ARGYLL AND BUTE COUNCIL

Internal Audit Section

INTERNAL AUDIT REPORT

CUSTOMER DEPARTMENT	**CUSTOMER SERVICES**
AUDIT DESCRIPTION	**VERIFICATION AUDIT**
AUDIT TITLE	**INTERNAL AUDIT REVIEW OF RECORDS MANAGEMENT PLAN**
AUDIT DATE	**NOVEMBER 2017**

2017/2018

1. BACKGROUND

This report has been prepared as part of the 2017/18 risk based Internal Audit Plan. The audit was conducted in accordance with relevant auditing standards with the conclusions detailed in this report based on discussions with key personnel and the information available at the time the fieldwork was performed.

Argyll and Bute Council (the Council) creates, collects, uses and disposes of a large amount of information during the course of carrying out its public duties. The Council needs to manage this information carefully to ensure that the record of its activities is accurate and complete and complies with the Public Records (Scotland) Act 2011 (PRSA).

Under the PRSA every public authority in Scotland must prepare and follow a Records Management Plan (RMP), which sets out the arrangements for managing public records. The Council's RMP has been developed in line with the model RMP provided by the Keeper of the Records of Scotland.

The Council's RMP was approved by the Strategic Management Team (SMT) in February 2016, and has been rolled out to all services throughout 2016. It was accompanied by a Records Management Development Plan, which outlines actions to improve records management practices.

2. AUDIT SCOPE, CONTROL OBJECTIVES AND RISKS

The scope of the audit was to evaluate compliance with the PRSA.

The table below sets out the control objectives and associated risks identified during the planning phase of the audit.

Control Objectives		
O1	Authority	Roles and delegated responsibilities are documented in policies and procedures and are operating well in practice.
O2	Occurrence	Sufficient documentation exists to evidence compliance with policies, procedures and relevant legislation.
O3	Completeness	Policies and procedures are aligned to relevant legislation and all required documentation is accurately and fully maintained.

O4	Measurement	Policies and procedures are in line with requirements of relevant legislation.
O5	Timeliness	Policies and procedures are regularly reviewed and updated as necessary.
O6	Regularity	Documentation is complete, accurate and not excessive and is compliant with the data retention policy. It is stored securely and made available only to appropriate members of staff.
Risks		
ORR GL02	Failure regarding compliance with governance and information management arrangements.	
Audit Risk	Failure to comply with the Public Records (Scotland) Act 2011.	

3. SUMMARY CONCLUSION

Our assessment against each of the identified control objectives are set out in the table below.

Control Objective	Assessment	Summary Conclusion
O1	Substantial	Plans, policies and procedures clearly define roles and responsibilities and are followed well in practice.
O2	Substantial	The RMP and its appendices and associated development plan has been approved by the “Keeper”.
O3	Substantial	The RMP development plan is being progressed with four actions already complete, one withdrawn, and the remaining being progressed. Arrangements for training and the completion of new disposal guidance are currently being scheduled. .
O4	Substantial	Policies and procedures are in line with the RMP and the PRSA.
O5	Reasonable	The Information Strategy 2014-18 has not been subject to annual review. This is stated as a requirement within the strategy.
O6	Substantial	Documentation reviewed is for use by all members of staff and is available for reference on the Council’s intranet.

4. AUDIT OPINION

The level of assurance given for this report is Substantial.

Level of Assurance	Definition
High	Internal control, governance and the management of risk are at a high standard with only marginal elements of residual risk, which are either being accepted or dealt with. A sound system of control is in place designed to achieve the system objectives and the controls are being consistently applied.
Substantial	Internal control, governance and management of risk is sound, however, there are minor areas of weakness which put some system objectives at risk and where specific elements of residual risk that are slightly above an acceptable level and need to be addressed within a reasonable timescale.
Reasonable	Internal control, governance and management of risk are broadly reliable, however although not displaying a general trend there are a number of areas of concern which have been identified where elements of residual risk or weakness with some of the controls may put some of the system objectives at risk.
Limited	Internal control, governance and the management of risk are displaying a general trend of unacceptable residual risk above an acceptable level and system objectives are at risk. Weakness must be addressed with a reasonable timescale with management allocating appropriate resources to the issues raised.
No Assurance	Internal control, governance and management of risk is poor, significant residual risk exists and/ or significant non-compliance with basic controls leaves the system open to error, loss or abuse. Residual risk must be addressed immediately with management allocating appropriate resources to the issues.

This framework for internal audit ratings has been developed and agreed with Council management for prioritising internal audit findings according to their relative significance depending on their impact to the process. The individual internal audit findings contained in this report have been discussed and rated with management.

A system of grading audit findings, which have resulted in an action, has been adopted in order that the significance of the findings can be ascertained. Each finding is classified as High, Medium or Low. The definitions of each classification are set out below:

Grading	Definition
High	Major observations on high level controls and other important internal controls. Significant matters relating to factors critical to the success of the objectives of the system. The weakness may therefore give rise to loss or error.
Medium	Observations on less important internal controls, improvements to the efficiency and effectiveness of controls which will assist in meeting the objectives of the system and items which could be significant in the future. The weakness is not necessarily great, but the risk of error would be significantly reduced if it were rectified.
Low	Minor recommendations to improve the efficiency and effectiveness of controls, one-off items subsequently corrected. The weakness does not appear to affect the ability of the system to meet its objectives in any significant way.

5. DETAILED FINDINGS

The following findings were generated by the audit.

Records Management Plan

The RMP is based on the model plan provided by the Keeper of the Records of Scotland (the Keeper). It contains all the mandatory elements and the required appendices and associated development plan have been approved by the Keeper.

Plans, Policies and Procedures

The RMP, Development Plan and Policy and Information Strategy have been made available to all staff via the Council's intranet site. The Council Constitution is also available on the intranet site and highlights the legal and business requirements of information held by the Council. We noted that the Council's Information Strategy has not been subject to an annual review as required by the strategy itself.

Records Management Plan – Development Plan

The development plan is being progressed to aid ongoing compliance with the requirements of the Keeper. It identifies 16 actions of which:

- four are complete
- nine are progressing and where target dates are set, these are on course for completion
- one has been withdrawn as it falls more specifically within the remit of another project
- two have been delayed (one by six months and one by a month).

<u>Guidance Documents</u>

Three actions in the RMP development plan relate to a need to develop appropriate guidance. Specifically:

- DP.6.01 – Develop guidance for the disposal of electronic documents based on the needs of each service

- DP.7.02 – Develop guidance for staff around the long-term storage of closed records, streamline and formalise existing processes
- DP.11.02 – Prepare guidance and templates to use to allow tracking of paper records.

Governance and Law are preparing guidelines regarding the disposal of electronic documents to be used as basis for other services to develop their own guidelines. This is on course for completion by the target date of December 2017 however, does not allow other services time to prepare their guidance.

Guidance on the long-term storage of closed records is partially addressed within the Information Asset Registers (IARs) and partially included within the national digital repository project. The Special Projects Officer continues to liaise with council services to identify and store these types of records.

The guidance and templates to allow tracking of paper records had been delayed by six months. It is currently being prepared and is scheduled to be submitted to the Information Security forum and Risk Management Group for review in December 2017.

Disposal

DP.6.02 – Develop corporate approach to the disposal of confidential paper records.

No meetings have been held recently however discussions have taken place with the waste management team in early 2016 regarding the assessment of current arrangements for disposing of confidential waste and options for a more consistent process across the Council. This action is to be progressed over the next few months in line with target date.

Archives

DP.7.01 – Consider the implementation of a digital repository and DP.10.01 – Review safeguarding arrangements for archives.

These tasks have been allocated to the Council's archivist for action. No target date has been set for the implementation of the digital repository as this is a national matter being looked at by the national association of archivists with a toolkit prepared and issued to

local authorities for feedback. A target date will be set for national implementation in due course. Safeguarding arrangements are scheduled to be reviewed over the next few months in line with target date.

Vital Records

DP.10.02 – Clearly identify the vital records of the organisation and ensure measures are in place to protect these records.

Entries within the IARs are assigned a risk level and Critical Activity Recovery Plans are in place for vital services. A template IAR action plan has been prepared and an entry is to be added regarding vital records and mitigating actions.

Training

DP.12.01 – Train Records Management Champions.
DP.12.02 – Produce and implement a training plan to encompass all employees.
DP.12.03 – Consider the addition of a core (level 1) competency to the Argyll and Bute Council Competency Framework.

The Governance and Risk Manager received training in March 2017 however training is still to be cascaded to Records Management Champions. Training requirements are to be discussed at the next meeting of the Information Security Forum with a view to complete this action by the end of March 2018. Training materials have been developed for the Council's online training system "LEON", and will be made available to all staff by the end of March 2018. The action to add a core (level 1) competency to the Council's Competency Framework is being considered to ascertain whether it is consistent with the Council's new behavioural framework (which is replacing the Competency Framework) or whether an alternative approach may be required.

There are no completion dates assigned to these tasks, however, dates have been proposed for the updated development plan to be passed to Strategic Management Team later this year.

6. CONCLUSION

This audit has provided a substantial level of assurance as the internal control, governance and the management of risk have been assessed as sound. There were three findings identified as part of the audit and these, together with agreed management actions,

are set out in the action plan included at appendix 1. These will be reported to the Audit & Scrutiny Committee and progress implementing the actions will be monitored by Internal Audit and reported to management and the Audit & Scrutiny Committee.

Thanks are due to staff and management for their co-operation and assistance during the audit and the preparation of the report and action plan.

APPENDIX 1 ACTION PLAN

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
1. Information Strategy		**High/ Medium**		
The Council's Information Strategy has not been subject to an annual review as required by the strategy itself.	Failure to regularly review strategy may lead to inefficient and ineffective operations resulting in non-compliance with agreed practice.	High	**Review of Information Strategy will commence at the next meeting of the ICT steering Board.**	**ICT Project and Liaison Manager** **22 November 2017**
2. Disposal Guidance				
Guidelines regarding the disposal of electronic documents will be completed by Governance and Law by the target date but not by other services.	Failure to adopt a consistent approach to disposal of electronic documents may lead to non-compliance with legislation resulting in fines and potential penalties.	Medium	**Target date will be revised to January 2018 to allow other services develop guidance.**	**Governance and Risk Manager** **31 January 2018**
3. Records Management Training				
Records Management Champions have yet to receive records management training; additionally, the online module is not yet available	Failure to provide adequate training for staff may lead to ineffective performance resulting in non-compliance with legal	High	**Slides have been prepared and will be made available on the Council's e-learning system. Proposed date for completion of**	**Governance and Risk Manager** **31 March 2018**

Findings	Risk Impact	Rating	Agreed Action	Responsible person agreed implementation date
for all staff to access. No completion date has been provided for these actions.	requirements.		**training actions will be 31 March 2018. This will be updated on the revised development plan for approval December 2017.**	

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