Appendix A

London Borough of Barnet

Internal Audit & Risk Management

Progress Report 2013-14 – Quarter 2

Caroline Glitre, Head of Internal Audit and Anti-Fraud

1. Introduction

The Internal Audit Plan was accepted by the Audit Committee on the 8th April 2013. This report follows the principles previously requested by the Committee, in that all audit reports with limited or no assurance will be summarised into key messages with some detail.

2. Final Reports Issued

This report covers the period from 1st July 2013 to 30th September 2013 and represents an up to date picture of the work in progress to that date. The Internal Audit service has over this period issued 18 reports in accordance with the 2013-14 Internal Audit Plan. The full list of completed audits during this period is included within Appendix B. The majority of reports issued in the current period were given satisfactory assurance, with 1 report given substantial assurance and 2 reports given limited assurance. The summary detail of those reports issued as limited assurance is included within section 3.

3. Key Findings from Internal Audit Work with Limited or No assurance

Title	Planning Service Performance			
Assurances	**No**	**Limited**	**Satisfactory**	**Substantial**
Audit Opinion				
Date final report issued	9 October 2013			
Background	Officers in the Planning Service review planning applications for developments and make recommendations as to whether they should be accepted or rejected based on complex guidelines, the Local Development Framework, which is supported by Supplementary Planning Documents (SPDs). The Planning Service transferred to the Development and Regulatory Services (DRS) external provider on 1st October 2013. This review was completed prior to the transfer. Performance indicators relevant to the Planning Service operation are as follows: - Major applications - within 13 weeks - Minor applications - within 8 weeks - Other applications - within 8 weeks The quarter 4 2012-13 Corporate Plan performance report reported an increase in the planning application backlog and a fall in customer satisfaction. For major applications, in particular, the Government set a target requiring 30% of major applications between July 2011 and June 2013 to be resolved within 13 weeks, failing which the Council would be under “special measures”. This would allow applicants to submit planning applications directly to the Planning Inspectorate. A Planning Service Recovery Plan was developed to address service delivery issues. The Planning Service Recovery Plan			

	was first documented 14 August 2012 and was updated on a quarterly basis. The performance reported at quarter 1 2013-14 showed significant improvement, in that compliance with planning application statutory timescales had increased to 74.3% (70% target), from 52.4% in quarter 4 2012/13. However, at quarter 1 there remained an issue on major applications which was only marginally above the “special measures” threshold.

Summary of Findings	As part of the audit we were able to give **'Limited'** assurance to the service, noting one high and five medium priority issues as part of the audit. The following area of good practice was noted: • Routine scrutiny and challenge at Senior Management level of the Planning Service Recovery Plan to monitor progress for improving service delivery and customer satisfaction. We noted the following significant issue: <u>Data quality</u> Audit trails were not available for inspection from Accolade, the system supporting the planning application backlog figures and the performance indicator speed of decision making outturn reported in the Planning Service Recovery Plan. Management indicated that they were extracted from the Accolade system at the time. Evidence of sample checks and data cleansing exercises to ensure the completeness and accuracy of data in Accolade prior to quarterly statutory reporting were not retained for inspection. The Data Quality Policy states that clear and complete audit trails should be maintained to demonstrate accuracy of all data. We noted the following other issues: • Key performance indicators (KPIs) and performance indicators (PIs) relevant to measuring the key Planning service delivery activity were not reflected in the Corporate Plan 2012-13. This meant that planning application backlog issues and issues relating to the outturn for the "speed of planning application decision making" performance indicator would not have been naturally escalated to more senior levels for scrutiny and challenge as part of the Council's Corporate Performance Management Framework. This may have delayed the implementation of action to avoid special measures which would have required that planning applications be sent directly to an external agency, the Planning Inspectorate, for assessment – a situation which may have damaged the Council's reputation. Arrangements should ensure that this situation does not arise following transition to the new provider. • Interviews with officers responsible for the error checking and reporting of planning application data in Accolade, the system for vetting and processing planning applications and dispatching related decisions, confirmed that they were not all sufficiently familiar with the Council's Data Quality Policy and guidance. • We noted that JCAD, the Council's risk management system, did not fully record Planning performance data quality

	risks. Where performance data issues exist related risks should be identified in JCAD for ongoing review and confirmation of ownership and stated mitigating controls. • Documented procedures governing the vetting of planning applications and the processing of related decisions, particularly for the timely and accurate input of statutory start date and decision dispatch date were not documented for referral. Documented procedures governing classification of planning applications were available for referral by officers but were not dated and subject to version control to ensure ongoing review and update. • A review of the administrator access in Accolade is required to ensure that it is suitably restricted to officers in line with their roles. • Controls were not in place to restrict the ability of officers to amend customer satisfaction survey responses.
Priority 1 recommendations, management responses and agreed action date	**Recommendation 1 – Audit Trails:** Audit trails supporting reported figures and controls to ensure the accuracy and completeness of related system data should be retained for inspection in line with the Data Quality Policy. **Management Comment 1:** Agreed. Data Quality training and development needs will be assessed for officers involved in the management/reporting of Planning performance data. Officers will undertake training/development initiatives, where applicable, to ensure that they are familiar with the Council's Data Quality principles and consider them on an ongoing basis in their day to day work. Note: This may be achieved through formal training courses, confirmation that officers have reviewed and understand the Data Quality Policy content or liaison with the Information Management team on how best to address identified developmental needs. **(Systems Support Manager (DRS) – 1 December 2013)** Audit trails supporting key Planning data and information reported, for example, key performance indicator (KPI) or performance indicator (PI) outturn from Accolade, will be retained for referral. **(Systems Support Manager (DRS) – Immediately)**

Title	Orion School			
Assurances	**No**	**Limited**	**Satisfactory**	**Substantial**
Audit Opinion				
Date final report issued	17 July 2013			
Background	The Orion Primary School is a community school with places for 545 pupils aged between 3 and 11 years of age. The School budget for 2012/13 was £2,863,072 with employee costs of £1,813,811 (63% of the delegated budget). The School was assessed as 'Outstanding' by OFSTED in February 2010.			
Summary of Findings	As part of the audit we were able to give **'Limited'** assurance to the school, noting two high and six medium priority issues as part of the audit (in order of priority): • Income – Checks are not carried out by an independent officer to verify that amounts banked agree to control records for all income collected; Transfers of money between staff are not signed for; Not all money is stored in a safe overnight; 'Breakfast Club' expenditure exceeds income received; Uniform stock records are not maintained; • Contracts – No visible evidence of 'value for money' exercise for current cleaning contract and IT equipment sourced by the School's IT maintenance provider; • Payroll – No visible evidence to confirm payroll reports are overseen; • Purchasing - Inconsistent checks found to verify that goods had been received; - Cost sharing arrangements with the neighbouring primary school have not been formalised; • Budget Monitoring – Transfers of funds between income and expenditure budget codes (virements) are not signed; • Lettings – The hirer is not invoiced in advance; arrangements with independently run after-school club organisers have not been formalised;			

	• Assets - Dates of acquisition, supplier details and purchase order numbers are not recorded for each item entered in the inventory records; • Governance – The Financial Management & Procedures Policy document does not: - Include detailed procedures for all income sources received by the School; - Reflect current procedures for providing budget reports to governors etc. Following our 'Schools Financial Values Standard' (SFVS) self – assessment review we were able to confirm that there were no major discrepancies in judgements noted, however, although the School has responded with 'Yes', in the area(s) outlined below, it is the opinion of audit that these areas are only met 'In-Part': • C16: The School has not provided evidence of collaboration, or consideration of any collaboration with other LA schools, for example, the sharing of staff, or joint procurement/contracting arrangements/LA consortia etc. There is evidence only for some traded services provision; • D18: Refer to findings 1, 3, 4, 5 & 8 (under section 2 of the report), which have been repeated from the last audit. Furthermore, confirmation of implementation of all audit actions was never received from the Chair of Governors, despite 2 requests; • D19: Controls over the purchasing, income, lettings and payroll systems should be tightened, refer to bullet points 1, 3, 4 & 6 above; • D23: The School's Asset register was not found to be up-to-date, refer to bullet point 7 above.

Priority 1 recommendations, management responses and agreed action date	**Recommendation 1:** Income Strict income controls and procedures should be in place to ensure effective financial management; a) Independent checks to verify amounts banked agree to source records. These checks should be visibly evidenced; b) Transfers of funds between staff should be agreed against source records and signed for in order to confirm that all income collected has been handed over for banking; c) All money should be held securely in the safe overnight; d) The School should investigate why there is a shortfall of £1469 in breakfast club income collected and report its finding to governors; e) A robust system should be introduced to identify all those requiring additional nursery provision at least weekly in advance. Additional nursery sessions should not be provided unless payment has been received in advance; f) Uniform stock records should be maintained in order to facilitate a regular reconciliation to sales and remaining stock. **Management Comment 1:** Agreed. The issues raised will be addressed. **(September 2013)** **Recommendation 2:** Contracts In order to ensure that the School is obtaining value for money and that its procurement arrangements are transparent and fair, a review of the LBB Contract Standing Orders for Schools (section 4.1.1, Appendix 2 of the Financial Guide for Schools document) should be carried out and appropriate action taken to ensure compliance. **Management Comment 2:** Agreed. The issues raised will be addressed. **(November 2013)**

4. Work in progress and effectiveness review

Appendix C includes a list of all of those audits at the planning, fieldwork, or draft reporting stages. Appendix D includes performance against the Internal Audit effectiveness indicators. We have met all targets within the plan with the exception of two indicators being rated Amber:

1) 40% of the annual plan has been delivered, which is below the target for quarter 2 of 47%. Although performance is currently below target, there are several reviews at the fieldwork stage, and the planning on several of the quarter 3 reviews has already commenced. Therefore we are confident that performance at the end of the next quarter will be on target.

2) Implementation of internal audit recommendations – the progress of quarter 2 recommendations is included in Appendix D where 67% recommendations are implemented. Last quarter 85% of recommendations had been implemented within the required timeframe. As such there has been a deterioration in the completion of audit recommendations in the timescales originally agreed. Representatives from the services involved will attend the Audit Committee to provide an updated position on implementation of the recommendations.

5. Liaison with Officers and External Audit

The Internal Audit Service is committed to the managed audit approach. Part of this includes regular liaison with External Audit to ensure that our work can be used by them as part of their financial accounts audit. Quarterly meetings, as a minimum, occur between external and internal audit.

Regular meetings have occurred with senior officers regarding implementing action plans in accordance with the agreed timeframe.

As part of the Internal Governance reviews of the four ‘Resource Enabling Boards’, Internal Audit officers have been working closely with Governance colleagues to ensure efficient and effective audits.

6. Changes to our plan

Since the Internal Audit Plan was approved there have been some changes within the quarter made to the original audit plan agreed in April 2013 in respect of timing and additional audits requested from Directorates.

Type	Audit Title	Reasons
Combined	Equalities Cross-cutting review (Q2) and Equalities Commissioning Group review (Q3)	Combined and will be undertaken in Q3.
Deferred	Business Continuity Data Quality	Deferred to Q3 to even out the phasing of audits across the year.
Deferred	Performance Management Framework	Deferred to Q3 so that all Framework Assurance reviews conducted in same quarter.
Deferred	Partnerships	Deferred to Q3 due to timings of other audits and availability of service staff.
Deferred	Health & Social Care Integration	Deferred due to further consideration of the scoping of the review being combined with the Public Health review in Q3.
Deferred	External Assurance - recommendation tracker review	Deferred due to major external contracts not yet being operational until the end of quarter 2.

7. Reports and assurance projects for management purposes

There were two assurance projects undertaken by internal audit that are not considered assurance reports (i.e. they do not give an assurance rating) but none the less aid management in assessing the effectiveness of their control environment. Within these reports if a significant issue has been identified as part of that review it has been included within this progress report:

- **Troubled Families – Payment By Results review**

The Children's Service requested Internal Audit assurance over its Troubled Families Payment By Results grant claim submission in July 2013. We were unable to substantiate the data used in the claim therefore it was not submitted.

The first step in preparing the data for the claim should be to identify the troubled families that the authority plans to work with in the coming months and years. We were provided with an estimated number of families without evidence to support it, or evidence that the families included meet the Department for Communities & Local Government criteria for being a troubled family.

Broadly sensible steps had been taken to track improvements in the main areas of education and progress to work, but per the above there was a lack of an audit trail linking the individuals that have improved to troubled families that the authority is working with.

Further work is ongoing with the service in order to be able to provide the assurance needed prior to the October 2013 claim submission deadline.

- **DRS Baseline**

We undertook a follow-up review after the March 2013 findings that a number of DRS key performance indicators included to measure the success of the contract were not robust in terms of data quality. The 11 KPIs tested in March 2013 were re-visited and we also looked at 5 additional KPIs.

We noted improvement in 5 of the 11 KPIs originally tested. However, overall across the population of 16 KPIs reviewed we concluded that two of the original KPIs remained 'incomplete' i.e. one or more issues were identified that are considered to have a significant and detrimental impact on the KPI, to the extent that the indicator does not provide a sound basis for measuring and reporting performance.

Results as at August 2013:

	Incomplete	Limited	Comprehensive
11 KPIs re-visited	2	6	3
5 new KPIs	0	4	1

Total	**2**	**10**	**4**

The two 'Incomplete' KPIs were as follows:

TSL KPI 03: To monitor whether an appropriate response has been issued in response to statutory deadlines

Management response:
This Indicator is earmarked to be reported from 2014 onwards as agreed during the dialogue process. The risks have been identified and considered tolerable.

SP KPI 03: To monitor the percentage of planned strategic documents and associated milestones completed and signed off by the Authority (i.e. Planned for completion each year adopted by the Authority).

Management response:
Management can now confirm baseline met for 2012/13.

Responsibility for the data to support all of the contractual KPIs now lies with the provider. We have issued a copy of our report to the Council's commercial team to inform their monitoring and scrutiny of KPI performance.

8. Risk Management

Since the last report the new risk assurance operational model came into effect. This has been focussed on supporting the organisation to identify, monitor, report and escalate risks as described within the risk management framework, and ensuring that risk management is evolving with the organisation. The corporate risk register reflects this development, with the identification and addition of risks deemed consequential to the achievement of the Corporate Plan. More generally, future threats are now reflected around population and demographic changes and government funding uncertainty. Quarter one was the first time partner risks (The Barnet Group, Public Health and HB Public Law) were reported as part of quarterly performance and work will continue to ensure that risk structures, retained risks and joint risks with partners are identified, treated and escalated as appropriate.

The final performance report for Quarter 1 can be found via the link below and includes the Quarter 1 corporate risk register:

http://barnet.moderngov.co.uk/documents/s10619/Annex%20A%20-%20Report%20to%20Cabinet%20Resources%20Committee%2024%20September%202013.pdf

Appendix B: 2013-14 work completed during quarter 2 including assurance levels

Audit Opinions on Completed Audits during the period

	Systems Audits	**Assurance**
1	Children in Need	Satisfactory
2	Transformation Q1 review	Satisfactory
3	KFS key controls – group 1 – Treasury Management & Pensions, Payroll, Accounts Payable, Income & Debt Management, Cashbook, Capital Programme	Satisfactory
4	KFS key controls - group 2 – Revenues and Benefits	Satisfactory
5	Children's Placements	Satisfactory
6	Safeguarding Adults – Data Quality review	Satisfactory
7	Welfare Reform - Governance Arrangements	Substantial
8	Workforce Board – Internal Governance Q2	Satisfactory
9	Assets & Capital Board – Internal Governance Q2	Satisfactory
10	NSCSO Mobilisation	Satisfactory
11	Planning Service Performance Management	Limited
12	RIPA review	Satisfactory
	Risk Assurance	
13	DRS Baseline	N/A

	School Audits	**Assurance**
1	Orion	Limited
2	Wessex Gardens	Satisfactory
3	Bell Lane	Satisfactory
4	St. James Catholic High	Satisfactory
5	Queenswell Junior	Satisfactory

Appendix C: Work in progress

The following work is in progress at the time of writing this report:

Work in progress

	Systems Audits	**Status**
1	Safeguarding Children Section 11	Fieldwork
2	PFI Contract	Fieldwork
3	Procurement Board – Internal Governance Q2	Fieldwork
4	Information Management & Customer Services – Internal Governance Q2	Fieldwork
5	Early Intervention and Prevention	Fieldwork
6	Partnerships	Fieldwork
7	IT controls - data integrity and security	Planning
8	Performance Management framework	Planning
9	Health & Social Care Integration	Planning
10	Information Management & Governance	Planning
11	People Management	Planning
	Assurance Projects	
12	Troubled Families – Payment by Results	Fieldwork

	School Audits	**Status**
1	Livingstone	Draft Report
2	Rosh Pinah	Draft Report

Appendix D: Internal Audit Effectiveness Indicators

Performance Indicator	Annual Target	End of Quarter 2
% of recommendations accepted	98%	100%
% of recommendations implemented	90%	67%
External Audit evaluation of Internal Audit	Reliance On IA	Quarter 4 assessment
Average client satisfaction score (above 3)	90%	90%
% of Plan delivered	47%*	40%
% of draft reports completed within 10 days of finishing fieldwork	90%	90%
Periodic reports on progress	Each Audit Committee	Achieved
Preparation of Annual Plan	By April	Quarter 4 assessment
Preparation of Annual Report (previous year)	Prior to A.G.S.	Achieved
Staff with professional qualifications	70%	75%
Staff development days	5 days	Quarter 4 assessment

* Quarter 2 target equated as 95% of quarter 1 and 2 activity

Appendix E: Quarter 2, 2013-14: Priority 1 Recommendations due

Code to ratings:

Shading	Rating	Explanation
	Implemented	The recommendation that had previously been raised as a priority one has been reviewed and was considered implemented.
	Partly Implemented	Aspects of the priority one recommendation had been implemented however not considered implemented in full.
	Not Implemented	There had been no progress made in implementing this priority one recommendation.

Audit Title, Recommendation and Date	Responsible Area	Initial Follow-Up Response from Management (July 2013 – part implemented)	Follow-up findings Q2 2013-14	Audit Assessment October 2013
1. Regeneration Programme (November 2012) **Project plans and dependency management** The review identified areas where the Council side programme and project plans and dependency management should be improved. a) Management should consider the introduction of Programme Plan to monitor competing priorities and project interdependencies b) The interim management process introduced for the effective management of projects should include planning and dependency management controls. In particular, this should include: • The introduction of appropriately detailed client side project plans, which ensure all tasks are identified, including the critical path. • Opportunity to ensure that progress is formally monitored and reviewed against an agreed baseline on a regular basis. • A process to ensure that all project and programme dependencies are identified assessed and agreed.	Regeneration Programme	**Project Level** At the project level this recommendation has been implemented. All regeneration projects now have comprehensive Project Initiation Documents, which detail major project milestones and project dependencies. These are supported by client side MS Project Plans as well as contractor delivery plans. Delivery against project milestones are monitored at individual project boards via project highlight reports, with slippage escalated to the Growth & Regeneration Operations Board as required. Every member of the regeneration team now has access to MS Project. **Programme Level** The initial Programme Definition Document (PDD) was produced alongside a critical path of programme activities. The Growth & Regeneration Operations Board agreed	A dependencies workshop was held on 3rd July 2013. During this workshop the process for dependency monitoring was set out and exercises were undertaken to further instil and explain this. A regeneration programme log has been developed as the main monitoring tool (information from this is used to populate the programme highlight report). The programme log includes: - Key programme documents (provides guidance and tracks monitoring frequency) - Change log (tracks changes that impact rag ratings as well as updates to key programme documents) - Summary terms of reference of programme and enabling boards as well as decision making triggers. - Governance schedule (provides timing of the above to enable forward planning of major or strategic decisions) - Risk log (actions to mitigate risks associated with dependencies are tracked here). - Issues log (actions to mitigate issues associated with dependencies are tracked here).	**Implemented** The regeneration programme log provides an appropriate method of monitoring dependencies. The Programme Definition Document includes an escalation route and monitoring process for dependencies, showing a long-term commitment to dependency management.

Audit Title, Recommendation and Date	Responsible Area	Initial Follow-Up Response from Management (July 2013 – part implemented)	Follow-up findings Q2 2013-14	Audit Assessment October 2013
Followed by coordinated and focussed action in order to ensure they are managed and monitored.		that further work was required on the dependency management, stakeholder engagement, communications, costs and benefits sections of the document. An initial dependency map has been drafted. A process for the continued identification, agreement and on-going monitoring and managing of regeneration dependencies is required. **Audit Assessment:** **Partly Implemented** *Further work has commenced to establish a process for the continued identification, agreement and on-going monitoring and management of regeneration dependencies. Engagement with Corporate Programmes to obtain advice and templates for dependency logging has been undertaken. An interactive workshop for the*	- Decisions log and forward plan of decisions - Key milestones (monitors performance against baseline as set by Annual Regeneration Report) including dependency critical points. - Critical path (identifies key workstreams as well as resource and process dependencies, monitoring start points and trigger points) - Budget - Decant (monitors decant schedule for regeneration programme – this will be integrated into the Council's Decant Strategy which is currently being updated and any changes will be subsequently reflected in the programme log.) - Dependencies log (identifies and monitors programme level dependencies and project specific dependencies). Project specific development trigger points or requirements as per phasing or deliverables are also identified and monitored in a separate spreadsheet for the whole programme lifetime and in the project logs. - Benefits log	

Audit Title, Recommendation and Date	Responsible Area	Initial Follow-Up Response from Management (July 2013 – part implemented)	Follow-up findings Q2 2013-14	Audit Assessment October 2013
		Regeneration team has been arranged where project and programme dependencies will be identified. Programme dependencies will be monitored by the Growth & Regeneration Operations Board and also through the Programme Highlight report which is presented monthly to Strategic Commissioning Board for approval. **Revised recommendation implementation date:** 30/08/2013	- Lessons learned log Key programme dependencies are reported on a monthly basis to the Growth & Regeneration Operations Board and Strategic Commissioning Board via Programme Highlight Report. This report is also circulated to Assets and Capital Board for information. Any immediate concerns associated with a dependency (and any decisions/ actions required as a result) will be highlighted on the cover note and summary section of the Programme Highlight Report (and relevant project highlight report) The process for dependency monitoring is set out in the Programme Definition Document (PDD). The PDD was approved by Strategic Commissioning Board on 17th September for approval. **Implemented**	

Audit Title, Issue and Date	Recommendation	Management Response	Responsible Officer	Deadline	Audit Assessment October 2013
2. Asset Management (Rent Review), June 2013 **Data Quality** <u>System update</u> The Property Support Officer indicated that valuers were required to independently check the input of rent review data to the Access system, including the next rent review date. There was however no evidence of such input and independent check. We tested 18 Delegated Power Reports (DPR's) outlining approved rents and agreed those rents, next review date and last review date to the system to ensure the correct input of rent review outcome details. Of the 18 tested, we noted 4 exceptions, 3 relating to incorrect last review and next rent review dates and one relating to the input of a new rent uplift figure which had not been applied in SAP owing to the invoice being disputed and cancelled. The system had not been corrected to reflect the previous rent. <u>System limitation for ensuring data quality</u> Further, the system was not tailored to fully support the automated rejection of inaccurate data input. For instance, we noted that a date input as 31/6/2010	A quality assurance framework to ensure data is processed accurately and timely should be implemented, for example a process: - to evidence the input and independent check of rent review DPR detail to the system and - to evidence independent review of DPR back rent calculations and DPR rent and back rent upload to SAP. The process for comparing SAP and system generated reports for comparison of rents in SAP and the system and the investigation of discrepancies should be undertaken periodically. The quality assurance framework should include the independent quality review of rent review delivery by officers to ensure that rent review outcomes are correct and completed within acceptable timeframes in	Agreed. A process will be developed which positively validates that the data entry has taken place and that it is a proper record.	Head of Estates	End August 2013	**Partly implemented** The rent review process was documented and included arrangements for ensuring the timely and accurate processing of rent review details to the property database and SAP. However the process for ensuring accurate processing had not been implemented and embedded in day to day operation.

Audit Title, Issue and Date	Recommendation	Management Response	Responsible Officer	Deadline	Audit Assessment October 2013
was accepted and converted to 10/6/1931 when it should have been rejected. <u>SAP update</u> The officer responsible for updating SAP with rent review outcomes confirmed that there were no independent review/reconciliation processes to ensure that rents and back rents associated with completed rent review cases had been correctly input to SAP on a timely basis. We tested 16 DPR's to SAP to ensure the accurate input of rent uplifts and back rent to SAP. Of the 16 tested, we noted 8 instances where the back rent differed from the approved DPR. There were 2 instances where the back rent and in one instance where the rent uplift in the completed DPR's had not been input to SAP. <u>Progress monitoring data</u> In addition, for rent review cases allocated for completion, we noted an allocated case which did not appear on the allocation schedule and noted that the date of allocation was not consistently recorded on the allocation schedule to optimise progress monitoring. We tested 10 cases due for review	line with case complexity. Note: The quality assurance framework need not review each case but should involve the review of a sample of cases in line with the risks.				

Audit Title, Issue and Date	Recommendation	Management Response	Responsible Officer	Deadline	Audit Assessment October 2013
between 01/01/2012 to 31/03/2012 to ensure that they had been allocated. Of 10 cases tested as due for rent review, 3 had been allocated. Of the 3 allocated, 1 was not recorded on the "Case List" to facilitate monitoring. For the 2 cases allocated and recorded, the date of allocation was not recorded to optimise progress monitoring. <u>Quality assurance of valuer delivery</u> In addition, we established that there were no internal arrangements to specifically quality assure rent review cases completed by officers to ensure that rent review processes, and negotiations were undertaken correctly and promptly.					

Audit Title, Issue and Date	Recommendation	Management Response	Responsible Officer	Deadline	Audit Assessment October 2013
3. Records Management (Children's Service), March 2013 **Access to Shared folders with personal information** We established that access to SEN Performance and Education Psychology electronic folders containing personal data was not restricted to the appropriate officers. Management confirmed that 52 of 98 officers who had access to the relevant electronic folders should not have had access. Management confirmed that there was no process to review access controls to ensure that access was appropriate. The practice was not in compliance with the Information Security Policy which referred to the use of access controls to protect information assets. In addition, it was not clear whether the functionality of the current system rendered these spreadsheets necessary. Teams maintain spreadsheets with personal data to support	Management should undertake periodic reviews of officers who have access to their electronic folders to ensure compliance with Information Governance policies. There should be a review of spreadsheets to ensure that those in use are necessary and compliment, rather than hinder, the current records management processes. A policy or procedure governing spreadsheet security should be developed and communicated to all teams. The policy should refer to following a risk based approach for decisions on how and whether to secure spreadsheets and should state the mechanisms for restricting access to or preventing the update of spreadsheets in line with identified risks.	Agreed. Access could be reviewed against records of staff with access which could be provided. Initiatives to increase the use of Tribal as a system for capturing information centrally are being considered. This should minimise duplication of information and the use of alternate local systems for recording information, facilitate the efficient retrieval of all relevant data and the efficient update of records. The Corporate Commissioning Council will need to be engaged in related decisions on initiatives.	Interim Assistant Director, Partnerships and Transformation	June 2013	**Partly implemented** The Tribal Project which aims to roll out the Tribal system already used by some teams in Education and Skills will reduce the need to retain children's data in shared folders and reduce the need for retaining data in secure spreadsheets. The Project has started and is due to complete in the summer 2014. As an interim measure, the Children's Service Data Team Manager and the Data Systems and Assurance Manager issued a circular to staff referring to the careful and considered use of spreadsheets. It also provided contact details of the Data Systems and Assurance Manager for related advice and guidance. A manual review of folder access will be undertaken shortly to identify all

Audit Title, Issue and Date	Recommendation	Management Response	Responsible Officer	Deadline	Audit Assessment October 2013
the current IT systems in use. Spreadsheet owners adopted different approaches to securing spreadsheets, some relying only on restricted access to the electronic folders in which the spreadsheets were saved and some had password protected spreadsheets. There was no policy on securing spreadsheets, or understanding the need for them, to ensure that a consistent approach was adopted across the Service.					officers with access to shared folders. Instructions will be issued to IS to remove officers confirmed with managers as not requiring access. It is envisaged that this process will be undertaken by the end of October/November 2013. **Due date**: Folder access review: October/November 2013. Implementation of Tribal: 30 June 2014
4. Records Management (Children's Service), March 2013 **Duplicate data held across teams / inconsistent and inaccurate data for a child held across teams**	A record change control process should be implemented which should involve capturing change to records centrally for communication across systems and teams.	Agreed. Initiatives to increase the use of Tribal as a system for capturing information centrally are being considered. This should minimise	Interim Assistant Director, Partnerships and Transformation	September 2013	**Partly implemented** The Tribal System review Project which aims to roll out the Tribal system used by some teams (Special Education Needs) across all teams in Education and Skills will reduce the

Audit Title, Issue and Date	Recommendation	Management Response	Responsible Officer	Deadline	Audit Assessment October 2013
We identified 2 instances where communicated changes to SEN records had not been updated in Tribal demonstrating the need for the introduction of compliance reviews. Management in the Education Psychology Team and SEN Performance team indicated that identified changes to personal data would be updated across all systems in their team and in other systems where there was a known involvement with the child. However there were no arrangements for teams to capture changes centrally for monitoring whether changes had been updated in their systems and for the communication of such changes to other teams for update in their system, where applicable. For instance, we found inconsistent address and contact detail information for 10 of 17 records for Children held by SEN Performance Team in Tribal and held by Education Psychology Team.		duplication of information and the use of alternate local systems for recording information, facilitate the efficient retrieval of all relevant data and the efficient update of records. The Corporate Commissioning Council will need to be engaged in related decisions on initiatives.			duplication of data across teams. Key data will be available centrally in one place in Tribal, so changes will be available to all officers without the need for the manual update of records across various teams. The Project has started and is due to complete in the summer 2014. In the interim, an initiative to provide teams without access to Tribal with read only access is being introduced, subject to of the availability of Tribal licences. Should the officer with read only access identify incorrect contact details, the correct data will be communicated to officers in SEN for them to update. **Due date**: Start of initiative to implement read only access in Tribal: Immediately – October 2013.

Audit Title, Issue and Date	Recommendation	Management Response	Responsible Officer	Deadline	Audit Assessment October 2013
					Implementation of Tribal: 30 June 2014
5. Records Management (Children's Service), March 2013 **Records retention and destruction** While arrangements existed and were followed to identify SEN paper records for destruction, responsible officers in the Education Psychology Team and SEN Performance Team indicated that there was no process for independently reconciling individual records that were scheduled to be destroyed to schedules of records available in the team. There were also no arrangements to ensure that records for the same child across teams and across the forms available (paper, electronic records and spreadsheets) were destroyed at the same time, where applicable.	Arrangements should be implemented for reconciling physical records for destruction in the archive to related theoretical records in the administration teams. Arrangements to communicate records destroyed across teams should be implemented to ensure that all relevant records for a client are destroyed simultaneously.	Agreed. This area would be addressed by the Children's Service Information Manager in a new role being agreed currently.	Children's Service Information Manager	September 2013	**Partly implemented** The current process for archiving SEN files for both the SEN team and the EP team will be reconciled in to one process with one file going to the archive unit and 1 process for destruction which will be in line with the corporate destruction process (35 years from closure). This process will be drafted, signed off and implemented by December 2013. There will also be a review of all records at the archive unit to ensure they have the correct destruction date. Currently a Capital bid for a Children's Service Records managers has been submitted which if successful will enable better management of the records destruction. **Due date** December 2013

Audit Title, Issue and Date	Recommendation	Management Response	Responsible Officer	Deadline	Audit Assessment October 2013
6. Records Management (Children's Service), March 2013 **Records retention and disposal processes:** - had not been implemented to identify expired records in Tribal. - were not implemented in line with Council policy for SEN records. The Council's Records Retention and Disposal policy referred to the destruction of records 35 years from closure not 35 years from date of birth applied by the Council. - resulted in the archiving of records in the incorrect year resulting in destruction after expiry and inconsistent dates of destruction between teams.	Management should determine and communicate the correct retention period for SEN records for inclusion in the Council's Records Retention and Disposal Policy. Records retention and destruction processes for electronic and paper records should be correctly and consistently followed in line with the Council's policy for retention and disposal.	Agreed. This area would be addressed by the Children's Service Information Manager in a new role being agreed currently. Children's Service management had not been consulted on the retention period included in the Council's Records Retention and Disposal policy. The correct retention period would need to confirmed and updated in the retention guidelines as necessary.	Children's Information Manager	September 2013	**Partly implemented** The retention policy of 35 years from closure has been confirmed. The current process for archiving SEN files for both the SEN team and the EP team will be reconciled in to one process with one file going to the archive unit and 1 process for destruction which will be in line with the corporate destruction process (35 years from closure). This process will be drafted, signed off and implemented by December 2013. There will also be a review of all records at the archive unit to ensure they have the correct destruction date. Currently a Capital bid for a Children's Service Records managers has been submitted which if successful will enable better management of the records destruction. **Due date** December 2013