages with the responsibilities of the Corporate Landlord.	Operational	Core
Resources	Trade Waste	To consider whether adequate control is in place covering trade waste income and expenditure, that appropriate agreements and other paperwork is in place, and that accounting arrangements are robust.	Operational	Wider
Resources	Joint Mortuary	To obtain assurance over the governance arrangements and the agreement in place for management of the Council's responsibilities in relation to the joint mortuary.	Operational	Wider
Resources	Fleet Management	To gain assurance over the key controls in place regarding vehicle usage.	Operational	Wider
Council Led HSCP Services	HSCP Delivery	To obtain assurance that adequate arrangements are in place to facilitate the delivery of Health and Social Care Partnership services.	Strategic	Core
Various	Consulting Opportunities	To support various opportunities for change, including providing appropriate checks and challenges to ensure risks, governance and internal controls are given timely consideration as part of key change programmes and systems development.	Various	Wider

Function	Auditable Area	Objective	Principal Risk	Assurance
2024/25				
Integration Joint Board	IJB Budget Setting and Monitoring	To ensure that appropriate arrangements are in place regarding IJB budget setting.	Financial	Core
Integration Joint Board	Counter Fraud[2]	To provide assurance that the IJB's arrangements for the prevention of fraud, bribery and corruption are adequate and proportionate.	Financial	Core
2025/26				
Integration Joint Board	Health and Social Care (staffing) Scotland Act 2019	To consider whether appropriate control is being exercised compliance with statutory guidance on safe staffing levels.	Strategic	Wider
Integration Joint Board	Alcohol and Drugs Partnership	To review the ADP's governance and working arrangements to ensure they are effective and fit for purpose.	Operational	Wider
2026/27				
Integration Joint Board	National Care Service Preparedness[3]	To consider whether appropriate control is being exercised over the anticipated changes to delivery as a result of the roll out of the National Care Service.	Strategic	Wider
Integration Joint Board	IJB Asset Management	To ensure resources are allocated appropriately and efficiently following a suitable asset management plan.	Operational	Wider

[2] This will be a joint review with NHS Grampian Internal Audit to provide wider assurance across controls in the region. Results of work from Aberdeenshire and Moray will also be considered and factored into reporting.

[3] Given the ongoing uncertainty around the introduction of the National Care Service on the IJB, further consideration will be given ahead of planning for 2026/27 to identify appropriate auditable areas and value adding work.

Function	Auditable Area	Objective	Principal Risk	Assurance
2024/25				
North East Scotland Pension Fund	Pension Fund Payroll	To consider whether arrangements are adequate to start and terminate payments from the pension fund payroll, and to ensure that payments are accurate.	Financial	Core
2025/26				
North East Scotland Pension Fund	Key Administrative Processes	To provide assurance over the fulfilment of the key administrative processes across the Pension Fund.	Operational	Core
2026/27				
North East Scotland Pension Fund	Complaints Handling	To ensure that the Fund's complaints procedure is being complied with and that data generated is used to monitor and improve performance.	Operational	Wider

4 Appendix 2 – Mapping to Council Structure (2024/25 only)

The below table maps the Internal Audit Plan for 2024/25 to the Council's Service Structure[4][5]. Where not presented, consideration has been given and assurance is provided that the 2025/26 and 2026/27 plans give reasonable coverage of the different services across the Council.

Commissioning	Customer	Children's and Family Services	Resources	Other
Commercial	**Customer Experience and People and Organisational Development**	**Children's Social Work**	**Finance**	**Health and Social Care and IJB**
• Procurement Fraud Controls	• Right to Work in the UK • Freedom of Information and Subject Access Requests • Councillors Governance • Education Maintenance Allowance	• Family Placement Services	• Trusts/Common Good Funds • Prevention of Fraud, Bribery and Corruption • Creditors System • National Fraud Initiative	• HSCP Commissioning • IJB Budget Setting • IJB Counter Fraud
Governance	**Early Intervention and Community Empowerment**	**Education**	**Capital**	**Noth East Scotland Pension Fund**
• Risk Management • Group Structure Assurance	• Housing Allocations and Choice Based Letting	• SEEMiS • Pre-School Commissioned Places	-	• Pension Fund Payroll
Strategic Place Planning	**Digital and Technology**		**Corporate Landlord**	
• Resettlement Governance	-		• Corporate Landlord Responsibilities	
City Growth	**Data and Insights**		**Operations and Protective Services**	
-	-		-	

[4] Internal Audit is aware of the ongoing work with regards to the Council structure and the impact this will have on where each Cluster may end up reporting. However as this will have minimal impact on the operations at this stage, the mapping has still been completed and seen to provide assurance.

[5] City Growth, Digital and Technology, Capital and Operations and Protective Services have not been assigned specific audits for 2024/25. However these areas have been covered in previous years and in future plans, and other reviews in year will touch upon these areas through interactions across functions. Due to the overlaps, where an audit has been mapped to a specific function, this will not be exclusive and Internal Audit will engage with the different stakeholders as part of the actual reviews.

5 Appendix 3 – Mapping to Council Risks (2024/25 only)

A review of the Council's risk register was carried out, focusing on those at the Corporate and Cluster levels, and those that are currently outwith appetite. This resulted in the identification of six key risk themes[6] that have been used for ensuring appropriate coverage of different areas across Council operations.

Identified Risk Areas[7,8]		
Workforce Capacity and Organisational Resilience	**Financial Sustainability**	**Compliance[9]**
• Risk Management • Councillors Governance • Right to Work in the UK	• Trust / Common Good Funds • Pension Fund Payroll • Prevention of Fraud, Bribery and Corruption • IJB Counter Fraud • IJB Budget Setting • National Fraud Initiative	• Freedom of Information and Subject Access Requests • Corporate Landlord Responsibilities
Procurement and Supply Chain	**IT, Systems and Cyber Security**	**Service Delivery[10]**
• Procurement Fraud Controls	• SEEMiS • Creditors System	• Group Structure Assurance • Housing Allocations and Choice Based Letting • Resettlement Governance • Education Maintenance Allowance • Pre-School Commissioned Places • Family Placement Services • HSCP Commissioning

[6] These six key risk themes have been identified by Internal Audit based on those main areas across the Council's Risk Register. Below these overarching themes are individual risks that are being managed through different mitigating actions and the Council has a range of different assurances over. There are also other unique risks that have not been included above; Internal Audit seeks to gain reasonable and not absolute assurance.

[7] Where an audit has been mapped to a certain risk, this will not be the only risk that the review will focus on; detailed scoping will be carried out prior to commencement of the work and it is anticipated that work will cut across many different risks. The mapping above is only for illustrative purposes to show consideration of the different risks the Council faces.

[8] Some audits are focused on wider aspects of the Council's operations that do not directly align with the six identified risks. Where this is the case, the audit has been mapped to the risk that is seen to most align or support the mitigation of overall.

[9] This category encompasses the corporate risks around Health and Safety Compliance, Climate Change and Civil Contingencies.

[10] This category encompasses the corporate risks around Reinforced Autoclaved Concrete Panels and Planks (RAAC) and the Council's responsibilities in relation to Resettlement and Asylum.