Education, Children and Families Committee

10.00am, Tuesday 13 September 2022

Internal Audit: Overdue Findings and Key Performance Indicators as at 26 January 2022 – referral from the Governance, Risk and Best Value Committee

Executive/routine	Executive
Wards	
Council Commitments	

1. For Decision/Action

1.1 The Governance, Risk and Best Value Committee has referred the attached report to the Education, Children and Families Committee for ongoing scrutiny of relevant overdue management actions.

Richard Carr
Interim Executive Director of Corporate Services

Contact: Rachel Gentleman, Committee Officer
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EDINBVRGH
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Referral Report

Internal Audit: Overdue Findings and Key Performance Indicators as at 26 January 2022 – referral from the Governance, Risk and Best Value Committee

2. Terms of Referral

2.1 On 8 March 2022, the Governance, Risk and Best Value Committee considered a report on Internal Audit Overdue Findings and Key Performance Indicators as at 26 January 2022.

2.2 The Governance, Risk and Best Value Committee agreed:

2.2.1 To note the status of the overdue Internal Audit findings as at 26 January 2022;

2.2.2 To note the status of IA Key Performance Indicators for audits that were either completed or in progress as at 26 January 2022;

2.2.3 To refer the report to the relevant Council committees for ongoing scrutiny of their relevant overdue management actions;

2.2.4 To refer the report to the Edinburgh Integration Joint Board Audit and Assurance Committee for information in relation to the current Health and Social Care Partnership position.

2.3 Following requests for clarification on the specific Internal Audit overdue findings that parent executive committees should focus on, an exercise has been completed that maps the findings included in this report to the specific committee based on their responsibilities detailed in the Council's committee terms of reference.

2.4 This exercise has identified an anomaly as there is currently no linear relationship between individual audit reports and committees, as it is possible for scrutiny of the actions in one Internal Audit report to be allocated across a number of Committees. For example, a review of Planning or Licensing could potentially result in operational service delivery actions being allocated to the Planning Committee and/or Regulatory Committee, with actions that relate to the ICT arrangements that these teams use being allocated to the Finance and Resources Committee.

2.5 As part of preparations for the new Council following the May 2022 Local Government elections, we will complete further work on this area to determine

whether there is a more effective way of ensuring a more linear allocation of responsibility for executive committee and oversight of overdue IA actions.

2.6 In the meantime, the information provided to each committee is based upon the allocation of agreed management actions in line with each committee's current terms of reference. A copy of the full report is also available online, with a link include in the background section of this referred report for reference.

3. Background Reading/ External References

3.1 Minute of the Governance, Risk and Best Value Committee – 8 March 2022

3.2 Governance, Risk and Best Value Committee – 8 March 2022 webcast

3.3 Internal Audit: Overdue Findings and Key Performance Indicators as at 26 January 2023 – full report to GRBV Committee

4. Appendices

Appendix 1 – report by the Chief Internal Auditor

Governance, Risk and Best Value Committee

10:00am, Tuesday, 8 March 2022

Internal Audit: Overdue Findings and Key Performance Indicators as at 26 January 2022

Item number	
Executive/routine	**Executive**
Wards	
Council Commitments	

1. Recommendations

1.1 It is recommended that the Committee:

1.1.1 notes the status of the overdue Internal Audit (IA) findings as at 26 January 2022;

1.1.2 notes the status of IA Key Performance Indicators (KPIs) for audits that are either completed or in progress as at 26 January 2022;

1.1.3 refers this paper to the relevant Council Executive committees for ongoing scrutiny of their relevant overdue management actions; and,

1.1.4 refers this paper to the Edinburgh Integration Joint Board Audit and Assurance Committee for information in relation to the current Health and Social Care Partnership position.

Lesley Newdall

Chief Internal Auditor

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Report

Internal Audit: Overdue Findings and Key Performance Indicators as at 26 January 2022

2. Executive Summary

Progress with Closure of Open and overdue Internal Audit findings

2.1 The overall progress status for closure of overdue IA findings is currently red (adverse trend with action required) as at 26 January 2022, based on the average position across the last three months.

2.2 Whilst the total number of open and overdue IA findings and associated management actions is decreasing (which is mainly attributable to delayed completion of the 2021/22 IA annual plan), increasing trends in the proportion of open IA findings that are overdue (KPI 3 in Appendix 1); the proportion of high rated overdue findings (KPI 7); and the proportion of findings that are less than 90 days overdue (KPI 8) are evident across the last three months, together with an increase in the number of overdue management actions (KPI 14).

2.3 These increasing trends in the last month are partially offset by improvement in the proportion of IA findings that are between three and six months overdue (KPI 10).

2.4 These outcomes confirm that further sustained focus is required on closure of overdue findings, with action required to ensure that open findings that are not overdue are closed by their originally agreed implementation dates.

2.5 Increased focus on closure of agreed management actions is evident following the secondment of two IA team members into the Place Directorate and Health and Social Care Partnership in October 2021. This is evident from increased levels of discussion and engagement on both open and overdue actions, and an increase in the volume of actions proposed for closure. However, as a number of the actions are historic and also complex to resolve, the full impact should be more apparent in the position at the end of February, with further progress evident by March 2022. Both secondments are currently scheduled to complete by 31 March 2022.

2.6 A reallocation of open and overdue findings and associated management actions has been performed across directorates and services to ensure alignment with the Council's refreshed organisational structure. This has resulted in an increased number of findings and actions for the Place Directorate.

2.7 Further detail on the monthly trends in open and overdue findings is included at Appendix 1.

Current position as at 26 January 2022

2.8 A total of 91 open IA findings remain to be addressed across the Council as 26 January 2022. This excludes open and overdue Internal Audit findings for the Edinburgh Integration Joint Board and the Lothian Pension Fund.

2.9 Of the 91 currently open IA findings:

2.9.1 a total of 42 (46%) are open, but not yet overdue;

2.9.2 49 (54%) are currently reported as overdue as they have missed the final agreed implementation dates. This reflects an increase of 3% in comparison to the November 2021 position (51%).

2.9.3 69% of the overdue findings are more than six months overdue, which remains aligned with the November 2021 position (69%), with 18% aged between six months and one year, and 51% more than one year overdue.

2.9.4 evidence in relation to 5 of the 49 overdue findings is currently being reviewed by IA to confirm that it is sufficient to support closure; and,

2.9.5 44 overdue findings still require to be addressed.

2.10 The number of overdue management actions associated with open and overdue findings where completion dates have been revised more than once since July 2018 is 39, reflecting a decrease of 5 when compared to the November 2021 position (44). This excludes the two completion date extensions applied to reflect ongoing Covid-19 impacts across the Council.

Annual Plan Delivery and Key Performance Indicators

2.11 IA Key Performance Indicators (KPIs) to support effective delivery of the 2021/22 IA annual plan confirm that action is required to ensure that services have greater awareness of the KPIs that apply to the audit process (these are included as an Appendix with each terms of reference) and engage proactively with IA to ensure that any potential impacts that could cause delays are identified and effectively managed. Four IA training sessions were delivered during December that covered these areas.

2.12 The KPIs also highlight areas where IA has not achieved their delivery timeframes. Some delays have been experienced, and these are mainly attributable to the time required to establish backfill support for IA secondments into Directorates, and unplanned sickness absence within the team.

3. Background

Open and Overdue IA Findings and Agreed Management Actions

3.1 Overdue findings arising from IA reports are reported monthly to the Corporate Leadership Team (CLT) and quarterly to the GRBV Committee.

3.2 This report specifically excludes open and overdue findings that relate to the Edinburgh Integration Joint Board (EIJB) and the Lothian Pension Fund (LPF). These are reported separately to the EIJB Audit and Assurance Committee and the Pensions Audit Sub-Committee respectively.

3.3 Findings raised by IA in audit reports typically include more than one agreed management action to address the risks identified. IA methodology requires all agreed management actions to be closed in order to close the finding.

3.4 The IA definition of an overdue finding is any finding where all agreed management actions have not been evidenced as implemented by management and validated as closed by IA by the date agreed by management and IA and recorded in relevant IA reports.

3.5 The IA definition of an overdue management action is any agreed management action supporting an open IA finding that is either open or overdue, where the individual action has not been evidenced as implemented by management and validated as closed by IA by the agreed date.

3.6 Where management considers that actions are complete and sufficient evidence is available to support IA review and confirm closure, the action is marked as 'implemented' by management on the IA follow-up system. When IA has reviewed the evidence provided, the management action will either be 'closed' or will remain open and returned to the relevant owner with supporting rationale provided to explain what further evidence is required to enable closure.

3.7 A 'started' status recorded by management confirms that the agreed management action remains open and that implementation progress ongoing.

3.8 A 'pending' status recorded by management confirms that the agreed management action remains open with no implementation progress evident to date.

3.9 An operational dashboard has been designed to track progress against the key performance indicators included in the IA Journey Map and Key Performance Indicators document that was designed to monitor progress of both management and Internal Audit with delivery of the Internal Audit annual plan. The dashboard is provided monthly to the Corporate Leadership Team and quarterly to the Committee to highlight any significant delays that could potentially impact on delivery of the annual plan.

Key Performance Indicator Dashboard

3.10 The IA key performance indicator dashboard has been reinstated for 2021/22 to support delivery of the annual plan by both services and the IA team; and prevent delays in completion of audits and finalisation of the IA annual opinion.

3.11 Reintroduction of the KPIs supported by monthly reporting to the Corporate Leadership Team and quarterly to the Committee will highlight any significant

delays that could potentially impact on delivery of the annual plan, and is aligned with the requirements of both the motion and addendum agreed at Committee in August 2021 requesting that audits will be carried out in line with the timescales set out in the agreed audit plan.

4. Main report

4.1 As at 26 January 2022, there are a total of 91 open IA findings across the Council with 49 findings (54%) now overdue.

4.2 The movement in open and overdue IA findings during the period 5 November 2021 to 26 January 2022 is as follows:

Analysis of changes between 11/08/2021 and 05/11/2021				
	Position at 05/11/21	**Added**	**Closed**	**Position at 26/01/22**
Open	108	0	17	91
Overdue	55	9	15	49

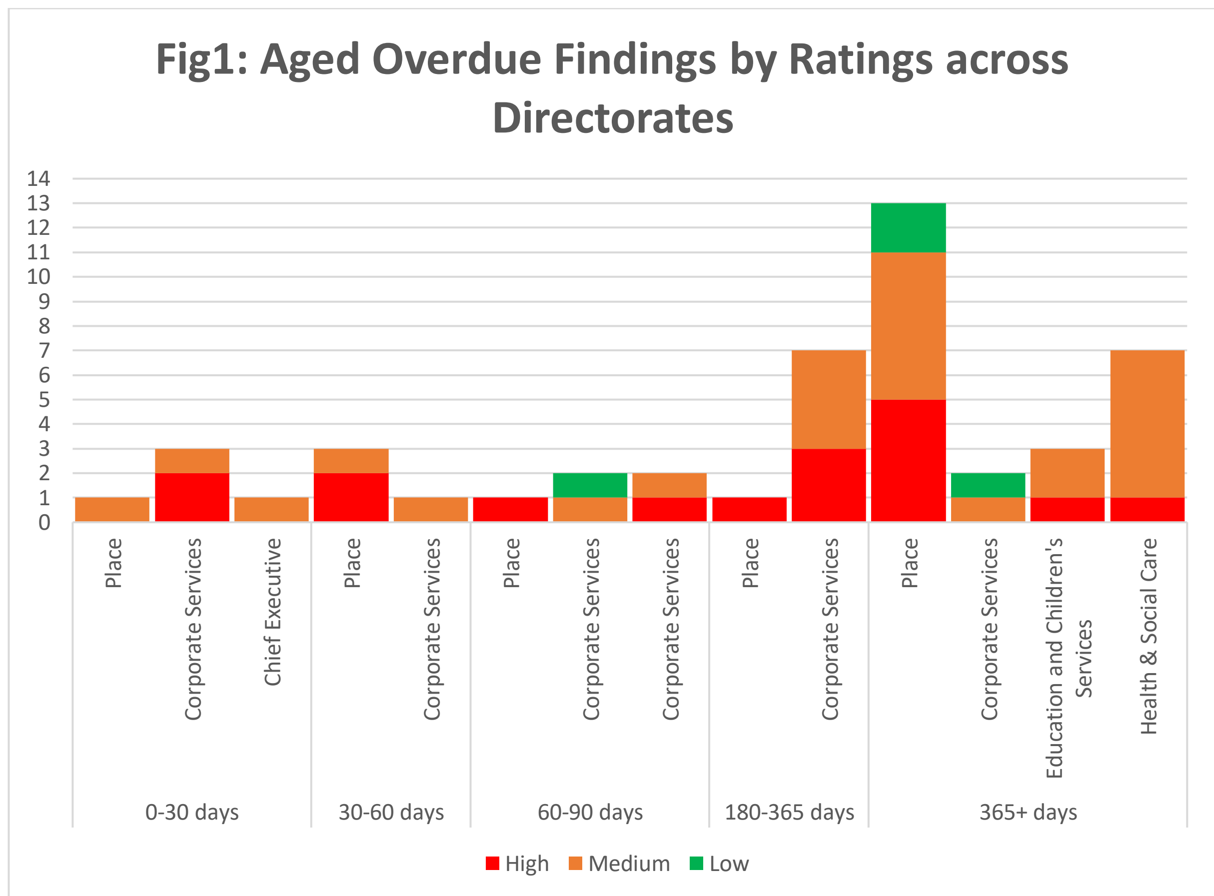
Overdue Findings

4.3 The 49 overdue findings comprise 18 High; 27 Medium; and 4 Low rated findings.

4.4 However, IA is currently reviewing evidence to support closure of 5 of these findings (2 High; 2 Medium; and 1 Low), leaving a balance of 44 overdue findings (16 High; 25 Medium; and 3 Low) still to be addressed.

Overdue findings ageing analysis

4.5 Figure 1 illustrates the ageing profile of all 49 overdue findings by rating across directorates as at 26 January 2022.



4.6 The analysis of the ageing of the 49 overdue findings outlined below highlights that Directorates made good progress last quarter with resolving findings between three and six months overdue, as the proportion of these findings has decreased. However, this is offset by limited improvement in the proportion of findings that are more than six months overdue; and a significant increase in the proportion of findings that are less than three months overdue.

- 13 (27%) are less than 3 months (90 days) overdue, in comparison to 13% as at November 2021;
- 2 (4%) are between 3 and 6 months (90 and 180 days) overdue, in comparison to 18% as at November 2021;
- 9 (18%) are between 6 months and one year (180 and 365 days) overdue, in comparison to 16% as at November 2021; and
- 25 (51%) are more than one year overdue, in comparison to 53% as at November 2021.

Agreed Management Actions Closed Based on Management's Risk Acceptance

4.7 During the period 6 November 2021 to 26 January 2022, three medium rated management actions were closed on the basis that management has retrospectively accepted either the full or residual elements of the risks highlighted by IA in the original audit report.

4.7.1 **Council Wide Brexit Impacts Supply Chain Management – Divisional and Directorate Supply Chain Management Risks (medium)** – whilst evidence has been provided confirming that work to identify critical suppliers and supply chain risks and implement alternative supplier arrangements (where required) has been completed for the majority of the Education and Children's Services directorate, the Estates and Operational Support division has been unable to provide evidence to support implementation due to operational constraints. This service area has now transitioned from Education and Children's Services into the Place Sustainable Development division, who have confirmed that they are comfortable with this approach.

4.7.2 **Cyber Security – Pubic Sector Action Plan – Cyber Essentials Accreditation (medium)** - management has accepted the risk that whilst vulnerability scanning has now been implemented across all three Council networks, it is not currently possible to confirm that vulnerabilities identified are being effectively addressed by CGI.

Digital Services has not yet been able to provide evidence from CGI of actions taken to address a sample of vulnerabilities identified, and is currently relying on CGI updates included in reports provided to the Security Working Group that vulnerabilities identified are being effectively remediated.

Management is also comfortable that the independent testing performed to achieve Cyber Essentials plus accreditation provides adequate assurance on network security, however this provides only 'point in time' assurance and currently covers only the Corporate, and not the Learning and Teaching or Peoples networks.

This remaining point will now be carried forward into the Technology and Vulnerability Management audit included in the 2021/22 IA annual plan that is currently in progress.

4.7.3 **First Line Project Governance – Directorate Project Portfolio Governance (medium)** – this action included four points and three have been fully completed.

Whilst a tiered governance approach that is proportionate to project values and/or risks will be introduced across Directorates, with high profile projects that do not meet the criteria for inclusion in the major projects portfolio subject to governance at Directorate level; mid-tier projects by Heads of Divisions; and low tier projects by Service Managers level; management has risk accepted the risks associated with not establishing formal governance forums to support ongoing oversight of these projects.

Agreed Management Actions Analysis

4.8 The 91 open IA findings are supported by a total of 218 agreed management actions. Of these,132 (61%) are overdue as the completion timeframe agreed with

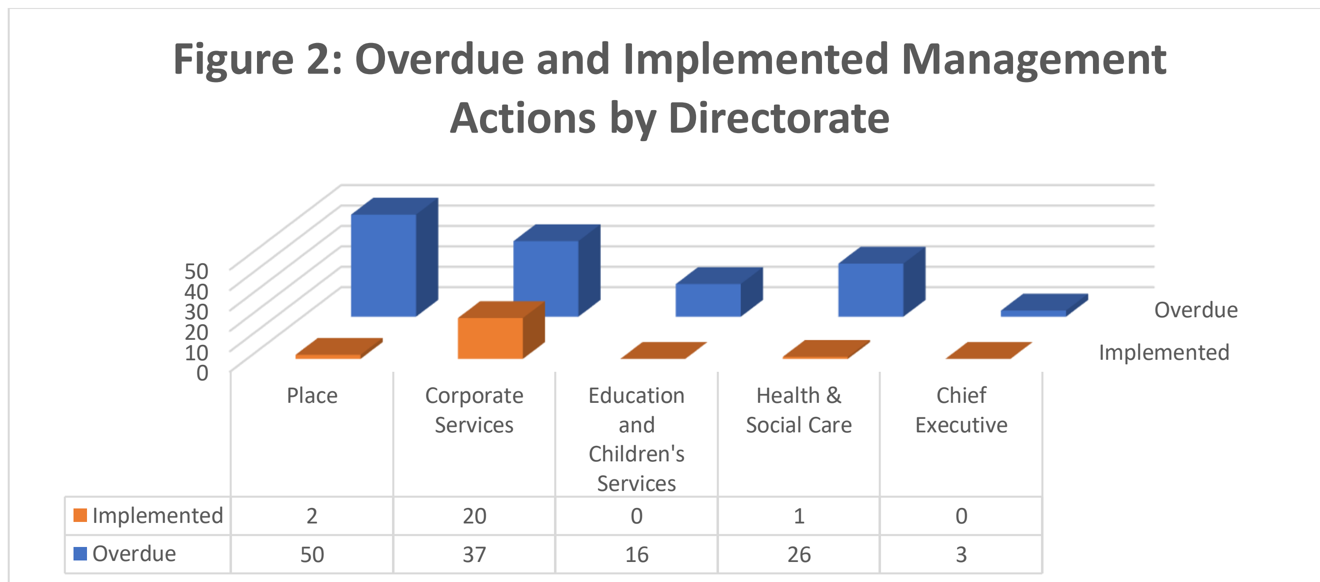
management when the report was finalised has not been achieved. This reflects a 7% decrease from the November 2021 position (54%).

4.9 Of the 132 overdue management actions, 23 have a status of 'implemented' and are currently with IA for review to confirm whether they can be closed, leaving a balance of 109 to be addressed.

4.10 Appendix 2 provides an analysis of the 132 overdue management actions highlighting their current status as at 26 January 2022 with:

- 23 implemented actions where management believe the action has been completed and it is now with IA for validation;
- 94 started where the action is open, and implementation is ongoing; and
- 15 pending where the action is open with no implementation progress evident to date.
- 31 instances (23%) where the latest implementation date has been missed and not revised; and,
- 39 instances (30%) where the implementation date has been revised more than once.

4.11 Figure 2 illustrates the allocation of the 132 overdue management actions across Directorates, and the 23 that have been passed to IA for review to confirm whether they can be closed.



	Place	Corporate Services	Education and Children's Services	Health & Social Care	Chief Executive
Implemented	2	20	0	1	0
Overdue	50	37	16	26	3

IA Review of Agreed Management Actions

4.12 A total of five findings supported by 23 agreed management actions had been proposed for closure as at 26 January 2022 and are currently with IA for review to confirm whether they can be closed. Of these:

- 4 were proposed for closure in January 2022 and are currently being reviewed;
- 4 were proposed for closure between 14 and 31 December and are currently being reviewed by IA following return from Christmas leave.

- 6 relate to either the Risk Management audit (completed by Azets) and the GRBV Committee Effectiveness review (completed by the Institute of Internal Auditors), and closure will be confirmed by these external organisations.
- Of the remaining 8, there are 2 where further action is required by IA. One requires final IA management review and, an update to the service is due for the remaining action.

4.13 With these two exceptions, IA has continued to achieve its established KPI for reviewing all implemented management actions within four weeks of the date they are proposed for closure by management. Consequently, this KPI has been assessed as green (refer KPI18 in Appendix 1).

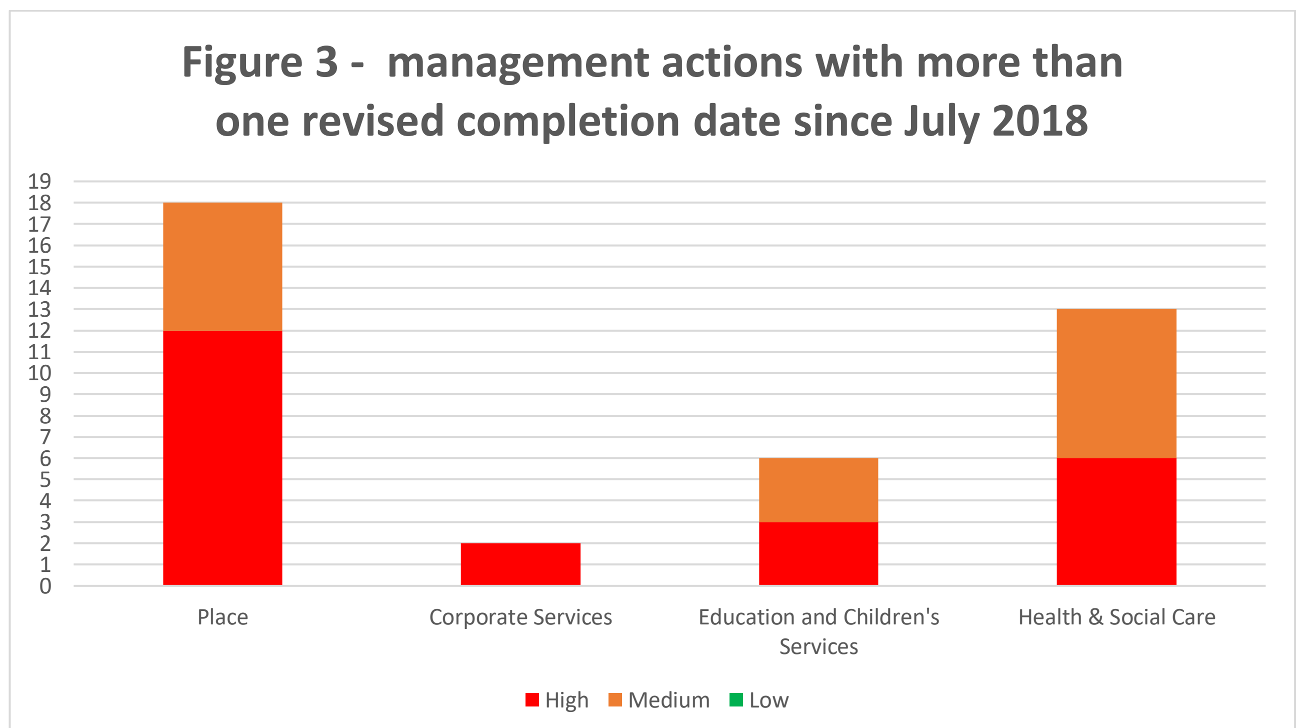
4.14 Where implementation dates longer than four weeks occur, these are supported by feedback to management requesting either additional evidence or a discussion to explain the context of the evidence provided. Where this is not provided by services within a further four weeks, the status of the action is reverted to 'started' until the further information requested is provided.

More Than One Revised Implementation Date

4.15 Figure 3 illustrates that there are currently 39 open management actions (including those that are overdue) across directorates where completion dates have been revised between two and six times since July 2018. This number excludes the two automatic extensions applied by IA to reflect the impact of Covid-19.

4.16 This reflects a decrease of 9 in comparison to the position at November 2021 (48).

4.17 Of these 39 management actions, 23 are associated with High rated findings, and 16 Medium, with the majority of date revisions in the Place directorate.



Key Performance Themes Identified from the IA Dashboard

4.18 The dashboard included at Appendix 3 reflects the current status for the 2 completed audits and the 20 audits in progress where terms of reference detailing the scope of the planned reviews have been issued. This highlights that:

4.18.1 Services are consistently taking longer than the 5-day KPI for feedback on draft IA terms of reference, with feedback received within the 5 days for only 7 of the 22 audits.

4.18.2 Executive Directors are generally providing feedback on draft terms of reference within the agreed 5-day response times. For Council wide audits responses are not consistently received from all Executive Directors.

4.18.3 Delays with final agreement on terms of reference often result in audit work commencing before the final terms of reference has been agreed and issued to ensure ongoing plan delivery.

4.18.4 Internal Audit reporting delays for the Planning and Performance Framework and Health and Safety audits were highlighted in the report presented to Committee in September.

4.18.5 There have been significant delays in agreeing management responses for the Planning and Performance Framework Design; Implementation of Asbestos Recommendations; and Parking and Traffic Regulations draft audit reports. IA engaging with management to finalise these responses is ongoing. It is acknowledged that some of these delays have been attributable to handovers within the IA team following the secondment of IA team members into directorates, and unplanned sickness absence within the IA team.

4.18.6 Completion of the Council Tax and Business Rates and Management and Allocation of Covid-19 grant funding has been delayed reflecting service capacity challenges caused by the introduction of new Scottish Government Covid business grants.

5. Next Steps

5.1 IA will continue to monitor the open and overdues findings position and delivery against key performance indicators, providing monthly updates to the CLT and quarterly updates to the GRBV Committee.

6. Financial impact

6.1 There are no direct financial impacts arising from this report, although failure to close findings and address the associated risks in a timely manner may have some inherent financial impact.

7. Stakeholder/Community Impact

7.1 If agreed management actions supporting closure of Internal Audit findings are not implemented, the Council will be exposed to the service delivery risks set out in the relevant Internal Audit reports. Internal Audit findings are raised as a result of control gaps or deficiencies identified during reviews therefore overdue items inherently impact upon effective risk management, compliance and governance.

8. Background reading/external references

8.1 Internal Audit Overdue Findings and Key Performance Indicators as at 11 August 2021 – Paper 8.1

8.2 Capacity to Deliver the 2021/22 IA Annual Plan – Paper 8.3

8.3 Internal Audit Journey Map and Key Performance Indicators - Paper 7.6 Appendix 3

9. Appendices

9.1 Appendix 1 – Monthly Trend Analysis of IA Overdue Findings and Management Actions

9.2 Appendix 2 – Internal Audit Overdue Management Actions as at 26 January 2022

9.3 Appendix 3 – Internal Audit Key Performance Indicators as at 26 January 2021

Appendix 1 - Monthly Trend Analysis of IA Overdue Findings and Management Actions

	Key Performance Indicator (KPI)	07/07/2021		11/08/2021		23/09/2021		05/11/2021		06/12/2021		26/01/2022		Trend
	IA Findings													
1	Open findings	85	100%	96	100%	113	100%	108	100%	104	100%	91	100%	Not applicable
2	Not yet due	32	38%	45	47%	64	57%	53	49%	53	51%	42	46%	Not applicable
3	Overdue findings	53	62%	51	53%	49	43%	55	51%	51	49%	49	54%	
4	Overdue - IA reviewing	8	15%	3	6%	9	18%	5	9%	6	12%	5	10%	
5	High Overdue	18	34%	17	33%	16	33%	17	31%	16	31%	18	37%	
6	Medium Overdue	29	55%	28	55%	29	59%	31	56%	29	57%	27	55%	
7	Low Overdue	6	11%	6	12%	4	8%	7	13%	6	12%	4	8%	
8	<90 days overdue	9	17%	9	18%	6	12%	7	13%	8	16%	13	27%	
9	90-180 days overdue	3	6%	2	4%	6	12%	10	18%	5	10%	2	4%	
10	180-365 days overdue	15	28%	13	25%	11	22%	9	16%	12	24%	9	18%	
11	>365 days overdue	26	49%	27	53%	26	53%	29	53%	26	51%	25	51%	

Management Actions

	KPI	07/07/2021		11/08/2021		23/09/2021		05/11/2021		06/12/2021		26/01/2022		Trend
12	Open actions	218	100%	233	100%	277	100%	259	100%	245	100%	218	100%	Not applicable
13	Not yet due	83	38%	103	44%	154	56%	118	46%	117	48%	86	39%	Not applicable
14	Overdue actions	135	62%	130	56%	123	44%	141	54%	128	52%	132	61%	
15	Overdue - IA reviewing	28	21%	17	13%	35	28%	28	20%	18	14%	23	17%	
16	Latest date missed	43	32%	70	54%	52	42%	34	24%	35	27%	31	23%	
17	Date revised > once	51	38%	48	37%	46	37%	44	31%	45	35%	39	30%	
18	IA 4 week response time	N/A		N/A		N/A		N/A		N/A				

Trend Analysis - key

Key	Meaning
	Adverse trend - action required
	Stable with limited change
	Positive trend with progress evident

No trend analysis is performed on open findings and findings not yet due as these numbers will naturally increase when new IA reports are finalised.

Appendix 2 - Internal Audt Overdue Management Actions as at 6 December 2021

Glossary of Terms

1. Executive Committee – This is the relevant Executive Committee that should have oversight of completion of agreed management actions
2. Project Name – This is the name of the audit report.
3. Issue Type – This is the priority of the audit finding, categorised as Critical; High; Medium; or Low
3. Issue Title - this is the titel of the issue in the Origina IA Report
4. Owner – The Executive Director responsible for implementation of the action.
5. Recommendation Title - this is the title of the recommendation in the original IA report
6. Agreed Management action – This is the action agreed between Internal Audit and Management to address the finding.
7. Status – This is the current status of the management action. These are categorised as:
   · Pending (the action is open and there has been no progress towards implementation),
   · Started (the action is open, and work is ongoing to implement the management action), and
   · Implemented (the service area believes the action has been Implemented and this is with Internal Audit for validation).
8. Estimated date – the original agreed implementation date.
9. Revised date – the current revised date. **Red** formatting in the dates field indicates the last revised date is overdue.
10. Number of revisions – the number of times the date has been revised since July 2018. **Amber** formatting in this field highlights where the date has been revised more than once.
11. Contributor – Officers involved in implementation of an agreed management action.

Ref	Executive Committee	Project Name	Issue Type	Issue Title	Owner	Recommendation Title	Agreed Management Action	Status	Esitmated Impement Date	No of Revisions	Revised Impl Date	Contributor
25	Education, Children and Families	Health and Safety – Managing Behaviours of Concern	Medium	CF2003 - Issue 3 - Governance and Management Information	Amanda Hatton, Executive Director of Education and Children's Services	CF2003 - Recommendation 3.1 - Committee Terms of Reference	Terms of reference will be refreshed for the Education and Children's Services (formerly C&F) Risk Committee and Health and Safety Group that clearly define: the roles and responsibilities of both committees; andthe level of scrutiny to be performed on health and safety incidents (including problematic behaviour).	Started	30/09/21	2	31/01/22	Anna Gray Gillian Barclay Kirsty Spence Liz Harrison Lorna French Lynn Paterson Martin Gemmell Michelle McMillan Nickey Boyle
26	Education, Children and Families	Health and Safety – Managing Behaviours of Concern	Medium	CF2003 - Issue 3 - Governance and Management Information	Amanda Hatton, Executive Director of Education and Children's Services	CF2003 - Recommendation 3.3 - SHE Assurance Portal Training	The Corporate Health and Safety team are currently updating SHE training to provide information about the revisions to the portal, the new SHE app and how to extract meaningful reports. Further agreed actions are:This will be shared with headteachers; Business Managers and Quality Improvement and Education Officers; Quality Improvement Managers; Senior Education Managers at the start of the new session.	Started	30/09/21	0	30/12/21	Anna Gray Gillian Barclay Kirsty Spence Liz Harrison Lorna French Lynn Paterson Martin Gemmell Michelle McMillan Nickey Boyle
62	Education, Children and Families	Records Management - LAAC	Medium	CW1705 Issue 1: Project file review process	Amanda Hatton, Executive Director of Education and Children's Services	CW1705 Issue 1.3: Quality assurance checks	Action rebased Nov 21 recognising that resourcing is currently only available from Business Support to complete QA review of 10 project files per month: 1. QA focus will be on current project team members, with appropriate focus onwhether merged files have been identified. 2. If there are any concerns with the outcomes for a current team member, the QA sample will be increased and they will be supported through training etc. 3. Business support will review 10 files per month (120 per year) and will provide feedback / outcomes to the Project Manager (Louise McRae). 4. Where the project team changes, there will be appropriate QA focus on new project team members. 5. If the project completes the review of all files (6,800 plus any others identified) before the QA process is complete, some project team members will be retained to complete QA (in addition to Business Support and ensuring that they're not reviewing their own files) and focus on remediation. 6. The CSWO will take (a future) request to retain project resources to CLT to ensure that an appropriate level of QA will be completed. 7. Files where errors were identified during the initial QA and were addressed will be subject to further QA to provide assurance that any significant concerns identified from the initial QA have been resolved. 8. The CSWO will determine the appropriate proportion of QA required (based on the total number of files reviewed) to give her a level of comfort as CSWO. 9.Internal Audit will review a sample of three months QA file reviews to confirm that the process outlined above is being consistently applied in practice.	Started	31/03/20	4	30/06/22	Alison Roarty Ani Barclay Freeha Ahmed Jackie Irvine John Arthur Liz Harrison Louise McRae Nichola Dadds Nickey Boyle Nicola Harvey Stephen Moir
99	Education, Children and Families	School admissions, appeals and capacity planning	High	CF1901: School admissions, appeals and capacity planning - Issue 2: Operational Processes - Admissions & Appeals	Amanda Hatton, Executive Director of Education and Children's Services	CF1901 Issue 2.3(b): Quality Assurance Checks in Schools	Schools business managers will be instructed to undertake sample quality assurance checks of evidence obtained from parents to support applications to ensure compliance with procedures. This will include completion of checks prior to completion of enrolment processes. Checking of completion will form part of the Communities and Families Self-Assurance Framework from 2021 onwards.	Started	30/06/20	2	28/02/22	Arran Finlay Claire Thompson Liz Harrison Lorna French Michelle McMillan Nickey Boyle

Ref	Executive Committee	Project Name	Issue Type	Issue Title	Owner	Recommendation Title	Agreed Management Action	Status	Esitmated Impement Date	No of Revisions	Revised Impl Date	Contributor
100	Education, Children and Families	School admissions, appeals and capacity planning	Medium	CF1901: School admissions, appeals and capacity planning - Issue 3: Process Documentation & Delivery Responsibilities	Amanda Hatton, Executive Director of Education and Children's Services	CF1901 Issue 3.1(d): Roles & Responsibilities Outwith Annual Process	The working group will review the roles and responsibilities for any tasks performed outwith the annual P1/S1 admissions, appeals and capacity planning process. These will be documented and communicated to all teams involved in the process. The review will include identifying key contacts for common non-annual admissions queries, for example, home schooling; private schooling; dealing with refugees; and requests for current or future capacity information, to ensure that they can be appropriately redirected and resolved.	Started	31/08/20	3	22/05/21	Alison Roarty Arran Finlay Gavin King Hayley Barnett Liz Harrison Lorna French Matthew Clarke Michelle Vanhegan Neil Jamieson Nick Smith Nickey Boyle Nicola Harvey Prarthana Lasure Sheila Haig Stephen Moir
132	Education, Children and Families	Unsupported Technology (Shadow IT) and End User Computing	High	CW1914 Issue 2: Ongoing shadow IT and end user computing management	Amanda Hatton, Executive Director of Education and Children's Services	CW1914 Rec 2.1c - Second line assurance and oversight (Education and Children's Services)	The following actions were discussed and agreed by the Council's Corporate Leadership Team and will be applied by all first line divisions and directorates. 1. divisions and directorates will confirm whether they are consistently applying shadow IT framework and meet the requirements of the Council's externally hosted ICT services protocol in their annual assurance statements, and with any gaps or instances of non-compliance disclosed; 2. reliance will be placed on third line oversight by Internal Audit (IA), acknowledging that the assurance provided in relation to the ongoing management of shadow IT technology applications across the Council will be considered as part of IA's ongoing risk based assurance proposals, with assurance unlikely to be provided on an ongoing basis.	Started	30/07/21	1	31/08/22	Crawford McGhie Jackie Irvine Liz Harrison Lorna French Michelle McMillan Nichola Dadds Nickey Boyle

Appendix 3 - Internal Audit Key Performance Indicators as at 26 January 2022

Directorate	Audit Title	Audit Progress	Terms of Reference Service Response <= 5 days post issue	Terms of Reference Director Response <= 5 days post issue	Close out meeting <= 5 days after fieldwork completed	Report issued by IA <= 10 days post close out meeting	Workshop <= 5 days after report issued	Date Mgt responses agreed <= 5 days post workshop	Final Draft to Directors <= 5 days post management response	Director approval <= 3 days from receipt	Final report issued by IA <= 5 days post director approval	Team Central updated by IA <= 5 days of final report	Comments
Corporate Services	Elections in Covid Environment - design review	Complete	3	2	1	10	0	0	2	n/a	n/a	7	Final report issued 31.5.21
Corporate Services	Design of the Scottish Local Government Living Wage Requirements	Complete	17	1	8	9	4	1	1	2	5	1	Final report issued on 28.10.21.
Corporate Services	Council Tax and Business Rates	Fieldwork	7	5	0	0	0	0	0	0	0	0	Fieldwork extended reflecting current resouring impacts on the Custmer team
Corporate Services	Cyber Security - technology vulnerability management	Planning	7	0	0	0	0	0	0	0	0	0	
Corporate Services	CGI performance reporting	Planning	7	0	0	0	0	0	0	0	0	0	
Corporate Services	Capital Budget Setting and Management	Planning	3	3	0	0	0	0	0	0	0	0	
Corporate Services	Payment Card Industry Data Security Standard Compliance	Planning	12	6	0	0	0	0	0	0	0	0	Delayed response on ToR was due to Christmas leave
Corporate Services	Employee Lifecycle Data and Compensation and Benefits Processes	Reporting	13	2	0	0	0	0	0	0	0	0	Fieldwork ongoing - awaiting information from HR
Corporate Services	Planning and Performance Framework design review	Reporting	26	2	3	35	15	13	9	0	0	0	Ongoing Engagement with Head of Service and Exec Direct on management responses.
Corporate Services	Digital and Smart City Strategy	Reporting	49	80	-2	5	14	0	0	0	0	0	Currently finalising management responses with the service.
Council Wide	Fraud and Serious Organised Crime	Fieldwork	74	64	0	0	0	0	0	0	0	0	Not all areas responded on draft ToR. Fieldwork delayed due to sickeness absence in key team.
Council Wide	Implementation of Whistleblowing and Child Protection Recommendations	Fieldwork	7	4	0	0	0	0	0	0	0	0	In fieldwork
Council Wide	Employee wellbeing	Planning	2	0	0	0	0	0	0	0	0	0	
Council Wide	Complaints Management	Planning	6	5	0	0	0	0	0	0	0	0	
Council Wide	Management and Allocation of Covid-19 grant funding	Planning	7	34	0	0	0	0	0	0	0	0	Fieldwork completion will be delayed reflecting pressures on Customer with Business Grants
Council Wide	Health and Safety - Implementation of asbestos recommendations	Reporting	6	6	34	17	4	0	0	0	0	0	No response received from Exec Direct Place on ToR. Ongoing engagement with services on mgt responses.
Education & Childrens Svs	Criminal Justice	Fieldwork	12	1	0	0	0	0	0	0	0	0	In fieldwork
Education & Childrens Svs	Early Years Education and Alignment with End Poverty Delivery Plan	Planning	No response	0	0	0	0	0	0	0	0	0	Reminder sent 17/1/22 for ToR issued 7 December
Place	Planning - householder applications and use of Uniform system	Fieldwork	5	14	0	0	0	0	0	0	0	0	
Place	The Management of Development Funding	Fieldwork	10	16	0	0	0	0	0	0	0	0	Final ToR issued on 13.01.22. Delays with receipt of information from service due to sickness absence.
Place	Housing Property Services Repairs Management	Planning	Not yet due	0	0	0	0	0	0	0	0	0	Responses on Terms of Reference due 28/1/22
Place	Parking and Traffic Regulations	Reporting	4	2	3	24	2	0	0	0	0	0	Ongoing engagement with service re management responses