AGENDA ITEM No. 9

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Performance and Audit Committee 24 September 2025
Agenda Item	9
Title	Audit Update

Summary

This report provides Performance and Audit Committee with an update on:-

- Any new audit activity relating to the Integration Joint Board since last reported to Performance and Audit Committee in March 2025
- Any new audit activity relating to the Health and Social Care Partnership since last reported to Performance and Audit Committee in June 2025
- A summary of all open audit recommendations

Presented by	Lesley Bairden, Head of Finance and Resources (Chief Financial Officer)

Action Required

Performance and Audit Committee are asked to note and comment on the report.

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

PERFORMANCE AND AUDIT COMMITTEE

24 September 2025

Report by Chief Financial Officer

AUDIT UPDATE

PURPOSE OF REPORT

1. This report provides Performance and Audit Committee with an update on:
    - Any new audit activity relating to the Integration Joint Board since last reported to Performance and Audit Committee in June 2025
    - Any new audit activity relating to the Health and Social Care Partnership since last reported to Performance and Audit Committee in June 2025
    - A summary of all open audit recommendations

RECOMMENDATION

2. Performance and Audit Committee are asked to note and comment on the report.

BACKGROUND

3. As agreed at the Performance and Audit Committee in June 2021 we continue to submit audit update reports to all meetings, including any new audit reports along with an overview of audit activity undertaken and an update on recommendations.

4. Audit activity for the HSCP is provided in full and includes current open audit actions across the HSCP and also where a Health Board or Council wide recommendation impacts on the HSCP. Specific actions from IJB audits are also detailed.

5. East Renfrewshire Council's Chief Internal Auditor undertakes the internal audit role for the Integration Joint Board. Ernst & Young also undertake an audit of the IJB Annual Report and Accounts and produce an action plan should they have any recommendations. East Renfrewshire Council's internal audit assign the following risk ratings to their findings:

High	• Key controls absent, not being operated as designed or could be improved and could impact on the organisation as a whole. • Corrective action must be taken and should start immediately.
Medium	• There are areas of control weakness which may be individually significant controls but unlikely to affect the organisation as a whole. • Corrective action should be taken within a reasonable timescale.
Low	• Area is generally well controlled or minor control improvements needed. • Lower level controls absent, not being operated as designed or could be improved

Efficiency	• These recommendations are made for the purposes of improving efficiency, digitalisation or reducing duplication of effort to separately identify them from recommendations which are more compliance based or good practice.

6. NHSGGC internal audit function is undertaken by Azets. They assign the following risk ratings to their findings:

4	• Very high risk exposure - major concerns requiring immediate senior management attention.
3	• High risk exposure - absence / failure of key controls.
2	• Moderate risk exposure - controls not working effectively and efficiently.
1	• Limited risk exposure - controls are working effectively but could be strengthened.

REPORT

Audit Activity relating to the Integration Joint Board Audit (Appendix 1)

7. The action plan at Appendix 1a will be superseded with the recommendation from Ernst & Young's annual audit report for the year ending 31 March 2025 presented to PAC on 24 September 2025.

East Renfrewshire Council Internal Audit Activity relating to the Health and Social Care Partnership (Appendix 2)

8. Since last reported, 4 new audit reports have been issued:-
   - Payments to Care Providers - MB1240ZC (issued 28 August 2025)
   - Risk Management and Corporate Governance - MB1239IM (issued 3 July 2025)
   - Project Management of Capital Projects - MB1235IM (issued 1 July)
   - Report on follow up of payroll audits - MB1237FM (issued 17 June 2025)

Payments to Care Providers

9. A copy of this audit report is included at Appendix 2A however at the time of writing the final HSCP response is yet to be submitted. This will be included in the next report to PAC.

Risk Management and Corporate Governance

10. This was a Council wide audit which made a total of 7 recommendations however only 2 impact on the HSCP, one of which is an HSCP specific recommendation. A copy of the audit report is included at Appendix 2B along with the response to the recommendations.

Project Management of Capital Projects

11. This was a Council wide audit which made a total of 15 recommendations. Whilst there were no HSCP specific recommendations, there were 7 affecting the HSCP and all Council departments. HSCP projects through the Council capital programme are currently minimal. In the event of future projects the HSCP will ensure we comply with all requirements. We have therefore not included the action plan, however full audit report is included for information at Appendix 2c.

Follow up of Payroll Audits

12. A copy of the audit report is included at Appendix 2D along with the response to the one recommendation impacting the HSCP. As this was follow-up work, the audit on the application of payroll (MB1201FM) has now been superseded and therefore removed from this report.

Recommendations from previous audits (Appendices 2-2)

13. At the June 2025 meeting, a total of 32 recommendations were reported. As a result of follow-up work noted above, 4 recommendations have been removed. Although 17 recommendations have been made from the new audits, only 10 have been added to our total as we have not included the 7 in relation to the capital programme.

14. This means we now have 39 recommendations in total; 13 open and 26 which are considered closed and awaiting verification.

15. The table below summarises the total number of recommendations impacting on the HSCP which are either open or yet to be verified by internal audit. Further detail is included in the relevant appendix along with changes since last reported in each 'status' section.

Audit Report and Appendix		No. changed to considered closed since last reported	Recommendations		
			Total no. for HSCP	HSCP consider closed (awaiting verification)	Total open
Care Providers	2A	(new)	8	0	8
Risk Management	2B	(new)	2	0	2
Follow up of Payroll	2D	(new)	1	1	0
Follow up of HSCP Audits	2E	2	2	2	0
Follow up of Ordering and Certification	2F	2	2	2	0
Bonnyton House	2G	0	17	16	1
Accounts Payable	2H	n/a	4	4	0
Accounts Receivable	2I	0	3	1	2
TOTAL			**39**	**26**	**13**

NHS Internal Audit Activity relating to the Health and Social Care Partnership (Appendix 3)

16. A report has been provided by the Chief Internal Audit, which is included at Appendix 3.

CONCLUSIONS

17. We will continue to report on all open audit recommendations relating to both the IJB and HSCP to provide assurance of control and enable oversight of previous audits and demonstrate progress.

RECOMMENDATIONS

18. Performance and Audit Committee are asked to note and comment on the report.

REPORT AUTHOR AND PERSON TO CONTACT

Lesley Bairden, Chief Financial Officer
Lesley.Bairden@eastrenfrewshire.gov.uk
11 September 2025

Chief Officer, IJB: Alexis Chappell

BACKGROUND PAPERS

PAC 26.06.2025 – Audit Update

Appendix	1A
Title	Ernst & Young 2023/24 Action Plan
Type	Internal Audit Activity relating to the Integration Joint Board
Status	First presented to PAC November 2024 No changes since reported March 2025

No	Finding / Risk	Grade	Recommendation	Management Response	Responsible Officer	Timing	Comments
1	**Financially sustainable planning**						
	The IJB's General Reserves were exhausted during 2023/24 and earmarked reserves have fallen to an unsustainable position. The scale of the financial volatility facing the IJB, including, prescribing and pay inflation, and the difficulty of delivering savings due to the complexity of service user requirements mean that adequate general reserves are essential to manage the level of risk. There is a risk that financial recovery measures will be necessary in 2024/25 to deliver financial balance.	Grade 1	The IJB must develop a realistic and sustainable financial plan that balances the risk associated with savings and supports the rebuilding of reserves in the medium term.	The budget agreed for 2024/25 included an over recovery target for savings to allow for forward planning including rebuilding of reserves. The tension between delivering savings and building reserves, particularly in the current climate is recognised.	Chief Financial Officer	31 March 2025	This will continue to be reviewed as part of revenue budget monitoring.

Classification of recommendations

Grade 1: Key risks and / or significant deficiencies which are critical to the achievement of strategic objectives. Consequently management needs to address and seek resolution urgently.

Grade 2: Risks or potential weaknesses which impact on individual objectives, or impact the operation of a single process, and so require prompt but not immediate action by management.

Grade 3: Less significant issues and / or areas for improvement which we consider merit attention but do not require to be prioritised by management.

Appendix	2A
Title	Payments to Care Providers MB/1236/FMZC
Type	East Renfrewshire Council Internal Audit Activity relating to the Health and Social Care Partnership
Status	New First presented to PAC September 2025

REPORT ON AUDIT OF PAYMENTS TO CARE PROVIDERS

Contents | **Page No**

Chief Auditor
MB/1236/FMZC
28 August 2025
(Reply due 26 September 2025)

East Renfrewshire COUNCIL

REPORT ON AUDIT OF PAYMENTS TO CARE PROVIDERS

1. INTRODUCTION

As part of the 2024/25 audit plan, an audit of Payment to Care Providers was carried out.

The last scheduled review of this area was impacted by the Covid pandemic in 2020. During 2024/25, at the time of the audit, HSCP finance processed 13,260 care provider invoices to a value of £44m, excluding vat.

The main risk of this area is that payments to care providers are not adequately controlled resulting in overpayments. There is also a risk if HSCP is not notified of a person passing, invoices continue to be paid where no service provided.

2. SCOPE

The scope of the review, as agreed with the Head of Finance and Resources was to ensure the following control objectives were addressed:

- Regular reconciliations are carried out between the ledger and Carefirst system
- Amounts invoiced by providers agree to service agreements on Carefirst and, where variations to invoice payments are made, records are kept and service agreements are updated promptly if required
- Service agreements are reviewed and evidenced on an ongoing basis
- Operational staff confirm at least annually that the service being invoiced has been provided
- ILF payments are correctly accounted for and reconciled on a regular basis
- Controls are in place to ensure there are no open care agreements for deceased persons
- Contracts are in place for all care providers

Audit testing covered the financial year 2024/25 up to month 11. At the time of the audit, finance staff were involved in testing the new system for HSCP, Mosaic which it is intended to go live late October 2025.
The assistance of HSCP staff throughout the audit is greatly appreciated.
This audit has been conducted in conformance with the revised Public Sector Internal Audit Standards.

3. GENERAL CONCLUSION

Based on the work carried out, the overall assessment is that there is **Reasonable Assurance** in relation to the achievement of care provider objectives.

There is a good reconciliation process in place to ensure costs recorded on the care management system, Carefirst, are reconciled to the ledger. The invoice payment process involves specialist staff comparing invoiced care costs to those held in the care management system and any differences between invoiced amounts and payments made were able to be explained and evidenced by staff. In sample testing 4 out of 30 cases analysed had not been reviewed in the previous 18 months and it is important that care packages are reviewed regularly to provide assurance the right care and the relevant costs are in place and that this can be evidenced.

The Independent Living Fund (ILF) is a fund, which enables disabled people with high support needs, to choose to live in their community. Based on sampling, some discrepancies were identified that require further work and it is recommended regular reconciliations take place to provide further assurance in this area.

Payment for care tends to be made two weeks in advance/two weeks in arrears and audit work around deceased persons identified that it was possible that credits owed to HSCP could be missed depending on timing. A periodic review of accounts, where a death has occurred in the two week period paid in advance, could ensure that final bills are always accounted for correctly.

The following points are made and require attention.

4. FINDINGS AND RECOMMENDATIONS

4.1 Reconciliations

All care provider invoices are manually updated to Carefirst, as there is no interface directly with the financial ledger Integra for the processing of invoices. Carefirst is the system where detailed person, care package, costs incurred and service agreement information is held. Care provider invoices are received and indexed to Integra by the Council's accounts payable team. HSCP finance team has detailed procedures in place to monitor and process invoices received in Integra to confirm the validity of the charge, rate charged, and record costs incurred by service agreement by person. In financial year 2024/25, circa 13,260 invoices were processed totalling £44m.

Care provider invoices are not uniform in their format across suppliers; invoices may cover multiple persons, multiple service agreements, Carefirst person reference may be omitted and back billing may occur where amendments to agreed hourly rate, such as increases to the living wage, are announced or retrospective changes to the National Care Home Contract. Invoices, except in the case of care homes, will be in arrears, and care homes invoice two weeks in arrears/two weeks in advance.

Reconciliations of the value of invoices processed in Carefirst to the value as processed in Integra are important to ensure invoices settled are the same in both systems and that costs are allocated to the relevant service to permit effective monitoring of actual spend versus budget. Without reconciliations, there is a risk payments could be recorded in one system and not the other, leading to potential errors.

Audit undertook a detailed review of 3 months reconciliations, taking original HSCP business intelligence reports and comparing to Integra. Sampling found reconciliations were completed in a timely manner and variances listed were investigated. Journals to reallocate costs to the relevant services within Integra were processed monthly, with the exception of month 3. Whilst, reconciliations do not confirm the validity of the charges, they evidence that all costs have been accounted for and that invoice information in both systems is consistent. No recommendations are made in respect of this area.

4.2 Invoices

A CareFirst report of all care provider paid invoices for 2024/25 was requested from the Finance Manager – Care & Support. A sample of 30 paid invoices were selected from this report. The invoices were traced to the financial ledger and a copy of the actual invoices obtained.

The HSCP Finance team check invoices to service agreements before payment and if the invoiced amount exceeds the service agreement or has any other anomalies, the invoice will be varied downwards and a lesser amount paid. Checks were carried out comparing the invoiced amount to the amount paid and also comparing the invoiced amount to the sum expected per the service agreement. Where there was a variation between the invoiced amount and the amount paid or between the invoiced amount and the service agreement, an explanation was requested from the finance team.

It was found that in 21 cases the exact invoiced amount was paid and this exactly matched the service agreement. In the remaining 9 cases there were either anomalies between the invoice and the sum paid or between the invoice and the service agreement. Enquiries were made with the Finance Manager – Care & Support who was able to provide further information regarding subsequent changes to service agreements, catch-up invoices and acceptable tolerances for these nine invoices that allowed all the anomalies to be resolved with a reasonable explanation.

As such, no recommendations are required in respect of the above findings.

4.3 Service Agreements

The files for the persons in the above sample were reviewed to see if there was evidence that the service agreements had been reviewed by HSCP and that they had confirmed that the service being invoiced was being provided to the person.

In 26 cases out of the sample of 30, there was evidence available on CareFirst to show that either the service agreement had been reviewed within the last 12 to 18 months, an appointment was scheduled for the review to take place or that the person was deceased and the services had been ended. In the remaining 4 cases, audit were unable to find evidence on CareFirst that a review of the services provided had been undertaken, however further discussion with key officers has shown that there were reviews for three of these in the last two years and in all four cases, there was ongoing case management based on the individual circumstances. Two social workers were contacted to ask if further information was available for these cases but no responses were received during the audit.

Operational staff should be confirming, at least annually, that the service being invoiced has actually been provided and that service being provided is still appropriate to the person.

Recommendations

4.3.1 A review of services provided for all persons should be carried out annually to ensure that the service being invoiced is being provided and is still appropriate to the needs of the person.

4.3.2 Details of the review should be recorded on CareFirst to evidence the outcome.

4.4 ILF Payments

The Independent Living Fund (ILF) is a fund, which enables disabled people with high support needs, to choose to live in their communities. ILF assessors are scheduled to undertake a review every two years of the care provided by ILF funds. ILF assessors will review in person, along with the person in receipt of the care package, their representative, care workers and social worker. ILF assessor reviews were impacted by the pandemic.

HSCP manages ILF for 18 persons and these were reviewed to confirm ILF monies were received, recorded against the correct ILF person and that reconciliations of ILF monies to invoices were undertaken. Monies received from the ILF were recorded by person, by month on excel spreadsheets and these were agreed to ILF letters. There were seven instances where the person contribution varies from the ILF information available. Three were queried with HSCP finance, two persons where no contribution was received, and in one instance a person contribution received appeared to be £103 per week as opposed to £43, and a refund may be due. Details of the remaining four discrepancies have been provided to HSCP and they have agreed to review these.

It was also noted that a refund of £37.3k to ILF had been made during the year for unused funding for one person. Audit's understanding is that the person did not receive the care associated with the ILF funding in previous years. The financial reconciliation of the ILF funding to invoices is complex; supplier invoices should differentiate between Council and ILF care provided, costs require to be attributed to the correct care package in Carefirst, invoices analysed to confirm the hours charged by year are in accordance with the funding and are incurred as expected. Once this reconciliation is completed, it is also crucial to ensure operationally that the service was provided.

Audit recognises the reconciliations for ILF may be time consuming and complex and that progress has been made in bringing the reconciliations up to date. Persons, however, are most likely to be amongst the most vulnerable and it is important that reconciliations alongside operational confirmation of service delivery are undertaken annually.

It is noted that there are no detailed reconciliation procedures notes for ILF available however officers have indicated that procedures notes will be put in place for all areas once the new system, Mosaic is implemented and as such, no recommendation is made at this time but this will be reviewed by Audit at a later date.

Recommendations

4.4.1 ILF funded services should be reconciled annually, alongside operational review to ensure services were delivered to persons.

4.4.2 ILF person contributions received should be reconciled annually to ensure monies received are in accordance with latest ILF awards.

4.4.3 Persons/Guardians to be notified timeously if amendments are required to contributions and any refunds due are to be processed in a timely manner.

4.5 Deceased Persons

Notifications of persons passing are received many ways, from family members, social workers, care homes, by email or by telephone. HSCP also receives notifications from registrars of deaths registered in the authority. When a notification is received, the Carefirst system is updated by selecting a field to flag the person has passed. A weekly system generated report is issued to all team managers showing which service agreements they need to end and authorise to close down. It was commented HSCP undertake an additional exercise circa every six months to flag to social work managers, instances where no payments have been made against a care package for them to contact the provider. This exercise may be impacted by the involvement in testing and migration to Mosaic.

A listing was obtained from HSCP finance of all persons, flagged as deceased, where a payment to a care provider had been made in 2024/25. The report listed a total of 442 persons, with 490 service agreements. An initial sample of 56 persons was selected to check service agreements were closed, and no discrepancies found. A further 24 persons listed as open on a weekly listing received for February 2025 were reviewed in May 2025 and all external contracts were closed, but three instances of ERC agreements were open, where there is no cost implication.

Three instances were found where the person record was updated because of a financial assessment or care home plan review. A cross check was done to confirm the care provider had ceased invoicing.

Care provider invoices are received for services two weeks in advance/two weeks in arrears. There is a risk if a notification of a death is received once an invoice is processed, that an element of the charge is due to be refunded to HSCP. A sample of

30 persons was selected to review if refunds were due and if they had been received. There were four instances where HSCP finance amended the invoice before settlement as death had been notified promptly and one instance of HSCP contacting the care provider as invoicing had ceased and no notification of death had been received despite a credit note being received.

There were six instances (3 providers), where further assistance from HSCP finance was required to verify whether the final invoice was correct and they agreed to progress this as Audit did not have direct access to all information needed. Four of these invoices will be addressed by an on-going reconciliation of the provider's invoices. Copy credit notes, totalling £1.4k, have been received for the remaining two queried by Audit.

Whilst there are various checks in place, there remains a small risk that a deceased person's care could be paid for in error if the care provider continues to invoice after the date of death and no notification of death was received from any of the potential sources.

Recommendations

4.5.1 Consideration to be given to undertaking a periodic review of deceased person final invoices to ensure costs are in accordance with contractual commitments.

4.5.2 Review of invoicing for four deceased persons, all relating to same provider, to be completed to confirm final invoices are appropriate.

4.6 Care Providers Contracts

A review of the suppliers relating to the original sample of 30 invoices was carried out to ascertain if there was a contract in place with the care provider and that the rates recorded on the contract agreed to those on the service agreement on CareFirst.

It was found that in 24 cases out of 30, the rate per the service agreements agreed to the rates stated in the supplier contracts/frameworks. In two cases the services provided were historical and were therefore not matched to a contract/framework.

In three cases the rates were slightly different and it was noted that these differences were due to uprating in line with inflation increase. In the remaining case, the service agreement was non-framework and audit could not identify an individual agreement on the document hub in respect of this service.

Recommendation

4.6.1 Management should ensure that a framework or contract is in place and readily available for all care providers which shows the agreed rate.

Chief Auditor
28 August 2025

Ref	Recommendation	Comments (if appropriate)	Timescale for completion	Status	Latest Note
4.3.1 (Med)	A review of services provided for all persons should be carried out annually to ensure that the service being invoiced is being provided and is still appropriate to the needs of the person.				New audit report - final response to be agreed
4.3.2 (Low)	Details of the review should be recorded on CareFirst to evidence the outcome.				as above
4.4.1 (Med)	ILF funded services should be reconciled annually, alongside operational review to ensure services were delivered to persons.				as above
4.4.2 (Med)	ILF person contributions received should be reconciled annually to ensure monies received are in accordance with latest ILF awards.				as above
4.4.3 (Low)	Persons/Guardians to be notified timeously if amendments are required to contributions and any refunds due are to be processed in a timely manner.				as above
4.5.1 (Med)	Consideration to be given to undertaking a periodic review of deceased person final invoices to ensure costs are in accordance with contractual commitments.				as above
4.5.2 (Low)	Review of invoicing for four deceased persons, all relating to same provider, to be completed to confirm final invoices are appropriate.				as above
4.6.1 (Med)	Management should ensure that a framework or contract is in place and readily available for all care providers which shows the agreed rate.				as above

Appendix	2B
Title	Risk Management and Corporate Governance MB/1239/IM
Type	East Renfrewshire Council Internal Audit Activity relating to the Health and Social Care Partnership
Status	New First presented to PAC September 2025

REPORT ON AUDIT OF RISK MANAGEMENT AND CORPORATE GOVERNANCE

Contents	Page No

Chief Auditor
MB/1239/IM
3 July 2025
(reply due 8 August.2025)

East Renfrewshire COUNCIL

REPORT ON AUDIT OF RISK MANAGEMENT AND CORPORATE GOVERNANCE

1. INTRODUCTION

As part of the audit plan 2024/25, an audit of Risk Management and Corporate Governance was carried out.

The Councils strategic risk register (SRR) is a key tool in supporting what it is trying to achieve at a strategic level. Risks can be reflective of the objectives of the Community Planning Partnership (CPP) vision "A Place to Grow," which is supported by the Organisational Checklist. These risks could cascade down to operational risk registers with clear links made wherever possible to risks at the strategic level. Each risk should have clearly defined mitigating actions alongside an owner and responsible officer who will monitor the risk and if the mitigating actions are effective. Risks should be regularly and effectively reported to both corporate and service management.

The Council is currently reviewing the Risk Management Policy and SRR and this is an opportunity to consider how the SRR reflects the strategic objectives in "A Place to Grow."

"A Place to Grow" was approved by Council in September 2024 and the delivery plan agreed in April 2025. It is therefore an ideal time to reset both the content, process and culture of risk management to ensure that it underpins strategic objectives in a dynamic and evolving way as it confronts and mitigates the risks we face.

Managing risk effectively is also a key part of the Councils assurance framework – the Code of Corporate Governance (COCG). CIPFA defines an assurance framework as:

"The means by which leaders, managers and decision makers can have confidence that the governance arrangements that they have approved are being implemented, operating as intended, and remain fit for purpose."

To this end it is crucial that the COCG is clear and concise and that the requirements of the code meet the overarching principles. It is also important that the supporting evidence shows that the requirements of the code have been met and have been effective. Any actions from the previous reviews should be specific, measurable, achievable, relevant and time-bound (SMART) and it is also important that completed actions can be evidenced.

The main risks associated with this area are that the Council's risk management processes are ineffective either at a strategic or operational level and the Council is exposed to a risk for which it is not prepared or for which it has weak or no mitigating actions. It is also a risk that reporting to management is ineffective and the right decisions are not made at the right time. Lastly, there is a risk that the Council's assurance framework is not clearly understood, supporting evidence is weak or poorly adopted and any actions agreed are not implemented on time and in a measureable way.

2. SCOPE

The scope of the audit was agreed with the Resilience Officer and the Strategic Services Lead Officer Business Operations and Partnerships prior to the start of the audit and covered the following control objectives:

Risk Management

- Compare the Strategic Risk Register to comparable Councils and identify any common risks management may consider for inclusion.
- Ensure the risks on Operational and Strategic Risk Registers are assessed and assigned to risk owners and responsible officers.

- Assess the mitigating actions recorded against a sample of risks to ensure the implementation of these can be verified.
- Assess the monitoring and reporting arrangements in place to ensure that Service and Corporate Management are routinely made aware of the risks affecting the Council

Corporate Governance

- The actions noted in the Corporate Governance report as being required are SMART and have been completed per timescale
- Evidence is available to demonstrate requirements meet the principles.
- The layout of the content of the code is clear, concise and can be easily followed
- Actions stated as having been completed arising from the previous year's code were checked that these could be evidenced.

Discussions with relevant staff took place and documentation was analysed to test the effectiveness of the processes in place.

3. GENERAL CONCLUSION

Based on the work carried out, the overall assessment is that there is **Substantial Assurance** in relation to the achievement of Risk Management and Corporate Governance objectives.

The audit highlighted that when compared to other Local Authorities, there are risks that appear consistently on other risk registers that are not part of the Councils SRR. Therefore there is an opportunity to review the ERC SRR and consider adding risks where appropriate and also perhaps to consolidate some risks currently in the register. There is a further opportunity as the Councils new CPP vision "A Place to Grow" beds in, supported by the Organisational Healthcheck, that the Strategic Risk register review, which is currently in progress in liaison with the Corporate Management Team and Zurich, will link more closely to the vision and its three pillars. Assurance can then be taken that if strategic risks are managed well this then contributes directly to the achievement of the Councils objectives and goals

Operational risk registers were also reviewed on a sample basis and it was found that there are a number of risks that appear within operational risks that are not then reflected within the SRR. It is potentially possible to directly link operational risks to the SRR which could facilitate providing better visibility of critical operational risks to the Corporate Management Team.

Reporting of risk can be inconsistent across departments and some risks recorded are not really risks but rather issues and should be reworded or reassessed. A review had already commenced of the overall risk culture and understanding of what constitutes a risk, and it is hoped that this report can support this.

The Code of Corporate Governance is a well written and laid out document following closely CIPFA guidance on delivering good governance in local government. There are small recommendations around better signposting to supporting evidence and suggestions around gaining assurance that key documents cited as evidence underpinning the effectiveness of the COCG have been read and understood on an ongoing basis.

The following recommendations are made and require attention.

4. FINDINGS AND RECOMMENDATIONS

4.1 Compare the Strategic Risk Register to comparable Councils and identify any common risks management may consider for inclusion.

A sample of 13 SRRs from other Local Authorities (LAs) was selected and an exercise undertaken to compare the Council's SRR to those in the sample. There are some risks unique to ERC, which is to be expected as each Council has different risks depending on a number of factors. However there were 11 main risk areas highlighted consistently in other Local Authority registers but not reflected in the ERC risk register. These are detailed in Table 1 below alongside the number of instances they occurred in the sample of 13 other Local Authorities.

Table 1

Potential New Risks	Instances
Climate change impacts /emissions / legislation	13
Workforce capacity and organisational resilience - including early learning and childcare staff and Strike action	11
Health and safety legislation/failure	9
Fraud and serious crime	9
Supply chain risks	7
Business organisational transformation	7
National Power Outage/ Weather/ terrorism / Business Continuity / Emergency planning/Public Health Emergency	6
Lack of engagement with communities	4
National Care Service implications	4
Standards in Public Life/ Failure of governance	4
The economy/ economic development	2

What is shown in this analysis is that there are some risks which appear regularly across other LAs and discussions could take place to assess whether these are applicable in East Renfrewshire for inclusion in the SRR.

A separate exercise was then undertaken to compare the Council's SRR to the CPP objectives within "A Place to Grow." Although this is a subjective exercise, all of the current risks on the ERC SRR could be linked to these objectives in some form, although in some cases only tenuously.

However, a further analysis then compared the potential new risks highlighted in table 1 above to the strategic objectives in "A Place to Grow," and it was easy to see how these new risks could link to strategic objectives if deemed applicable. Although the Economy/Economic Development only features in 2 out of the 13 authorities sampled, it is noted that it features prominently within "A Place to Grow".

Finally a sample of operational risk registers were reviewed to confirm if there are links between operational risks and the current SRR. The Environment Department and Business Operations and Partnerships Department were selected as a sample. Simultaneously further analysis was also undertaken to assess whether operational risks could be meaningfully connected to the potential new risks recorded in table 1 above.

Again, it is acknowledged that this analysis is subjective and as a further note it is possible at times to link an operational risk to more than one Strategic Risk.

Table 2 below summarises this analysis. There are 16 risks within the operational risk register in Environment that it was difficult to link to the current

SRR and 49 operational risks within Business Operations and Partnerships that it was similarly difficult to link. On all occasions these could be linked to one or more of the new potential risks highlighted at table 1.

Table 2

Department	Number of Operational Risks	Risks with no Clear Link to Current SRR
Environment	29	16
BOP	108	49

It is important to ensure that critical operational risks are made known to the Corporate Management Team on a timeous basis. To facilitate this, consideration could also be given to how the operational risks link to risks in the SRR.

Recommendations

4.1.1 Risks identified as appearing regularly in other LAs Strategic Risk Registers should be considered for inclusion within the ERC SRR.

Action: Chief Executive

4.2 Ensure the risks on Operational and Strategic Risk Registers are assessed and assigned to risk owners and responsible officers.

All Strategic Risks and operational risks have been allocated to responsible officers, this aspect of the process is working well and no recommendations are made.

There is evidence within the HSCP that risk registers have not been consistently reviewed and updated 6 monthly as required.

Recommendation

4.2.1 Risk registers should be reviewed 6 monthly and updated regularly to reflect current risks.

Action: Chief Officer HSCP

4.3 Assess the mitigating actions recorded against a sample of risks to ensure the implementation of these can be verified.

A sample of risks was taken across various departments from both the SRR and Operational Risk registers. It was found on many occasions that good mitigating actions are in place and evidence is held to support that these actions are effective.

Within Environment, the Operational Risk Register is a work in progress as it is subject to ongoing review and update and as such has gaps in some areas around risk controls, proposed risk controls and evidence held. It is recommended that this review is progressed and the gaps are filled in the operational register as soon as practically possible.

For two of the sample items, evidence of mitigation was not apparent but the relevant services have confirmed that appropriate actions has been taken and will be better evidenced in future.

Recommendation

4.3.1 All operational risks should have risk controls, proposed risk controls and evidence to support these actions. It should also be noted where this evidence is held.

Action: Director of Environment

4.4 Assess the monitoring and reporting arrangements in place to ensure that Service and Corporate Management are routinely made aware of the risks affecting the Council

Reporting of strategic risk is working well within the Council with the SRR reported bi-monthly to CMT, bi-annually to the Audit and Scrutiny Committee and annually to Cabinet. There is separate reporting in each department to Departmental Management Team meetings as appropriate to the department and the risks they manage. There are differing arrangements at operational risk level with some departments having a department wide risk register and others having risks recorded at individual team level.

In general terms whilst reporting is regular, and updating risks and mitigating factors takes place, risk could be managed in a more cohesive and organisational way by improving the risk culture and the understanding of risks.

Some operational risks are actually not recorded correctly, or indeed, it could be argued that they are not risks. Examples of this relate to mitigating actions failing and these are recorded as the risk.

Also, embedding risk as an integral part of service delivery, would ensure that every operational decision made includes an understanding of the risk involved – creating an organisation that is risk literate and fully functioning in relation to dynamically managing risk.

Recommendation

4.4.1 All Directors should work closely with the resilience officer to improve the organisational culture towards risk throughout ERC and to ensure all risks recorded are risks and not issues.

Action: All Directors

4.5 The actions noted in the Corporate Governance report as being required are SMART and have been completed per timescale

All actions reviewed as part of the audit noted in the corporate governance report were SMART, they were specific, measureable, achievable, relevant and timebound. All but one were achieved within the timescales planned and this was due to the General Election impinging on officer time and priorities.

4.6 Evidence is available to demonstrate the corporate governance requirements meet the principles

A sample of requirements were reviewed and it was found that these consistently would support the achievement of the related principle. Evidence is available to show that the requirements are operating effectively and providing assurance.

In one requirement reviewed, A2.4 around assurance that external service providers are required to act with integrity and high ethical standards, a key Standard Operating Procedure (SOP) related to Contract and Supplier Management should be included as evidence of assurance and a link added to the Corporate Procurement Strategy to the SOP.

Although strong evidence is detailed in the code consistently, it is difficult to evidence in some cases that key documents are being read and understood by employees, councillors or members of the public – this is an inherently difficult area to be able to have definitive evidence. The corporate induction checklist has excellent signposts for new employees to important documents like the Equal Opportunities Policy, Information Security Policies and also the Employee Code of Conduct.

Recommendations

4.6.1 Consideration should be given to how better ensure that all employees are aware of and have read the key documents listed in the code of corporate governance relevant to their role like the employee/members codes of conduct.

Action: Director of Business Operations and Partnerships

4.6.2 The Contract and Supplier management SOP could be considered a key supporting document to COCG requirement A2.4, additionally a hyperlink to this SOP could be considered in the Corporate Procurement Strategy to assist access to this document.

Action: Head of Finance

4.7 The Layout of the content of the code of governance is clear, concise and can be easily followed.

The principles in the COCG align closely with the principles contained within the CIPFA guidance document "Delivering Good Governance in Local Govt: Guidance Notes for Scottish Authorities." The COCG is very well laid out in a clear format with supporting evidence listed.

Audit found as part of the review that, unconnected to the layout of the COCG itself, it wasn't always easy to find the supporting evidence. Hyperlinks or additional signposting to aid the reader in finding the supporting evidence could ensure the code is easily followed right through from Principle to supporting evidence.

Recommendation

4.7.1 Consideration to be given to adding hyperlinks or signposting where practical to the Code of Corporate Governance to allow easy access to supporting documentation.

Action: Director of Business Operations and Partnerships

4.8 Actions stated as having been completed arising from previous year's code were checked that these could be evidenced.

Thirteen actions arising from the previous year's code were assessed to confirm if they had been completed within timescales and if this could be evidenced.

Eight of the actions had been completed with one being outwith the original timescale due to the General Election impacting staff's ability to complete the action. This has subsequently been completed. The remaining five actions are either on hold or the target date has not been reached.

The eight actions completed were all able to be evidenced and therefore no recommendations are made.

Chief Auditor
3 July 2025

Ref. / Risk Rating	Recommendation	Comments (if appropriate)	Timescale for completion	Status	Latest Note
4.2.1 (Low)	Risk registers should be reviewed 6 monthly and updated regularly to reflect current risks.	We are currently reviewing our governance arrangements including reporting arrangements between SMT, HSCP CMT and the IJB. This will include oversight of both operational and strategic risks.	31-Dec-25	Open	
4.4.1 (Efficiency)	All Directors should work closely with the resilience officer to improve the organisational culture towards risk throughout ERC and to ensure all risks recorded are risks and not issues.	The HSCP will continue to work with the Council's Resilience Officer to improve risk culture.	31-Dec-25	Open	

Appendix	2C
Title	Project Management of Capital Projects MB/1235/IM
Type	East Renfrewshire Council Internal Audit Activity relating to the Health and Social Care Partnership
Status	New First presented to PAC September 2025

REPORT ON AUDIT OF PROJECT MANAGEMENT OF CAPITAL PROJECTS

Contents	Page No

Chief Auditor
MB/1235/IM
1 July 2025
reply due 1 August 2025)

East Renfrewshire COUNCIL

REPORT ON AUDIT OF PROJECT MANAGEMENT OF CAPITAL PROJECTS

1. INTRODUCTION

As part of the audit plan 2024/25, an audit of Project Management of Capital Projects was carried out.

The Council has a large variety of Capital Projects each year as part of its Capital Plans. These plans include projects relating to all Council assets including those managed on behalf of the Leisure Trust. Projects are also undertaken in relation to Housing Assets funded via the Housing Revenue Account.

Capital projects come in all shapes and sizes from large multi-million pound and multi-year construction projects to lower value work on Council Housing which would be completed in weeks. Each project may require a slightly different approach, however, a sound project management methodology is imperative, irrespective of the project being managed.

In terms of the non HRA projects, the majority commence through a Capital Project Appraisal (CPA) document which is discussed and rated by the Capital Asset Management Group (CAMG) before recommendations are made to Council on the viability and prioritisation of projects. The CPA is effectively a business case for the project. It is a comprehensive document which should embed the project within the Council's overall strategy and objectives and also link to key planning documents like the Capital Investment Strategy, and the various asset management plans in place within the Council. The CPA also details major stakeholders and responsible officers, the benefits and risks related to the project, and costing information.

The CPA has many aspects which align closely to the five case Business Case model outlined in Scottish Government and Treasury Management guidance around the management of Capital projects. According to this guidance, the 5 cases to be made for each project are:

- Strategic
- Economic
- Commercial
- Financial
- Management

A well completed and maintained CPA will make all of these cases and will also include a high level view of spend and timelines, including the ongoing revenue implications of the project, alongside details of how risk will be managed.

The process is slightly different within Housing. Strategic documents like the Local Housing Strategy and Stock Condition Survey inform the 10 year HRA Business Plan and allow prioritisation of resources available. Projects and budgets are discussed at the Social Housing Investment Board (SHIB) before being collated into a Housing Revenue Account (HRA) Capital programme and presented to Council for approval. CPAs were prepared on a trial basis in recent years within the HRA but not continued.

As each individual project moves ahead there should be clear effective project management and governance processes in place. These should include a critical pathway if appropriate, and there should be effective communication and reporting on costs, timescales and quality to allow key stakeholders access to the right information at the right time, including escalation of issues when required. The business case/CPA and associated documents should be updated, alongside the risk register, as the project moves through its lifecycle.

The main risks associated with this area are that planning documents, particularly the CPA/business case is not in place or is not effective and that

each project is not planned and executed with strong governance and risk management processes. There are associated risks around cost increases or timescales not being met and that associated key decisions are not made at the right time involving all stakeholders due to ineffective governance and monitoring.

2. SCOPE

The scope of the audit was agreed with the Director of Environment prior to the start of the audit and covered the following control objectives:

- Ensure that there is a completed capital project appraisal form in place in compliance with financial regulations. This is the equivalent of a business case.
- Ensure each project has been effectively planned with strong governance and risk management processes in place and these are utilised throughout the planning stage and demonstrated through the full life cycle of the project.
- Ensure each project is executed utilising effective project management methodologies and processes and each project is resourced effectively with monitoring processes agreed around cost, time and quality.
- Ensure each project is monitored effectively involving regular and accurate reporting and engagement with all stakeholders at the right time. Any changes are well managed through agreed change management processes.

A sample of three contracts was selected, The Neilston Learning Campus project, the Refurbishment of Capelrig House and a Housing Capital Works Project around Internal Element Renewals. Discussions with relevant staff took place and documentation was analysed to test the effectiveness of the processes in place.

This audit has been conducted in conformance with the Public Sector Internal Audit Standards.

3. GENERAL CONCLUSION

The audit highlighted that the CPA form is an excellent planning document and initial vehicle for the project to allow it to progress to a decision and on to execution, incorporating many aspects of Scottish Government and Treasury guidance.

Where the CPA model is less effective is that at times it is not in place at all, not comprehensively completed, and also may not be a “living document” i.e. when the project is approved and moves forward it is not revisited throughout the lifecycle of the project to ensure the original objectives and benefits agreed at the outset are achieved. Audit Scotland guidance around good practice for public bodies in managing capital projects recommends that:

“The business case is reviewed throughout the lifecycle of the project, to help test that any changes affecting it are justified, provide value for money and to help re-inforce proper reporting.”

It was also found that there are good reporting mechanisms in place, around Council Budgetary Control, the Environment Capital Project Board and the Social Housing Investment Board (SHIB). However, each of the three projects in the sample fell behind schedule, significantly at times, but these were not escalated appropriately at the respective boards. The general implications around timescales slipping and the contractual impact do not appear to have been discussed in detail or escalated effectively for further action to senior management.

Within these reporting structures, risk management is high level and may lack impact. It is important that each major project has its own risk register and that this is embedded in day to day project management.

Internal project management tends to be undertaken by subject matter experts within the Council who can have conflicting priorities in their day to day work. Whether Project Management is procured or undertaken "in house" there should be an effective process of internal management to ensure the project stays on track and that senior management has the information and the opportunity to make decisions at the right time.

In audit work elsewhere it was found that there is a good Standard Operating Procedure (SOP) in place around Contract and Supplier Management with several touch points and overlaps to project management of capital projects. As well as more specific findings, it is recommended that a process is developed to support effective project management of capital projects with templates and guidance to managers including guidance around the CPA process and ongoing project management. The Contract and Supplier Management SOP could be considered as a starting point and where possible good practice identified and incorporated into this new guidance.

The following recommendations are made and require attention.

4. FINDINGS AND RECOMMENDATIONS

4.1 Ensure that there is a clear vision and direction for each project and a completed capital project appraisal form/business case.

It is crucial for the management of a capital project that a working business case is in place. Where a CPA has been completed this can act as a business case but only if maintained as an evolving document throughout the life of the project. If there is no CPA it is important that a business case of a similar nature is in place and maintained. Comprehensive CPAs or business cases were not in place for any of the three projects sampled.

In the Capelrig House project, the scale and scope of the project changed due to the particular circumstances of this work. Initially there was a partnership in place with an external charity to fully refurbish the interior and the exterior of the building for ongoing use by the charity themselves, however no contract was ever put in place. Subsequently, the charity could then no longer continue in the project but the external refurbishment of the building remained crucial to protect this A listed building. There is a CPA in place only for this refurbishment work but perhaps not as extensively completed as it would have been in different circumstances. As a result, the connection to strategic objectives is not as strong in this CPA as in others. The CPA was lacking on the various roles and responsibilities of those involved in the project.

Draft CPAs were prepared within Housing at the inception of the SHIB in 2023 but these have not been maintained. CPAs must be prepared for each project submitted for inclusion in the General Fund and Housing Capital plans as per the financial regulations of the Council. Although the overall governance structures within Housing are good, as there are no up to date CPAs or business case documents there is no one point of reference holding all the roles and responsibilities for each project. In an earlier audit on Contract and Supplier Management, the Standard Operating Procedure was reviewed. It was concluded that the Contract and Supplier Management Plan was crucial and including this for managing capital projects would strengthen the process.

Also in two of the four workstreams within the Internal Upgrade programme within the Housing Capital project there were problems with contractors which subsequently have resulted in delays in both these workstreams and procurement of replacement contracts is under way. Having these issues

detailed on a day to day risk register and having a clear exit plan should difficulties arise, could have made transitional arrangements easier.

For the Neilston Leisure Campus, as the project moved into the delivery phase, ongoing project management was via external consultants employed to manage the project. However this should be augmented by the Councils Internal management process. Ensuring the CPA is maintained and updated as the ongoing business case to support the work is important to ensure ultimate management of the project remains with the Council.

Recommendations

4.1.1 Each project should have a business case or a CPA. This should be an evolving document updated and maintained throughout the life cycle of the project.

4.1.2 Each CPA or business case should have clear links to all relevant strategic objectives.

4.1.3 A contract and supplier management plan could be considered as a template document to underpin management of each project. This would be a one page document summarising key contacts, timescales, community benefits and performance indicators.

Action: All Directors

4.1.4 Any project which involves partnership with an external body should be covered by a contractual arrangement at the earliest stage possible.

4.1.5 A clear exit strategy to cover the end of a contract or a failure by the contractor should be in place. This would help to allow continuity of contract cover and for planned work to go ahead as soon as practically possible.

Action: Director of Environment

4.2 **Each project should be effectively planned with strong governance and risk management demonstrated throughout.**

In all three projects sampled there were significant delays in delivery.

The Capelrig House project had a six month timeline with practical completion in April 2024, this project was completed in January 2025 – a nine month delay. The Neilston Learning Campus experienced a 15 week delay in phase 1 against an expected timeline of approximately 74 weeks. The 2024/25 Kitchen and Bathroom workstreams within the Internal Element Renewals project in Housing were both delayed due to procurement and contractual issues.

Projects are reported to Council as part of overall budgetary control and although mentioned, the significant delays on all three projects were not specifically highlighted as part of this process.

There is a good reporting structure within the Environment Department. The Capital Project Board meets regularly and considers reports and flashcards which update senior management on progress including updates on Housing projects which have been previously discussed at the SHIB. These are potentially strong governance vehicles for senior management to be kept appraised of progress if used appropriately. Flash cards include a clear process to allow escalations and decisions for the group.

Where this process has been less effective is in the actual escalation of issues. In the flashcards used and discussed in all the projects sampled, the delays

involved although discussed were never escalated, almost exclusively categorised as having no escalations and updates were for noting only.

The Capelrig project in particular was so significantly delayed that the contracts in place expired, requiring discussions with the procurement manager and the Chief Officer – Legal and Procurement to allow final payments to be made. In cases of delay, procurement and legal should be informed at the earliest opportunity to allow consideration of the contractual cover in place and if extensions are required.

There is currently a process led by the procurement team where officers are emailed a reminder that contracts they are managing are expiring. This reminder is issued 20 weeks from the expiry date. In order to include shorter contracts it would be beneficial if a second reminder was issued 10 weeks from expiry to ensure appropriate arrangements are made.

Flashcards are used to report projects to the Environment Capital Project Board and also to the SHIB and risks are reported here at a high level. Day to day risk was embedded well in the Neilston Learning campus project but not as strongly in the Capelrig House project or within Housing Internal Element Renewals work. It is essential that managing risk and related reporting is seen as an active and vital part of project management and an operational risk register should be in place for all major projects. This should be separate from high level reporting and should include managing risks around costs, timescales and quality and be supported by a strong change management process.

Recommendations

4.2.1 A clear process should be in place with operational management involving escalation using an objective measure as to when a delay will be escalated to senior management i.e. a % over time/cost, all subject to a de-minimis contract value. Delays should then be reported to the appropriate stakeholders at the appropriate time.

4.2.2 Procurement and Legal must be advised as early as possible of any project delays to ensure the contractual implications of this are fully understood and appropriate action taken, again subject to a de-minimis level and an objective measure of the time delay i.e. a % over time.

Action: All Directors

4.2.3 Alongside detailed health and safety risks covered in project documentation there should be an overarching project risk register held for major projects which is updated throughout the project life cycle as a minimum for larger value, longer timescale projects.

4.2.4 The risk register should include risks around timescale, cost and quality and be closely linked to a strong change process with clear processes and escalation routes appropriate to the scale of the project.

Action: Director of Environment

4.2.5 A second reminder should be issued by procurement 10 weeks from the expiry date of the contract to allow arrangements to be put in place to extend the contract if necessary.

Action: Head of Finance

4.3 Each project is executed utilising effective project management and there is effective monitoring processes around cost, time and quality.

It is acknowledged East Renfrewshire is a small authority and resources are stretched. This can lead to projects being managed by officers with a large portfolio of work and staff to manage alongside managing a complex project. It

can be argued that project management can be a separate discipline from a subject matter expert - both can be driving forces in a successful project.

Whilst it is unlikely this resource could be employed in every project, an internal specific project management resource, if available, could augment and support internal experts in the management of the project itself, ensuring an appropriate project management methodology throughout.

Recommendation

4.3.1 Consideration should be given when possible to utilising a separate internal project management resource if available for larger or more complex projects.

Action: Director of Environment

4.4 Each project is monitored with regular reporting and engagement with stakeholders at the right time including effective change management.

Each project should have a benefits owner alongside clearly defined benefits. Within Housing, updated CPAs have not been maintained and whilst the SHIB provides a good governance structure, some of the detail around benefits and the ability to monitor if these have been achieved is lost without a dynamic CPA/business case being in place. The Capelrig CPA lacks some detail around the benefit owner and this could be clearer at the outset of each project.

The nature of the Internal Element Renewals programme is such that the work tends to be relatively short term i.e. 2 to 3 weeks in length. Benefits can be measured in terms of numbers completed each year however the procurement challenges have meant numbers achieved have not been as planned. In the Capelrig project, the benefits changed as the project evolved. The project is now complete and discussions are ongoing as to the future use of the building. This means it is unclear whether the benefits identified in the latest CPA will be realised or remain relevant.

It is good practice to evaluate projects post completion and reflect on lessons learned. There is a clear lessons learned process in place around the Neilston Learning Campus and this exercise will be undertaken in the near future. Within Housing, as work is completed, residents are encouraged to complete a survey around their experience to consider what went right and what went wrong. However in the Capelrig project, no post evaluation work has been undertaken and this is not routinely undertaken for most non HRA capital work. It is acknowledged that this evaluation work if undertaken for all projects could be overly onerous on already stretched resources but if undertaken on a sample basis could result in useful learning for future projects.

Recommendations

4.4.1 The CPA/Business case should clearly detail the benefits of the project and the benefit owners and ensure that all future whole lifecycle costs implications are contained within them, including budgetary provision for future revenue costs.

4.4.2 Timescales for the delivery of benefits should be measurable, clear and updated if necessary. If benefits are not realised, either on time, or not at all these should be reported clearly to stakeholders.

Action: All Directors

4.4.3 A post project evaluation should be undertaken on at least a sample basis with the evaluation methodology tailored to each project subject to a de-minimis level being applied.

Action: Director of Environment

4.5 Project Management of Capital Projects – Overarching recommendation

In any contractual situation it is important that the Council retains ownership of the service being provided by effectively managing the relationship. The Council currently has a Standard Operation Procedure in place around Contract and Supplier management. There are several areas of overlap between this process and the management of Capital Projects, including but not exclusively:

- The creation of a Contract and Supplier Management Plan
- Review Meetings and format/agenda/minutes
- Non – Conformance Reports
- Guidance around an Exit Strategy
- Templates around areas such as the Contract and Supplier Management Plan and creating a Risk Register.

It is acknowledged that managing a service contract can be very different to managing a large Capital Project but there are areas of good practice identified which are common to both and the SOP could be reviewed to build on this good practice in relation to managing a capital project. It is also acknowledged that it is difficult to create a "one size fits all" process for managing Capital projects within the Council as they can be very different, however it is imperative to try to create a process that would apply to all built around common themes i.e.

- An effective and evolving CPA/business case based around the Scottish Govt 5 case model.
- Effective reporting on progress including costs, timescales and quality.
- Strong governance and risk management
- Objective measures to underpin escalation of issues to senior management
- Post project evaluation and lessons learned.

There are specific recommendations around the projects reviewed above. However as the Council continues to manage projects of this nature, an effective process, designed to manage Capital Projects and applied by those managing the projects could address many of the issues raised above.

Recommendation

4.5.1 A Project Managers guide/Standard Operating Procedure should be designed and implemented to support and provide a reference point to those managing Capital Projects, especially the delivery phase, to allow a consistent approach across the Council to be adopted.

Action: Director of Environment

Chief Auditor
1 July 2025

Appendix	2D
Title	Follow-up of Payroll Audit MB/1237/FMX
Type	East Renfrewshire Council Internal Audit Activity relating to the Health and Social Care Partnership
Status	New First presented to PAC September 2025

REPORT ON FOLLOW-UP OF PAYROLL AUDITS

Contents	Page No

Chief Auditor
MB/1237/FM
17 June 2025
(response due 18 July 2025)

East Renfrewshire COUNCIL

REPORT ON FOLLOW-UP OF PAYROLL AUDITS

1. INTRODUCTION

As part of the 2024/25 audit plan, a follow-up audit of previous reports issued in relation to payroll was carried out.

2. SCOPE

The scope of the audit was to ensure that all of the recommendations which were accepted in the departmental responses had been implemented in the timescales stated. The following reports were included in the audit:

- ERCLT Payroll Reporting (MB/1172/FM issued 19 January 2023)
- Audit of Payroll (MB/1194/FM issued 30 January 2024)
- Application Audit of Payroll (MB/1201/FM issued 23 August 2024)

A total of 43 recommendations were made in the above reports, of which one (1194) was not accepted in the original departmental response and 8 are no longer applicable. Follow up testing showed that 9 of the remaining recommendations are still outstanding.

Name of audit	Number of original recommendations	Number not accepted or no longer applicable	Number not implemented
ERCLT Payroll Reporting (MB/1172/FM issued 19 January 2023)	15	1	2
Audit of Payroll (MB/1194/FM issued 30 January 2024)	20	6	3
Application Audit of Payroll (MB/1201/FM issued 23 August 2024)	8	1	4
Total	**43**	**8**	**9**

3. GENERAL CONCLUSION

Good efforts have been made to implement most of the original recommendations however nine recommendations remain outstanding and these are included again below.

RECOMMENDATIONS NOT IMPLEMENTED

4. ERCLT Payroll Reporting (MB/1172/FM)

4.1 Payroll Overpayments

It was noted at the time of the last audit that invoices raised in relation to the overpayment of ERCLT employees were erroneously being raised in the Council's financial ledger rather than ERCLT's financial ledger. As such, it was recommended that all monies that had been recovered through these invoices should be reimbursed to ERCLT.

Audit has been advised that work is currently being undertaken to ascertain the exact sum due to ERCLT and then arrangements will be made for the sum to be transferred with the assistance of the Finance Business Partner.

It was previously noted that all ERCLT payroll debtors invoices were incorrectly raised in the council ledger. Since the previous audit, all invoices now seem to be getting raised in the correct ledger however there are still several where no monies have been paid towards the debt and these should be transferred to the ERCLT ledger.

Recommendations

4.1.1 Audit should be informed when the monies recovered by debtor account by the Council in relation to ERCLT employees is reimbursed to ERCLT.

Action: Director of Business Operations & Partnerships

4.1.2 All ERCLT payroll debt invoices where amounts are still fully outstanding should be transferred to the ERCLT ledger.

Action: Director of Business Operations & Partnerships

4.2 Ledger Codings for Salary Costs

It was previously noted that the employee types used by ERCLT (LG employee, instructor and casual) had been wrongly transferred from the old payroll system to the new system for a number of employees. It was recommended and agreed that ERCLT could notify HR of the changes required and that these would be made. There is no evidence that ERCLT notified HR of any changes required so this point is considered closed with the onus on ERCLT to notify HR of any future changes required.

5. FOLLOW UP OF AUDIT OF PAYROLL (MB/1194/FM)

5.1 Contracted Hours

At the time of the last audit it was recommended that a BOXI report should be written to identify all employees where the contracted hours do not match the hours per the employees work pattern. Thereafter, amendments should be made as necessary to ensure that employees contracted hours and working patterns are consistent.

Audit obtained a copy of the BOXI report from the Information & Development Assistant who advised that 29 employees had been identified and work was underway to resolve these anomalies. Thereafter, the report will be run on a monthly basis and any anomalies resolved as they arise.

As such, no recommendations are made at this time but audit will revisit this are in due course to ensure that all 29 employee records have been amended and that regular reports are being generated and reviewed.

5.2 Maternity Leave

It was identified at the time of the last audit that the system is using public holiday days to extend the occupational and statutory maternity pay periods by adding the number of public holidays during the period to the maternity pay entitlement which is incorrect and causes the employee to be overpaid.

The iTrent Payroll Systems Officer advised that a fix has been applied to the test system to resolve this issue but it has not yet been rolled out to the live system.

Recommendation

5.2.1 The necessary fix should be applied to the live system to ensure that the treatment of public holidays for employees on maternity leave is correct.

Action: Director of Business Operations & Partnerships

5.3 Payroll Overpayments

It was previously noted that payroll overpayments being recovered by deduction through payroll could not be identified on the balance sheet by Audit and it was recommended that Audit be advised of the cost centre and account code where the debt is posted to on the financial ledger. Audit have not yet been advised of this and as such, the recommendation is included again below.

Recommendation

5.3.1 Audit should be advised of the cost centre and account code where debt relating to payroll overpayments which is being recovered through payroll deductions is posted on the ledger.

Action: Director of Business Operations & Partnerships

5.4 Annual Leave Purchase

In the original audit, recommendations were made to correct some anomalies between annual leave purchase deductions per payroll and the flexi system. HR have advised Audit that the anomalies were addressed but this could not be verified due to the flexi system no longer being used and historical records being unable to be accessed. As a result, no recommendation is re-made and this point is considered closed.

6. FOLLOW UP OF APPLICATION AUDIT OF PAYROLL (MB/1201/FM)

6.1 Data Retention

An earlier review of the information saved on the payroll drive identified files dating back to 2013 which should already have been deleted in accordance with the records management policy. The records management policy states that the data retention period should be six years plus current year for payroll records and thereafter the records should be destroyed. This recommendation has been made in three previous audit reports but has not yet been implemented. Alternatively, if it is deemed inappropriate to delete these older records, the records management retention schedule should be revised to reflect actual practice.

Recommendation

6.1.1 A review of the files held electronically on the payroll drives should be conducted and files older than seven years deleted to ensure compliance with the records management policy.

Action: Director of Business Operations & Partnerships

6.2 Plain Time Overtime

It has been highlighted several times in previous audit reports that in some cases, employee's plain overtime hours continue to be incorrectly coded to additional basic

hours instead of the plain overtime payroll code. Additional basic is treated as pensionable pay and as such should only ever be used for part time employees.

A sample of 5 employees that had claimed additional basic pay were selected to ascertain if the hours claimed related to additional basic pay or plain time overtime hours. In 3 cases (BOP – employees 6619644 & 6607342, Environment 6603693) out of 5 it was established that the claim was wrongly coded and should have been posted to plain time overtime.

Recommendation

6.2.1 Directors must ensure that line managers are aware that plain time overtime must be used instead of additional basic for full time employees.

Action: Director of Business Operations and Partnerships, Director of Environment

6.3 Overtime Claims

It was previously noted that overtime claims were being submitted claiming time and a half before the threshold of 37 hours had been worked by the employee. A sample of 5 overtime claims were selected where it appeared possible that the employee had claimed time and a half before reaching the 37 hours threshold. In two of these cases (ERCLT employee 6606895 and Environment 6612335) the employees had on multiple occasions claimed time and a half for two hours instead of plain time for these two hours. It is acknowledged that overtime guidance has been circulated to line managers previously but anecdotal evidence shows that line managers are still approving claims submitted at the incorrect rate as above.

Recommendation

6.3.1 Directors must ensure that line managers reject overtime claims for time and a half if 37 hours have not been worked by the employee that week.

Action: Director of Environment
ERCLT Director of Finance & Business

6.4 Overtime Claims for Grade 10+ Employees

It has been recommended on previous occasions that line managers must ensure, where an employee at grade 10 or above is claiming overtime, that the claim is authorised by an employee at grade 18 or above. Consideration must also be given to whether an overtime payment is appropriate or whether time off in lieu at plain time is more appropriate.

The HR Overtime and Working Pattern Enhancements Policy states that "*an employee who is graded Grade 10 or over is not eligible for overtime except in exceptional circumstances"* and that *"the normal recompense for employees Grade 10 or over, where it is required, should be time off in lieu at plain time for the period worked"*

An overtime report was generated for 2024/25 that showed there were 48 employees at G10 and above who had claimed overtime in the year, of which, 39 claimed overtime at the enhanced rate of time and a half or double time. A sample of 5 of these employee's claims were selected and enquiries made to determine if the claim had been approved by an officer at G18+ in accordance with the policy.

It was found that in two cases there was documentary proof that the claim has been approved by an officer at G18+. In two cases (Environment employee 6609840 and HSCP employee 6616034) audit were advised that verbal authorisation of the claim had been given by a G18+ but there was no documentary evidence to support this. In the final case (HSCP employee 6605748) there was evidence of authorisation being

provided by a G18+ officer for future trips of the same nature but there was no evidence that the sampled claim had been authorised by a G18+ offer prior to it being submitted to payroll.

As above, it is acknowledged that guidance regarding the overtime policy has been circulated to line managers but it is evident from testing carried out that the policy is not always being followed.

Recommendation

6.4.1 In accordance with the Overtime and Working Pattern Enhancement Policy, line managers must ensure that where an employee at grade 10 or above is claiming overtime that the claim is authorised by an employee at grade 18 or above and evidence of this is available. Consideration must also be given to whether an overtime payment is appropriate or whether time off in lieu at plain time is more appropriate.

Action: Director of Environment
Chief Officer of HSCP

Chief Auditor
16 June 2025

Ref. / Risk Rating	Recommendation	Comments (if appropriate)	Timescale for completion	Status	Latest Note
6.4.1 (Low)	In accordance with the Overtime and Working Pattern Enhancement Policy, line managers must ensure that where an employee at grade 10 or above is claiming overtime that the claim is authorised by an employee at grade 18 or above. Consideration must also be given to whether an overtime payment is appropriate or whether time off in lieu at plain time is more appropriate.	Communications will be issued to both SMT and HSCP CMT	30-Sep-25	Considered closed (pending verification by internal audit)	Communication issued

Appendix	2E
Title	Follow-up of HSCP Audits MB/1233/FM
Type	East Renfrewshire Council Internal Audit Activity relating to the Health and Social Care Partnership
Status	First presented to PAC June 2025 Changes since last reported June 2025:- 4.1.1 and 5.1.1 considered closed

Ref. / Risk Rating	Recommendation	Comments (if appropriate)	Timescale for completion	Status	Latest Note
4.1.1	Audit should be advised when the review of the policy is complete and a copy of the revised policy should be provided.	Redesign work remains ongoing however HSCP have met with ERC Council Corporate Finance and agreed we will apply the same agreement that is used for community alarms. Unpaid debt will be dealt with on a case by case basis and not prevent people from obtaining a place. A separate policy is therefore not required.	31-Jul-25	Considered Closed	New Audit - response to be finalised
5.1.1	Line mangers responsible for monitoring absence should be instructed to ensure that they are using the current RTW form which is available on the Council Intranet.	The staff group involved in the sample have been contacted regarding the use of correct paperwork. A further update will be included in the staff bulletin as a reminder to all staff.	31-Aug-25	Considered Closed	Email sent 08.07.2025

Appendix	2F
Title	Follow up of Ordering and Certification MB/1221/FM
Type	East Renfrewshire Council Internal Audit Activity relating to the Health and Social Care Partnership
Status	First presented to PAC June 2025 Changes since last reported to PAC June 225:- - 4.1.2 now considered closed - 4.2.1 now considered closed

Ref. / Risk Rating	Recommendation	Comments (if appropriate)	Timescale for completion	Status	Latest Note
4.1.2 (Med)	Employees with responsibility for ordering must ensure that approved suppliers are being used where available.	A communication will be issued and we will review the orders identified in the sample to allow us to determine whether any targeted work is required with a particular staff group.	31-May-25	Considered closed (pending verification by internal audit)	A reminder has been issued to staff with responsibility for ordering. Further work to understand why particular suppliers had been selected was undertaken. This was due to reduced availability from the usual supplier.
4.2.1 (Med)	Employees with responsibility for ordering must ensure that the appropriate reference is added to the order to evidence that a contract is being used for the purchases.	As above	31-May-25	Considered closed (pending verification by internal audit)	As above

Appendix	2G
Title	Bonnyton House MB/1217/ZC
Type	East Renfrewshire Council Internal Audit Activity relating to the Health and Social Care Partnership
Status	First presented to PAC March 2025 No changes since last reported June 2025

Ref. / Risk Rating	Recommendation	Comments (if appropriate)	Timescale for completion	Status	Latest Note
4.1.1 (Med)	The employee withdrawing cash from bank accounts for the location must lodge monies in safe and update the appropriate record promptly in person to maintain chain of custody of funds. (petty cash, amenity fund, corporate appointeeship account).	New processes now in place.	31-Dec-24	Considered closed (pending verification)	Actioned
4.2.1 (Low)	Input VAT should only be claimed where an item is applicable to VAT and supported by a valid VAT receipt.	Actioned, with reminders on process.	31-Dec-24	Considered closed (pending verification)	Actioned
4.3.1 (Low)	Staff at location should be reminded the individual item limit for petty cash is £25 and that petty cash is for minor items of expenditure only.	All staff involved have been informed and aware of the process. Regular checks will take place by management.	31-Dec-24	Considered closed (pending verification)	Complete
4.3.2 (Low)	Staff at location to be advised receipts must not be split to avoid breaching the petty cash limit set for individual items of expenditure.	All staff involved have been informed and aware of the process. Regular checks will take place by management.	31-Dec-24	Considered closed (pending verification)	Complete
4.4.1 (Low)	Appropriate action must be taken on highlighted suppliers as identified by the 2023/24 Procurement spend review before any future orders are placed with those suppliers.	The correct procurement process is being followed.	31-Dec-24	Considered closed (pending verification)	Complete
4.5.1 (Low)	HSCP to take appropriate action to close dormant bank account Bonnyton House Sensory Fund ending 2569.	Account to be closed.	31-Jan-25	Considered closed (pending verification)	Bank account was closed in 2024.

4.5.2 (Med)	Two employees should be involved in banking where possible and consideration given to restricting amounts of cash to be carried if only one person is involved.	Staff are aware of the importance of two employees being involved in banking of monies.	01-Dec-24	Considered closed (pending verification)	Complete
4.6.1 (Low)	Management must ensure that all paperwork required by the Maximising Attendance guidance is completed accurately and uploaded to Itrent promptly as evidence of compliance.	Staff attended training and this task is now being undertaken in the Care Home	01-Dec-24	Considered closed (pending verification)	Complete
4.7.1 (Med)	Client recipient's name must be included on income receipts when issuing duplicate receipts and any void receipts marked as such.	All staff involved have been informed and aware of the process.	01-Dec-24	Considered closed (pending verification)	Complete
4.7.2 (Med)	Receipt number should be recorded on CL2 client savings record.	Full review was undertaken with spot checks now in place to ensure that this is being carried out.	01-Dec-24	Considered closed (pending verification)	Complete
4.7.3 (Low)	Only one receipt book for client receipts should be in use at any one time.	All staff involved have been informed and aware of the process.	01-Dec-24	Considered closed (pending verification)	Complete
4.9.1 (Med)	A process for recording and returning cash held on behalf of deceased persons and/or prior clients must be established and documented.	Analysis is ongoing and a process in place for maintaining this going forward.	01-Dec-24	Considered closed (pending verification)	Complete

4.9.2 (Low)	A process for recording personal items found which relate to prior clients and/or deceased persons should be established and documented.	Process to be completed.	31-Jan-25	Considered closed (pending verification)	Personal items have been returned to clients/clients family as appropriate.
4.9.3 (High)	An analysis of bank account ending 2724 (SW Corp Appoint'ship) to be undertaken to identify balance by client and analysis maintained on an on-going basis going forward.	CL2 forms have all been audited and new processes are in place. Account review is currently ongoing.	31-Jan-25	Considered closed (pending verification)	Analysis completed May 2025
4.9.4 (Low)	HSCP need to take appropriate action to safeguard existing monies and jewellery relating to deceased and/or prior clients until a process is established.	Audit and review has taken place and family members have been contacted where appropriate.	31-Jan-25	Considered closed (pending verification)	Complete
4.9.5 (Low)	Where possible, a review of CL2 forms for deceased and/or prior clients from 2020 to date should be undertaken to ascertain all monies were appropriately accounted for.	CL2 forms been audited and deceased residents monies are being dealt with in the appropriate manner - Legal team have been contacted	31-Jan-25	Considered closed (pending verification)	Audit has been completed
4.10.1 (Low)	All laptops, desktops and mobile phones to be accurately reflected on inventory; with asset number and serial numbers recorded for all appropriate items	Existing inventory being reviewed	31-Jan-25	Open	Review of current year inventory ongoing.

Appendix	2H
Title	Audit of Accounts Payable MB/1216/IM
Type	East Renfrewshire Council Internal Audit Activity relating to the Health and Social Care Partnership
Status	First reported to PAC September 2024 No changes since reported to PAC November 2024 All recommendations considered closed

Ref/Risk Rating	Recommendation	Comments (if appropriate)	Timescale for completion	Status	Latest Note
4.3.1 (Med)	Goods receipts should only be input at the appropriate level in relation to the actual goods received.	A reminder will be issued to Business Support staff	31-Oct-24	Considered closed (pending verification)	Communication issued to business support staff
4.3.3 (Med)	Following invoice authorisation, the order should be checked and if no more spend is expected against the order, it should be forced complete, including forcing the Goods Receipt complete if necessary to remove this accrual from the ledger.	A reminder will be issued to Business Support staff	31-Oct-24	Considered closed (pending verification)	as above
4.4.2 (Low)	Staff should be reminded if an Eform is started on Integra but then subsequently not used, these should be cancelled on the system.	A reminder will be issued to Business Support staff	31-Oct-24	Considered closed (pending verification)	as above
4.6.1 (Low)	An appropriate expense head should be used at all times in order to easily identify expenditure. If one is not available, consideration should be given to creating a new one to properly reflect the nature of the spend incurred and if in any doubt, the Finance Business Partner should be contacted for advice.	A reminder will be issued to Business Support staff	31-Oct-24	Considered closed (pending verification)	as above

Appendix	2l
Title	Audit of Accounts Receivable MB/1212/IM
Type	East Renfrewshire Council Internal Audit Activity relating to the Health and Social Care Partnership
Status	First reported to PAC September 2024 No changes since last reported March 2025

Ref/Risk Rating	Recommendation	Comments (if appropriate)	Timescale for completion	Status	Latest Note
4.1.1 (High)	Directors must ensure that they have appropriate processes in place to notify Payroll immediately as soon as they are aware that an employee they are responsible for will be leaving the Council to ensure unnecessary payroll related debt is not incurred.	A reminder will be sent to managers. Further commas to be included in the staff bulletin along with the reminders from the payroll audit.	30 Sep 2024 31 Dec 2024	Considered closed (pending verification)	Reminder included in managers bulletin
4.7.4 (Med)	Departments must ensure that invoices are raised in advance of the service being provided where possible to minimise the risk of bad debts.	The HSCP has an agreed process in place with the debtors team. We will review this to identify whether any change may improve this and will also inform any changes to process from the implementation of the finance module within Mosaic. In relation to services for care it is not appropriate to raise invoices in advance.	31-Dec-24	Open	
4.7.5 (Med)	Improved communication and joint ownership of the debt recovery process between accounts receivable and departments needs to be established to aid income recovery. Departments should make consistent use of reports available to monitor outstanding debt	As above	31-Dec-24	Open	

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

PERFORMANCE AND AUDIT COMMITTEE

24 September 2025

Report by Chief Auditor

NHSGGC INTERNAL AUDIT PROGRESS REPORT 2024/25

PURPOSE OF REPORT

1. To provide summary details of the audits completed by the NHS Greater Glasgow and Clyde (NHSGGC) internal auditors during 2024/25. The internal audit service is currently provided by Azets.

BACKGROUND

2. The East Renfrewshire Integration Joint Board directs both East Renfrewshire Council and NHSGGC to deliver services on its behalf to enable it to deliver on its strategic plan.

3. Both East Renfrewshire Council and NHSGGC have internal audit functions which conduct audits across their organisations and report the findings of these to their respective audit committees.

NHSGGC INTERNAL AUDIT ACTIVITY TO JUNE 2025

4. The reports in appendix 1 provide a summary to the Performance and Audit Committee of the internal audit activity undertaken within the NHSGGC received since the last meeting.

5. Details of three reports were received, one was classified as needing minor improvement and two as needing substantial improvement.

RECOMMENDATION

6. The Committee is asked to:

(a) Note the contents of the report.

M Blair, Chief Auditor
7 August 2025

APPENDIX 1

NHSGGC INTERNAL AUDIT PROGRESS REPORT 2024/25

1. **Reports Issued**

Details of three audits from the 2024/25 audit plan has been provided by the NHSGGC internal auditors as summarised below.

Review	Overall audit rating (Note 1)	No. of issues per grading (Note 2)			
		4	3	2	1
Medicines Governance	Substantial Improvement required	0	3	12	1
Staff Training and Development	Minor Improvement required	0	4	2	1
Strategic and Operational Planning	Substantial Improvements required	0	1	7	0

2. **Medicines Governance**

This report covered the governance of medicines including access to medicines, bringing approved medicines into use, safe handling and adhering to budgets and savings targets.

Generally it was concluded that medicines policies and governance arrangements are not kept up to date in line with review cycles. Wider service planning needs to be in place for new medicines to ensure costings and savings are fully understood. The report acknowledges that financial savings are well monitored but re-forecasting during the year could be improved.

The report concluded that **substantial improvement** was required and there were 17 areas of weakness identified in total, 3 at grade 3, 12 at grade 2, 1 at grade 1 and 1 advisory only.

The three grade 3 recommendations covered:

- completion of mandatory training course on medicines administration needs to be better monitored to ensure better compliance
- better monitoring of the indicative full service cost to bring a new medicine into use needs to be carried out regularly
- more regular and accurate tracking of projected savings throughout the year is needed.

3. **Staff Training and Development**

There has been a focus on staff training and development in recent years with generally upward trends in core mandatory and statutory training compliance rates. Areas of challenge remain relating to staff development with only 56% of NHSGGC Agenda for Change staff having completed a Personal Development Plan and Review (PDP&R) on the Turas Appraisal system and challenges on how information is recorded and then reported. The report rating indicated **substantial improvement** was required and there were seven areas of weakness identified, 4 at grade 3, 2 at grade 2 and 1 at grade 1 and all were accepted by management.

The four grade 3 recommendations are all relating to PDP&Rs as follows:

- Review connections within induction portal to ensure consistent information is communicated
- Review the communications plan to ensure the PDP is used fully to support future performance and career developments

- Roles and responsibilities at all levels need to focus on accountability and action planning to ensure process is monitored and reviewed
- Review the process for monitoring compliance for recording PDP&R conversations

4. **Strategic and Operational Planning**

The NHS has four strategic priorities, Better Health, Better Care, Better Value and Better Workforce and these are captured in the Annual Delivery Plan (ADP), the NHS's overarching strategic plan. The ADP adopted a whole system approach to 2025/26 including representations from the six HSCPs which brings challenges due to different timetables and different time periods covered making collaboration problematic at times.

Good practice was identified around the ADP being clear and comprehensive with a supporting action tracker, there is a comprehensive assurance framework and it was found that most underlying strategies have sufficient reporting. Winter planning involves good early work and the identification of key dependencies. The report rating indicated that **minor improvement** was required and 8 recommendations are made, 1 at grade 3 and 7 at grade 2.

The grade 3 recommendation highlighted the need for an estates strategy that articulated objectives and deliverables to assist the organisation in achieving its strategic goals.

Note 1 *- The overall audit report rating is based on the following table:*

Immediate major improvement required	*Controls evaluated are not adequate, appropriate, or effective to provide reasonable assurance that risks are being managed and objectives should be met.*
Substantial improvement required	*Numerous specific control weaknesses were noted. Controls evaluated are unlikely to provide reasonable assurance that risks are being managed and objectives should be met*
Minor improvement required	*A few specific control weaknesses were noted; generally however, controls evaluated are adequate, appropriate and effective to provide reasonable assurance that risks are being managed and objectives should be met.*
Effective	*Controls evaluated are adequate, appropriate, and effective to provide reasonable assurance that risks are being managed and objectives should be met.*

Note 2 *- Issues within these reports are graded on the following basis.*

4	*Very high risk exposure – major concerns requiring immediate senior management attention that create fundamental risks within the organisation*
3	*High risk exposure – absence/failure of key controls that create significant risks within the organisation*
2	*Moderate risk exposure – controls not working effectively and efficiently and may create moderate risks within the organisation*
1	*Limited risk exposure – controls are working effectively but could be strengthened to prevent the creation of minor risks or address general house-keeping issues.*