Internal Audit Report

Annual Validation Review

14 May 2026

CD2509

Overall Assessment	Reasonable Assurance

Contents

This Internal Audit review is conducted for the City of Edinburgh Council under the auspices of the 2025/26 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2025. The review is designed to help the City of Edinburgh Council assess and refine its internal control environment. It is not designed or intended to be suitable for any other purpose and should not be relied upon for any other purpose. The City of Edinburgh Council accepts no responsibility for any such reliance and disclaims all liability in relation thereto.

The internal audit work and reporting has been performed in line with the requirements of the Global Internal Audit Standards (UK Public Sector) and as a result is not designed or intended to comply with any other auditing standards.

Although there are specific recommendations included in this report to strengthen internal control, it is management's responsibility to design, implement and maintain an effective control framework, and for the prevention and detection of irregularities and fraud. This is an essential part of the efficient management of the City of Edinburgh Council. Communication of the issues and weaknesses arising from this audit does not absolve management of this responsibility. High and Critical risk findings will be raised with senior management and elected members as appropriate.

Executive Summary

Overall Assessment	Reasonable Assurance

Engagement conclusion and summary of findings

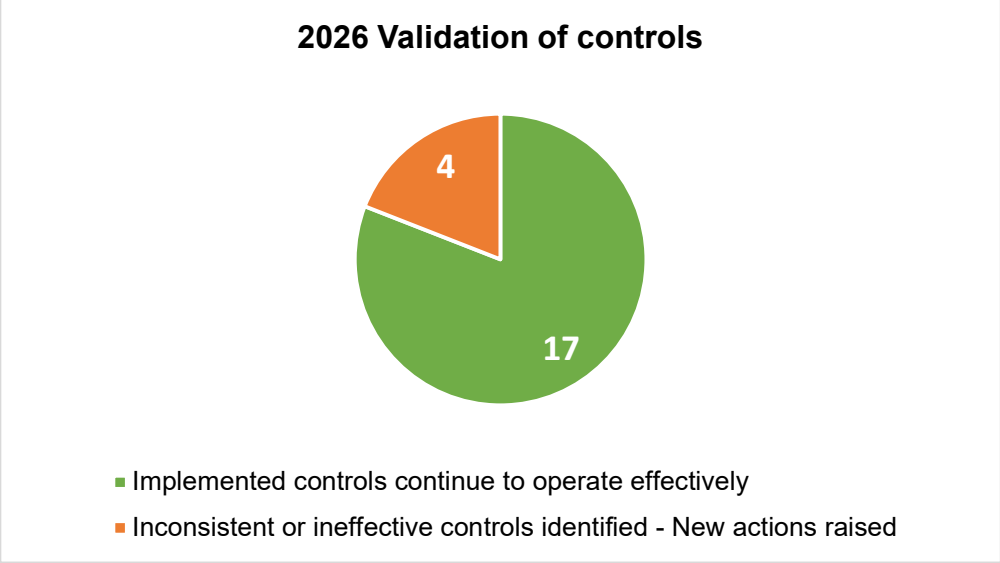
Review of a sample of previously implemented audit actions closed between 1 January 2024 and 31 December 2024, confirmed that the majority of actions agreed for previously completed audits have been sustained and associated controls continue to operate as effectively.

However, a number of key controls across the following audits have not been sustained or are operating ineffectively:

- **Self-Directed Support** – inconsistent processes to ensure effective management and oversight of over and underspends in Children's Services
- **Complaints Management** – underdeveloped oversight processes for Directorate oversight of the management of complaints in the Customer and Corporate Services Directorate
- **Safety of Council Operated Heavy Vehicles** – limited evidence that confirmation of pre-employment checks was communicated and retained
- **Health and Safety – Asbestos Management** – migration of the final historic asbestos registers to CAFM should be completed with oversight processes implemented to provide assurance over the ongoing completeness of records held.

Control validation results

Based on the sample of closed management actions, the review confirmed that of the 21 actions reviewed, 17 (81%) were functioning as originally validated. However inconsistent of ineffective controls were identified for 4 actions (10%). Details of actions and results is provided in Appendix 1.



Audit Code and Title	Findings	Priority Rating
CEJ2203 Self-Directed Support (Children's Services)	Management of over/underspends	Medium
CW2101 Complaints Management	Directorate Oversight (Customer and Corporate Services)	Medium
PL2403 Safety of Council Operated Heavy Vehicles	Pre-employment checks	Medium
CW2006 Health and Safety – Asbestos Management	Migration of Historic Asbestos Registers to CAFM and Oversight Processes	Medium

Background and scope

Internal Audit (IA) raise findings and recommendations where audit outcomes confirm that the controls established to mitigate the Council's risks are either inadequately designed or are not operating effectively.

When finalising internal audit reports, management actions are agreed by Directorates which should address the control weaknesses identified in the findings. Implementation of these agreed actions will provide assurance that the associated risks are effectively managed, reducing the Council's overall exposure to risk. It is essential that the management actions (once implemented) are effectively sustained. If not, the Council remains exposed to an unnecessary level of risk.

A 'validation' audit is included in the annual plan to assess whether management actions implemented to address audit findings raised in previous years have been sustained and remain effective.

Between 1 January 2024 and 31 December 2024, a total of 261 management actions in scope were implemented (66 High, 144 Medium and 51 Low).

In October 2022, following CLT and GRBV approval, a risk-based approach to Internal Audit review and validation of evidence to support closure of management actions was implemented. As a result, a self-attestation process for all low rated actions and a sample of medium actions was introduced, with the remaining medium actions and all high actions being full validated by Internal Audit.

The 2024/25 annual validation audit includes a sample of low, medium, and high rated actions, including those closed as self-attested.

Scope

The objective of this review was to confirm whether a sample of management actions closed between 1 January and 31 December 2024 continue to be effectively sustained.

A sample of 21 actions across 18 audits was selected covering audits across the Council and the Health and Social Care Partnership. Further details of the sample selected are included at Appendix 1.

Where controls detailed in the agreed actions are no longer effectively sustained, the relevant actions have been reopened and will be tracked to completion.

Reporting Date

Testing was undertaken between October 2025 and March 2026.

Audit work concluded on 27 March 2026, and the findings and opinion are based on the conclusion of work as at that date.

Findings and Management Actions

1. Self-Directed Support (Children's Services) - Management of Over/Underspends

Finding Rating	Medium Priority

Management of over/underspends - Closed August 2024

Findings, recommendations and what management agreed to do

The audit highlighted that while there was quarterly budgetary reporting on Self-Direct Support spend, there were no action plans in place to manage over/underspends.

Internal Audit recommended that action plans were created to support management of over and underspends including recording the reasons for the under/overspends, what will be done to address them, and responsible officers.

Management accepted the recommendation and advised that a report would be created and maintained by Children's Services which included the actions taken to tackle SDS over/underspends, and that the plan would include the reason for the over/under spends, actions taken by whom and when.

They also advised that any risks identified would be escalated to the Children's Services and/or the Children, Education and Criminal Justice risk registers.

Closure of action

The action was closed on the basis that the service had developed the reporting processes and action plans as stated with evidence of supporting risk management processes. The action was complete in July 2024.

2026 position

Internal Audit requested evidence to demonstrate that the agreed processes were sustained and continue to operate effectively. The following issues were highlighted

- **overspend action plan** – has not been updated since July 2024 and is out of date providing limited assurance that reasons for overspends are understood and being resolved
- **scrutiny by Head of Service** – the overspend action plan as at July 2024 states that SDS spending patterns would be scrutinised and reported to the Head of Service on a quarterly basis, however no quarterly reporting occurred with the frequency changed to annual in November 2025
- **SDS finance action tracker** - there is evidence the tracker has been updated since July 2024, but it is not reviewed every 8 weeks as stated. In addition, the tracker was incomplete with no dates or action owners and risks identified in meetings are not reflected in the risk register.
- **risk register** – comparison of the December 2025 register to July 2024 notes little change with exception of some action dates.

Residual Risks

- **Financial and Budget Management** – increased risk of recurring overspends if there is inconsistent management and oversight.

Future service actions - Management of Over/Underspends

Action	Owner	Lead(s)	Target Date
1. Present a further report to Corporate Leadership Team for consideration around eligibility criteria, Self Directed Support (SDS) package thresholds and respite limits and request support to take proposal to Committee.	Corporate Director, Children's, Education and Communities	Head of Service, Children's Practice Teams Team Manager, CAD Services	31/10/2026

Action	Owner	Lead(s)	Target Date
2. Revise Tracker to include details of when each over and underspend needs to be reported throughout the year. Overspend tracker needs to be clear on who will report this and who to - be clear on actions. Tracker will form the agenda. Separate actions will be considered for CAD and Locality oversight. 3. Dedicated Team Leader who will have oversight on CAD SDS 4. Work with finance and business support colleagues to further improve tracking budget, projected and actual spend (significant work will be required to transition processes developed in Swift to new processes within Mosaic. 5. Request support from Corporate Risk Team to undertake a repeat of the previous deep dive into SDS with CAD risks and update Service and Divisional Risk Register accordingly. 6. Section 23 and SDS for CAD will be undertaken by CAD only and no longer additionally sit within SW Hospital Team (they will use locality budget).	Corporate Director, Children's, Education and Communities	Head of Service, Children's Practice Teams Team Manager, CAD Services	31/10/2026

2. Complaints Management

Finding Rating	Medium Priority

Directorate Oversight (Customer and Corporate Services) Closed March 2024

Findings, recommendations and what management agreed to do

The audit found the Council lacked consistent oversight and consolidated reporting for complaints due to standalone recording systems and unclear responsibilities. Performance monitoring relied on a single corporate KPI, overlooking broader Directorate outcomes, and although annual data met SPSO requirements, Directorates lacked the service-specific metrics and accountability structures needed for ongoing oversight.

Internal Audit recommended that the service should apply and complete a review of internal complaints management processes to:

- establish directorate level complaints oversight processes aligned with the Council's Corporate Complaints policy
- ensure that established processes for dealing with stage 2 investigation complaints were in place
- ensure appropriate quality assurance processes to confirm that complaints are handled appropriately
- implement directorate level complaints performance monitoring to support complete and accurate reporting on complaints information to CLT, the public, and the SPSO
- establish directorate level processes to drive service improvements based on complaints lessons learned.

Corporate Services agreed that a suitable Directorate-level oversight and assurance process would be implemented to support compliance with the Corporate Complaints Policy. Progress was to be monitored quarterly, with available data integrated into monthly KPI performance reviews.

2026 position

Management acknowledged that ongoing aspects of this action were overlooked due to long-term sickness. As a result, the review of internal complaints management processes within Corporate Services is not fully sustained. Directorate-level complaints oversight is currently lacking, with limited reporting on stage 2 investigations, quality assurance, performance monitoring, and continuous improvement. Management have now commenced work to address this action; a dedicated 'complaints' section has been added to the directorate's quarterly compliance & assurance (QC&A) questionnaire, effective February 2025.

Residual Risks

- **Regulatory and Legislative Compliance -** incomplete and inaccurate statutory performance reporting in line with SPSO requirements.
- **Service Delivery -** service improvements and efficiencies are not identified and implemented and limited opportunity to demonstrate that complaints inform service improvement.

Further service actions – Directorate Oversight and Reporting on Complaints

Actions	Owner	Lead(s)	Target Date
1. Reporting on complaints will continue as part of the monthly KPI performance reporting to the Directorate Management Team however further work will be explored so that greater detail may be made available. 2. Further questions will be considered and added to the Quarterly Compliance & Assurance Questionnaire to ensure that adequate assurance is being provided across the Directorate in terms of compliance with procedures, stage 2 investigations and how information gained through the complaints process is being used to affect change.	Corporate Director of Customer & Corporate Services	Operations Manager, Customer & Corporate Services	31/07/2027

3. Safety of Council Operated Heavy Vehicles

Finding Rating	Medium Priority

2.1: Evidence of pre-employment checks - Closed December 2024

Findings, recommendations and what management agreed to do:

The Recruitment and Onboarding team within Human Resources should mandate provision of evidence to demonstrate satisfactory completion of fitness to drive health checks and licence checks before an unconditional offer of employment letter is issued to any candidate being appointed to a driving role.

Management agreed that a reminder would be issued to the HR Onboarding team confirming that where a driver is being onboarded the recruiting manager must confirm that the appropriate checks with Fleet have been completed. For HGV drivers this should also include confirmation from the candidate and their GP about their fitness to drive.

Closure of action:

The action was closed as 'not verified' on the basis that the service had reminded the onboarding team all onboarding checks should be completed and confirmed as complete by the recruiting manager.

However, as no new drivers had been recruited to December 2024, Internal Audit could not verify the process was operating as expected. The action was marked for follow up in a future validation audit to allow a review of a sample of drivers at a later date.

2025/26 position:

Audit checked a sample of drivers to the eDavis system to confirm that they had valid licences for HGV driving. Audit further requested from recruiting managers the confirmation that checks had been carried out to verify that drivers were fit to drive.

Testing confirmed that all newly recruited drivers were able to drive HGVs, and that this was recorded accurately on the system. However, there was limited evidence that confirmation of onboarding checks, particularly medical checks, were being systematically communicated to the recruiting manager or retained for reference.

Residual Risks:

- **Health and Safety –** medical checks may not have been carried out on drivers
- **Regulatory and Legislative Compliance** - evidence of medical checks is not available, leading to potential legislative issues

Further service actions – Confirmation and Retention of Evidence of Pre-Employment Checks

Action	Owner	Lead(s)	Target Date
1. Re-communicate that managers need to confirm onboarding checks have been completed and that this information should be retained 2. Confirmation that onboarding checks have been completed will be required to go through the recruitment system.	Corporate Director, Place	Head of Operational Support, Performance & Improvement, Fleet & Workshops Manager	31/05/2026

4.Health and Safety - Asbestos Management

Finding Rating	Medium Priority

Population of CAFM system - Closed April 2024

Findings, recommendations and what management agreed to do:

Internal Audit recommended that all asbestos registers were loaded into the CAFM system and electronically maintained with a target date established with regular monitoring of progress with this activity.

Management agreed that asbestos registers would be manually transferred from the current PDF version and populated directly into CAFM where they would be maintained in the CAFM asbestos module.

Closure of action:

The service established the CAFM asbestos module as the authoritative repository for asbestos information. All new survey data and reinspection updates needed to be entered directly into the system, and the completion date was extended to allow adequate time to complete. Management confirmed that the programme to transfer registers was progressing and provided supporting evidence. The action was closed on the basis of self-attestation that the programme was on track to be completed. The action was marked for follow up in a future validation audit to confirm.

2026 position:

A consistent data-capture process has been introduced to ensure that new asbestos information is recorded in a structured, quality-controlled format. Estates and Facilities Management now perform periodic checks to confirm that new asbestos information is being stored and maintained in line with operational procedures.

A proportion of historic asbestos registers remain in PDF format and have not yet been fully migrated into the CAFM system. Until migration is complete, there is a risk that some legacy data may be incomplete, inconsistent, or not immediately accessible in the centralised system.

Residual Risks:

- **Service Delivery –** operational impacts persist while legacy registers remain outside CAFM, although the risk reduces over time as more data is transferred and new data is fully controlled.
- **Information and Technology** - potential delays in accessing historic asbestos information, reduced efficiency in planning works, and limited assurance that all legacy data is fully aligned with current records.

Further service actions – Migration of Historic Asbestos Registers to CAFM and Oversight Processes

Action	Owner	Lead(s)	Target Date
1. Complete Full Migration of Legacy Registers: Continue the phased manual transfer of all remaining asbestos registers into the CAFM asbestos module. 2. Introduce Periodic Data Quality Reviews: Implement quarterly checks to confirm accuracy, completeness, and consistency of asbestos data within CAFM. 3. Formalise the Asbestos Information Management Procedure: Document and embed the end-to-end process for maintaining asbestos data, ensuring clarity of roles, responsibilities, and update requirements. 4. Progress Reporting to GRBV: Provide updates on migration progress, data quality findings, and any emerging risks until full completion is achieved.	Corporate Director, Place	Asbestos Manager Operational Safety Manager	30/04/2027

Appendix 1 – Previous Audits Reviewed

A sample of actions across the following audits were reviewed as part of the 2025/26 annual validation review:

Directorate	Audit Code and Title	Rating	Validation Result
Customer and Corporate Services	CS2203 – Insurance Services	Low	Sustained
	CS2206 – CGI Technology Risk Management	High	Sustained
		Medium	Sustained
	CS2301 – Key Financial Systems: Debtors	Low	Sustained
	CS2305 – Key Financial Systems: VAT	Medium	Sustained
Cross Directorate	CD2303 – Supplier and Contract Management	Medium	Sustained
	CD2306 – Overtime and expense payments	Medium	Sustained
	CD2310 – Corporate Property Helpdesk	High	Sustained
	CD2311 – Health and Safety	Medium	Sustained
		High	Sustained
	CW2205 – Management of the Housing Revenue Account	Medium	Sustained
	CW2006 – Health and Safety: Asbestos Management	Medium	**Not Sustained**
	CW2101 – Complaints Management	Medium	**Not Sustained**
Health and Social Care Partnership	HSC2202 – Sensory Support	Medium	Sustained
		High	Sustained
Place	PL2306 – Housing Property Services: Repairs Right First Time	Medium	Sustained
	PL2308 – Fleet Asset Management Plan	Medium	Sustained
	PL2312 – Health and Safety: Outdoor Infrastructure	High	Sustained
	PL2402 – City Deal: Managing Cost Inflation	Medium	Sustained
	PL2403 – Safety of Council Operated Heavy Vehicles	High	**Not Sustained**
Children's Services	CEJ2203 - Self-Directed Support (Children's Services)	Medium	**Not Sustained**

Appendix 2 – Assurance and Priority Rating Definitions

Overall Assurance Ratings	
Substantial Assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.
Reasonable Assurance	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.
Limited Assurance	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.
No Assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.

Finding Priority Ratings	
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.
Low Priority	An issue that results in a small impact to the achievement of objectives in the area audited.
Medium Priority	An issue that results in a moderate impact to the achievement of objectives in the area audited.
High Priority	An issue that results in a severe impact to the achievement of objectives in the area audited.
Critical Priority	An issue that results in a critical impact to the achievement of objectives in the area audited. The issue needs to be resolved as a matter of urgency.