Internal Audit

Progress Report 2015-16 – Quarter 1

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1. Introduction

The Internal Audit Plan was accepted by the Audit Committee on the 30th April 2015. 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. Schools Audit Approach

Schools key risks

As reported to the Audit Committee in April, earlier in the year we undertook a Schools Assurance mapping exercise to document the 'three lines of defence' around key risks to schools i.e. operational controls, management controls and independent assurance.

This identified potential gaps in coverage and therefore in the Autumn term we are piloting an updated schools audit programme to provide independent assurance over those areas. During the pilot stage we will seek feedback from the schools and any findings will be an Appendix to the main audit report and not impact on the school's audit rating.

Follow-Up audits

At the April meeting of the Audit Committee, it was agreed that we would conduct follow-up audits of two schools that had received Limited Assurance ratings: St. Andrews and Pardes House, and that the Head teacher and / or Chairman of the Board of Governors of schools be requested to attend the next Audit Committee meeting in July if we were not satisfied with the responses received. The appropriate follow-up work has been completed and we are satisfied that the recommendations due have been implemented, see section 7.

It was also agreed that we would review the procedures for escalating actions in the event of schools that fail to respond to audit recommendations.

The Scheme for Financing Schools sets out the financial relationship between the authority and the schools which it funds. It contains requirements relating to financial management and associated issues, binding on both the authority and on schools. The Scheme states that 'the Chief Finance Officer shall arrange an adequate and effective internal audit, under his/her independent control, to examine the schools' accounting, financial and other operations.'

A change to the follow-up process included in the Scheme for Financing Schools is planned which would bring our approach to schools more in line with non-schools audits, where officers have to attend the Audit Committee when we find that high priority recommendations have not been implemented:

- When an audit results in high priority recommendations, internal audit will confirm, by reviewing appropriate evidence, whether these recommendations have been implemented within the agreed timescales. This follow-up will form part of the Internal Audit quarterly reporting to the Audit Committee (see section 7 for the findings from the follow-ups undertaken in Q1).
- If high priority recommendations are found not to have been implemented within agreed timescales, or the school does not respond to the request for a follow-up visit, the school will receive a warning letter from the Director of Education & Skills threatening to withdraw delegation. The Audit Committee will receive a report on where in the escalation process each school is if they have not dealt with the issues raised.

Summary of Proposed changes

This proposal has been discussed and agreed with the Commissioning Director for Children & Young People, the Education & Skills Director and the Strategic Commissioning Board (SCB).

Area	Rationale	Notes
Pupil Premium	New part of Ofsted inspection	• If audit testing finds weaknesses in controls we would recommend that the school have an independent Pupil Premium review undertaken (by the BPSI or another body). • Also refer concerns to the School Improvement team who would then contact the school to follow this up.
Governance	National concerns over schools governance	• Expansion to current testing of governance. • Refer any concerns to the School Improvement Team
Safeguarding	Increased emphasis in Ofsted inspection	• High level testing on pre-employment checks, policies, reporting • Refer any concerns to the School Improvement Team / their Safeguarding consultants
Anti-Fraud	Unexpectedly low number of fraud referrals from Barnet's schools	• School to complete Schools Anti-Fraud checklist • Review response and refer to CAFT if any areas of concern identified
Follow-up	Requested by Audit Committee, brings in line with non-schools audits	• Follow-up Priority 1 recommendations to confirm timely implementation and report findings to Audit Committee on a quarterly basis

Resource Impact

We estimate that the addition of these areas will add a day to the audit of each school. During the pilot we will confirm this. Currently we audit Barnet's 96 schools with a delegated budget on a 3 year cycle.

Current – 3 year cycle	Approximate number of schools audited each year	Approximate days per audit	Audit days in plan
	30	3	100

Of the 96 schools, only 14 were rated as Limited Assurance at their last audit visit. We therefore propose that if the pilot leads to an agreed change to the Schools Audit approach, that we move to a Risk-based system.

We would apply the following triggers. If any of these triggers are met, **we would treat the school as a Priority and keep the school on the 3 year cycle - or bring an audit forward:**

1. Limited or No Assurance on last audit
2. Change of Leadership
3. Schools Improvement or Schools Finance raise a concern
4. CAFT referral

If none of these triggers met, move to 5 year cycle

	Year 1	Year 2	Year 3	Year 4	Year 5		Year 6
Priority schools (estimate 30)	10	10	10	10	10		10
Other schools (estimate 65)	13	13	13	13	13		13
Total schools each year	**23**	**23**	**23**	**23**	**23**		**23**
Current audit days per school	3	3	3	3	3		3
Pilot - additional estimated days per school	1	1	1	1	1		1
Total days per audits	**4**	**4**	**4**	**4**	**4**		**4**
Total	92	92	92	92	92		92
Follow ups	6	6	6	6	6		6
Total annual days needed	**98**	**98**	**98**	**98**	**98**		**98**

Second visit

3. Final Reports Issued

This report covers the period from 1st March 2015 to 30th June 2015 and represents an up to date picture of the work in progress to that date. The Internal Audit service has over this period issued 16 reports in accordance with the 2015-16 Internal Audit Plan. In summary, the assurance ratings provided were as follows:

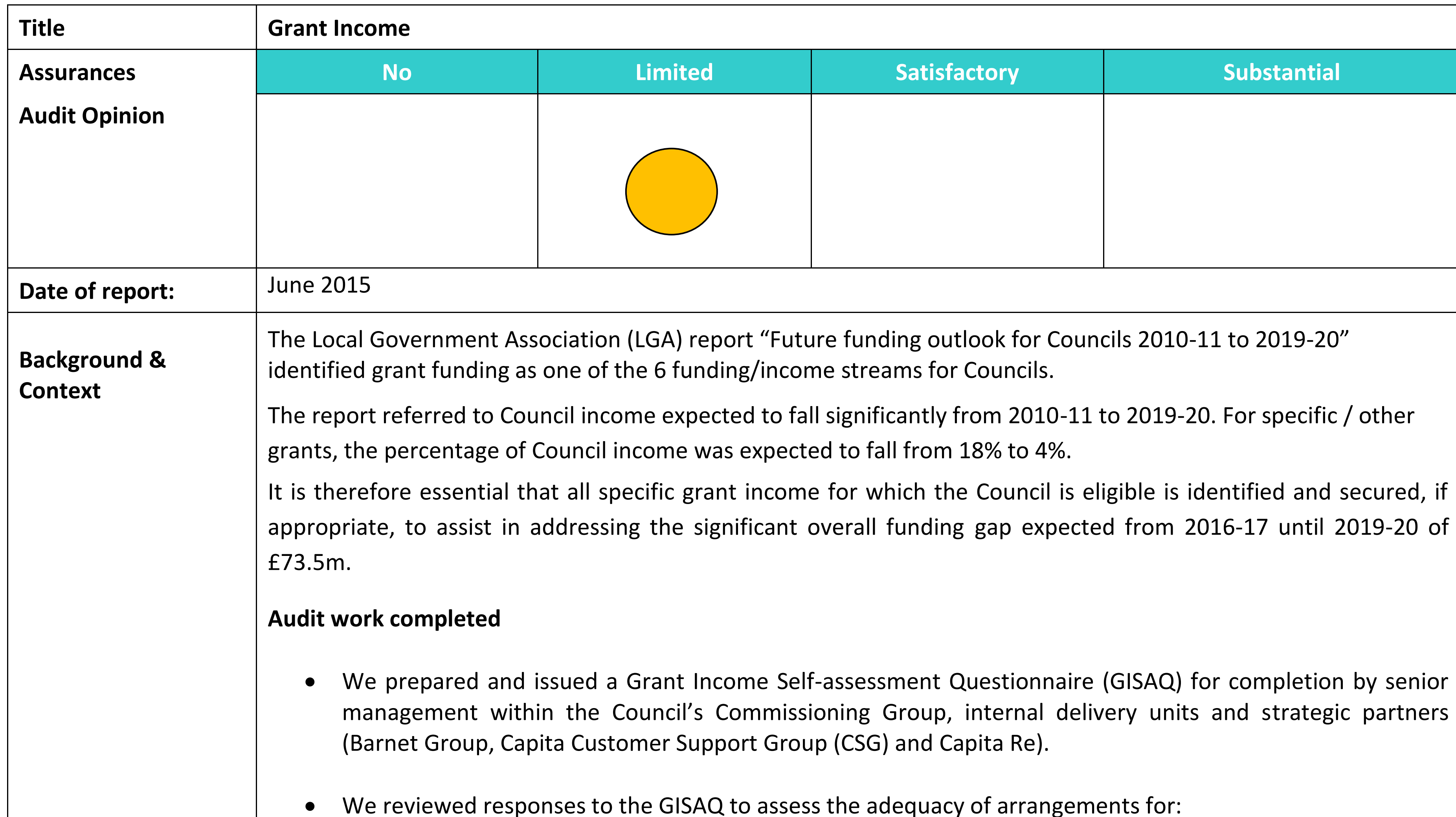
Substantial	2
Satisfactory	7
Limited	4
No	0
N/A	3
Total	**16**

Table 1: 2015-16 work completed during quarter 1 including assurance levels		
	Systems Audits	**Assurance**
1	Grant Income	Limited
2	People Management – Pre-Employment Checks	Limited
3	Internal Governance – Decision Making	Satisfactory
4	Barnet Group – Internal Audit and Housing Risk Management	Satisfactory
5	Business Continuity Strategy	Satisfactory
6	Project Management Toolkit follow-up	N/A
	Advisory Reviews	**Assurance**
7	Data Quality – Re KPI 2.2 Category 1 defects Rectification Timescales completed in time - Follow-Up	N/A
	Grants	**Assurance**
8	Community Capacity Grant	N/A
	School Audits	**Assurance**
9	Pardes House*	Limited
10	Fairway	Limited
11	St. Theresa's	Satisfactory
12	St. Michael's	Satisfactory
13	Underhill	Satisfactory
14	Sacks Morasha	Satisfactory
15	Monkfrith	Substantial
16	Dollis Infant	Substantial

The summary detail of those reports issued as Limited assurance is included within section 4.

* See outcome of Follow-Up audit of Pardes House within section 7

4. Key Findings from Internal Audit Work with Limited assurance



Title	**Grant Income**			
Assurances	**No**	**Limited**	**Satisfactory**	**Substantial**
Audit Opinion		●		
Date of report:	June 2015			
Background & Context	The Local Government Association (LGA) report "Future funding outlook for Councils 2010-11 to 2019-20" identified grant funding as one of the 6 funding/income streams for Councils. The report referred to Council income expected to fall significantly from 2010-11 to 2019-20. For specific / other grants, the percentage of Council income was expected to fall from 18% to 4%. It is therefore essential that all specific grant income for which the Council is eligible is identified and secured, if appropriate, to assist in addressing the significant overall funding gap expected from 2016-17 until 2019-20 of £73.5m. **Audit work completed** • We prepared and issued a Grant Income Self-assessment Questionnaire (GISAQ) for completion by senior management within the Council's Commissioning Group, internal delivery units and strategic partners (Barnet Group, Capita Customer Support Group (CSG) and Capita Re). • We reviewed responses to the GISAQ to assess the adequacy of arrangements for:			

	- **Grant identification**: pro-actively identifying/"scanning" for potential grants that may be applicable for service delivery; - **Grant evaluation**: arrangements to assess grant conditions and whether an application/bid for the grant should be made, including the assessment of the exit strategy once the grant funding ceases and engagement with Strategic Finance for support/advice for proper consideration of financial conditions linked to the grant; - **Review:** senior management scrutiny/challenge of the grant evaluation; and - **Decision making:** clear records and audit trails of decisions, for referral/review where necessary, as to whether to proceed or not proceed with the bid/ application for grant funding to embed accountability for effective decision making. • We identified grants on the Grant Finder website and within "National Audit Office Local Government Funding: Assurance to Parliament – Government grants paid to local authorities (2013-14)", published 23 June 2014, to assess for their pro-active identification by the relevant officers and for records of decisions as to whether to proceed with making a bid/application for the grant funding.
Summary of Findings	There are one priority 1 and two priority 2 recommendations. We issued 14 grant income self-assessment questionnaires to Delivery Units and the Commissioning Group. We received 12 responses (86%), including from those delivery units likely to be the main recipients of grant income (Adults & Communities, Education & Skills, Family Services, Street Scene, Barnet Group and Re). The following significant issue was noted: - **Grant identification** - Of the 12 responses received, there were 5 areas where pro-active arrangements for identifying grants need to be defined and formally implemented. (Priority 1). The following other issues were noted: - **Grant evaluation and approval** - Of the 12 responses received, there were 4 areas where grant

	evaluation and approval processes need to be developed. Engagement with the Commissioning Group's Head of Finance was not undertaken as a matter of course. Documented procedures governing grant evaluation were not available for referral in 10 of the 12 areas (Priority 2). - **Grant decision making** - Of the 12 responses received, arrangements for the recording and retention of related decisions were robust for only 3 areas as they included a formal record of the decision for referral and review where necessary (Priority 2).

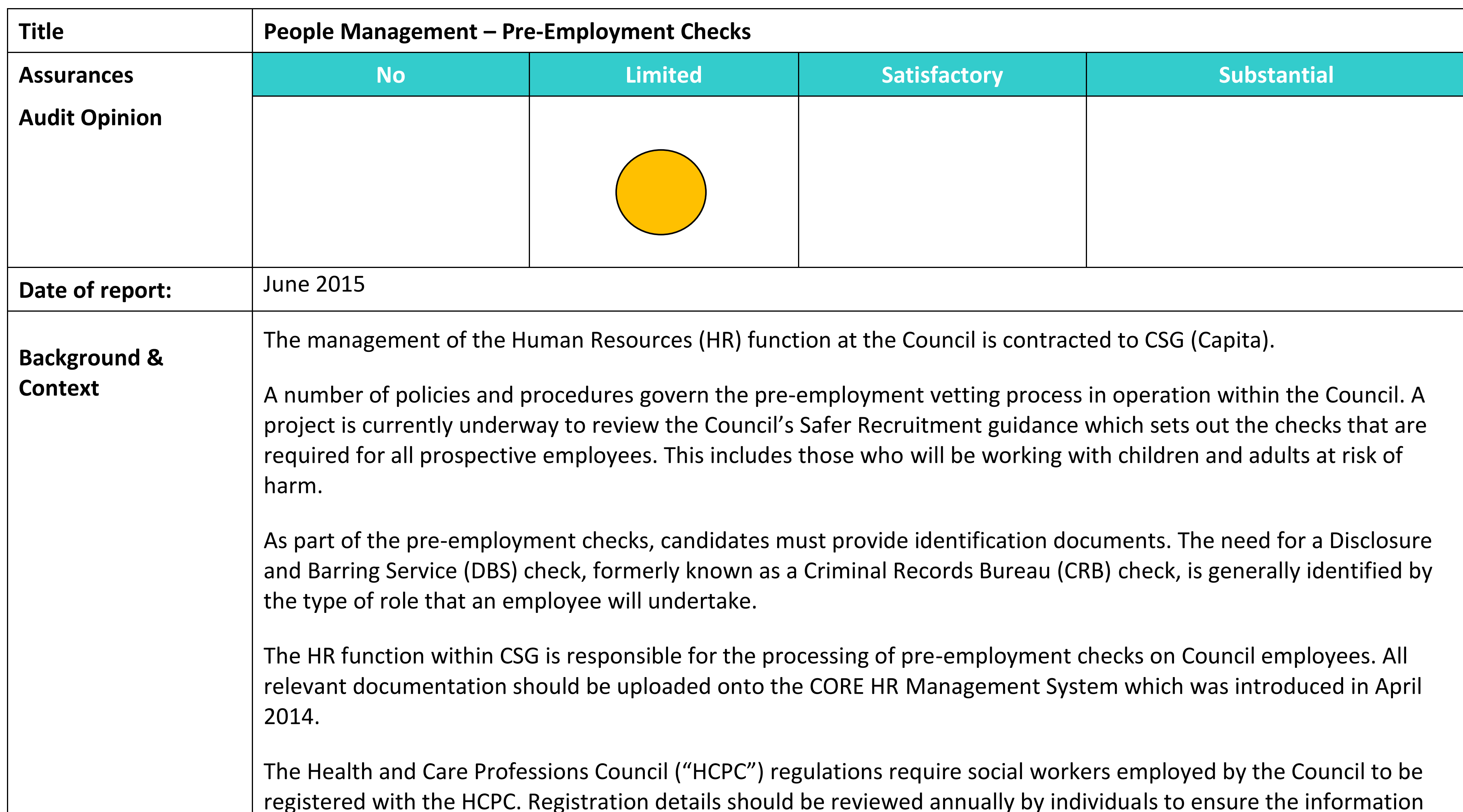
Priority 1 recommendations, management responses and agreed action dates

1. Grant Identification

Recommendation	Management Response	Responsible Officer	Deadline
Roles/arrangements for pro-actively identifying grant opportunities should be implemented. a) We suggest that roles for pro-actively identifying grants could be undertaken as part of existing structures as follows: (i) Delivery Units together with their Commissioning Directors should consider the options available, including the possibility of a dedicated team/officer for pro-actively identifying grants depending on resources / the significance of grants available in that area. (ii) Service area leads pro-actively identify grants in their area. Local business improvement / performance teams challenge	Across commissioning portfolios (in commissioning group or Delivery units) grants databases will be maintained which evidence horizon scanning, at least once every quarter. Evidence may include communication with relevant central government departments or the use of grant finder. 'Invest to save' options will also be explored, for example the possibility of engaging an appropriate grants finding company.	Commissioning Directors for: • Adults and Health; • Children & Young People; • Growth and Development; and • Environment Commercial and Customer Services Director Supported by Finance	1 September 2015

for proactive identification, undertake proactive reviews themselves and co-ordinate related reporting of horizon scanning outcomes as part of their local performance management arrangements. (iii) CSG service areas: Senior Responsible Officers (SROs) client-side at the Council pro-actively identify grants in their CSG responsibility areas or arrange for CSG Capita leads to undertake this role, with SRO monitoring CSG identification activity. b) Existing performance management arrangements should be used to embed accountability for pro-active grant identification by relevant officers/teams, for example as part of Delivery Unit Management Agreements, through local performance indicators or through the staff objectives/performance review/appraisal process. c) Eligible grants identified should be formally documented and reported to Senior Management to ensure that grant identification processes are undertaken routinely and that senior management are involved in the decision making process. This could form part of Senior Management		(Commissioning Group)	

Team (SMT) standing agendas. d) All eligible grants for which applications will **<u>not</u>** be submitted should be reported to the Commissioning Group's Head of Finance sufficiently <u>in advance</u> of application deadlines, 5 working days as a minimum, to consider whether decisions not to apply were appropriate and challenge as necessary. e) Procedures should be documented governing identification arrangements in each area. The procedures should include: • grant identification mechanisms such as the use of the Grant Finder website, Internet searches and pro-active engagement with known funding bodies. • arrangements for the escalation/communication of grant opportunities to the relevant areas for evaluation if identified centrally • arrangements for the recording and reporting of all grant opportunities, identified for follow-up/monitoring and reporting • arrangements for the timely escalation to the Commissioning Group's Head of Finance for all eligible grants for which applications will not be submitted.			



Title	People Management – Pre-Employment Checks			
Assurances	No	Limited	Satisfactory	Substantial
Audit Opinion		●		
Date of report:	June 2015			
Background & Context	The management of the Human Resources (HR) function at the Council is contracted to CSG (Capita). A number of policies and procedures govern the pre-employment vetting process in operation within the Council. A project is currently underway to review the Council's Safer Recruitment guidance which sets out the checks that are required for all prospective employees. This includes those who will be working with children and adults at risk of harm. As part of the pre-employment checks, candidates must provide identification documents. The need for a Disclosure and Barring Service (DBS) check, formerly known as a Criminal Records Bureau (CRB) check, is generally identified by the type of role that an employee will undertake. The HR function within CSG is responsible for the processing of pre-employment checks on Council employees. All relevant documentation should be uploaded onto the CORE HR Management System which was introduced in April 2014. The Health and Care Professions Council ("HCPC") regulations require social workers employed by the Council to be registered with the HCPC. Registration details should be reviewed annually by individuals to ensure the information			

	recorded is up to date. The Council should assure itself that social workers employed to undertake work on its behalf have appropriate HCPC registration.
Summary of Findings	There are three priority 1 and one priority 2 recommendations. We identified the following issues as part of the audit: • **Safer Recruitment training and guidance available to staff** - In line with Council procedure, when a new employee is recruited or an existing employee changes role, the requirement for any pre-employment or additional vetting procedures should be identified by the Line Manager from the details in the role description. We confirmed that the current Council guidance available to Line Managers does not contain sufficient detail regarding the current statutory requirements relating to DBS clearances and no on-going training is provided by Human Resources. We were informed that the Safer Recruitment procedures are currently being updated and were reviewed by the Workforce Board on 10 June 2015. These include more information on DBS requirements and will be made available to Line Managers when they are finalised. **(Priority 1)** • **Monitoring of HCPC registration of social workers** - All social workers employed by the Council are required to be registered with the HCPC. Social workers should renew their registration before the expiry date to ensure continued compliance with their employment conditions. We confirmed that registration documentation is not required to be provided by social workers to evidence compliance with their employment contract. Additionally, there is no formal monitoring of the registration status of social workers undertaken by the Council or CSG to independently validate registration status. Our detailed testing identified one case where a social worker employed by the Council was not listed on the HCPC website. **(Priority 1)** • **Accuracy and completeness of vetting information held on Council employees** - The CORE Human Resources management system was introduced in April 2014 and all employee data was transferred from the previous SAP system. We confirmed that a formal data cleanse was not performed before the information was transferred. As a

	result, management are aware that there are issues with the completeness and accuracy of the data held in CORE, although the extent of the issues has not been quantified. There is also no formal mechanism in place to capture any change in roles of existing employees using CORE to ensure continued compliance with safeguarding legislation. An exercise is currently being undertaken by the HR management team to validate all information held in the CORE system. One of the objectives of the exercise is to ensure that all Council employees have the correct clearance for their role. **(Priority 1)** • **Annual audit results of pre-employment checks performed by Comensura** - The Council has a contract with Comensura Limited ("Comensura") to provide agency staff when the existing resources are unable to meet demand. Comensura are able to use third party recruitment agencies when the skills and expertise of the role cannot be met by the staff on their register. In these cases Comensura are still responsible for meeting the conditions of the contract with the Council and performing the pre-employment checks before staff are assigned. Comensura are also required to perform an annual audit of the third party agencies used to provide staff to the Council. The audit includes testing that agency staff have the correct DBS clearance specified in the role description. Management were unable to provide evidence that Comensura had provided the Council with the result of the audit performed in the 2014/15 financial year although we were able to validate that monthly spot checks performed independently by the Council are operating effectively. **(Priority 2)**

Priority 1 recommendations, management responses and agreed action dates

1. Safer Recruitment training and guidance available to staff

Recommendation	Management Response	Responsible Officer	Deadline
a) The revised Safer Recruitment guidance should be formalised and made available to all Line Managers within the Council following formal approval by	Revised policy and guidelines were submitted to Workforce Board (WFB) 10th June for 30 day consultation. If no further consultation required the policy and guidelines will be approved and	Lead Human Resources Consultant Human Resources	a) 31 August 2015 b) and c) Initial

the Workforce Board in August 2015. b) Human Resources should develop training on the new guidance. c) All Line Managers within the Council should be mandated to attend a formal briefing on the new guidance to ensure they fully understand their role and responsibilities.	released. These will be placed on the intranet with briefing sessions arranged as required – it has been noted that this is a formal recommendation and therefore further discussion will take place with the client to determine requirements. Many of the managers have raised concerns (either through WFB or independently) in relation to the guidance and applying consistent methodology to determining which posts do or do not require checks. With this in mind Capita intend to propose to the client the introduction of a new DBS consistency forum with representation from each DU; the intention being that the forum will debate requirements for posts where there is any uncertainty with the aim to ensure consistent application of requirements against posts across the DU's. WFB also requested that an appendix of posts requiring/not requiring checks was developed, this has been considered since the last WFB but further discussion will be required with the client to establish how this would work in practice. A formal meeting will be set up for discussions between client strategy, client assurance, client safeguarding and Capita to determine the next steps.	Operations Director, CSG Human Resources Operational Manager, CSG	discussion at the WFB meeting in July 2015, full implementation by 31 August 2015
2. Monitoring of HCPC registration of social workers			

Recommendation	Management Response	Responsible Officer	Deadline
a) Management should complete the risk assessment process for the case where HCPC registration could not be confirmed and ensure that it is appropriate for them to remain in post. b) The Council should consider whether to introduce a requirement for all social workers to provide evidence of HCPC registration. c) Management should agree a clear procedure for the monitoring of HCPC registration, clarifying the respective responsibilities of Adults & Communities, Family Services and Human Resources. d) The Council should consider how to formally monitor HCPC registration, including the expiry date of all social worker registration. Management should continue to develop the functionality of CORE to support this process. If relevant, reminders should be sent to all social workers when a registration is due to expire. e) The Council should produce an Engagement and Communications Plan to communicate any new monitoring procedures to ensure	The case identified as being non-compliant will be raised with the DU Director and a risk assessment will be undertaken, with the appropriate decision being made by the DU Director as to whether that employee should have HCPC registration or be supervised (or other alternative action taken) whilst registration is being obtained. A review is currently underway for all employees whose role requires HCPC registration and those found to be non-compliant will be addressed as above. A process will be written and submitted to WFB for consultation and approval for the monitoring with guidance notes which will include a requirement for all social workers to provide evidence of HCPC registration. This will be cross referenced with an HCPC website check. Once document is approved it will be placed on the intranet and briefing sessions held as appropriate A decision will need to be made as to where the responsibility rests for monitoring registration going forward. A formal meeting will be set up for discussions between client strategy, client assurance, client safeguarding and Capita to facilitate this discussion. Irrespective of where the responsibility lies CORE is currently being	Lead Human Resources Consultant Human Resources Operations Director, CSG Human Resources Operational Manager, CSG	All – 31 July 2015

social workers are aware of their responsibility to provide timely evidence of registration.	developed to record and provide management information to support this process. Work is already underway to develop CORE to store information relating to both DBS and HCPC. This work is currently in test phase with the aim to transfer data from manual spreadsheets to the system in July 2015. Reminders for Social Workers will be considered alongside the discussion regarding responsibility for monitoring in the meeting described above. Implementation of this process will follow in due course. Engagement and communication for all Social Workers will form part of the plan addressed in the meeting described above. Consideration and approval of this guidance will need to be discussed as well as the communication methodology. Implementation of this process to follow in due course. The meeting described above will be critical in informing what action should be taken by the Council to investigate Social Workers who fail to provide relevant evidence. Outcomes of this discussion will form part of the guidance and engagement for managers and employees alike.		
3. Accuracy and completeness of vetting information held on Council employees			
Recommendation	**Management Response**	**Responsible Officer**	**Deadline**

a) The Council should complete the review of all information held in the CORE system as soon as possible. b) DBS clearances should be obtained for all roles where gaps are identified in the information held on CORE. c) A formal change in role form should be introduced and all Line Managers should be made aware of their responsibilities in notifying Human Resources when additional clearances are required.	The review of information held in CORE is currently underway. DU's are already undertaking an exercise to review whether a position requires a DBS check or HCPC registration as previously stated. Where there is uncertainty this will be reviewed through the DBS Consistency Forum described above. Data collated is being referenced back to establishment data in CORE and data is currently being prepared to complete test uploads within week commencing 29th June 15. The aim will be to have this recorded against live records in early July. Any gaps in information once data is loaded will either be addressed through the DBS consistency forum or raised with Managers as gaps. The Establishment Control Movers form has already been updated to capture the requirements of the post and the incoming employee. The aim will be for this to trigger the operations team to begin the process for upgrading if required and current certification doesn't already trump the requirements of the post. These updated forms will be embedded via Engagement and Communications channels.	Lead Human Resources Consultant Human Resources Operations Director, CSG Human Resources Operational Manager, CSG	All – 31 July 2015

<table>
<tr><td>Title</td><td colspan="4">Pardes House School
Please also see Section 7, Implementation of Internal Audit recommendations, which confirms that since the audit the high priority recommendations have been implemented</td></tr>
<tr><td rowspan="2">Assurances
Audit Opinion and Direction of Travel
Last audit:
Satisfactory Assurance
May 2011</td><td>No</td><td>Limited</td><td>Satisfactory</td><td>Substantial</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Date of report:</td><td colspan="4">March 2015</td></tr>
<tr><td>Background & Context</td><td colspan="4">Pardes School is a Voluntary Aided school with places for 236 boys aged between 4 and 11 years of age. The School budget for 2014/15 was £1,238,584 with employee costs of £908,379 (73% of the delegated budget).
The School was assessed as ‘Good’ by OFSTED in Mar 2011.</td></tr>
<tr><td>Summary of Findings</td><td colspan="4">As part of the audit we were able to give Limited assurance to the school, noting two high and seven medium priority issues as part of the audit (in order of priority):
<u>Income</u> – Paperwork is incomplete for all money received into the school office. Therefore a complete reconciliation between money received and money banked was not possible (Priority 1);
<u>Payroll</u> – Lack of financial control due to no segregation of duties or evidence of independent review and overtime being paid without completion of authorised timesheets (Priority 1);
<u>Financial Planning</u> – No medium term School Development Plan exists, no three year budget;
<u>Budget Monitoring</u> – When the budget is set for the year, an amount of income is requested from the Governors to code to I13 Governors contributions to balance the budget to zero;
<u>Purchasing</u> – Payments are made without an approved Purchase Order. These costs are not recorded as a committed expense, and accurate budget monitoring is not possible, expenses have been paid to the Headteacher that have not been authorised by the Chair of Governors;
<u>Contracts</u> – Contracts were not available for cleaning, security and computer services. There was no evidence of</td></tr>
</table>

	regular review of contracts; • Lettings –The school does not have an approved lettings policy, and a signed agreement is not held for organisations that use the premises on a regular basis. Insurance should be checked on an annual basis; • Assets– The Inventory contains incomplete entries, only items purchased after January 2013 are included.

Priority 1 recommendations, management responses and agreed action dates

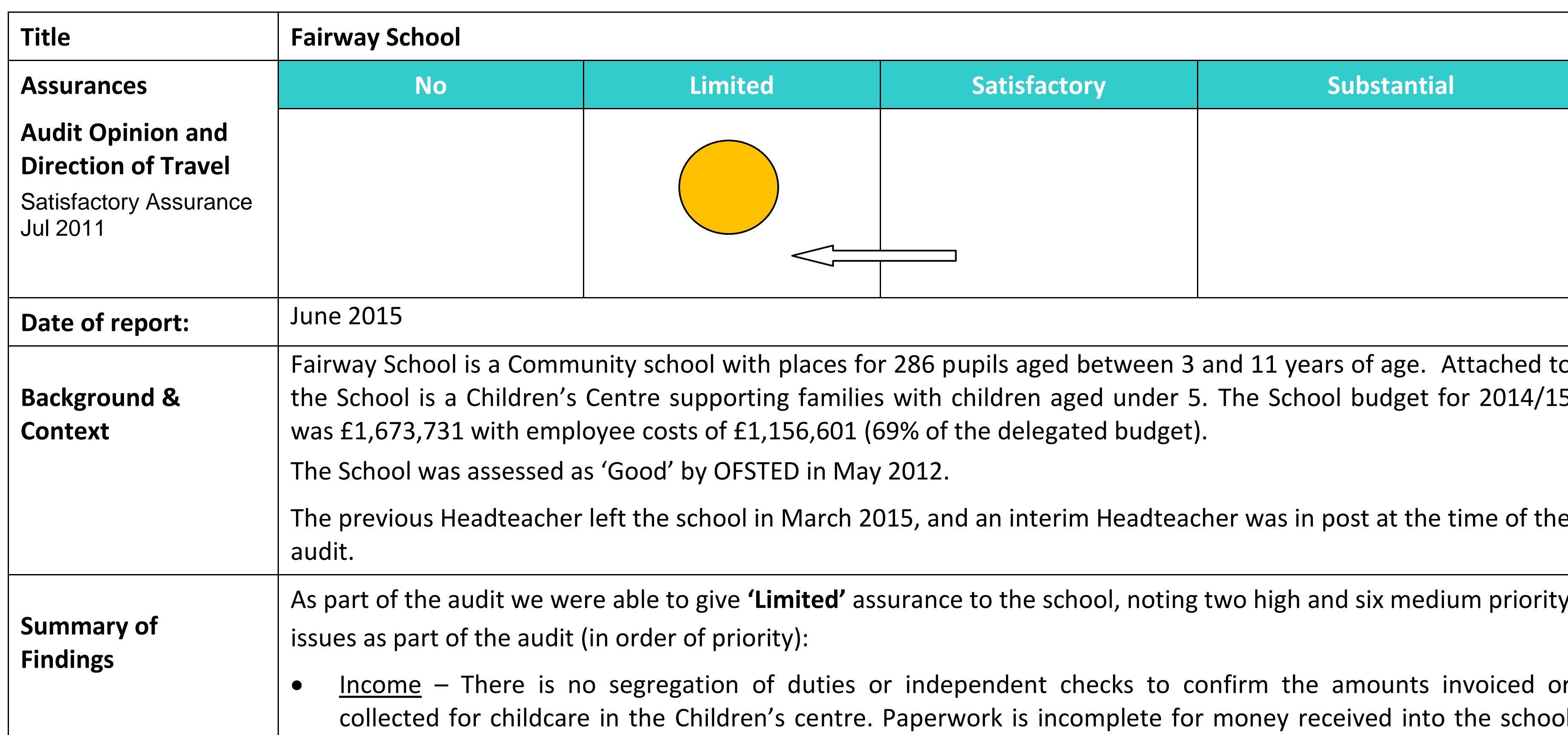
1. Income

Recommendation	Management Response	Responsible Officer	Deadline
Strict income controls and procedures should be in place to ensure effective financial management. Independent checks should be carried out to verify amounts banked agree to source records. These checks should be visibly evidenced. Refer to the Barnet Schools Financial Guide, section 7 (Income collection and administration) to ensure that there is a proper audit trail.	New income from parents has been inputted into spreadsheets and new banking method has been implemented. Our new banking partner will ensure we will deposit cheques and any cash directly with the local branch.	Schools Business Manager	Implemented April 2015

2. Payroll

Recommendation	Management Response	Responsible Officer	Deadline
As payroll constitutes the largest area of expenditure for the School, it is recommended that at least two officers are involved in checks over the monthly payroll reports. The School should refer to the Barnet Schools Financial Guide, section 4.1-4.7 (Internal Financial Control) and page 16 (Payroll) of the 'Keeping Your Balance' document, issued jointly	Payroll is (I agree) an area that requires improvement. Our plan is for the following to be implemented: 1. Headteacher to sign final changes on a monthly basis 2. Headteacher to sign off all month-end figures.	Head Teacher	April 2015

by Ofsted and the Audit Commission for guidance with payroll, to ensure that the school has adequate control over its payroll costs and personnel data.	3. Headteacher to check staff scale points / hours / TLRs etc on a monthly basis. 4. To ensure any HR/payroll changes are documented properly and filed in relevant staff files.		



Title	**Fairway School**			
Assurances	**No**	**Limited**	**Satisfactory**	**Substantial**
Audit Opinion and Direction of Travel Satisfactory Assurance Jul 2011		●	←	
Date of report:	June 2015			
Background & Context	Fairway School is a Community school with places for 286 pupils aged between 3 and 11 years of age. Attached to the School is a Children's Centre supporting families with children aged under 5. The School budget for 2014/15 was £1,673,731 with employee costs of £1,156,601 (69% of the delegated budget). The School was assessed as 'Good' by OFSTED in May 2012. The previous Headteacher left the school in March 2015, and an interim Headteacher was in post at the time of the audit.			
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 – There is no segregation of duties or independent checks to confirm the amounts invoiced or collected for childcare in the Children's centre. Paperwork is incomplete for money received into the school			

	office for afterschool club, and Children's centre play sessions, swimming and football (Priority 1); • Purchasing – Lack of confirmation of receipt of goods. Paperwork missing for credit card expenditure for the Children's centre. No authorisation of meals invoices (Priority 1); • Governance –The 'Notice of Authorised Signatories' and credit card policy should be revised and approved by Governors to reflect current procedures in school. Procedures relating to the Children's centre should be documented and approved; • Financial Planning –No medium term School Development Plan exists; • Payroll – No information provided from the Children's centre to allow a complete reconciliation of unpaid leave and sickness pay; • Voluntary funds – The accounts for the Amenities account were last audited for the year ended 31 March 2012; • Assets– The Inventory is incomplete, it does not include date of purchase or cost. No evidence of annual review, or authorisation of disposals.

Priority 1 recommendations, management responses and agreed action dates

1. Income

Recommendation	**Management Response**	**Responsible Officer**	**Deadline**
Strict income controls and procedures should be in place to ensure effective financial management. Independent checks should be carried out to verify amounts banked agree to source records. These checks should be visibly evidenced. Refer to the Barnet Schools Financial Guide, section 7 (Income collection and administration) to ensure that there is a proper audit trail.	All monies coming into school however small MUST be accounted for, logged and banked Independent checks will be carried out to verify amounts banked agree to source records. Fun club ledger will be prepared showing all income, record of debt, balance and carry forward each week. Inventory of school uniform will be prepared with ledger of sales and payments.	Interim Headteacher/Business manager/Children's centre manager	July 2015

	Children's centre income will be collected in a locked box and counted by two members of staff before banking.		
2. Purchasing			
Recommendation	**Management Response**	**Responsible Officer**	**Deadline**
The School should ensure that: a. All goods or services should be checked against the delivery note. The check should be recorded on the delivery note. Invoices for payment should be matched with delivery notes of the receipt of goods or work carried out; b. The documented purchasing system is followed for all purchases. This should include authorisation, confirmation of receipt of goods, payment and reconciliation. Refer to the Barnet Financial Guide for schools, section 4 (Internal Financial Controls) and section 6 (Value for money and Purchasing) for guidance.	All goods or services will be checked against the delivery notes A written policy for purchasing procedures for the school and children's centre will be completed and ratified by the Governing Body. This will be followed for all purchases.	Business Manager Headteacher	Immediately September 2015

5. Advisory reviews for management purposes

There was one advisory review undertaken by internal audit that does not give an assurance rating but none the less aids management in assessing the design and effectiveness of their control environment. If a significant issue has been identified or a Priority 1 recommendation made as part of these reviews further detail is provided within this progress report below. Priority 1 recommendations are followed up in line with the Audit Committee's standard follow-up process.

Any potential independence threats have been managed when undertaking these reviews in that the staff involved in the reviews have not audited / will not audit the area concerned for at least 12 months before or after the advisory work.

	Advisory Reviews	
1	Data Quality – Re KPI 2.2 Category 1 defects Rectification Timescales completed in time - Follow-Up	See section 7, Implementation of Internal Audit recommendations

6. Work in progress

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

Table 2: Work in progress		
	Systems Audits	**Status**
1	Regeneration – Brent Cross	Draft Report
2	Risk Management Framework	Draft Report
3	School Improvement	Draft Report
4	Transforming Care Grant	Draft Report
5	Financial Assessment (joint with CAFT)	Fieldwork
6	Transformation Q1 - Libraries	Fieldwork
7	Contract Management - Toolkit Compliance Q1 – Home Care and Premier Partnerships	Fieldwork
8	CSG Invoicing / Gain Share Agreements	Planning
9	Information Security - Cyber Risk (joint with CAFT)	Planning
10	Better Care Fund – Pooled Budget Arrangements	Planning
11	Procurement – Compliance with Contract Procedure Rules (CPRs)	Planning
12	Procurement – Conflict Management	Planning
13	Troubled Families – Payment By Results – Q2	Planning
14	Shared Legal Service – Clienting and Governance	Planning
	Schools Audits	
15	Martin Primary School	Draft Report
16	Pavilion Pupil Referral Unit (PRU)	Draft Report

7. Implementation of Internal Audit recommendations

Quarter 1, 2015-16: Priority 1 Recommendations due

Code to ratings:

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

Audit Title and Recommendation	**Responsible Area**	**Response from Management**	**Audit Assessment for Audit Committee (July 2015)**
1. The Care Act - LGA Stocktake Submissions A periodic check of the financial model should be completed by an appropriately skilled member of staff to rectify any errors which could lead to incorrect financial forecasts being generated. Ideally the check should be undertaken by a member of staff who is not	Assistant Director of Finance, Customer and Support Group (CSG) 20 June 2015	<u>Report Action</u> The financial model which supports the financial impact of the Care Act changes due to come in from 1st April 2015 and then April 2016 is very complex and as highlighted above contains 830 referenced cells and 20 core pieces of data. The points	**Not implemented** Management from CSG have confirmed that since the time of the audit the financial model has not been updated with any new or revised information. Additionally, the figures generated by the model have not been used for any financial planning within the Council. Therefore it has not been possible for Officers to complete periodic checks of calculations or verify references are correctly updated when new data is added to the model.

Audit Title and Recommendation	Responsible Area	Response from Management	Audit Assessment for Audit Committee (July 2015)
directly responsible for updating the model. Additionally when the model is updated with new data, the references should also be correctly updated to allow for a full audit trail to support the revised figures		highlighted effect the model for 2016/17 onwards and not 2015/16 which is considered in the Council's medium term financial plan. In order to mitigate the risk moving forward, we shall review the model to identify if it's feasible to reduce the number of referenced cells which will allow for an independent member of the Finance Services to review the model on a periodic basis. At the same time, when the independent review is undertaken we shall ensure any core data is clearly referenced back to supporting documentation.	Management confirmed the next change to the financial model is due to be in October 2015, when the Department of Health is expected to publish guidance relating to the legislative changes coming into force in April 2016. The Care Act Implementation Project Manager confirmed to us that this approach is acceptable. **Revised implementation date:** 30 November 2015
2. Barnet Homes Contract Management Follow-up **Benefits Management** a) The planned benefits of the Barnet Homes contract should be clarified and agreed;	Housing & Environment Lead Commissioner / Contract Manager	Report Action The next phase of the project to develop the longer term Management Agreement which could include a full Options Appraisal. --------------------------------------	**Partly Implemented** The 2015/2016 Delivery Plan has continued the identification of Barnet Homes key deliverables and the benefits required by the Council. The Barnet Homes Performance Review Group review progress on key objectives and the 2015/2016 extended suite

Audit Title and Recommendation	Responsible Area	Response from Management	Audit Assessment for Audit Committee (July 2015)
b) A benefits management process should be introduced to ensure that the realisation of planned benefits is monitored regularly and threats to the achievement of planned benefits escalated appropriately; and c) Management should agree baseline figures, targets and methods of measurement for planned benefits		**Revised implementation date:** From April 2015	of management performance indicators. The draft Heads of Terms, which went to the Housing Committee on 29th June, includes further enhancements including baselines, targets and agreed methods of measuring benefits. These were agreed and provided they form a key part of the new long-term management agreement then all our original findings will have been addressed and the recommendation implemented.
3. Permanency Routes **Permanency process and control - Records management and documentation retention** A policy for naming and saving key adoption and kinship documentation consistently should be developed, communicated, implemented and monitored during supervision to facilitate the efficient retrieval of documentation where	Service Manager – Provider Services / Data and Performance Manager 30/9/14 Acting Children's Social Care Assistant Director / Data and Performance	Report Action Naming conventions for documents to be jointly reviewed with the Information Manager, revised guidance to be issued, key documents to be agreed and added to file audit template. Review of ICS system commencing in September 2014 to incorporate findings from this audit. ----------------------------------	**Partly implemented** The process for identifying and saving templates, used in the adoption and SGO process, in ICS for retrieval by social workers had started but had not been completed at the date of the follow-up audit. Retrieval and use of such ICS system templates by social workers will automatically ensure that key document files are correctly saved in WISDOM with the correct file name as part of the system configuration. Social workers will need to be reminded to use the templates in ICS when undertaking their work. Management indicated that inconsistencies with

Audit Title and Recommendation	Responsible Area	Response from Management	Audit Assessment for Audit Committee (July 2015)
necessary. Documentation, clearly evidencing scrutiny and approval/sign-off of recommendations and decisions, should be retained in all cases to evidence that key processes were undertaken and that necessary reports were considered when decisions were taken.	Manager 30/9/14	Revised implementation date: 31 May 2015.	regard to naming conventions and retrieval of documentation would be completed by 31 July 2015.
4. Data Quality Re KPI 2.2 **Compliance with definition** The KPI should be collated and reported in line with the formal definition KPI 2.2 NM. The Commercial team should assess whether and apply, if considered necessary or appropriate, any financial impact to date. The Council's Data Quality policy should be communicated to all officers responsible for	RE Strategy & Performance Manager / Partnership Relationship Manager 31 July 2014 onwards Revised to 1 April 2015	<u>Report action</u> As agreed in May, since July 2014 onwards KPI NM 2.2 reporting now includes all Category 1 defects whether they are potholes or pavement repairs. From November 2014 KPI NM 2.2 reporting will also include Category 1 defects proactively identified by Highways Inspectors during the course of planned cyclical inspections. This addition has been made possible by the	**Partly Implemented** We inspected the underlying data related to KPI 2.2 for January, February and March of this year. Responsibility for the entry of rectification times into the Exor system lies with the Direct Labour Organisation (DLO), managed by Re. The responsibility for checking that the reported outturn, generated via reports from Exor, is correct lies with Re. We can confirm that the data included both potholes and pavement repairs as per the KPI definition. In January and February returns also contained defects proactively identified from Highways Inspectors (36 and 38 respectively). No category 1 defects were reported by Highways Inspectors in the course of

Audit Title and Recommendation	Responsible Area	Response from Management	Audit Assessment for Audit Committee (July 2015)
the input, recording, processing, collation, reporting and challenge of performance outturn.		recent development of interactive reporting for Exor (the Highways IT system) that makes it possible to identify and report on this dataset within Exor. More importantly; the planned rollout of interactive Exor reports developed in October 2014 will replace the existing manual spreadsheet based systems. A period of testing and data validation within the new system is scheduled for completion in time for November 2014 reporting cycle results. A number of new processes and training with relevant staff, scheduled as part of Re's transformation programme will be utilised to increase understanding and awareness of the data collection processes within the interactive reports and requirements of KPI definitions and methodology.	their duties in March. We were informed this is most likely a result of the Risk Assessment Matrix for prioritising highway defects being implemented by Highway Inspectors in February and, therefore, it is feasible that the Inspectors subsequently gained increased confidence in prioritising defects which were previously logged as Category 1 as Category 2 or Category 3 defects. We confirmed that management within the Council's Commercial team decide whether to impose financial reductions and there is evidence that this happens where considered appropriate. We confirmed that in October 2014 the Re Customer Services Hub was reminded of the Council's Data Quality Policy. In late-2014 there was also a briefing to KPI owners regarding the audit findings and learning points, together with a reminder to staff regarding the importance of adhering to the Council's Data Quality Policy. **Detailed testing - Accuracy** From January to March there were 2576 reported category 1 defects. We selected a sample of these defects across the 3 month period to verify the accuracy of the reported 'pass' or 'fail', against source data. The reported outturn over the 3 month period

<table>
<tr><th>Audit Title and Recommendation</th><th>Responsible Area</th><th>Response from Management</th><th>Audit Assessment for Audit Committee (July 2015)</th></tr>
<tr><td></td><td></td><td>Re Customer Service Hub staff training is being rolled out to ensure appropriate criteria for the vetting and categorisation of repair types (required when logging new customer service requests) and will be completed by Monday 20th October. The relevant teams will start using documented guidance so that the recording and monitoring of types of repairs (i.e. category 1 vs. 2) is applied correctly, in line with the Authority's Data Quality Policy.

The Authority's Data Quality Policy document will be distributed to relevant KPI data owners. Workshop meetings are scheduled in November to raise staff awareness, to ensure the appropriate criteria is applied when dealing with future caseload.

The Authority will take these findings into consideration within</td><td>was a pass rate of 2479 (i.e. rectified within timescales) which equates to 96.23%

We found exceptions with 6 (29%) of our sample, i.e. for those 6 defects we were unable to confirm that the reported outcome ('pass' or 'fail') was correct. The causes of the exceptions are summarised as follows:

<table>
<tr><th>Cause</th><th>Impact</th></tr>
<tr><td>Date in Exor incorrect, should have been a 'Fail'</td><td>'Pass' overstated by 1 and 'fail' understated by 1</td></tr>
<tr><td>Entry duplicated in Exor</td><td>'Pass' overstated by 1</td></tr>
<tr><td>Inadequate audit trails to confirm 4 'Passes' as per Exor</td><td>Unknown impact</td></tr>
<tr><td>Total Net Impact</td><td>'Pass' overstated by 2 and 'fail' understated by 1</td></tr>
</table></td></tr>
</table>

<table>
<tr><th>Audit Title and Recommendation</th><th>Responsible Area</th><th>Response from Management</th><th>Audit Assessment for Audit Committee (July 2015)</th></tr>
<tr><td></td><td></td><td>the contract management framework.

Revised implementation date: 1 April 2015</td><td>
Detailed testing - Completeness
We selected a further sample of Category 1 repairs completed by the DLO across the 3 month period as per their daily worksheets, and verified whether these were included in the KPI return to give assurance over the completeness of the reported data. We found exceptions in 6 (30%) of our sample, i.e. there were discrepancies between the worksheets and the reported outturn as per Exor. The causes of the exceptions are summarised as follows:

<table>
<tr><th>Cause</th><th>Impact</th></tr>
<tr><td>Exor report parameters did not pick up cases as the repair date was after the report date. However report date was >48 hours after the incident was reported so definitely fails</td><td>‘Pass’ overstated by 2 and ‘fail’ understated by 2</td></tr>
<tr><td>1 repair in DLO</td><td>‘Pass’</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Audit Title and Recommendation</th><th>Responsible Area</th><th>Response from Management</th><th>Audit Assessment for Audit Committee (July 2015)</th></tr>
<tr><td></td><td></td><td></td><td>
<table>
<tr><td>daily worksheet not included within Exor report</td><td>understated by 1</td></tr>
<tr><td>Entry duplicated in Exor</td><td>‘Pass’ overstated by 1</td></tr>
<tr><td>Date in Exor incorrect, should have been a ‘Pass’</td><td>‘Pass’ understated by 1 and ‘fail’ overstated by 1</td></tr>
<tr><td>Date in DLO’s daily worksheet different to date in Exor</td><td>No impact</td></tr>
<tr><td>Total Net Impact</td><td>Pass overstated by 1 and ‘fail’ understated by 1</td></tr>
</table>
Across both our samples, we confirmed a net impact of the ‘pass’ rate being overstated by 3 and the ‘fail’ rate being understated by 2. Whilst the reported KPI met the Council’s Data quality principles of ‘timeliness’ as well as ‘accessibility and transparency’,
</td></tr>
</table>

Audit Title and Recommendation	Responsible Area	Response from Management	Audit Assessment for Audit Committee (July 2015)
			it did not meet the definition with regards to 'accuracy and completeness' and 'reliability'. Re management have confirmed that since the audit follow-up fieldwork regular daily and weekly reports have been created by Re which has improved data quality by ensuring data is input correctly and at an appropriate time. **Further action for full implementation**: Management within Re and the DLO should work together to investigate and agree the causes of the exceptions identified to ensure that in future the KPI is collated and reported in line with the formal definition KPI 2.2. We will follow-up to confirm progress again in October, undertaking detailed testing of July, August and September's reported outturn for KPI 2.2.

Audit Title and Recommendation	Audit Assessment for Audit Committee (July 2015)
5. SWIFT and WISDOM Backups for Wisdom should be tested.	**Implemented** A test successfully restoring WISDOM data was completed and validated 21-24 April 2015.

Audit Title and Recommendation	Audit Assessment for Audit Committee (July 2015)
6. SWIFT and WISDOM Roles and responsibilities for data restoration should be defined and documented. This should be communicated to all stakeholders.	**Implemented** The Disaster Recovery (DR) process which refers to the recovery of the priority platinum systems such as WISDOM and SWIFT is documented and the DR solution will be implemented shortly in line with this design. Roles and responsibilities for escalating, authorising and implementing the restoration of SWIFT and WISDOM are clear and allocated to the CSG ICT Service Delivery Manager, the Head of Information Management, the Strategic Commissioning Board and Capita Infrastructure Teams with the technical know-how to implement data restores where approval for the invocation of the DR Plan is given.
7. Permanency Routes **Annual Reviews – Part a** Annual reviews of SGO & Adoption support plans including financial allowances should be routinely planned and implemented. For reviews of allowances, the adoptive parent or special guardian should, in line with the guidance, be required to provide an annual statement of his/her financial circumstances.	**Implemented** Responsibility for the Adoption and Special Guardianship Allowance (SGO) annual reviews is now clear and allocated to the Adoption Team supported by Family Service Business Support Resource (Family Services Finance Team). An annual review template letter and financial assessment form to capture the financial position of the recipient has been designed and is used when requesting the required information from recipients of the allowance. Business Support commenced the SGO annual review initiative for 199 SGO cases on 19 June 2015 of which 42 had been returned by 16 July. A log of requests and responses are kept by the team for the review and monitoring of submissions. The annual review of adoption allowances is planned and will commence

Audit Title and Recommendation	Audit Assessment for Audit Committee (July 2015)
	once the SGO reviews, which are a higher priority, have been completed.
8. Permanency Routes **Annual Reviews – Part b** Application of DfE Standard Means Test Model & North London Adoption Consortium agreed protocol on Adoption Allowances to be applied to all new Adoption Allowances.	**Implemented** Only one new adoption allowance, time limited for 6 months, had been agreed since the date of the audit in September 2014. The adoption allowance was not means tested as the decision to pay the allowance was based on siblings and not just one child being adopted. The allowance was also time limited for 6 months to provide support during the initial stages of the adoption. Management indicated that financial means testing was not the only consideration in determining whether adoption allowances would be paid. Financial means testing using the Department for Education (DfE) means test model is now undertaken for all new SGO agreements.
9. Permanency Routes **Annual Reviews – part c** Updated information on the financial circumstances of Adopters and Special Guardians to be requested prior to the annual review. Allowances to be temporarily suspended if information is not supplied.	**Implemented** An annual review template letter and financial assessment form to capture the financial position of the recipient has been designed and is used when requesting the required information from recipients of the allowance. The letter emphasises that the failure to return the form may result in the payment being suspended.
10. Permanency Routes **Annual Reviews – Part d**	**Implemented** The SGO practices now include the consideration of SGO allowances as part of the SGO support. Responsibility for undertaking and supporting SGO

Audit Title and Recommendation	Audit Assessment for Audit Committee (July 2015)
Overall review of practice in relation to SGO's to include financial allowances.	annual reviews is clear and allocated to officers/management in the Family Service Business Resource Team. The annual review of SGO allowances has started.
11. Your Choice Barnet Review **Day Centre Staff - Right to Work** YCB should confirm that pre-employment checks including Right to Work are contractually agreed with each employment agency and that the signed final copy of each individual contract is kept centrally on file at YCB. The contract should detail that relevant checks will be undertaken prior to agency staff commencing work at YCB.	**Implemented** Management confirmed that seven employment agencies are currently used by YCB. For staff from two of the employment agencies YCB confirmed they verify Right to Work status at the pre-employment interview. For each of the remaining five employment agencies – where Right to Work checks are not completed by YCB at the pre-employment stage – we confirmed that site visits had been completed and were supplied with: • Signed Terms of Business agreements from the employment agencies. • Written confirmation by agencies that they complete Right to Work checks on agency staff before sending them for assignments.
12. Your Choice Barnet Review **Day Centre Staff – Right to work** The contract with YCB will be updated to include a clause in relation to requiring all employees/agency staff to have their Right to Work status confirmed.	**Implemented** The contract with The Barnet Group, the parent company of YCB, has been updated to include a clause requiring The Barnet Group to conduct right to work checks prior to employment. The Barnet Group must contractually agree with each employment agency that pre-employment checks, including right to Work checks, are completed for each agency employee supplied. The contract places an obligation on The Barnet Group to retain Right to Work checks in one central location which is accessible to all appropriate staff.
13. The Care Act - LGA Stocktake Submissions	**Implemented**

Audit Title and Recommendation	Audit Assessment for Audit Committee (July 2015)
The current training database and attendance lists should be cross matched against the current staff list to ensure that records are up to date and correct, and that all staff who require training are captured on training records. If current staff lists are not accurate Adults & Communities should continue to engage with HR to rectify this issue.	The Adults and Communities Performance Team supplied us with an establishment list which was provided to them by HR. The Workforce Lead provided us with lists of new starters and leavers within the delivery unit which covered March, April and May of 2015. These lists are provided by the Performance Team regularly which allows the Lead to update the Care Act training list to ensure it is up-to-date. We verified that a sample of staff within the establishment list had been included in the Delivery Unit's training database with no exceptions.
14. Data Quality (Self Directed Support) Audit trails supporting outturn for reporting periods should be retained for independent scrutiny and testing, in line with the Data Quality Policy, as a minimum to support corporately reported outturn and any other key reporting, for example, for statutory returns. The Information Team should undertake periodic spot checks to ensure that reported outturn is supported by sufficient audit trails / source documentation. Officers should be reminded, for example at supervision, to save the relevant documentation correctly in WISDOM.	**Implemented** Spot checks were undertaken to ensure that the reported outturn for self-directed support is supported by the appropriate audit trails and source documentation in WISDOM, the Adults and Communities social care records management system and SWIFT, the Adults and Communities social care system. Evidence of the spot checking exercise by the Adults and Communities Performance Team (Information), the team responsible for these checks, was retained for review and scrutiny.
15. Re Governance Arrangements **Decision Making** Re should prepare an appropriate Authorisation Limits	**Implemented** Re has finalised an Authorisation Limits document specifying financial limits for financial and procurement decisions and authorisation levels for different contract types. The document will be ratified at the July 2015 Re JV Board.

Audit Title and Recommendation	Audit Assessment for Audit Committee (July 2015)
document which specifies financial and procurement decisions can be made at each level of the organisation. This document should also include authorisation limits on signing of contracts to provide services to other bodies.	
16. Re Governance Arrangements **Risk Register and Risk Reporting** Re's complete risk register should be presented to the JV Board meeting for review. The JV Board should then decide the frequency with which it wants the full risk register to come to the JV Board. Directors should satisfy themselves that all key risks preventing the achievement of Re's objectives are mitigated adequately and that opportunity risk is maximised.	**Implemented** Re's risk register was presented to the Re JV Board for review. The risk register was complete and recorded a clear thread between gross risk, treatment and residual risk demonstrating the considered and adequate mitigation of risks. The risk register will be reviewed at each JV Board.
17. Re Governance Arrangements **Financial Reporting** Re should work with its Directors to ensure that financial reporting is fit for purpose and understood by management. Re should ensure that papers presented contain suitable narrative to describe the financial performance and position of Re.	**Implemented** Re Senior Management indicated that the financial reports had been extended to include all the relevant information for the JV board. Council representation on the JV Board confirmed that financial reporting was now adequate and understood, although it will continue to evolve as Re moves into new business areas.
18. Re Governance Arrangements **Council Decision Making and Conflicts of Interest**	**Implemented** The latest version of the Re Conflicts of Interest register is published on the

Audit Title and Recommendation	Audit Assessment for Audit Committee (July 2015)
The latest version of the Conflicts of Interest register should be published on the Council's website.	Council's website.
19. Re Governance Arrangements **Council Decision Making and Conflicts of Interest** The JV Board should proactively review conflicts of interest at each meeting and ensure that the log contains any perceived, potential and actual conflicts of interest recognised to date.	**Implemented** The Conflicts of Interest register recording potential, actual and perceived conflicts of interest is now reviewed at the Regional Enterprise (Re) JV Board.
20. Re Governance Arrangements **Council Decision Making and Conflicts of Interest** The Council should ensure that the log is reviewed and agreed by the Council's Monitoring Officer. This should take into account the recent changes to the Council's senior management structure.	**Implemented** The incumbent Monitoring Officer (MO) reviewed the Re CoI Register as part of this follow-up exercise. No significant issues were raised. The MO did re-iterate the need for more frequent review when conflicts were raised to ensure the optimum challenge for status, the sufficiency of appropriate mitigation and retention of the advice received. Officers confirmed that when issue are logged in future they will be reviewed at that time by the Council's Monitoring Officer.

Schools follow-up of High Priority Recommendations

Pardes House, March 2015

Recommendation	Audit Assessment for Audit Committee (July 2015) *Implemented / Partly Implemented / Not Implemented*
21. Income Strict income controls and procedures should be in place to ensure effective financial management. Independent checks should be carried out to verify amounts banked agree to source records. These checks should be visibly evidenced. Refer to the Barnet Schools Financial Guide, section 7 (Income collection and administration) to ensure that there is a proper audit trail.	**Implemented** Follow up audit visit 23 June 2015 confirmed appropriate use of 'Journeys and Trips Spreadsheet' (financial Guide for schools 7.5). Paying in slips to the bank are now reconciled to completed sheets.
22. Payroll As payroll constitutes the largest area of expenditure for the School, it is recommended that at least two officers are involved in checks over the monthly payroll reports. The School should refer to the Barnet Schools Financial Guide, section 4.1-4.7 (Internal Financial Control) and page 16 (Payroll) of the 'Keeping Your Balance' document, issued jointly by Ofsted and the Audit Commission for guidance with payroll, to ensure that the school has adequate control over its payroll costs and personnel data.	**Implemented** Follow up audit visit 23 June 2015 – checked payroll reports now signed by Headteacher. School Business Manager overtime is now authorised by Headteacher by completion of overtime form.

St. Andrews CE School, April 2015

Recommendation	Audit Assessment for Audit Committee (July 2015) *Not yet due / Implemented / Partly Implemented / Not Implemented*
Income Strict income controls and procedures should be in place to ensure effective financial management. Independent checks should be carried out to verify amounts banked agree to source records. These checks should be visibly evidenced. Refer to the Barnet Schools Financial Guide, section 7 (Income collection and administration) to ensure that there is a proper audit trail.	**Not yet due** **Status at June 2015:** **Not Implemented** Additional staff member to do checks from September 2015
Lettings The School should refer to the Barnet Schools Financial Guide, section 7.9 (Lettings Policy and Administration) for guidance with lettings, to ensure that all income due to the School is identified, collected and recorded promptly. The Financial Guide for schools section 7.9 states that 'The income from lettings should be paid into the same account from which the related expenditure was paid i.e. the school's Delegated Budget / Budget Share Account. However, in Voluntary Aided Schools where the premises are owned by the Governors, then	**Not yet due** **Status at July 2015:** **Partly Implemented** Summary of regular clubs and lettings spreadsheet reviewed. This recommendation is still Partly Implemented as at June 2015 lettings invoices are not being issued for all letting. See Financial Guide for Schools 7.9

Recommendation	Audit Assessment for Audit Committee (July 2015) *Not yet due / Implemented / Partly Implemented / Not Implemented*
it is permissible for the income to be paid into the Governor's account but only if all identifiable costs associated with providing the letting are reimbursed to the school's delegated budget. Where income from lettings is paid into the Governors account then the Lettings Policy should set out the frequency at which associated costs are reimbursed to the delegated budget together with the basis on which these are calculated.'	
Payroll As payroll constitutes the largest area of expenditure for the School, it is recommended that at least two officers are involved in checks over the monthly payroll reports. Refer to the Barnet Financial Guide for schools, section 4 (Internal Financial Controls), and page 16 of the 'Keeping Your Balance' document, issued jointly by Ofsted and the Audit Commission for guidance.	**Not yet due** **Status at June 2015:** **Partly Implemented** Signed payroll report for Dec 2014-May 2015 reviewed. This recommendation is still Partly Implemented as at June 2015 we have been told that the Headteacher checked payroll from April 2014 to Nov 2014, but there was no evidence provided to support this.

8. Internal Audit effectiveness review

We have met all targets within the plan with the exception of one indicator being rated Amber:

1) Implementation of internal audit recommendations – as per section 7 above, the progress of the 22 high priority recommendations due for implementation in quarter 1 is that 77% of recommendations have been fully implemented compared to a target of 90%.

   A summary of the status is as follows:

Status	**Number**	**%**
Implemented	17	77
Partly Implemented	4	18
Not Implemented	1	5
Total	**22**	**100**

Performance Indicator	Target	End of Quarter 1
% of plan delivered	19%*	21%
Number of reviews due to commence vs. commenced in quarter	95%	100%
% of reports year to date achieving: • Substantial • Satisfactory • Limited • No Assurance • N/A	N/A	 14% 43% 14% 0% 29%
Number / % of Priority 1 recommendations: • Implemented • Partly implemented • Not implemented in quarter when due	90%**	77%

* Based on 95% complete of those due in quarter

** Performance of 50-89% considered Amber; performance <50% considered Red.

9. Changes to our plan

Since the Internal Audit Plan was approved agreed in April 2015 there has been one change as follows:

Type	Audit Title	Reasons
Cancelled	Troubled Families – Payment by Results – Q1	No submission made in Q1

10. 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 Internal Governance reviews, Internal Audit officers work closely with Governance colleagues to ensure efficient and effective audits.

Officers within the Assurance Group work closely with Capita and the Barnet Group in line with agreed protocols that both clarify and put in place practical arrangements around the relevant Audit, Fraud and Risk contract or management agreement clauses.

11. Risk Management

The final performance report for Quarter 4 was presented to the Performance and Contract Monitoring Committee on 12th May 2015 and can be found via the link below:
http://barnet.moderngov.co.uk/documents/s23156/Final%20Outturn%20and%20Quarter%204%20Performance%20Monitoring%20201415.pdf

Appendix H to the report is the Quarter 4 corporate risk register:
http://barnet.moderngov.co.uk/documents/s23141/Appendix%20H%20-%20Corporate%20Risk%20Register.pdf

Quarter 1 performance, including the corporate risk register, will go to the September meeting of the Performance and Contract Monitoring Committee.