North Lanarkshire Council

Report

Audit and Scrutiny Panel

☐approval ☒noting **Ref** KA/LM/ASP/Sept 2021 **Date** 22/09/21

Internal Audit: Follow up of actions previously agreed by management in response to audit recommendations

From Ken Adamson, Audit and Risk Manager

Email adamsonk@northlan.gov.uk **Telephone** 07939 280602

Executive Summary

The purpose of this report is to update the Panel on the results of Internal Audit's follow-up work reviewing the extent to which management have implemented those actions previously committed to in response to recommendations in Internal and External Audit reports.

Information is contained in respect of the last two years External Audit outputs and those actions in response to Internal Audit recommendations which were due to be completed in the period to the end of June 2021.

The Panel should note that where actions are not yet 'complete' this does not mean that no relevant activity has been undertaken by management and that sometimes the actions taken/progress made to date will have reduced the risk exposure in respect of the weaknesses previously identified even although the action is not yet complete.

16 of the 33 actions agreed in response to relevant Internal Audit recommendations have been fully completed, with 15 being partially implemented and two being no longer relevant. four of the 11 actions agreed in respect of External Audit outputs have been completed, two have been partially implemented, three are not yet due and two are no longer relevant.

Of the 15 Internal Audit actions not yet fully implemented, we have assessed that five of these present a level of residual risk that requires to be highlighted to the Panel.

Recommendations

The Panel is invited to:

(1) note the contents of this report; and

(2) consider whether there are any issues arising from this report on which they wish to receive further information from relevant management.

The Plan for North Lanarkshire

Priority	All priorities
Ambition statement	All ambition statements

1. Background

1.1 All Internal and External Audit reports contain management responses to audit recommendations which generally include a commitment to specific actions by a stated timescale. This report presents an overview of progress by management in addressing all External Audit recommendations made in the last two years and all 'Red' and 'Amber' Internal Audit recommendations which were previously reported as outstanding or where the proposed actions were due to be completed by the end of June 2021.

1.2 The format of this report is designed to focus on those issues where non-implementation of agreed actions presents the most significant ongoing risk to the Council and to enable the Panel to more effectively hold relevant senior management to account.

1.3 In that regard, Internal Audit has assessed the potential risks arising from those planned actions agreed in response to Internal Audit recommendations which are not yet fully completed. Information on those which are assessed by Internal Audit as having a 'High' or 'Medium' residual risk rating is detailed at Appendix 1 for Internal Audit recommendations. There are no such actions assessed with a 'High' or 'Medium' residual risk rating in respect of External Audit recommendations. Information on those which are assessed by Internal Audit as having a ''Low' residual risk rating is, for transparency, shown at Appendix 2 for Internal Audit recommendations.

1.4 The updates from management on progress to date have been verified on a sample basis by Internal Audit as part of the preparation of this report. However, it should be noted that this review has focused on whether planned actions have been completed and has not included detailed substantive testing of whether the implemented actions have been effective in addressing previously identified weaknesses.

---

2. Report

Actions previously agreed by management – Internal Audit recommendations

2.1 Table 1 below shows whether management have implemented those actions previously committed to in response to 'Red' and 'Amber' Internal Audit recommendations which were due to be completed by the end of June 2021. Overall, 16 of the agreed actions have been completed, 15 are partially implemented and two are no longer relevant.

Table 1 **Head of Service Area**	**Complete**	**Partially implemented**	**No longer relevant**	**Total**
Asset and Procurement Solutions	0	2	1	3
Audit and Risk	1	1	0	2
Business Solution	6	6	1	13
Communities	1	0	0	1
Financial Solutions	3	2	0	5
Legal and Democratic Solutions	1	0	0	1
People and Organisational Development	1	0	0	1
Planning, Performance and Quality Assurance (Health and Social Care)	1	4	0	5
Planning and Regeneration	2	0	0	2
TOTAL	**16**	**15**	**2**	**33**

2.2 One of the two issues assessed as being no longer relevant relates to Creditors and the other relates to the Governance of Capital Projects. Each of these actions have been separately followed up as part of more recently undertaken detailed audit work in these areas and where appropriate updated recommendations have been made in these audit reports.

2.3 Table 2 below shows the results of Internal Audit's assessment of the potential residual risk arising from those planned actions which have been partially implemented (definitions for the residual risk ratings can be found at Appendix 3).

Table 2 **Head of Service Area**	**Total not yet completed**	**Residual Risk Rating**		
		High	**Medium**	**Low**
Asset and Procurement Solutions	2	0	2	0
Audit and Risk	1	0	1	0
Business Solution	6	0	1	5
Financial Solutions	2	0	0	2
Planning, Performance and Quality Assurance (Health and Social Care)	4	0	1	3
TOTAL	**15**	**0**	**5**	**10**

2.4 Appendix 1 provides a detailed update on the five previously agreed planned actions which have only been partially implemented and which are assessed by Internal Audit as having a 'Medium' residual risk rating.

2.5 Appendix 2 provides summary information on the 10 actions not yet completed but which have been assessed by Internal Audit as having a 'Low' residual risk.

2.6 We will continue to monitor and re-assess the residual risk for these outstanding actions, each cycle, until we are satisfied that the planned actions have been fully completed and previously identified weaknesses have been addressed.

Actions previously agreed by management – External Audit recommendations

2.7 Table 2 below shows the status of actions agreed by management in response to External Audit reports issued in the last two years (2019/20 and 2020/21). Internal Audit has concluded that four of the 11 agreed actions have been completed, two have been partially implemented, three are not yet due and the remaining two actions are no longer relevant.

Table 2 **Report Title/Year**	**Completed**	**Partially implemented**	**Not yet due**	**No longer relevant**	**Total**
2019/20					
Interim Audit Report	1	2	0	1	4
Annual Report	2	0	0	1	3
2020/21					
Interim Audit Report	1	0	3	0	4
TOTAL	**4**	**2**	**3**	**2**	**11**

2.8 The 2019/20 Interim Audit Report action assessed as 'no longer relevant' relate to an action for which External Audit have made a new recommendation as part of their 2019/20 Annual Report. Similarly, the 2019/20 Annual Report action assessed as 'no longer relevant' relates to an issue on which External Audit have made a subsequent recommendation as part of their 2020/21 Interim Report.

3. Public Sector Equality Duty and Fairer Scotland Duty

3.1 **Fairer Scotland Duty**

There is no requirement to carry out a Fairer Scotland assessment in this instance.

3.2 **Equality Impact Assessment**

There is no requirement to carry out an equality impact assessment in this instance.

4. Impact

4.1 **Financial impact**
No impact because of this report.

4.2 **HR policy / Legislative impact**
No impact because of this report.

4.3 **Technology / Digital impact**
No impact because of this report.

4.4 **Environmental impact**
No impact because of this report.

4.5 **Communications impact**
No impact because of this report.

4.6 **Risk impact**
There is the potential for increased risks in relation to the relevant control environment or governance arrangements in those areas where agreed actions designed to address previously identified weaknesses are not fully implemented.

5. Measures of success

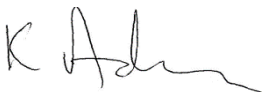
5.1 Internal Audit report each cycle to the Audit and Scrutiny Panel on the progress made by management in implementing actions previously committed to in response to Internal and External Audit reports.

6. Supporting documents

Appendix 1 Internal Audit recommendations: Management actions 'not yet complete' and residual risk assessed as 'High' or 'Medium'.

Appendix 2 Internal Audit recommendations: Management actions 'not yet complete' where residual risk assessed as 'Low'.

Appendix 3 Residual Risk Rating definition



Ken Adamson, Audit and Risk Manager

Appendix 1 Internal Audit recommendations - management actions 'not yet complete' and residual risk assessed as High/Medium

No	Report/ Head of Service	Identified risk	Details from original recommendation	Current position per management update	Proposed management action and target date	Assessment of residual risk
1	Carbon Management (Head of Asset & Procurement Solutions)	Setting clear targets enables key stakeholders to understand how and where reductions in carbon emissions reductions are to be achieved and, along with relevant performance reporting, assist those charged with governance to better monitor and challenge performance.	Management should: (1) set short, medium and longer-term targets for carbon emission sources across the Council that help support the delivery of local and national ambitions; and (2) establish performance arrangements/ and/or reporting framework such that performance against targets and future actions are monitored and reported to key stakeholders at appropriate intervals. Category: Amber Timescale: February 2021	(1) A Climate Plan, intended to replace the former Carbon Management Plan has been drafted for consultation and sets a series of annual reduction targets, allocating reduction targets to the three main types of emissions: stationary (buildings), fleet and waste. (2) Work is continuing to improve the robustness of the reporting framework with a review of all indicator templates. A webpage has been established for a summary report of the annual Public Sector Climate Change Duties Report and a report will go to Committee in Cycle 1, 2022 providing an update on this annual submission. A spreadsheet has been established, with a breakdown of data requirements and sources for the annual report and this monitors data requests and receipts, as well as noting revision dates of indicator templates. **Note*: A report from the Head of Asset and Procurement Solutions reporting progress to date in this area and future actions planned is included as a separate agenda item.**	Following consultation, the finalised Climate Plan will be presented to Committee for consideration and approval. Thereafter the targets incorporated in the plan will be used to measure the Council's performance in terms of reducing its footprint as well as incentivise action. Implemented by: February 2022	**MEDIUM**
2	Carbon Management (Head of Asset & Procurement Solutions)	Inadequate management arrangements may increase the risk that the Council may fail to effectively progress improvements in carbon management initiatives and adaptation arrangements and fail to achieve or influence carbon emission reductions consistent with Scottish Government policy objectives, local ambitions and relevant statutory obligations. The Carbon Management Plan may not be consistent with legislative requirements and/or good practice.	Management should (1) review the current governance arrangements for progressing the climate change/net-zero carbon agenda in light of recent developments to ensure it remains 'fit for purpose' in providing clear strategic direction; and (2) consider reviewing the Carbon Management Plan against recognised good practice, amending the plan as necessary where omissions/areas for improvement are noted. Category: Amber Timescale: February 2021	(1) The remit of the recently established Carbon and Energy Group has been revised, with focus on the full scope of building emissions. Membership of the group has been expanded to reflect this. (2) A Climate Plan, intended to replace the former Carbon Management Plan has been drafted for consultation and sets a series of annual reduction targets, allocating reduction targets to the three main types of emissions: stationary (buildings), fleet and waste. **Note*: A report from the Head of Asset and Procurement Solutions reporting progress to date in this area and future actions planned is included as a separate agenda item.**	As the Council continues to develop its understanding of the scope and scale of action required to dramatically reduce its emissions, the strategy and management of climate change will continue to evolve. Implemented by: February 2022	**MEDIUM**

Appendix 1 (cont.) Internal Audit recommendations - management actions 'not yet complete' and residual risk assessed as High/Medium

No	Report/ Head of Service	Identified risk	Details from original recommendation	Current position per management update	Proposed management action and target date	Assessment of residual risk
3	Risk Management (Head of Audit & Risk)	The absence of a fully documented corporate risk register, subject to relevant monitoring and challenge, may mean that key stakeholders fail to fully understand the key risks the Council faces and in turn may consequently fail to take appropriate action to mitigate them.	The Chief Executive should ensure that the three corporate risks under development are completed and moved to 'live' status as a priority; Category: Amber Timescale: March 2021	The three corporate risks are still under development and have not yet been completed. The current position regarding all corporate risks was reported to the Panel, as part of the Risk Management update report, in June 2021 and reflected discussions at CMT. Delays in implementation are largely due to the need to reframe the HSCI risk taking into account current developments relating to the Scottish Government's plans in respect of a National Care Service and the Asset Rationalisation risk reflecting uncertainty around the Council's operating models and consequential asset requirements post-pandemic.	Action still requires to be taken by the relevant Services to progress the three corporate risks. Work is continuing in this area and the Risk Team are engaging with relevant lead officers with a view to ensuring completion of these risks to 'live' status. Implemented by: October 2021	**MEDIUM**
4	Business Continuity & Disaster Recovery (Head of Business Solutions)	Disaster recovery plans and/or testing arrangements may not be adequate and/or robust and/or meet management requirements and/or opportunities to improve resilience may not be recognised or actioned.	The Head of Business Solutions should ensure that the ICT Disaster Recovery Plan is reviewed and updated as a matter of priority with an appropriate testing programme established and implemented. Category: Red Timescale: October 2019	ICT Disaster Recovery Plan has been reviewed, updated and formally presented to the Corporate Resilience Management Team. A testing programme for Gold applications is in place. Whilst this meets the recommendation, and the current DR Plan is reflective of IT and Service resources available, Business Solutions advise that the plan is based on historic Service assessments and as such is not considered as robust or effective as it could/should be. In recognition of the further improvements required Business Solutions have developed a draft ICT Systems Disaster Recovery Standard which was presented to the Data Management Team (DMT) in July 2021 for comment in advance of being presented to the September 2021 meeting of Data Governance Board (DGB) for approval. This standard defines the overarching processes that will be put in place to ensure going forward that all ICT systems have appropriate DR plans and testing programmes. A defined approach to testing is included within this Standard. A corporate process has been introduced to enable classification of applications as Gold/Silver/Bronze (in line with the draft Standard) and any major changes to systems are assessed against these criteria and reported through the EAGG for approval. However, further consideration is required as to when individual systems will be reclassified against the standard to ensure it is up-to-date and reflective of the current environment, service delivery expectations and available resources.	The ICT Systems Disaster Recovery Standard will be presented to the DGB for approval in September 2021. Management will then consider how this standard will be applied to existing systems to ensure an appropriate classification is allocated and DR plans, including updated testing expectations, are documented for each system. This will require consideration of the risks, issues and challenges associated with this. All currently categorised P1 Applications will be re-assessed against these standards by December 2021, however categorisation does not equate to physical change. It must therefore be recognised that it will take a number of years before the DR plan and testing regime are reflective of the new standards. This transition will require Business Solutions and Service support.	**MEDIUM**

No	Report/ Head of Service	Identified risk	Details from original recommendation	Current position per management update	Proposed management action and target date	Assessment of residual risk
5	Self-Directed Support (Head of Performance, Planning and Quality Assurance (Health and Social Care))	Where support plans are not sufficiently detailed, including SMART outcomes, the Service may be unable to effectively monitor individual cases. Failure to retain documentation or adequately record information in respect of the assessment, review and monitoring of service users' care could result in there being insufficient or inadequate evidence to support the processes being undertaken and/or decisions made. If guidance is inadequate, or is not sufficiently detailed, staff may not be fully aware of expected practice and this could impact on the service being received by individuals.	Management should: (1) ensure that support plans provide adequate detail on identified needs and outcomes, outlining how these will be addressed by the individual budget and that outcomes contained within these plans are SMART; (2) introduce an appropriate and consistent way of recording and filing all information and decisions made in respect of assessing, reviewing and monitoring individual service users' care packages to clearly demonstrate how identified needs and outcomes have been met/progressed; (3) remind staff of the importance of fully completing and storing all relevant documentation in line with expected practice and corporate records management policies; and (4) prepare a single comprehensive guidance document which provides clear and concise information on all aspects of self-directed support ensuring expected working practices are in line with legalisation and setting out clearly what documentation is to be completed and retained. Category: Amber Timescale: March 2021	(1) The Service have developed a training programme to be delivered to all front-line staff who complete assessment and support planning and are ensuring the training is delivered at the level appropriate to staff team. This has been an ongoing piece of work and the Service are working with Training, Organisation and Development Team to get this online, with dates beginning in August/September 2021. (2) & (3) The Service have linked with localities to set up service user folders for collating all relevant info regards assessment, and support planning. (4) The comprehensive document has been completed and will be implemented following training. Recent operational pressures and need to prioritise resources within the Service have impacted on progressing these actions which has resulted in a delay to full implementation of the recommendations.	The comprehensive guidance document will be signed off, circulated, and implemented following delivery of training. It is proposed that training will start to be rolled out in July 2021 with an estimated completion date of December 2021. Implemented by: December 2021	**MEDIUM**

Appendix 2 Internal Audit recommendations - management actions 'not yet complete' and residual risk assessed as Low

Head of Service/ Report Details	'Low' residual risk actions not yet complete	Issue	Current Status	Internal Audit comment
Head of Business Solutions				
Information Governance (June 2019)	1	There is a need to determine a mechanism through which to assess compliance with expected retention arrangements.	The review of the retention schedule is complete. Software has been purchased to supplement Office 365 to manage destruction of records according to the retention schedule. A pilot for implementation of this software is underway and full rollout will continue during 2021. Delay in implementation is due to the rollout of Office 365. Revised date: December 2021	Action has been taken and there is a clear plan for completion of the remaining issues outstanding.
Governance of Capital Projects (December 2019)	2	The Council's project management arrangements and 'project management model review programme' require to be reviewed and updated.	Development of the Council's programme management arrangements were paused due to Covid-19. A report submitted to CMT in June 2021, provided detail on tasks planned for the review and refresh on the corporate Project Management Model. Action will now commence in line with this. Delay in implementation is due to the impact of Covid which led to work in this area being paused. Revised date: Ongoing	We acknowledge that action to review and refresh the corporate Project Management Model and achieve deliverables will be undertaken using the approach outlined in the report submitted to CMT in June 2021.
Digital NL – Review of Progress (October 2020)	1	Arrangements need to be developed and put in place with regards to the monitoring and reporting to key stakeholders on performance measures for the Digital NL programme.	A Performance Review for Business Solutions has taken place and the performance arrangements continue to be developed. Delay in implementation is due to the impact of Covid which led to work in this area being paused. Revised date: December 2021	There has been a significant amount of activity in this area and we are satisfied that management are being proactive in addressing the actions required to meet the revised timescale.
Information Governance (February 2021)	1	Appropriate arrangements need to be put in place to achieve re-certification of Cyber Essentials both currently and in future years.	A Cyber Essentials submission was made but the Council failed to meet the requirements for recertifying against the new format for Cyber Essentials. Management is considering the next steps with regards to Cyber Essentials compliance. In the meantime, the Service will formally complete the PSN accreditation process. Revised date: Ongoing	Completion of this action is dependent on achieving Cyber Essentials. The requirements for completing and achieving which are now more challenging and onerous. We acknowledge that the Service are actively considering alternative compliance mechanisms.

Appendix 2 (continued) Internal Audit recommendations - management actions 'not yet complete' and residual risk assessed as Low

Head of Service/	'Low' residual risk actions not yet complete	Issue	Current Status	Internal Audit comment
Head of Financial Solutions				
Creditors (March 2020)	1	A weakness in the control environment was identified, as the electronic link between PECOS and e-Financials ceased with interim arrangements not being enough.	Revised interim arrangements were implemented and notified to Services. An action plan and testing of the interface linking PECOS to e-Financials is underway. An increased resource allocation will enable completion of this interface. Delays in implementation of this action are a result of a combination of technical challenges, competing priorities of the teams involved and external parties' ability to engage. Revised date: March 2022	We are satisfied that the identified actions are sufficient to mitigate the risks identified and are being progressed with due urgency.
Financial Management (March 2021)	1	There is a need for the Council's financial arrangements to be self-assessed against the revised CIPFA Management Code 2019 to be undertaken.	An initial review and evidence gathered provides assurance that the financial arrangements recommended by the Code are present within the Council's process and procedures. A detailed timeline has been devised for a formal self-assessment of the evidence gathered, production of an action plan for improvement and reporting of same to Committee. Revised date: January 2022	We are satisfied that initial action has been taken and management has committed to fully undertaking the remaining actions in line with the timescale provided.
Head of Performance, Planning & Quality Assurance (Health and Social Care)				
Arrangements for assessing the performance and quality of external social care providers (October 2018)	1	Arrangements for reporting on monitoring activity to senior management and elected members need to be formulated.	A revised Social Work governance framework, detailing reporting arrangements, has been drafted and will be finalised and implemented in the coming weeks. Plans are underway to develop a report on monitoring activity undertaken. Revised date: March 2022	Significant action has been taken to address the issues raised and management has committed to fully undertaking the remaining actions.
Self-Directed Support (November 2020)	2	Monitoring procedures require to be fully developed, approved and implemented. Monitoring checks need to be undertaken regularly for all providers and recorded in the centralised database. The model used to assess and calculate the individual budget needs to be reviewed and updated.	Monitoring procedures have been developed and implemented across the main commissioned services. These arrangements are being refreshed and consolidated. All monitoring checks, including enhanced monitoring, are being recorded on the monitoring database which will facilitate reporting of performance. An updated budget assessment tool has been created and is currently being tested. It is intended that this will be rolled out in the period July – December 2021. A lack of admin support and the recent needs of the Service have impacted on the progress of these actions. Revised date: December 2021	Action has been taken to address/progress the issues raised and management has committed to fully undertaking the remaining actions.

Appendix 3 Residual Risk Rating definition

Internal Audit Assessment of Residual Risk from non-implementation	
High	Non-implementation of actions has the potential to significantly undermine the relevant control environment.
Medium	Non-implementation of actions has the potential to impact upon the achievement of the control environment.
Low	Other issues which require management attention but which pose less significant or less immediate impacts to the control environment.