Appendix A

London Borough of Barnet

Internal Audit & Risk Management

Progress Report 2012-13 – Quarter 4
(up to reporting deadline of 25th March 2013)

Maryellen Salter, Assurance Director

1. Introduction

The Internal Audit Plan was accepted by the Audit Committee on the 26th April 2012. 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 30th November 2012 to the 25th March 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 26 reports in accordance with the 2012-13 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 5 reports given limited assurance. The summary detail of those reports issued as limited assurance are included within section 3.

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

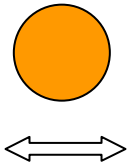
Title	Records Management – Children's Service			
Assurances	**No**	**Limited**	**Satisfactory**	**Substantial**
Audit Opinion & Direction of Travel				
Date final report issued	March 2013			
Background	Records management is the systematic control of an organisation's records, throughout its life cycle, in order to meet operational business needs, statutory and fiscal requirements and community expectations. Effective management of information allows for fast, accurate and reliable access to records, ensuring the timely destruction of redundant information and the identification and protection of vital and historically important records. The following council-wide polices apply: • Data Protection Policy • Information Security Policy • Information Sharing Policy • Records Retention and Disposal policy. We reviewed records management processes in two teams in the Children's Service, the SEN Performance Team and the Educational Psychology Team.			

Summary of Findings	We reviewed records management processes in the SEN Performance Team and the Educational Psychology Team.
	
	We identified the following significant issues:
	• In relation to the retention and destruction of records, we noted the following:
	  • There were no arrangements to reconcile records physically destroyed to theoretical records of records for destruction.
	  • records retention and disposal processes had not been applied for Tribal, had not been applied in line with Council policy for SEN records and were incorrectly and inconsistently applied between teams.
	• Access to electronic folders with personal and sensitive SEN data was not restricted to those officers where the access was necessary for their role. There was no policy to limit the use of spreadsheets in teams where approved systems such as Tribal would adequately support service delivery and to ensure a consistent approach to securing spreadsheets, where their use was approved, with personal data across teams. Spreadsheets record the children subject to transport arrangements and their addresses for collection, details of pending SEN performance reviews for communication to attendees and record the names and dates of birth of children for the archiving and destruction of related files. The expectation was that spreadsheets with personal data should be password protected to prevent unauthorised access and update.
	• There were no arrangements for teams to capture changes centrally for the communication of such changes to other teams for update in their system, where applicable and for monitoring whether changes had been updated across systems and teams.
	
	We identified the following issues:
	• Record management practices were not consistently followed by all teams to ensure the accuracy, security and appropriate and timely sharing of SEN records across the Service.
	• Where records management practice was governed by documented procedures, they included inaccuracies and did not refer to all requirements for sound records management for example the retention and destruction process stated in procedures referred to the destruction of records at the age of 25 instead of destruction 35 years from closure as referred to in Council's Records Retention and Disposal policy for SEN information.
	• Some officers (23%) had not undertaken the compulsory E-Learning Information Governance training necessary to raise awareness of polices relevant to records management. The processes for ensuring that the E-Learning training was undertaken by all staff were not robust.

	• Arrangements for disabling leavers from Tribal were not robust, relying on notifications by the relevant management which generally increases the risk that leavers may not be promptly disabled in the system. • Arrangements for identifying all information and records held for a child were not efficient as there was no central record of where all records for a child could be located across teams and systems. The system relied upon individual staff knowledge of where records may be located across systems. Arrangements for being aware of where all information for a child is available are necessary to ensure effective decision making and service delivery. • We established that arrangements did not exist for monitoring compliance with polices and procedures relating to records management. Compliance reviews are necessary to ensure that records are not misplaced or lost, that related data is accurately maintained across systems and that information is shared appropriately and securely. • There was no evidence of management review to ensure that appropriate information was shared securely and appropriately in line with the Council's Information Sharing Policy. We noted the following low priority issues: • We noted an instance where the cabinet holding the keys to the storage cabinets with SEN files was left unlocked. • For paper records, we reviewed the removal of files from Cabinets and the use of the file location indicator document as a control to indicate to other staff where the file could be located. In the sample we reviewed we found that 4 out of 5 files could not be located.

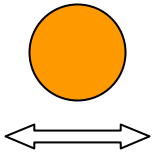
Priority 1 recommendations	**Recommendation 1:** Management should undertake periodic reviews of officers who have access to their electronic folders to ensure compliance with Information Governance policies. There should be a review of spreadsheets to ensure that those in use are necessary and compliment, 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. **Recommendation 2:** A record change control process should be implemented which should involve capturing changes to records centrally for communication across systems and teams. **Recommendation 3:** 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. **Recommendation 4:** 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.

Management Responses and agreed action dates	**Management Comment 1:** 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. **(June 2013)** **Management Comment 2:** Agreed. 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 update of records. The Corporate Commissioning Council will need to be engaged in related decisions on initiatives. **(September 2013)** **Management Comment 3:** Agreed. This area would be addressed by the Children's Service Information Manager in a new role being agreed currently. **(September 2013)** **Management Comment 4:** 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. **(September 2013)**

Title	Contract Procedure Rules Compliance for under £25k – Environment, Planning and Regeneration			
Assurances	**No**	**Limited**	**Satisfactory**	**Substantial**
Audit Opinion & Direction of Travel Previous audit 2011-12 – Contract Management (limited assurance)				
Date final report issued	December 2012			
Background	The Contract Procedure Rules (CPRs) cater for the use of suppliers for supplies, services and works involving expenditure below 24,999 (the minimum selection threshold for competitive quotations) as part of a contractual relationship, to expedite service delivery without the need for more onerous selection processes while still aiming to optimising value for money outcomes from such arrangements.			

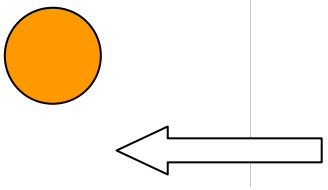
Summary of Findings	There were two significant issues identified as part of this audit: • Contracts less than £25,000 (and above £5,000) were not included within the EPR Contracts Register as required by the Council's Contract Procedure Rules. • Currently there is no pro-active review of vendor spend for assessment with the Service for future procurement exercises and ensuring compliance with procurement requirements for transparency and competition. The EPR Business support team follows a re-active process for monitoring vendor spend. This approach means that non-compliant spend may not be identified at the earliest possible stage to expedite completion of compliance action. We identified the following issues: • A key officer in the EPR Business Support Team had not completed the procurement e-learning session and the Procurement and Contract Monitoring in EPR training. In addition, another officer confirmed that he was not aware of how to undertake vendor spend analysis in SAP, a key control for ensuring threshold levels as defined by the Contract Procedure Rules are not exceeded. • Documented procedures provided by the EPR Business Support team for monitoring and evaluating vendor spend on a re-active basis for compliance action had not been updated to reflect the most recent CPR thresholds. Further, procedures did not define roles and responsibilities and were not dated and version controlled to ensure they were updated and subject to on-going review. The procedures describe the re-active support process followed by the EPR Business Support team for identifying vendor spend in response to requests from contract managers. The process identifies whether proposed spend will exceed CPR thresholds and ensures the implementation of action to make the contract CPR compliant, where necessary. . • Most contract managers reflected on the Directorate contracts register had not undertaken the CAFT E-Learning Fraud Awareness Training necessary for understanding fraudulent practices associated with procurement, the consequences of such fraudulent activity and commmunication of obligation to report concerns. • A register of declared conflicts of interests was not maintained for review and decision making around officer involvement in procurement and contract management activity.

Priority 1 recommendations	**Recommendation 1:** Arrangements for EPR Business Support Team systematically identifying and investigating vendor relationships below £25,000 for inclusion in the Directorate contracts register should be introduced. Confirmed relationships below £25,000 should be included in the directorate contracts register. Where spend is identified for vendors delivering services covered by other relationships which have been made CPR compliant, they should be removed from SAP. **Recommendation 2:** Routine pro-active reviews of vendor spend in SAP below £25,000 should be undertaken by the EPR Business Support Team. The review should take place as noted within the procedures published by the Corporate Procurement Team. Identified spend below £25,000 not on the contracts register should be investigated further with the Service and Corporate Procurement. Compliance action should be implemented and implementation monitored for future aggregated spend expected to exceed CPR thresholds. Where spend above £5,000 is not expected to exceed the £25,000 threshold, the relationship should be included on the Directorate contracts register as required by the Contract Procedure Rules.
Management Responses and agreed action dates	**Management Comment 1:** The contract register was determined to exist for contracts above £25k initially. Work is now underway with Corporate Procurement to agree a common and structured method for inclusion of contracts under £25k on the register and presentations of same. **(March 2013)** **Management Comment 2:** The agreed process with Corporate Procurement will include access to routines reports. It will also consider processes for managing categories of spending within the Services register in order to ensure consistency of approach. **(March 2013)**

Title	Equalities			
Assurances	**No**	**Limited**	**Satisfactory**	**Substantial**
Audit Opinion & Direction of Travel An Assurance Level of "limited" was provided in 2010-11 for Equalities.				
Date final report issued	March 2013			
Background	The public sector Equality Duty set out in the Equality Act 2010 requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people when carrying out their activities.			

Summary of Findings	Overall we recognise the sound procedures in place to comply with the Equality Act. We noted the following areas of good practice: • Based on our sample testing, the Council has complied with the Equality Duty, which requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people when carrying out its activities. • There is a systematic process to review equality impact assessments through the finance and business planning group that meet monthly. • There is a robust quality control process for completion and review of Equality Impact Assessments as Directorates have developed their own quality assurance of Equality Impact Assessments, and all Council, Cabinet Committee and other Committee papers and Delegated Powers Reports must be circulated and cleared by the Chief Executive's Service for strategy and equalities issues. We did however identify the following significant finding as part of the audit: • The Council does not have measurable, published equality objectives in place, as required by the Equality Act 2010. In addition, we found the following other issues for consideration: • The Equality Policy has not been updated since 2010 and it does not take account of the Equality Act, Duty or Specific Duties. • Some Directorates are unclear as to the advice and assistance available centrally, and what is required of Directorates with regrads to Equalities and the completion of Equalities Impact Assessments. • Some Directorates have developed their own guidance and there is a lot of informal and ad hoc sharing of knowledge and experience. However, all of those interviewed as part of our review felt that there was an opportunity to develop central guidance and a knowledge bank of Equalities Impact Assessments. • Whilst all Council, Cabinet and other Committee papers must be signed off by the Chief Executive's Service, there are no formal performance indicators for measuring corporate performance on Equalities. There is an opportunity to record information on advice and assistance which has been requested by Directorates in order to evidence and improve organisational performance on Equalities

Priority 1 recommendations	**Recommendation 1** The Council should immediately put in place and publish specific, measurable equality objectives and ensure that plans for monitoring and reporting the objectives are set and followed.
Management Responses and agreed action dates	**Management Comments** The council has now agreed and put in place measures to track progress against its Strategic Equalities Objective, which is enshrined in its constitution and is published in its annual Corporate Plan. The measures – which are based around community cohesion and council support to different groups - will be reported publicly as part of the council's quarterly reporting cycle. Reporting will formally begin in Quarter 4 2012-13. The council is taking the opportunity, through its transition to a commissioning organisation, to review its equalities objectives and reporting framework to ensure they are in line with the changing nature of the borough in terms of its diversity – as highlighted in the recent release of Census data. This review will be completed by the end of April 2013. Any changes to the council's specific duties, or the way in which progress is monitored, following the review will be implemented and reported against publicly from Q2 of the 2013-14 performance cycle. **(Implemented)**

Title	Foster Carers			
Assurances	**No**	**Limited**	**Satisfactory**	**Substantial**
Audit Opinion & Direction of Travel Satisfactory Assurance (2011-12)				
Date final report issued	March 2013			
Background	The objective of the Foster Carers payment process is to ensure foster carers are paid in a fair and timely manner. Payments should be made only to authorised foster carers, and the amount should be in line with regulatory standards for minimum payments.			

Summary of Findings	We noted the following areas of good practice: • All policies and procedures are reviewed annually and version-controlled. We identified the following significant issue as part of the audit: • In our sample of 31 payments we identified two "Regulation 24" carers (where a relative, friend or other person connected with the child fosters the child) who did not have foster carer agreements in place in line with statutory regulations. We also found a regular foster carer without a signed panel agreement in place, and two carers with annual reviews carried out between May and July 2012 which were still awaiting a manager's signature, again contrary to statutory regulations. In addition to the main findings, we also identified the following issues: • Of our sample of 31 payments, 10 (32% of sample) were made for which no commitment form was available for audit to review and 1 (3%) had not been authorised by a manager, both contrary to internal procedures, and 1 (3%) had not been made in a timely manner. Commitment forms outline the required payment level for each foster carer and should be used by the finance team to authorise payments in the payment run. • One (3%) of our sample of 31 payments identified a payment where the child's data had not been anonymised when being sent through SAP, the Council's financial system for making payments. This meant that the child's name and approximate age were visible to all users of the council's SAP systems. • The Swift system in use does not allow easy identification of payment authorisers and the majority of commitment forms are not scanned into Swift meaning that the finance team are not able to check these when compiling the payment run, contrary to internal procedures. • Whilst most policies and procedures are available to all staff on the practicemanual.co.uk area for Barnet our testing found that the Detailed Scale of Payments documents were not on the website.
Priority 1 recommendations	**Recommendation 1** All foster carer authorisations should be carried out in line with statutory requirements and authorised at the appropriate level. Where foster carer agreements have been entered into and reviews have been carried out, they should be signed off.

Management Responses and agreed action dates	Agreed.

Title	Legal Services - clienting			
Assurances	**No**	**Limited**	**Satisfactory**	**Substantial**
Audit Opinion Direction of travel not applicable, no previous review in this area.				
Date final report issued	March 2013			
Background	A joint legal service (HB Law) was established with the London Borough of Harrow in September 2012. Barnet Legal Service staff transferred to Harrow providing legal advice to both Harrow and Barnet Councils. This was approved by the Cabinet Resources Committee on 4 April 2012.			

Summary of Findings	Since the joint legal service went 'live' in September 2012 service has continued to be provided to the Council at standards previously observed. Crucially, the Council (as Commissioner) has not identified any downturn in the performance of the joint legal service. We have not however reviewed the joint legal services working practices as part of this review. Areas of good practice During the review several areas of good practice were identified, including: • The governance arrangements and roles and responsibilities are clearly documented within the Inter Authority Agreement. • Comprehensive financial monitoring, in relation to the joint legal service, is provided by Corporate Finance. • A comprehensive report is provided by the joint legal service to the Strategic Monitoring Board, which included performance against key performance indicators (time, cost and quality) and customer satisfaction information. There were four findings from this review (three 'Priority One' (High) and one 'Priority Two'(Medium)) as summarised below: Priority One • Contract Management - The review identified areas where the client side management of the Joint Legal Service (JLS) contract could be strengthened. There is currently no Contract Manager in place. The Contract Manager post for the JLS will form part of the Commercial arrangements, as part of the retained organisation. However this recruitment process has been delayed since September 2012. Risk Management -The review found areas where the client side risk management controls could be improved. The Inter Authority Agreement clearly sets out the risk management procedure which the JLS should maintain in the delivery of the service. However, the absence of a Contract Manager may result in this process not operating effectively in practice. Risks noted within the project prior to go 'live' were not transferred internally for those retained risks identified. • Benefits Realisation - The review found that there was no documented process in place for ensuring that the cost, quality and effectiveness benefits, set out in the original business case, were regularly monitored and managed to ensure that they are fully realised. The review was unable to identify a nominated person responsible, in the absence of a Contract Manager, for the ongoing monitoring, management and realisation of benefits.

	The review also found that there were no documented baseline figures for the benefits to be monitored against. <u>Priority Two</u> Customer Satisfaction - The review found that the Council did not have visibility of the content of customer satisfaction feedback collected or the JLS process in place to act on customer feedback as required. The Council are required to conduct their own client side monitoring of customer satisfaction in order to verify the information provided by the JLS, however, the review was unable to identify processes in place to monitor and act on customer opinions in the absence of a Contract Manager.

Priority 1 recommendations	**Recommendation 1:** Management should consider implementing an interim resource solution until the permanent Contract Manager is appointed, to ensure that all the Council's contractual management obligations are adequately resourced and that the Joint Legal Service (JLS) provides the service in accordance with its obligations under the IAA. **Recommendation 2:** Management should ensure that the Council's risk management process is adopted and that risks facing the Council in relation to the Joint Legal Service (JLS) are: • Identified, analysed, sufficiently mitigated and recorded on the Council's JCAD system; and • Regularly monitored, managed and escalated appropriately. Management should ensure that, once appointed, the Contract Manager is actively engaged in JLS case work risk management processes. **Recommendation 3:** Management should implement a process to ensure that the benefits identified in the original Joint Legal Service (JLS) business case are fully realised. This should include: • Identifying baseline measurements for the realisation of benefits to be measured against • Ensuring that each benefit has an owner responsible for ensuring its realisation; and • Regular monitoring and management of benefits, supported by reporting to Strategic Monitoring Board as appropriate.

Management Responses and agreed action dates	**Management Comments 1:** An interim resource solution is currently be explored with the Head of Commercial it is expected that this will be in place by mid-April 2013. **Management Comments 2:** Risk Management processes will be adopted immediately. (April 2013) **Management Comments 3:** Benefits realisation will be monitored and followed-up through the contract manager and will be designed in liaison with the Head of Commercial.

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. As at the end of March there was only one report outstanding with Adults Social Care and Health for the review of the Mental Health Partnership.

As we are not at the end of the quarter for reporting purposes as such a number of the performance indicators have not been finalised, however of those reports issued 90% have been issued within 10 days of finalising fieldwork and the service has had a number of quality performance questionnaires returned, of which 100% have been returned with a rating over 3 (satisfactory) with the majority rated as Excellent. Quarter 1, 2 & 3 information has been included for reference in Appendix D.

Implementation of internal audit recommendations – there has been an increase in council-wide performance for the implementation of recommendations within the quarter. Last quarter (quarter 3) the number of recommendations implemented was 87.5%, representing 7 out of 8 recommendation implemented in the quarter that were due. The progress of quarter 4 recommendations is included in Appendix E where 4 out of the 5 (80%) recommendations are implemented, one outstanding is now considered closed for reporting to the Audit Committee as the action left outstanding is for the Landlord to complete.

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.

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 2012 in respect of timing and additional audits requested from Directorates.

Type	Audit Title	Reasons
Additional to plan	NSCSO key performance indicators	Reviewed key performance indicators as drafted for the NSCSO contract and reviewed for data quality characteristics.
Additional to plan	DRS Key Performance Indicators	Reviewed key performance indicators as drafted for the DRS contract and reviewed for data quality characteristics.

7. Reports for management purposes

There were two reports issued 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:

- NSCSO and DRS key performance indicators – a number of key performance indicators included to measure the success of both contracts were not robust in terms of data quality. For example, policies and procedures governing the collection of data were not in existence, some targets did not have baseline data, some data was inaccurate, and some of the source data was not adequately protected from data loss or data error. These reviews were a proactive audit requested from the projects to ensure that any issues could be rectified pre-contract sign.

8. Risk Management

Risk Management continues to embed across the Council. An Assistant Director Challenge Group discusses risks contained within Directorate and the Corporate Risk Register on a quarterly basis. The corporate risk register was recently reported to full council on the 5th March as part of the Annual Budget.

Appendix B: 2012-13 work completed during quarter 4 including assurance levels as at March 2013

Audit Opinions on Completed Audits during the period

	Systems Audits	Assurance
1	Records Management – Adults Social Care and Health	Satisfactory
2	Records management – Children's Service	Limited
3	Income and Debt Management	Satisfactory
4	Contract Procedure Rules compliance – Environment, Planning and Regeneration under £25k	Limited
5	Budget Management	Satisfactory
6	Equalities	Limited
7	Information Governance	Satisfactory
8	Risk Management	Satisfactory
9	Payroll	Satisfactory
10	Customer Financial Affairs	Satisfactory
11	Public Health Integration	Satisfactory
12	Foster Carers	Limited
13	Legal Services – clienting	Limited
14	DRS KPIs	N/A
15	NSCSO KPIs	N/A

	School Audits	Assurance
1	Moss Hall	Satisfactory
2	Danegrove	Satisfactory
3	Dollis Junior	Satisfactory
4	Whitings Hill	Satisfactory
5	Broadfields	Satisfactory
6	Brunswick Park	Satisfactory
7	Edgware Infant	Satisfactory
8	Northway	Satisfactory
9	Mapledown	Satisfactory
10	Cromer Road School	Satisfactory
11	St John's (N11) School	Satisfactory

Appendix C: Work in progress

The following work is in progress at the time of writing this report (March 2013):

Work in progress		
	Systems Audits	**Status**
1	Mental health Agency	End of Fieldwork
2	Asset Management Plan (Rent Review)	Draft Report

Appendix D: Internal Audit Effectiveness Indicators

Performance Indicator	Annual Target	End of Quarter 1	End of Quarter 2	End of Quarter 3
% of recommendations accepted	98%	100% (Met)	100 (Met)	100(Met)
% of recommendations implemented	90%	54% (Not Met)	44% (Not Met)	87.5% (Partially Met)
External Audit evaluation of Internal Audit	Reliance On IA	Quarter 4 assessment	Quarter 4 assessment	Quarter 4 assessment
Average client satisfaction score (above 3)	90%	100% (Met)	100% (Met)	100% (Met)
% of Plan delivered	16%*	17% (Met)	44% (Met)	81% (Met)
% of draft reports completed within 10 days of finishing fieldwork	90%	100% (Met)	90% (Met)	90% (Met)
Periodic reports on progress	Each Audit Committee	Achieved (Met)	Achieved (Met)	Achieved (Met)
Preparation of Annual Plan	By April	Quarter 4 assessment	Quarter 4 assessment	Quarter 4 assessment
Preparation of Annual Report (previous year)	Prior to A.G.S.	Complete (Met)	Complete (Met)	Complete (Met)
Staff with professional qualifications	70%	75% (Met)	75% (Met)	75% (Met)
Staff development days	5 days	Quarter 4 assessment	Quarter 4 assessment	Quarter 4 assessment

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