NORTH AYRSHIRE COUNCIL

29 September 2020

Audit and Scrutiny Committee

Title:	**Internal Audit Reports issued**
Purpose:	To inform the Committee of the findings of Internal Audit work completed since the last meeting in January 2020.
Recommendation:	That the Committee considers the outcomes from the Internal Audit work completed.

1.   Executive Summary

1.1   The Council's local Code of Corporate Governance requires effective arrangements to be put in place for the objective review of risk management and internal control. Internal Audit is an important element in this framework as it reviews internal controls and offers Elected Members and officers an objective and independent appraisal of how effectively resources are being managed.

1.2   The remit of the Audit and Scrutiny Committee includes the monitoring of Internal Audit activity. The submission and consideration of regular reports assists the Committee in fulfilling this remit.

2.   Background

2.1   This report provides information on Internal Audit work completed since the last meeting in January 2020. Internal control reviews have been completed in respect of the areas detailed in Appendix 1 to this report. The aim of these reviews is to provide assurance that the internal control framework within the areas examined is appropriate and operating effectively.

2.2   The findings from each audit assignment have been notified in writing to the Chief Executive, the Section 95 Officer and the relevant Executive Director and Head of Service on the completion of each assignment. Where appropriate, this has included an action plan with recommendations for improving internal control. Appendix 1 includes the report and action plan from each audit.

2.3 The findings from 5 separate audit assignments are detailed at Appendix 1 to this report and the levels of assurance for each are noted in the table below:

Audit Title	Assurance Level
ICT Assets	Limited
Agency Staff and Workers	Limited
Self-Directed Support	Reasonable
Library and Information Service	Reasonable
Bereavement and Burial Service	Reasonable

2.4 The most significant findings are:

- limited assurance was obtained with regard to the controls around ICT assets particularly in relation to lack of budget holder approval for ICT procurement, physical security and confirmation ICT assets have been properly sanitised.
- there is no evidence of the HR guidance 'Engaging Agency Workers and Personal Service Companies' being correctly applied within the Council.
- Reasonable assurance was obtained around the Self-Directed Support scheme, but it was noted that very limited staff training on the scheme has taken place since 2013.
- Reasonable assurance was obtained with regard to the processes to control internet access from Library PC's.
- A risk assessment should be carried out on the Library Service's current plan to replace PCs with tablets. This should cover how the portable devices will be secured to prevent theft, but also how access to the internet will be controlled.
- reasonable assurance was obtained with regard to the current processes within the Bereavement Team. The processes on the mainland are robust, however the fact that Arran is not aligned with this process creates a level of risk within the Service.

2.5 A further 6 reports which received substantial assurance have been finalised since the last Committee. These are listed in the table below and have not been included within this report following consultation with the Chair. These reports are available to Elected Members on request.

Audit Title	Assurance Level
Capital Monitoring	Substantial
Treasury Management	Substantial
SEEMIS	Substantial
Commercial Refuse	Substantial
Licensing	Substantial
Carefirst	Substantial

3. Proposals

3.1 It is proposed that the Committee considers the outcomes from the Internal Audit work completed since the last meeting in January 2020.

4.   Implications/Socio-economic Duty

<u>Financial</u>

4.1   None.

<u>Human Resources</u>

4.2   None.

<u>Legal</u>

4.3   None.

<u>Equality/Socio-economic</u>

4.4   None.

<u>Environmental and Sustainability</u>

4.5   None.

<u>Key Priorities</u>

4.6   The work of Internal Audit helps to support the efficient delivery of the strategic priorities within the Council Plan 2019-2024.

<u>Community Wealth Building</u>

4.7   None.

5.   Consultation

5.1   The relevant Services are consulted on Internal Audit findings during each audit assignment.

Mark Boyd
Head of Finance

For further information please contact **Paul Doak, Senior Manager (Audit, Fraud, Safety and Insurance),** on **01294-324561**.

Background Papers
None.

ICT ASSETS

1 Background

1.1 The ICT Assets audit is part of the approved 2019/20 audit plan and focused on procurement, recording and monitoring, security and disposals.

1.2 The audit focused on Corporate ICT Assets only and excluded Education ICT Assets.

1.3 The period covered by the audit is 1st April to 30th September 2019.

1.4 There is a contract in place with HP Inc UK Ltd and XMA Limited for the procurement of desktops, laptops and tablets. There is also a contract in place with RE-Tek UK Ltd for the secure collection and disposal of ICT equipment.

1.5 Requests for new ICT assets are logged via the ICT Service Desk system. The current system is called EHD but ICT will be moving to a new system called Samanage. Once a job is raised, the job is added to the Procurement job queue to allow the ICT Services admin assistant to raise a purchase order via Integra. Goods will be receipted by the ICT Services admin assistant and invoices are processed by Business Support.

1.6 Discovery software is an asset management system used to record all physical PCs and laptops. System Centre is a Microsoft product which provides a list of all Windows-based network devices. IGEL is the system used to record virtual devices.

2 Objectives and Scope

2.1 The main objectives of the audit were to ensure that:
- ICT assets are procured in line with Council policy and have been appropriately approved.
- ICT assets are appropriately recorded, managed and insured.
- Proper security controls are in place for ICT assets and access to ICT equipment is appropriately restricted.
- ICT Assets are disposed of in compliance with regulations and NAC policies and inventories are updated accordingly.

3 Findings

Procurement

3.1 The Integra approval route is determined by the requisition point selected when the purchase order is processed. ICT Services have access to all requisition points; however, all the purchase orders in this audit had an ICT requisition point which means they were approved by ICT Services and not the budget holder. There was no evidence that budget approval was obtained when the job was logged via the ICT Service Desk system. This issue has been highlighted previously by Internal Audit. Further discussions with IT Services confirmed the current Integra approval process should remain; therefore, budget holder approval must be obtained at the time of the request for a new ICT asset within the new service desk system. **(action a)**

3.2   The ICT procurement form states the revenue and capital account codes that should be used for the procurement of ICT hardware and the Service should advise the cost centre.   ICT advised that no standard finance codes are used and the person requesting the procurement advises the finance codes to be used. From the testing carried out, there were 18 different account codes used for the purchase of ICT hardware. In addition, the auditor extracted all transactions coded to the revenue code (26051) and capital code (70017). There were 15 suppliers coded to the revenue code, including HP Inc UK Limited. There were 9 suppliers coded to the capital code, including HP Inc UK Limited and XMA Limited. **(action b)**

3.3   Internal Audit tested a sample of 10 purchase orders and all 22 devices purchased were traced to Discovery, System Centre or IGEL using the serial number.

3.4   The Accounts Payable section advised that if there is a difference between the goods received and the invoice, the invoice will require to be certified. The report of all ICT purchase orders raised with HP and XMA was reviewed and all invoices were certified. Capita have confirmed that the Certifier box populates whether or not the invoice was actually certified and advised that this is "working as designed" and cannot be changed.   The auditor obtained further assurance that where there is a genuine difference, an invoice certification email is issued, and an invoice will not be paid until the invoice has been certified.

Recording, Monitoring and Insurance

3.5   There is no single inventory record in ICT for all our ICT Assets as different inventory systems are used for different purposes. An analysis of a Discovery and System Centre report which were run on the same day showed major differences between the 2 reports when matching serial numbers. ICT advised that the information provided to audit included historical information which accounted for a high number of the discrepancies.

3.6   ICT Services advised they had stopped investigating devices that haven't been audited in the last 90 days as the time spent investigating this was too time consuming. ICT Services confirmed that devices are automatically disabled after 90 days of non-use. As a result, they are introducing a new process to monitor and report on devices that have not logged on in the last 90 days which will include automatically contacting the last logged on user and their current line manager.   This new process should help to ensure the Discovery system accurately reflects the current status of ICT devices and will help ensure the devices on Discovery and System Centre reconcile more accurately. **(action c)**

Security

3.7   ICT Services advised that laptops are now encrypted with integrated Bitlocker functionality although there is still a selection of older devices using Sophos Safeguard. Internal Audit tested to ensure all laptops on Discovery and System Centre were encrypted and found a high number of discrepancies indicating potential unencrypted laptops. ICT Services investigated this during the audit and advised the information provided to audit included historical information and when they analysed current devices (devices that have logged on within the last 90 days) they confirmed all devices were encrypted. The new process documented at 3.6 will help ensure assets on Discovery have the proper status to identify our current devices.

3.8 Access to the data centre at Bridgegate House is via a key. ICT Services advised they hold a key and the other key is held by the Council Officer at Bridgegate House. ICT Services have a record for the key they hold but the last entry was January 2019. There is no such record maintained at Bridgegate House. It would be more secure to change this access to card entry linked to the Kelio system in line with the access controls for the data centre at Cunninghame House. This would provide an audit trail for who is accessing the secure area. **(action d)**

3.9 The auditor reviewed Kelio access for secure ICT areas at Cunninghame House and Bridgegate House. Access is mostly restricted to relevant ICT employees and Council Officers. The Senior Manager Employee Services has confirmed there are no robust procedures in place for Kelio admin to deal with the movers and leavers report to ensure cards with access to secure ICT areas are amended or deactivated accordingly. This action has been noted in a recent Kelio audit report and management are taking action to rectify this.

3.10 The auditor identified 4 visitor cards which grant access to the ICT secure areas at Cunninghame House and Bridgegate House. When checked, 2 of these cards have been used to access the secure areas. ICT Services confirmed they do not hold any visitor cards. The Council Officer confirmed they only hold one visitor card. There are 3 visitor cards that cannot be accounted for. IT Services cancelled these cards during the course of the audit.

Disposal of ICT Assets

3.11 The auditor reviewed the process and paperwork for disposing of ICT assets for 8 disposal jobs and found the following:
- The paperwork for 5 out of 8 reconciled but in 3 cases extra items were uplifted as per the paperwork provided by Re-Tek.
- The Special Waste Consignment Note (SWCN) is used to record the number of each item type advised to be picked up and the number collected. It was not signed by the NAC contact in 4 cases and it was not signed by the Re-Tek employee in 1 case.
- In 2 cases the SWCN recorded the number of each item type advised to be picked up but did not state the number of items collected. The actual figures should be reconciled to the other paperwork.
- One of the SWCN was not provided to ICT Services by the NAC contact.
- The Waste Electrical and Electronic Equipment (WEEE) certificate was not provided in 1 case.

  (action e)

3.12 The disposal company provides a management report listing all assets picked up per job and a sanitisation report providing data sanitisation assurance on the data storing assets required to be sanitised with no possibility of data recovery. This assurance has been performed in compliance with the UK government standard. The auditor reconciled the management report and the sanitisation report for devices requiring to be sanitised and found discrepancies in 2 disposal jobs resulting in 8 devices that should have been sanitised which have not been included in a sanitisation report. The disposal company confirmed that all 8 devices did not have a hard disk drive installed on them so didn't need sanitised. **(action f)**

4   Internal Audit Opinion

4.1   Overall, limited assurance was obtained with regard to the controls around ICT assets particularly in relation to lack of budget holder approval for ICT procurement, physical security and confirmation ICT assets have been properly sanitised.

Definitions of Assurance Levels:

Substantial	The framework of governance, risk management and control is adequate and effective.
Reasonable	Some improvements are required to enhance the adequacy and effectiveness of the framework of governance, risk management and control.
Limited	There are significant weaknesses in the framework of governance, risk management and control such that it could be or could become inadequate and ineffective.
None	There are fundamental weaknesses in the framework of governance, risk management and control such that it is inadequate and ineffective or is likely to fail.

NB The level of assurance given is at the discretion of Internal Audit.

KEY FINDINGS AND ACTION PLAN
ICT ASSETS

Action	a
Finding	All purchase orders in the period being audited were approved by ICT Services and not the budget holder. There was no evidence budget approval was obtained when the job was logged via the ICT Service Desk system.
Action Description	Evidence of budget holder approval should be obtained at the request for a new ICT device within the new service desk system.
Risk	ICT devices are purchased without the knowledge and approval of the budget holder.
Priority (1, 2, 3)	1
Paragraph Reference	3.1
Managed by	Fiona Walker, Head of Service (People and ICT)
Assigned to	Carolann McGill, Team Manager Customer Experience
Due Date	30/10/2020
Management Comment	A budgetary approval process will be established, and approval will be recorded on Samanage ITSM

Action	b
Finding	Although the ICT procurement form states the revenue and capital account code that should be used for the procurement of ICT hardware, testing showed that 18 different account codes were used to purchased ICT hardware.
Action Description	ICT Services should consult with Finance regarding the best way to standardise the account codes to be used when procuring ICT hardware and the customer should only advise ICT of the cost centre to be used.
Risk	Inappropriate coding of procurement making it difficult to produce management information on ICT purchases.
Priority (1, 2, 3)	1
Paragraph Reference	3.2
Managed by	Fiona Walker, Head of Service (People and ICT), Mark Boyd (Head of Service (Financial and Customer Services).
Assigned to	Brendan Quigley (Senior Manager ICT), David Forbes (Senior Manager Finance).
Due Date	31/08/2020
Management Comment	Finance will provide ICT with a list of appropriate account codes (revenue and capital) to be used for ICT purchases. Thereafter ICT will use these account codes for purchasing and will only ask Services to provide the appropriate cost centre when an order is being placed through the ICT Service Desk. Where Services do not have sufficient budget in the finance code used, it will be the responsibility of budget holders to liaise with their accountant to ensure that either budget is transferred, or the expenditure is balanced by other underspends.

Action	c
Finding	ICT Services advised they had stopped investigating devices that haven't been audited in the last 90 days as the time spent investigating this was too time consuming. They are introducing a new process to monitor and report on devices that have not logged on in the last 90 days.
Action Description	ICT Services should document the new process for reporting and actioning devices that have not logged in the last 90 days to ensure appropriate action is taken and Discovery is updated to accurately reflect the status of such devices.
Risk	The asset management system does not accurately reflect the current ICT estate.
Priority (1, 2, 3)	1
Paragraph Reference	3.6
Managed by	Fiona Walker, Head of Service (People and ICT)
Assigned to	James McNeil, Team Manager IT Operations
Due Date	30/10/2020
Management Comment	An automated process to email users about devices not used for more than 90 days will be developed. This includes the creation of new monitoring reports. In addition: • The policy of new device for old to disposal will be enforced, where appropriate. • Old devices to be disabled on AD immediately after replacement. • The updated procedure will be defined and documented and added to Samanage ITSM as knowledge

Action	d
Finding	Access to the data centre at Bridgegate House is controlled via a physical key and there is no adequate audit trail of employees accessing this date centre.
Action Description	ICT Services should facilitate a discussion with PMI about changing the current key control access to the data centre at Bridgegate House to a swipe card entry system to restrict access to key employees only and to allow an adequate audit trail of employees accessing this data centre to be maintained. In the interim ICT Services should request the Council Officer at Bridgegate maintains a log of who uses the key.
Risk	There is no adequate record of employees accessing the secure data centre.
Priority (1, 2, 3)	1
Paragraph Reference	3.8
Managed by	Fiona Walker, Head of Service (People and ICT)
Assigned to	James McNeil, Team Manager IT Operations
Due Date	30/08/2020
Management Comment	• IT Services will facilitate a discussion with PMI re swipe card access. • The Council Officers (note: caretaker/s at Bridgegate) will be instructed to not to provide the key held locally within

Bridgegate House unless approved by a senior / team manager in IT Services. This key will be used for backup only.
- The caretaker/s at Bridgegate will be instructed to maintain a log of who uses the key stored at Bridgegate.
- IT Services staff will be instructed to use the key stored at IT Services - Cunninghame House only and will be required to complete a log entry whenever the key is checked out. This log will be held within IT Services.

Action	e
Finding	The auditor reviewed the process for disposing of ICT assets for 8 disposal jobs and found missing paperwork, paperwork that was not signed or completed properly and discrepancies between what the company was advised to pick up and what was picked up.
Action Description	ICT Services should: • remind the disposal company to ensure that all Special Waste Consignment Notes are properly completed and signed • remind NAC contacts to sign the Special Waste Consignment Note and to send it to ICT Services to check and retain • contact the disposal company for missing paperwork
Risk	Lack of a clear audit trail for the disposal of our ICT assets that hold NAC data.
Priority (1, 2, 3)	2
Paragraph Reference	3.11
Managed by	Fiona Walker, Head of Service (People and ICT)
Assigned to	Iain Chisholm, Team Manager Contracts & Assets
Due Date	31/10/2020
Management Comment	• Retek will be formally requested to ensure their drivers fully complete sign and retain copies of all paperwork. • NAC staff will be reminded within the disposal process to retain an provide IT with copies of all paperwork. • Please note, only one piece of missing paperwork was identified. IT Services will ask Retek if they can provide a copy of the one missing WEE certificate.

Action	f
Finding	The auditor reconciled the management report and the sanitisation report and found discrepancies in 2 cases identifying 8 devices that should have been sanitised which have not. The disposal company have confirmed the 8 devices had no hard disk drive.
Action Description	ICT Services should request the disposal company amends the sanitisation report to include a summary of assets per category in line with the management report. ICT Services should reconcile the records to ensure all expected ICT assets have been sanitised and query any discrepancies with the disposal company immediately, to allow them to investigate and rectify.
Risk	Devices containing data have not been sanitised in line with the UK HMG Government Standard.
Priority (1, 2, 3)	1
Paragraph Reference	3.12
Managed by	Fiona Walker, Head of Service (People and ICT)
Assigned to	Iain Chisholm, Team Manager Contracts & Assets
Due Date	31/10/2020
Management Comment	Desktop PCs without hard drives – Retek provide 2 separate reports, one that records the chassis serial number and the other that records the hard drive serial number before it gets sanitised. If a device does not have a hard drive then it will only appear in the first report without explanation of why it isn't in the 2nd report. This issue was discussed with Retek just before COVID to amend or create new reports. A solution will be discussed with Retek upon Retek re-opening their business.

Priority Key used in Action Plan

1 (High)	Control weakness where there is a material impact on the achievement of the control objectives, generally requiring prompt attention.
2 (Medium)	Control weakness which needs to be rectified, but where there is no material impact on the achievement of the control objectives.
3 (Low)	Minor weakness or points for improvement.

AGENCY STAFF AND WORKERS

1   Background

1.1   The Council supplements its permanent workforce with agency staff in instances where skills or capacity are not available in-house.

1.2   In April 2017, HMRC introduced new legislation which makes local authorities responsible for assessing whether labour provided by agency workers or personal services companies (PSCs) qualifies as 'off-payroll working'. If the contract is classed as meeting the definition of 'off-payroll working', the Council becomes responsible for deducting PAYE and National Insurance from invoiced amounts.

1.3   Employee Services has responded to this legislation change by creating guidance for managers which clearly sets out roles and responsibilities.

2   Objectives and Scope

2.1   The main objectives of this audit were to ensure that: -
- Services using agency or PSC staff are correctly assessing whether off-payroll working is occurring.
- Standing Orders are being adhered to when appointing agency or PSC staff.

3   Findings

Assessment of off-payroll working

3.1   Building Services were the predominant user of agency staff during the 12-month period being reviewed (Building Services accounted for 87% of the total spend through agency staff ledger codes) and therefore testing focussed on their contracts.

3.2   6 suppliers provided the agency staff being used by Building Services.

3.3   Building Services were unable to provide evidence of employment status checks being carried out for each of these suppliers during the course of the audit. **(action point a, b)**

3.4   Payroll are responsible for calculating PAYE and NI deductions, at the request of the Service. Since the introduction of the new legislation Payroll confirmed that they have only been asked to do this for 1 supplier.

3.5   The classification of this supplier by Property Management and Investment (PMI) as a PSC has recently been brought into question and is currently being reviewed by PMI management. PMI have not retained any paperwork to justify the previous decision to treat the supplier as undertaking 'off-payroll working' and have therefore been advised by Employee Services to carry out the assessment again. This assessment will allow PMI to identify the correct treatment for the supplier, quantify any overpayment and formally advise Employee Services of the corrective adjustment required within the payroll system. **(action point c)**

Standing Orders compliance

3.6 The Council's contract register was reviewed to ensure it included the 6 suppliers referenced in 3.2 above. Only 4 were found to have live contracts with the Council. **(action point d)**

3.7 A comparison of the actual spend on agency staff against the suppliers listed on the contract register highlighted a further instance of off contract spend. Transport have been using a supplier approved to provide Building Services agency staff to supply mechanics - which is out with the scope of the contract. In addition, Transport have not undertaken an assessment of whether this labour qualifies as 'off-payroll working' and the resulting invoices have been miscoded in Integra. Transport have agreed to correct the miscodings and ensure future invoices are coded correctly. **(action point a, d, e)**

4   Internal Audit Opinion

4.1 Overall, limited assurance was obtained with regards to the adherence to Council procedures and guidance when Services are using Agency staff.

4.2 There is no evidence of the HR guidance 'Engaging Agency Workers and Personal Service Companies' being correctly applied within the Council.

4.3 Breaches of Standing Orders relating to Contracts have also been identified during audit testing.

Definitions of Assurance Levels:

Substantial	The framework of governance, risk management and control is adequate and effective.
Reasonable	Some improvements are required to enhance the adequacy and effectiveness of the framework of governance, risk management and control.
Limited	There are significant weaknesses in the framework of governance, risk management and control such that it could be or could become inadequate and ineffective.
None	There are fundamental weaknesses in the framework of governance, risk management and control such that it is inadequate and ineffective or is likely to fail.

NB The level of assurance given is at the discretion of Internal Audit.

KEY FINDINGS AND ACTION PLAN
AGENCY STAFF AND WORKERS

Action	a
Finding	There is no evidence of employment status checks being undertaken and retained when using agency staff or PSCs
Action Description	All Services should be reminded of the existence, and need to apply, the Council's HR Guide on 'Engaging Agency Workers and Personal Services Companies'
Risk	Failure to comply with HMRC requirements resulting in financial consequences for the Council: reputational risk
Priority (1, 2, 3)	1
Paragraph Reference	3.3,3.7
Managed by	Fiona Walker (Head of Service - People and Transformation)
Assigned to	Jackie Hamilton (Senior Manager - Employee Services)
Due Date	Complete
Management Comment	An email has been sent to Heads of Service reinforcing the importance of compliance with this legislation. The email included a link to the Engaging Agency Workers and PSC HR Guide and requested that Heads of Service ensure all managers adhere to the guide.

Action	b
Finding	There is no evidence of Building Services carrying out employment status checks when using agency staff or PSCs
Action Description	Retrospective checks should be undertaken as a priority. If these checks indicate off-payroll working has been undertaken the financial implications must be quantified, and Employee Services notified of the corrective actions required.
Risk	Failure to comply with HMRC requirements resulting in financial consequences for the Council: reputational risk
Priority (1, 2, 3)	1
Paragraph Reference	3.3
Managed by	Yvonne Baulk (Head of Service - Physical Environment)
Assigned to	Leigh-Ann Mitchell (Senior Manager - Governance)
Due Date	Complete
Management Comment	All agency workers currently in use within Building Services have confirmed that they are working within the scope of IR35. Agencies will be asked to confirm this on an individual basis for any new workers provided.

Action	c
Finding	PMI have failed to comply with HMRC's 6-year retention period for employment status checks making it impossible to confirm whether payroll deductions have been erroneously paid on behalf of the supplier. Initial findings indicate that an overpayment is likely to have occurred, but this is yet to be quantified.
Action Description	PMI to conclude the review as soon as possible, identify any overpayment and formally notify Employee Services of the payroll adjustment required. All relevant staff should be reminded of the Council's HR Guide on 'Engaging Agency Workers and Personal Services Companies'.
Risk	Failure to comply with HMRC requirements resulting in financial consequences for the Council: reputational risk
Priority (1, 2, 3)	1
Paragraph Reference	3.5
Managed by	Yvonne Baulk (Head of Service - Physical Environment)
Assigned to	Alison Diamond (Team Manager Property Management & Investment)
Due Date	31 January 2020
Management Comment	The on-line HMRC assessment tool has been re-run and Payroll have been advised of the outcome. A screenshot of the confirmation has been retained by PMI. A process has been established to ensure the appropriate payments and deductions are applied. Previous overpayments have been quantified and will be recouped by the Council, this is being progressed by PMI / Procurement and Payroll. PMI team managers have been reminded of the "Engaging Agency Workers and Personal Services Companies" HR Guidance.

Action	d1
Finding	Standing Orders relating to Contracts have not been complied with.
Action Description	Building Services to liaise with Corporate Procurement to rectify the instances of off contract spend.
Risk	Breach of legislation: breach of Standing Orders
Priority (1, 2, 3)	1
Paragraph Reference	3.6
Managed by	Yvonne Baulk (Head of Service - Physical Environment);
Assigned to	Leigh-Ann Mitchell (Senior Officer - Governance)
Due Date	Complete
Management Comment	Building Services had issues trying to source agency workers through a previous framework. This was discussed with Internal Audit and Corporate Procurement who both advised that if a time period passed and framework agencies could not provide anyone then they could go to the open market for this resource. Further guidance received is that any other available frameworks would be investigated prior to going ahead with off contract orders or a quick quote would be carried out dependant on value and urgency. If this continues to be an issue Corporate Procurement will manage this with the providers on the framework. When the new framework was implemented, Building Services asked what should happen with any agency workers in place prior to this who were not on the current framework and the guidance from Corporate Procurement was that there was no action required with the workers we had at that point on the old contract as these would remain part of the old contract. It is common for awards from frameworks to outlast the framework itself.

Action	d2
Finding	Standing Orders relating to Contracts have not been complied with.
Action Description	Transport to liaise with Corporate Procurement to rectify the instances of off contract spend.
Risk	Breach of legislation: breach of Standing Orders
Priority (1, 2, 3)	1
Paragraph Reference	3.7
Managed by	David Hammond (Head of Service - Commercial)
Assigned to	Gordon Mitchell (Corporate Transport Manager)
Due Date	Complete
Management Comment	A new contract has recently been awarded for the supply of specific building trades, unfortunately this does not include mechanical trades. The current agency staff member working within the Transport Hub terminated his time with effect of the 25 October 2019. The team will engage with Corporate Procurement team to identify the most appropriate route which will meet our future needs within the Councils Standing Orders.

Action	e
Finding	There is no evidence of Transport carrying out employment status checks when using agency staff or PSCs
Action Description	Retrospective checks should be undertaken as a priority. If these checks indicate off-payroll working has been undertaken the financial implications must be quantified, and Employee Services notified of the corrective actions required.
Risk	Failure to comply with HMRC requirements resulting in financial consequences for the Council: reputational risk
Priority (1, 2, 3)	1
Paragraph Reference	3.7
Managed by	David Hammond (Head of Service - Commercial)
Assigned to	Gordon Mitchell (Corporate Transport Manager)
Due Date	Complete
Management Comment	The Transport Hub carried out retrospective employment checks with our main supplier All Needs and they have confirmed that all staff supplied are not off payroll working. All future checks will be carried out prior to the commencement of work by agency staff.

Priority Key used in Action Plan

1 (High)	Control weakness where there is a material impact on the achievement of the control objectives, generally requiring prompt attention.
2 (Medium)	Control weakness which needs to be rectified, but where there is no material impact on the achievement of the control objectives.
3 (Low)	Minor weakness or points for improvement.

SELF-DIRECTED SUPPORT

1 Background

1.1 In 2013, a law on social care support, the Social Care (Self-directed Support) (Scotland) Act 2013 was passed by the Scottish Parliament. The Act empowered people to decide how much ongoing control and responsibility they want over their own support arrangements.

The Act places a duty on Councils to offer people four options as to how they receive their social care support. The four options are: -
1. the Council pay money directly to the client or carer who arranges their own support by employing care staff or buying services from one or more organisations;
2. North Ayrshire Health and Social Care Partnership does not pass money to providers or support organisations in the delivery of option 2, all funds remain within the Health and Social Care Partnership and we commission the chosen support agency whilst allowing the person to arrange and direct their care;
3. the client requests the Council to choose and arrange the support they think is right; and
4. the client chooses a mix of these options 1, 2 and 3 for different types of support.

1.2 Audit Scotland issued a progress report in 2017 with the following key messages: -
- although positive progress has been made in implementing Self-Directed Support not everyone is getting the choice and control envisaged in the strategy,
- there is a need for effective training and management support to raise confidence to make decisions with clients about their support,
- Council budget challenges restrict the choice clients have,
- against the background of challenging recruitment and retention of staff it is difficult to offer flexible services, and
- implementation stalled as the Integrated Joint Boards were formed, resulting in organisational change and loss of experienced staff.

1.3 In June 2019, the Care Inspectorate Scotland issued a thematic review of self-directed support in six Scottish councils which identified areas for improvement, especially in recording and evidencing positive client outcomes.

2 Objectives and Scope

2.1 The main objectives of this audit were to: -
- obtain background information related to payments;
- ensure the assessment is carried out in compliance with the Act and all its regulations and that service users are informed of the options;
- that suitable funding methods have been agreed to ensure fairness, regularly reviewed to ensure they are appropriate for Council budgets; and
- that the annual review of the choice of options are completed.

2.2 The audit focused on Option 1 service users. There were 217 service users under this option at March 2019, with actual expenditure in 2018/19 of £2.936m.

3 Findings

Background

3.1 All procedure documents were completed in 2013. The common tenets of the process have not changed.

3.2 Online support is readily available through the 'Carena' website (Care and Support North Ayrshire), providing a number of links to independent guidance and support. However, it was noted that the web page link to North Ayrshire Council guidance is broken and returns an error message. **(Action a)**

3.3 There was a training programme implemented in 2013 and limited training has been completed in the intervening period. There has been a pattern of high turnover of staff within HSCP (during the 2018/19 financial year there were 225 leavers (13%) and 232 (14%) new starts). Whilst not all new staff will be front line social care practitioners, there is a risk that new team members have not been suitably trained to encourage the promotion of the policy in North Ayrshire. **(Action b)**

Assessment and Outcome Planning

3.4 A sample of 29 cases was selected to complete compliance tests. Apart from four files, there was evidence of assessment recorded on CareFirst. **(Action c)**

3.5 From the sample, 28 service users had a lead worker allocated. Due to the resignation of a lead worker one service user has been waiting, for less than a month, to be allocated a new lead worker.

3.6 Service users agree a direct payments contract with North Ayrshire Council. This forms a legal agreement identifying the Council's assessment of needs, financial implications and a breakdown of costs. Service users are assisted by a Social Worker or through the Independent Living Advisor to ensure there was one point of contact for service users, families and Senior Managers/Budget Holder when completing the Direct Payments Request form.

3.7 A review of the contract related paperwork for the test sample indicated that these contracts, as retained by North Ayrshire Council, were incomplete. Missing information included incomplete Direct Payments forms, and the calculator output was not evidenced for some of the sample. **(Action c)**

Funding Provision

3.8 A review of the sample confirmed that regular reviews of funding were being undertaken; however, the agreed amount for a large number of the sample reviewed evidenced an inconsistency of recording observations on CareFirst. **(Action c)**

3.9 Examination of the assessment reviews were indicative of positive impact being experienced by the service user; however, there is no evidence of this information being assessed to inform development of the self-directed support to other clients. North Ayrshire Health and Social Care Partnership are currently undertaking a self-assessment of the approach to self-directed support in line with the Director's 'Thinking Different, Doing Better' experience, which aims to empower practitioners to meet individuals' outcomes in more creative, person-centred ways. **(Action d)**

Review and Monitoring

3.10   From the sample selected, eight had been reviewed within the 12-month anniversary of the agreement, eight within 1½ years and seven were in excess of this period. The remaining six were not recorded on CareFirst. **(Action c)**

3.11   HSCP staff track progress of the direct payments through a spreadsheet on Microsoft Excel. Where the values of the self-directed care were recorded on CareFirst, the information matched that recorded on the spreadsheet.

3.12   Since 2017, following client reviews, there have been 239 monetary clawbacks at a total value of £947,033. Trend analysis indicates a slight decrease in the number and value of clawbacks since 2017. From the sample tested 12 had clawbacks recorded in the last calendar year.

4   Internal Audit Opinion

4.1   Overall, reasonable assurance was obtained with regard to the administration of self-directed support.

4.2   Option 1 take-up of self-directed support as part of the overall Health and Social Care provision of service remains low. This audit focused on Option 1 which is only one of the 4 options under SDS, is based on individual client choice and is not necessarily reflective of a failure to promote choice and control over how care is delivered.

Definitions of Assurance Levels:

Substantial	The framework of governance, risk management and control is adequate and effective.
Reasonable	Some improvements are required to enhance the adequacy and effectiveness of the framework of governance, risk management and control.
Limited	There are significant weaknesses in the framework of governance, risk management and control such that it could be or could become inadequate and ineffective.
None	There are fundamental weaknesses in the framework of governance, risk management and control such that it is inadequate and ineffective or is likely to fail.

NB The level of assurance given is at the discretion of Internal Audit.

KEY FINDINGS AND ACTION PLAN
SELF-DIRECTED SUPPORT

Action	a
Finding	Online links to North Ayrshire Self-Directed Support lead to an error page
Action Description	Ensure that all links on the Council's internet site are working.
Risk	Individuals are unable to find the relevant information to access the services available to them.
Priority (1, 2, 3)	3
Paragraph Reference	3.2
Managed by	Isabel Marr, Senior Manager Health and Community Care
Assigned to	Nicola Teager, Communication and Engagement Officer (HSCP)
Due Date	Complete
Management Comment	The Self-Directed Support (SDS) Team have met with the recently appointed Partnership Communications Officer to ensure the information available to the public/staff is clear, current and accessible with the correct contact details. On the transfer of information from Council site to Health and Social Care Partnership site the links were lost/removed and this has been rectified.

Action	b
Finding	Limited training in relation to self-directed support has been completed since 2013.
Action Description	A training gap analysis in relation to self-directed support should be undertaken, where staff assessed as requiring training are identified and an information programme put in place.
Risk	This will ensure that a consistent approach is taken to the roll-out of self-directed support and allay the Audit Scotland identified risk that social workers were not confident to assist service users to make a fully informed choice.
Priority (1, 2, 3)	1
Paragraph Reference	3.3
Managed by	Isabel Marr, Senior Manager Health and Community Care
Assigned to	Kimberley Mroz, Policy Manager SDS
Due Date	31 March 2021
Management Comment	The SDS Team will work closely with the Learning & Development Team and Practitioners to complete a training needs analysis and develop appropriate training and awareness courses to be delivered across North Ayrshire during 2020-21. This will be part of the re-launch of SDS and communicate changes to any processes and policies to practitioners.

Action	c
Finding	Assessment records retained on service user files are inconsistently recorded on CareFirst.
Action Description	All assessment records relating to service users should be recorded on CareFirst.
Risk	There is a risk that when a challenge is made key evidence is missing and the Council will be unable to evidence that assessments have been completed and what has been agreed with the client.
Priority (1, 2, 3)	1
Paragraph Reference	3.4, 3.7, 3.8 and 3.10
Managed by	Caroline Cameron, Chief Finance and Transformation Officer
Assigned to	Eleanor Currie, Finance Manager
Due Date	30 June 2020
Management Comment	The services not currently contained on Care First relate to Children with a Disability Care Packages where service user agreements are not yet held on Care First. The finance team and service are working together to ensure appropriate sharing of information and an agreed process and timeframe for transferring these services onto Care First. In the meantime the information is currently recorded and held out-with Care First and there is work underway to ensure improved processes for children's care packages, this is also referenced in the recent audit of Community Based Support.

Action	d
Finding	North Ayrshire Health and Social Care Partnership are currently undertaking a self-assessment of self-directed support.
Action Description	A method should be developed for recording outcomes as a result of self-directed support to assess and build on positive outcomes, as identified in the Care Inspectorate thematic review of Self-Directed Support in Scotland.
Risk	There is a risk that the Council is unable to evidence the positive outcomes for clients and use this information to encourage others to be more involved in directing how their care and support is delivered to best meet their needs. Failure to learn lessons from previous experience.
Priority (1, 2, 3)	1
Paragraph Reference	3.9
Managed by	Isabel Marr, Senior Manager Health and Community Care
Assigned to	Kimberley Mroz, Policy Manager SDS
Due Date	30 September 2020
Management Comment	The purpose of the Support Plan is to record personal outcomes and to enable the practitioner, at the point of review, to measure outcomes. The SDS Review Team will provide clarity for practitioners and service users and ensure that the choice in relation to SDS option is clearly and consistently recorded.

Priority Key used in Action Plan

1 (High)	Control weakness where there is a material impact on the achievement of the control objectives, generally requiring prompt attention.
2 (Medium)	Control weakness which needs to be rectified, but where there is no material impact on the achievement of the control objectives.
3 (Low)	Minor weakness or points for improvement.

LIBRARY AND INFORMATION SERVICE

1   Background

1.1   In recent years, Libraries have had to evolve the services they provide in order to support the changing needs of the community. This has resulted in a move towards digital technology.

1.2   Such technology presents new potential risks to the Service, which must be considered and mitigated where possible.

2   Objectives and Scope

2.1   The objective of this audit was to ensure that: -
* Processes are in place to prevent of the loss of library assets
* Sufficient controls are in place to prevent inappropriate content being viewed on Library IT equipment

3   Findings

Library Assets

3.1   Spydus (library management software) is used to: -
* Record all lending and returns
* Identify late returns and generate reminder letters
* Hold the fixed asset register for the service

3.2   Libraries charge members of the public for lost books, and do not allow any further borrowing until payment has been made.

3.3   Discussions with the Service highlighted that there is a delay in updating Spydus if the member pays the invoice at a Council building, other than a library. Audit and the Service discussed ways to improve this situation in both the short and longer term, and the Service is currently looking into these.

3.4   Libraries currently maintain a manual fixed asset register, in addition to the one within Spydus. Audit and the Service discussed whether, as an efficiency, the Service could dispense of the manual record.

3.5   Audit used matching software to compare the asset register held in Spydus to the manual register. Differences were found between the two. **(action point a)**

IT Access Controls

3.6   Libraries currently use ICAM software to control access to PCs. ICAM: -
* Assigns an access profile to each user, based upon date of birth information in Spydus
* Keeps a log of each user's activity whilst on the library PC

3.7   Users are assigned one of 3 profiles, either 'child', teen' or 'adult' – with the 'child' and 'teen' profiles being based on access rights within Education.

3.8   Discussions with IT confirmed that whilst the access profiles assigned by ICAM were originally set up to be similar to those in Education, there is no ongoing link between the profiles in the two Services, meaning that profile access updates in Education don't automatically update those in Libraries.

3.9   There is a risk that over time the access profiles within Education and Libraries could diverge, meaning that children can access different content from Library and Education PCs. **(action point b)**

3.10   Libraries are currently looking at utilising more of the space within their buildings and are therefore considering reducing the number of PCs and moving towards more portable devices such as tablets.

3.11   Audit have had discussions with the Service with regards to preventing the theft of these portable devices, but have not yet identified a suitable solution.

3.12   Consideration needs to be given to the fact that iPads and Android tablets are not currently allowed on the Council's network as they are not deemed to be secure enough. ICAM would therefore not be available to provide access profiles.

3.13   These devices would have to access the internet via the public wi-fi network and, unless access control software is procured, would need to rely on either the filtering of the wi-fi provider, or the staff within the library setting appropriate filters and blocks on each device.

3.14   At present, the Library service only has 4 tablets available for use by the general public - 2 of which are used by young children and therefore don't have any browser access, and Library staff have restricted the browser access on the other 2 devices.

3.15   Moving away from PCs and more towards tablets potentially creates an additional risk to the Council. **(action point c)**

4   **Internal Audit Opinion**

4.1   Overall, reasonable assurance was obtained with regard to the current processes for monitoring Library assets. The Service is using bespoke library management software which is effective at monitoring the movement of books etc. The Service needs to confirm that the fixed asset information held within Spydus is accurate.

4.2   Reasonable assurance was obtained with regard to the processes to control internet access from Library PC's. ICAM software controls access rights, although a process should be put in place to ensure 'child' and 'teen' access rights are regularly reviewed.

4.3   A risk assessment should be carried out on the Service's current plan to replace Library PCs with tablets. This should cover how the portable devices will be secured to prevent theft, but also how access to the internet will be controlled.

Definitions of Assurance Levels:

Substantial	The framework of governance, risk management and control is adequate and effective.
Reasonable	Some improvements are required to enhance the adequacy and effectiveness of the framework of governance, risk management and control.
Limited	There are significant weaknesses in the framework of governance, risk management and control such that it could be or could become inadequate and ineffective.
None	There are fundamental weaknesses in the framework of governance, risk management and control such that it is inadequate and ineffective or is likely to fail.

NB The level of assurance given is at the discretion of Internal Audit.

KEY FINDINGS AND ACTION PLAN
LIBRARY AND INFORMATION SERVICE

Action	a
Finding	Differences were noted when reconciling the Service's manual fixed asset register to that held in Spydus.
Action Description	Both registers should continue to be maintained until the Service have investigated the differences and can be sure that the register on Spydus is accurate and complete. Once this has been completed, and the accuracy of records in Spydus has been confirmed, the Service can stop maintaining the manual register.
Risk	Inability to identify missing assets. Duplication of effort maintaining 2 registers.
Priority (1, 2, 3)	2
Paragraph Reference	3.5
Managed by	Rhona Arthur, Head of Service (Connected Communities)
Assigned to	Heather Benson (Systems and Performance Officer), Alison McAllister (Library and Information Manager)
Due Date	31/3/2021
Management Comment	Agreed

Action	b
Finding	Online access profiles for school aged individuals are not being regularly reviewed to ensure they stay in line with those used with Education.
Action Description	If it is not possible to link the profiles between the two Services, regular contact should be made with Education to enquire if any profile updates have been made, so that any changes can be reflected in ICAM profiles.
Risk	School aged individuals may be able to access content deemed inappropriate by Education from a Library PC.
Priority (1, 2, 3)	2
Paragraph Reference	3.9
Managed by	Rhona Arthur, Head of Service (Connected Communities)
Assigned to	Alison McAllister (Library and Information Manager)
Due Date	31/3/2021
Management Comment	Agreed

Action	c
Finding	There are new risks to the Service which need to be considered when planning a move from PC suites to tablets.
Action Description	A risk analysis to identify all the potential issues with moving from PCs to tablets and other portable devices should be undertaken. Options to mitigate these risks should be investigated before going ahead with the rollout.
Risk	Theft of tablets; loss of corporate browser filtering allows inappropriate or illegal activities to be undertaken using Council IT facilities
Priority (1, 2, 3)	2
Paragraph Reference	3.15
Managed by	Rhona Arthur, Head of Service (Connected Communities)
Assigned to	Heather Benson (Systems and Performance Officer), Alison McAllister (Library and Information Manager)
Due Date	31/3/2021
Management Comment	Agreed

Priority Key used in Action Plan

1 (High)	Control weakness where there is a material impact on the achievement of the control objectives, generally requiring prompt attention.
2 (Medium)	Control weakness which needs to be rectified, but where there is no material impact on the achievement of the control objectives.
3 (Low)	Minor weakness or points for improvement.

BEREAVEMENT AND BURIAL SERVICES

1   Background

1.1   The Bereavement and Burials Team ('The Team') are responsible for managing all lair sales and interments within North Ayrshire Council cemeteries.

2   Objectives and Scope

2.1   The main objectives of this audit were to: -
- confirm that detailed records of lair sales and interments are being kept,
- ensure all lair sales and interments are been invoiced,
- Review how the Council's Bereavement Charter is supporting the public

3   Findings

Record Keeping

3.1   All mainland and Cumbrae lair sales and interments are managed via dedicated software called BACAS (Burial and Cremation Administration Service).

3.2   This software holds details of every lair within North Ayrshire cemeteries (with the exception of Arran). Staff use BACAS to confirm which lairs are available for purchase and to then record all subsequent lair sales, interments, memorial permits.

3.3   The Team supplement BACAS with the use of a shared electronic diary for recording all booked funerals, an electronic filing system so that no paperwork is passed between staff, and a workforce app which allows supervisors to manage workloads and allocate tasks electronically to squads within cemeteries.

3.4   A review of the process by Audit found it to be good with check lists used to prompt staff to ensure that all steps of the process are completely accurately.

3.5   Staff on Arran are not using BACAS and operate their own manual system for managing the lair sale and interment process. Whilst no specific issues were found with this system during audit testing, no operational reasons for Arran having a completely different process from that on the mainland were identified.

3.6   Having a manual system on Arran increases the risk of: -
- Business continuity issues due to operating separately from the rest of the Service
- Loss of data due to manual records not being backed up
- Poorer information being available to management due to Arran activity not being included in any reports or statistics pulled from BACAS

(action point a)

Invoicing

3.7   Mainland invoices are raised by Business Support, whilst Arran invoices are raised by Debt Recovery. **(action point a)**

3.8 Audit obtained a report from BACAS of all interments, lair sales and transfer of titles recorded since April 2019. A sample of these was then traced to the subsequent sales invoice to ensure that the Council is reclaiming all income due to it. In addition, the lair number quoted on each invoice in the sample was checked to ensure it matched the one recorded on BACAS.

3.9 In addition, a sample of invoices was selected and traced into BACAS, again ensuring the lair number quoted on the invoice tied to that noted in BACAS.

3.10 During testing it was noted that one week's worth of services (from July 2019) had not been invoiced.

3.11 Bereavement Services could demonstrate that the request to raise these specific invoices had been passed to Business Support. Bereavement Services has now arranged for the missed invoices to be raised and have amended their process to include a check that all requests to Business Support have been actioned.

3.12 2 of the invoices reviewed during testing were found to have incomplete lair information noted on them.

3.13 Bereavement Services have raised this issue with Business Support and reiterated the importance of ensuring the invoice narrative is exactly as provided.

North Ayrshire Bereavement Charter ('The Charter')

3.14 The Charter was set up in 2017 as a vehicle for improving the overall service provided to grieving families.

3.15 4 funeral directors and 11 local clergy are signed up to the Charter and are listed as such on the Council's website.

3.16 It is reasonable to assume that members of the public might rely on this as a direct endorsement by the Council of these local businesses.

3.17 However, Audit testing confirmed that there were no criteria set out for joining the Charter in 2017, nor is there a regular review process to ensure that those listed as being part of the Charter remain as appropriate businesses for the Council to be directly associated with. This potentially puts the Council's reputation at risk. **(action point b)**

4 Internal Audit Opinion

4.1 Overall, reasonable assurance was obtained with regard to the current processes within the Bereavement Team. The processes on the mainland are robust, however the fact that Arran is not aligned with this process creates a level of risk within the Service.

Definitions of Assurance Levels:

Substantial	The framework of governance, risk management and control is adequate and effective.
Reasonable	Some improvements are required to enhance the adequacy and effectiveness of the framework of governance, risk management and control.
Limited	There are significant weaknesses in the framework of governance, risk management and control such that it could be or could become inadequate and ineffective.
None	There are fundamental weaknesses in the framework of governance, risk management and control such that it is inadequate and ineffective or is likely to fail.

NB The level of assurance given is at the discretion of Internal Audit.

KEY FINDINGS AND ACTION PLAN
BEREAVEMENT AND BURIAL SERVICES

Action	a
Finding	Staff on the mainland and Cumbrae are managing the interment process electronically, whilst staff on Arran continue to use manual records.
Action Description	Arran should be aligned with the mainland's processes and procedures.
Risk	Business continuity issues due to operating a completely separate system on Arran; manual records are not backed-up in the same way that electronic records are.
Priority (1, 2, 3)	2
Paragraph Reference	3.6, 3.7
Managed by	David Hammond, Head of Service (Commercial Services)
Assigned to	Mark McNeil (Manager Streetscene)
Due Date	31 March 2021
Management Comment	The Service has been attempting to digitise Arran Bereavement Services in line with the mainland, and this has been highlighted again to IT to progress. The main issue is that since the upgrade to Office 365, our software system, BACAS has not been compatible. IT have arranged a workaround in that we can access BACAS via a virtual window however this is not available on Arran. The matter is currently with the software provider and IT to resolve, we understand the software provider is looking at a remote option rather than access from the server.

Action	b

Finding	The North Ayrshire Bereavement Charter is not as formal an arrangement as is implied on the Council website.
Action Description	A review of the Charter set up should be undertaken. Consideration should be given to formalising the Charter by having admission criteria or checks undertaken on local businesses before they are listed as members. A relaunch of the Charter to raise its profile while encouraging more local businesses to sign up should be considered.
Risk	Implied relationship with local businesses creates a reputational risk to the Council if a party currently listed as part of the Charter fails to provide an adequate service.
Priority (1, 2, 3)	2
Paragraph Reference	3.17
Managed by	David Hammond, Head of Service (Commercial Services)
Assigned to	Mark McNeil (Manager Streetscene)
Due Date	31 March 2021
Management Comment	At the next review of the charter the Service will consider moving away from the use of the word charter as the definition of the word appears to be the crux of the issue raised. Another other option would be to formalise the agreement with partners and thereafter police it. We are of the view that such formalisation and regulation would send a negative message to partners who we have worked hard to build good working relationships with, so voluntary compliance is our preferred approach. In the meantime, the Head of Service is happy to accept the risk noted. Should the Service receive any complaints about a funeral director who has failed to meet commitments no. 3 or 4 (the only two applying to external funeral directors) the Service would point out to the customer that their contractual relationship is between themselves and the funeral director and the Council is not a third party to that agreement nor have we ever committed to policing paperwork or timekeeping of funeral directors as part of the Charter.

Priority Key used in Action Plan

1 (High)	Control weakness where there is a material impact on the achievement of the control objectives, generally requiring prompt attention.
2 (Medium)	Control weakness which needs to be rectified, but where there is no material impact on the achievement of the control objectives.
3 (Low)	Minor weakness or points for improvement.