Internal Audit

Progress Report 2016-17 – Quarter 1

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July 2016

Contents

1. Introduction

The Internal Audit Plan was approved by the Audit Committee on the 19th April 2016. As previously requested by the Committee, this report covers audit reports with limited or no assurance which are summarised into key messages with some detail.

2. Final Reports Issued

This report covers the period from 1st April 2016 to 31st June 2016 and represents an up to date picture of the work in progress to that date. The Internal Audit service has over this period issued 3 reports as final in accordance with the 2015-16 Internal Audit Plan and 15 in relation to the 16/17 plan. In summary, the assurance ratings provided for reports issued in final were as follows:

Substantial ✓✓✓	1
Reasonable	8
Limited	3
No	-
N/A	6
Total	**18**

Table 1: Work completed during quarter 1 including assurance levels

	Systems Audits	Assurance	Number of recommendations by risk category				
			Critical	High	Medium	Low	Advisory
Audits from the 2015/16 internal audit plan being reported this quarter							
1	Establishment List	Limited	-	2	4	1	-
2	Parking Administration	Limited	-	1	2	1	-
Audits from the 2016/17 plan being reported this quarter. Note: our assessments are reported using a new framework (see Section 8)							
3	CCTV	Reasonable	-	-	4	-	-
4	Supervision: Adult Social Care	Reasonable	-	1	2	1	-
5	Supervision: Children's Social Care	Reasonable	-	-	4	-	1
6	Purchase Cards	Reasonable	-	-	4	2	-
7	Street Scene- Follow up review	N/A					

8	Establishment list- Follow up review	N/A
9	ITDR- Follow up review	N/A
10	IT Change Management- Follow up review	N/A
	Grants / Payments by Results	
11	Social Care Capacity Grant	N/A
	Advisory Reviews / Management Letters	
12	Risk Management	N/A
	Schools Audits	
13	Brookhill Nursery	Limited
14	Edgware	Reasonable
15	Moss Hall Nursery	Reasonable
16	Barnfield	Reasonable
17	All Saints (NW2)	Reasonable
18	Chalgrove	Substantial ✓✓✓

The summary detail of those reports issued as Limited or No assurance is included within section 3. The summary detail of management letters resulting in high priority recommendations is included within section 4.

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

Title	Establishment list
Audit Opinion	**Limited Assurance**
Date of report:	June 2016
Background & Context	An establishment list is a report designed to capture the Council's organisational structure as well as core employee details. The establishment list includes both filled posts and vacancies. The "Core Personnel" module of Core (the Council's HR system) is used to produce the establishment list. An accurate establishment list and robust controls over employee standing data is important to ensure accurate payroll payments are made, facilitate effective workforce planning and budgeting. This review considered the control in place to ensure that the establishment list is accurate and up to date and ensure that only appropriate changes are made to employee standing data. It should be noted that certain weaknesses identified have been followed up subsequent to the completion of fieldwork and an exercise has been completed to refresh the Establishment List as part of the Unified Reward project. A follow up of certain issues identified through this review can be seen in ***Section 4: Follow up reviews***.
Summary of Findings	This audit has identified two high, three medium and two low rated findings. We identified the following issues as part of the audit: • **Changes to the establishment list (High risk) -** It is not possible to produce a full list of changes made to the establishment list within Core (the Council's HR system). The requests from the delivery units and supporting documentation for the changes have not been logged and retained in a systematic order and therefore could not all be obtained within the timescales of the audit for the sample selected. A list of authorised submitters – roles that have authority to submit Establishment List Control Forms ("ELCFs") and make changes for a specific part of the organisation - is not maintained and available to CSG staff to assess whether requests have been made by individuals with the prerequisite delegated authority. • **Quarterly review of the establishment list (High risk)**– Quarterly updates to the establishment list are performed via

Title	Establishment list
	confirming with the responsible officers – officers assigned to perform sign-off of the establishment list for a specific part of the organisation – that the establishment list is up-to-date. A full list of the officers responsible for sign-off in the quarterly establishment list review process is not formally maintained or reviewed on a regular basis. The changes can be submitted using two methods: a spreadsheet summarising changes or individual ELCFs for each change. The guidance does not state the types of changes that can be submitted via spreadsheet. There are no validation checks against the list of changes submitted by the delivery units as part of the quarterly review process to confirm all of the changes requested via spreadsheet have been processed accurately. The tracker used to monitor the quarterly process was not updated for 1/2 (50%) of quarters sampled and for 1/2 (50%) quarters sampled evidence of the communication sent out as part of the July confirmation process could not be provided as it has not been retained. For 6/20 sampled departments (30%) the sign-off forms could not be obtained to demonstrate that the responsible officer had confirmed the completeness and accuracy of the establishment list as part of the quarterly process. • **Guidance and procedure documents for processing Establishment List Controls Forms (ELCFs) (Medium risk)** – The CSG team in Belfast can process changes on the Core HR system which is now used to record employee changes and changes in posts. A detailed procedure document for staff is only available for six of the seven types of establishment list control forms (ELCFs) and is outdated. The induction training plan for new staff does not include a section on processing the establishment list control forms. • **Quality checks (Medium risk)** - Self-checks, peer and manager quality checks of establishment list changes are performed by the CSG team in Belfast. Weekly reports are prepared showing the number of self-checks logged. The report does not include all categories of establishment list changes and only includes statistics on self-checks for Leaver forms. We were told that team Leader checks are completed but evidence is not retained therefore this could not be verified. **Access to Core (Medium risk)** – Access to Core (HR system) is restricted. A list of people with access to Core can be produced by department or for the whole organisation. However, the list is not reviewed for completeness or accuracy on a regular basis.

Priority 1 recommendations, management responses and agreed action dates

1. Changes to the establishment list

Recommendation	Management Response	Responsible Officer	Deadline
List of authorised submitters	List of authorised submitters		

Title	Establishment list			
a) A list of the roles that have authority to submit the forms and make changes to the establishment list should be created and should state which department or delivery unit the officer has authority over. b) The list should be reviewed on a monthly basis to ensure it is up-to-date and captures any restructure in the organisation. c) The updated list should be communicated to the HR team in Belfast to ensure they can perform their responsibility effectively. d) The procedure notes and guidance for the HR team in Belfast should be updated to state that the name of the submitter on the form should be checked within Core to confirm they are in the post as per the authorised submitters list before the form is processed. <u>System generated list of standing data changes</u> e) The Council should investigate the feasibility of creating a new report showing the full listing of establishment list changes from Core. <u>Processing of standing data changes</u> f) The HR team in Belfast should keep a record of the ELCFs that they receive in a systematic manner (e.g. in a log or in an appropriately controlled shared folder to ensure ease of validation of changes after these have been made. All changes should be cross-referenced to the reference numbers of the records on Core. g) CSG staff should be reminded that changes to the establishment list should not be processed unless a	a-d) The authorised signatories list that the Council already requires will be used for this purpose. <u>System generated list of standing data changes</u> e) Agreed. <u>Processing of standing data changes</u> f) Already in place. g) Already in place. h) The procedure which is currently implemented through the recommendations from Workforce Board will capture the information and ensure it is stored this in an auditable format.	Operations Director	a-d) Implemented (see follow up section below) e) 30/09/2016 f-g) Implemented (See follow up section below)

Title	Establishment list		
valid ELCF or original email from the submitter is provided. h) Copy of the supporting evidence should be retained on file. New procedure documents should be developed for HR staff and include the list of evidence required to retain for each change made.			
2. Quarterly review of the establishment list			
<u>Methods of submitting errors for correction</u> a) As planned, the Council should eliminate the option to submit changes to the establishment list via spreadsheet with the suggested amendments and instruct the officers to submit the establishment list control forms for all changes instead. <u>List of the responsible officers</u> b) A full list of the responsible officers for the quarterly review process should be created and reviewed quarterly prior to the start of the next quarterly review process. c) The list could be based on the list of authorised submitters (recommendations 1d-1g above). d) If establishment list is shared with employees outside of the list of the responsible officers, the Data Protection team should be informed of the potential data breach. <u>Validation checks</u> e) As part of the new monthly sign-off process, the sign-off sheet should be counter-signed by the officer who	<u>Methods of submitting errors for correction</u> a) Agreed. <u>List of the responsible officers</u> b-c) The authorised signatories list that the Council already requires will be used for this purpose. d) Agreed. <u>Validation checks</u> e) Agreed. <u>Quarterly review process</u> f) Monitoring of the process will be completed via the Operations Director and the Belfast SDM. The tracking of progress will also be monitored via Workforce Board.	HR Director	a-j) Implemented (see follow up section below)

Title	Establishment list			
processed the changes or validated that the requested changes have been processed. <u>Quarterly review process</u> f) The tracker should be updated as planned to monitor the progress of the monthly review process for each month. g) Evidence of the communication with the responsible officers should be retained to support analysis of the progress made in the quarterly tracker by the Workforce Board as required. <u>Quarterly review sign-off sheets</u> h) Responses from the responsible officers during the quarterly sign-off process should be retained to ensure transparency and enable validation checks. i) The sign-off sheets should be held centrally to ensure a full audit trail and enable validation checks. j) A full list of changes submitted by the officer should be attached to the sign-off sheet because the sheet is signed subject to the changes being processed by HR.	g) Agreed. <u>Quarterly review sign-off sheets</u> h) Agreed i) Agreed j) Agreed		

Internal Audit
Establishment List, February 2016
Follow-up (Phase 1), June 2016

Executive Summary

An audit was held in February 2016 to review the appropriateness and effectiveness of the Council's controls in place to ensure that the establishment list is accurate and up to date and ensure that only appropriate changes are made to employee standing data. The audit highlighted a number of areas for improvement, from which recommendations for improvement have been made.

The follow-up audits are being undertaken using a phased approach. The main body of this document covers Phase 1 and considers the recommendations that were made regarding control design to address deficiencies identified in the initial review for those issues that were assessed as "high risk." We have not been able to test the operating effectiveness of controls as part of this follow up due to updates to the Establishment List being processed outside of business as usual controls as part of the Unified Reward project. Phase 2 will look at the extent to which controls have been embedded and are operating effectively over a longer period of time. Fieldwork for phase 2 will occur in Q4.

We identified 5 action items for review that met the criteria for Phase 1 that relate to the high risk findings identified. 100% of the actions have been completed from a control design perspective at the time of testing.

Status	Description	Total
Implemented	Evidence provided to demonstrate that the action is complete	5
Partially Implemented	Evidence provided to show that progress has been made but the action is not yet complete	-
Not Implemented	No evidence seen of the action being progressed or completed	-

Detailed Status Updates

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
1. Changes to the establishment list: *Control design and operating effectiveness*	
List of authorised submitters a) A list of the roles that have authority to submit the forms and make changes to the establishment list should be created and should state which department or delivery unit the officer has authority over. b) The list should be reviewed on a monthly basis to ensure it is up-to-date and captures any restructure in the organisation. c) The updated list should be communicated to the HR team in Belfast to ensure they can perform their responsibility effectively. d) The procedure notes and guidance for the HR team in Belfast should be updated to state that the name of the submitter on the form should be checked within Core to confirm they are in the post as per the authorised submitters list before the form is processed. **Action:** Recommendation accepted	**Implemented (control design)** a-d) A list of authorised budget holders has been formulated and communicated to support the change management process.

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
Processing of standing data changes f) The HR team in Belfast should keep a record of the ELCFs that they receive in a systematic manner (e.g. in a log or in an appropriately controlled shared folder to ensure ease of validation of changes after these have been made. All changes should be cross-referenced to the reference numbers of the records on Core. g) CSG staff should be reminded that changes to the establishment list should not be processed unless a valid ELCF or original email from the submitter is provided. Copy of the supporting evidence should be retained on file. h) New procedure documents should be developed for HR staff and include the list of evidence required to retain for each change made. **Action:** Recommendation accepted	**Implemented (control design)** f-h) Process documents and guidance has been produced and uploaded on to the Intranet to support the process for changes to standing data. The new process clearly sets out that all changes to the establishment list need to be supported by a completed and authorised ELCF. New ELCF templates have been formulated to support change requests and ensure all information is captured and that there is consistency in requests made. Briefing sessions have been provided to relevant staff to communicate the new establishment control processes and these have also been communicated to all staff through Council wide communications. CSG staff have developed a template log to record details of all changes made that captures required information. It should be noted that due to the Unified Reward process changes to standing data have not been processed in line with the business as usual process described above. It has therefore not been possible to test the operating effectiveness of revised controls. The extent to which controls are effective will be assessed in Q4 in the next stage of follow up.

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
2. Quarterly review of the establishment list: *Control design and operating effectiveness*	
Methods of submitting errors for correction a) As planned, the Council should eliminate the option to submit changes to the establishment list via spreadsheet with the suggested amendments and instruct the officers to submit the establishment list control forms for all changes instead. Validation checks b) As part of the new monthly sign-off process, the sign-off sheet should be counter-signed by the officer who processed the changes or validated that the requested changes have been processed. Quarterly review process c) The tracker should be updated as planned to monitor the progress of the monthly review process for each month. d) Evidence of the communication with the responsible officers should be retained to support analysis of the progress made in the quarterly tracker by the Workforce Board as required. Quarterly review sign-off sheets e) Responses from the responsible officers during the quarterly sign-off process should be retained to ensure transparency and enable validation checks. f) The sign-off sheets should be held centrally to ensure a full	**Implemented (control design)** a-f) The monthly sign off process has been designed in line with audit recommendations and communicated to staff via briefing sessions and through Council wide communications. The new business as usual process has not been implemented at the date of follow up testing due to the Unified Reward project and the associated baselining of establishment list data. It has therefore not been possible to test the operating effectiveness of revised controls. The extent to which controls are effective will be assessed in Q4 in the next stage of follow up. **Note:** It should be noted the Unified Reward project undertaken full review of the establishment data was undertaken to ensure that data was accurate to inform the Unified Reward process. During this process 1400 letters were sent to employees. The error rate associated as part of this process was less than 1% (6 letters). As part of this process 50 data fields for every employee were reviewed by managers and HR business partners. It should be noted that the Unified Reward process has not been reviewed as part of this review however this is a key activity in improving the accuracy of the establishment list.

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
audit trail and enable validation checks. **Action:** Recommendation accepted	
<u>List of the responsible officers</u> g) A full list of the responsible officers for the quarterly review process should be created and reviewed quarterly prior to the start of the next quarterly review process. The list could be based on the list of authorised submitters (recommendations 1d-1g above). h) If establishment list is shared with employees outside of the list of the responsible officers, the Data Protection team should be informed of the potential data breach. **Action:** Recommendation accepted & completed	**<u>Implemented (control design)</u>** g-h) A list of authorised budget holders has been formulated and communicated to support the change management process.

Title	Parking Permit Administration
Audit Opinion	**Limited**
Date of report:	June 2016
Background & Context	The responsibility for processing parking permit applications for Barnet residents has been contracted to CSG (Capita) by the Council. Members approved a change to the current process and from October 2015 parking permits have been issued based on the carbon emissions of the vehicle. In addition changes to the administration process resulted in supporting documentation being checked after the application has been processed. Applications will be granted after the documentation is attached to the application. Documentation will then be reviewed by CSG team and any issues or errors will subsequently be investigated, with the possibility of a permit being withdrawn if the documents provided are not in accordance with requirements. There is an Operational Level Agreement ("OLA") in place for this aspect of the CSG service which was intended to address the fact that the CSG contract does not include specific requirements related to parking permit administration process, including timescales to deliver each aspect of the permit functions. The OLA was introduced on 23/02/2016 shortly before the commencement of fieldwork and a number of the provisions were not operational at the time of audit. The implementation of the OLA will alleviate some of the more significant issues identified through this review.
Summary of Findings	This audit has identified one high, three medium and one low rated recommendation. We identified the following issues as part of the audit: • **Roles and responsibilities (High risk)** – The overarching CSG contract sets out at a high level the services that are to be provided through the contract and is orientated around outcomes. It does not detail specific roles and responsibilities around the provision of services in relation to Parking Permit Applications. This has resulted in a lack of clarity around requirements around the extent of procedures that were to be performed by CSG in verifying Parking Permit applications as well as other service standards such as the target timescales in performing key parking administration processes. In addition there was no adequate performance management framework in place to identify and resolve performance issues in relation to the Parking Permit Application process to ensure an appropriate service was being provided by CSG. It should be noted that the OLA that has recently been agreed with management defines roles and responsibilities and addresses some of the issues identified however new arrangements were not fully embedded into procedures at the date of

<table>
<tr><th>Title</th><th>Parking Permit Administration</th></tr>
<tr><td></td><td>testing.

• <u>Chaser letters for missing documentation (Medium risk)</u> - In line with the new procedures implemented in October 2015, when the details of an application are verified and the documentation is subsequently found to be incorrect, the individual should be contacted with a follow up letter requesting missing information. This is currently processed manually, with the individual being added to a spreadsheet at CSG which is sent to a separate officer responsible for issuing the letters. Our testing identified two out of 25 cases (8%) where follow up letters were not sent for missing information.

• <u>Site visits to CSG (Medium risk)</u> - On a monthly basis, the Council's Contract Performance Officer undertakes a site visit to CSG in Coventry where the parking permit administration process is completed. The site visit includes reviewing compliance with the agreed procedures. Our testing identified that in July 2015, no report had been produced for the site visit. Discussion with management confirmed that prior to the recruitment of the Contracts Performance Manager in November 2015; these visits were not performed as no other individual had responsibility or capacity for carrying out these reviews and documenting the reports.</td></tr>
<tr><td colspan="2">Priority 1 recommendations, management responses and agreed action dates</td></tr>
<tr><td colspan="2">1. Roles and responsibilities</td></tr>
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Recommendation	Management Response	Responsible Officer	Deadline
It is recognised that the introduction of the new OLA will improve the control environment in place and alleviate the control issues identified and therefore management should: a) Embed the arrangements set out in the OLA into procedures in relation to Parking Permit administration; and b) On an ongoing basis the Parking Client Team should assess performance against the new performance measures in place and highlight performance	As has been noted above the new Operational Level Agreement has been introduced which addresses the lack of specific requirements in the CSG Contract in relation to this service area. The development of the OLA followed a detailed review of the existing process and procedures and it also sort to incorporate the changes required in process to accommodate the Emissions Based and e- permit. We recognise some of the shortfalls which are why significant work has been done with	Sam Pandya – Contract Performance Monitoring Officer	**Implemented**

Title	Parking Permit Administration		
issues arising to the Commercial Team to consider the escalation of performance measures relating to Parking Administration to contractually enforceable standards as a PI or KPI.	implementing the OL and supporting CSG with training and ensuring all process maps and documentation has now been updated. We welcome a secondary audit follow up so that Assurance can see that the recommendations have been dealt with and we are confident the changes made will give much better assurance at a follow up audit.		

Title	Brookhill Nursery
Audit Opinion	**Limited Assurance**
Date of report:	June 2016
Background & Context	Brookhill Nursery School is a Community nursery school with 113 children on roll and 78 full time equivalent places for pupils aged between 3 and 5 years of age. The School budget for 2016/17 is £649,216 with employee costs of £571,433 (88% of the delegated budget). The School was assessed as 'Outstanding' by OFSTED in November 2013.
Summary of Findings	As part of the audit we were able to give **'Limited'** assurance to the school, noting two Priority 1 and five Priority 2 issues as part of the audit (in order of priority): • **Income** – There was no documented system for chasing invoices for childcare between September 2015 and March 2016. The amount of uncollected income was not available at the audit. **(Priority 1).** • **Payroll** – Unauthorised overtime sheets were entered into the payroll system for payment. Controls were not in place to stop a member of staff entering claims for overtime for herself using her own log-in **(Priority 1).** • **Governance** – The financial management policy and procedures document should include agreed responsibilities

Title	Brookhill Nursery
	of current staff members, procedures for collecting income and should not include Petty cash as no Petty cash is held **(Priority 2)**. • **Financial Planning** – The three year budget is not up to date **(Priority 2)**. • **Unofficial funds** – The remaining 'cash in hand' noted on the auditor's statement and in the ledger for the unofficial fund could not be located at the audit visit **(Priority 2)**. • **Assets** – Insufficient detail is recorded in the Asset register to separately identify each asset **(Priority 2)**. **Compliance with 'Schools Financial Values Standard' (SFVS)** - following our SFVS self – assessment review it is the opinion of audit that there were no major discrepancies in judgements noted however contrary to the School's self-assessment some of the assessment areas had met in Part. (**Priority 2**).

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. Refer to the Barnet Schools Financial Guide, section 7 (Income collection and administration) to ensure compliance.	We appreciate the importance of the above and we have amended our financial management policy to include a system for chasing outstanding debts. These include producing debtor reports fortnightly, which are reviewed by the SBM and chased. We are also introducing advance invoicing from September 2016.	Head teacher/School Business Manager	01 September 2016

2. Payroll

Recommendation	Management Response	Responsible Officer	Deadline
As payroll constitutes the largest area of expenditure for the School, it is recommended	The school uses the Capita HR system for its payroll where you are not able to enter any	Head teacher/School Business Manager	01 September 2016

Title	Brookhill Nursery			
that at least two officers are involved in checks over the monthly payroll reports. The School should refer to the 'Keeping your Balance' document, section E (Financial Controls) and section H (Payroll) for guidance with procedures. Alterations to the payroll must be authorised by someone other than the person preparing the alteration and not by the person the alteration relates to.	changes to your own payroll records. This must have been a one-off transaction that was entered using another staff members log in. We have reinforced the importance of not sharing passwords and log in details. Timesheets are now processed on a timely basis. We also employed LBB School Finance Support over the period who would be responsible for checking the timesheets to the payroll records. Any amendments to the payroll records are documented and authorised in accordance with the notice of authorised signature document and then input by a member of our admin team. Following this advice we have asked HR to issue new log in details to all office administrators.		

4. Follow up reviews

Internal Audit
IT Change Management Review
Follow-up: Phase 1 of 2 (June 2016)

Executive Summary

An audit was held in March 2016 to review the appropriateness and effectiveness of the Council's IT Change Management process, including related governance, policies, process, procedures and controls that are in place to manage changes to the IT applications and infrastructure that support the Council's services. The audit highlighted a number of areas for improvement, from which 30 recommendations for improvement have been made.

The follow-up reviews are being undertaken using a 2-phased approach. Phase 1 has been conducted in June 2016 and considers the recommendations that were made regarding control design to address deficiencies identified in the initial audit. Phase 1 was also determined by the actions that were marked as either completed within the initial audit report, or where the action due date was set for April or May 2016. The follow-up review for Phase 2 will look at the extent to which controls have been embedded and are operating effectively over a longer period of time. A date for Phase 2 is yet to be scheduled, but is anticipated towards the end of 2016.

Of the 30 recommendations highlighted from the main audit in March 2016, 14 recommendations met the criteria for the Phase 1 follow-up review. 57% of the actions have been completed, 29% are still in progress and 14% have not been completed. The items which are not yet completed will be re-assessed as part of the Phase 2 follow-up review. A summary of the outcome is shown in the table below:

Status	Description	Total
Implemented	Evidence provided to demonstrate that the action is complete	8
Partially Implemented	Evidence provided to show that progress has been made but the action is not yet complete	3
Unconfirmed	Exceptional case where evidence was unable to be provided but both the Council and Capita CSG confirm that the action is complete	1
Not Implemented	No evidence seen of the action being progressed or completed	2

Detailed Status Updates

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
3. Process Lifecycle: *Control design*	
1.2 Changes are not reviewed to determine whether successful and identify lessons learned for continuous improvement. Change records are not completed in a timely manner, resulting in inaccurate status reporting, potential inaccuracies to IT configuration information available for future IT change impact assessment and dependency analysis and lack of triggering the post-change review process.	

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
a) Update the IT Change Management policy to include a mandatory review of all failed Request for Change (RFCs) to identify the cause of failure. **Action:** Recommendation accepted & completed **Responsible Officer:** Head of Service Delivery (CSG)	**Implemented** We examined *P0030 Change Management Procedure for the London Borough of Barnet v2.3.* We noted that the updated change management procedure now includes additional responsibilities assigned to the Change Manager: • Change requesters are required to complete a *Failed Change Report* for all failed changes; • *Failed Change Reports* are reviewed for lessons learned; and • Service improvement recommendations are raised with the Service Delivery Manager (SDM)
b) Where Council services are affected, inform and update in a timely manner, explaining which services are unavailable, what work-arounds are available and the estimated time until service is restored. **Action:** Recommendation accepted & completed **Responsible Officer:** Head of Service Delivery (CSG)	**Implemented** We reviewed the existing *Change Assessment Template* and noted that a new section has been added, to request and document information about how to communicate any service unavailability as a result of the change. As the template has been recently implemented, there is only one hand-written template available for change record *CHG0056550*l to test its effectiveness.
d) Review IT Change Management service metrics and monitor on an ongoing basis. This will allow early identification of issues and inform proactive changes to the IT Change	**Not Implemented** We reviewed the IT Change Management service metrics within the

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
Management process, policy, design or procedure as well as identifying staff that require additional change training and support. **Action:** Recommendation accepted & completed **Responsible Officer:** Head of Service Delivery (CSG)	*ICT CSG Monthly Report for May 2016*. We noted that the metrics detail the volume of change each month, categorised by the number of emergency, standard and project-related IT changes. These metrics are not currently adequate to satisfy the recommendation. Capita CSG Management have stated an intent to establish a failed change governance meeting, reviewing failed changes on a quarterly basis for service improvement actions. This meeting was not established at the time of this review. **Revised implementation date:** 2 September 2016

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
3.3 Emergency Changes carry an increased risk to the business as this type of change does not go through the same level of assessment and approval as a normal change.	
a) Define the project-related criteria and controls required for acceptance into the Emergency Change process. **Action:** Recommendation accepted & completed **Responsible Officer:** Head of Service Delivery (CSG)	**Implemented** We examined an email dated 31/03/16 issued by the Change Manager to the Technical Change Advisory Board (CAB), Customer CAB and project stakeholders giving guidance on the use of the emergency change category. We also examined the approvals of changes *CHG0055130* and *CHG0054472*. Both showed that the categorisation of the emergency change was appropriately challenged by the Change Manager. Capita CSG should consider establishing metrics to monitor the ongoing effectiveness of this process (see finding 1.2d).
4. Change Testing & Validation: *Control design*	
2.1 A lack of testing environments for some Council IT services and a lack of testing of the change back-out procedures increases the likelihood of problems during release/ implementation.	
a) Identify which IT services could have an unacceptable impact to the Council's services should there be a prolonged outage.	**Partially Implemented** At the time of this review, actions are still being undertaken to fulfil

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
Action: Recommendation accepted **Responsible Officer:** Mike Bourgoine, Head of Service Delivery (CSG) **Target date:** 30 April 2016	the recommendation. We examined the *P0066 Systems and Applications Register v1.4, DR Dependency Mappings spreadsheet v5.2* and *OBIS008b Service Catalogue* Applications *Inventory*. IT systems are classified as Platinum, Gold, Silver or Bronze, based on the impact to the Council services, however we noted that: • The impact assessments for the applications listed are accurate as at the start of the Council's contract with Capita CSG (2011) and have not been reviewed or updated since. There is no process in place to ensure regular review of this data. • There are a number of existing applications listed, where the classification is unknown and has not been updated since 2011. • New applications taken on since 2011 have been added to the service catalogue but have remained unclassified, meaning that their impact to the Council services is not formally known or documented within the service catalogue. The impact of IT changes cannot therefore be assessed accurately as the information is not current. We also examined *Barnet DR Summary v5.1* that captured the work being undertaken as part of the DR Classification Review to reassess IT systems. Capita CSG has stated that the impact assessment and agreement with the Council is still in progress. **Revised implementation date:** 28 October 2016

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
b) Where the underpinning IT services do not have a test environment, or the existing test environment configuration differs from production, ensure proposed options for remediation have been presented to Council and Council's response recorded. **Action:** Recommendation accepted & completed **Responsible Officer:** Programme Director (CSG)	**Partially Implemented** Examining *P0066 Systems and Applications Register v1.4* showed that there is a record of systems with a User Acceptance Testing (UAT) environment, however the data has not been updated since 2011. We did not see evidence of a review process to verify Council's agreement that the information is still current. This would be important, especially for any new systems added since the contract was taken on in 2011. **Revised implementation date:** 8 July 2016
5. Result of Sample Records Testing: *Operating effectiveness*	
3.3 A lack of test plan increases the likelihood of unforeseen IT incidents during release/ implementation which may cause an impact to Council services.	
b) Vital IT services must have like-for-like configuration environments to allow appropriate levels of testing for IT change. Where this is not possible, ensure that the risk is accepted by all stakeholders (refer to Recommendation 6.1b). **Action:** Recommendation accepted & completed	**Not Implemented** We examined *P0066 Systems and Applications Register v1.4*. Where an IT application is listed as having a UAT environment in place, we could not determine whether this environment was like-for-like. This limits a true representative test of a change to be undertaken.

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
Responsible Officer: Head of Service Delivery (CSG)	**Revised implementation date:** 8 July 2016
3.5 Emergency changes may not be properly reviewed and approved if they are not sent to the correct approval group, resulting in an increased likelihood of unforeseen IT incidents causing an impact to Council services.	
The IT Change Manager must ensure that all change records are routed to the correct Change Advisory Board or re-classified if the priority has changed. **Action:** Recommendation accepted & completed **Responsible Officer:** Head of Service Delivery (CSG)	**Implemented** We reviewed a variety of CAB minutes and emails, which showed that emergency changes raised by projects were challenged by the Change Manager and subsequently re-classified.
5. Governance of IT Change Management: *Control design*	
5.1 A lack of an approved IT Change Management process, aligned with good practice, may result in the risk that inappropriate or incorrect changes are made to the IT environment.	
a) Update the IT Change Management procedure document to include the agreed findings from this review. Obtain approvals and circulate the procedure to the required parties. **Action:** Recommendation accepted & completed	**Implemented** We reviewed *P0030 Change Management Procedure for the London Borough of Barnet v2.3*.

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
Responsible Officer: Head of Service Delivery (CSG)	IT change process design amendments were made and documented. We also saw evidence of the distribution, review and approval of the document updates.
b) Update all policies, procedures and processes to include ownership, responsibility and accountability information. Communicate to the required parties. **Action:** Recommendation accepted & completed **Responsible Officer:** Head of Service Delivery (CSG)	**Implemented** We reviewed *P0030 Change Management Procedure for the London Borough of Barnet v2.3*. Reviewer names had been updated and review dates are now in sequence. Amendments were made to the document ownership, accountability and responsibility information.
5.2 Lack of clear roles and responsibilities for the members of Change Advisory Boards increase the risk of changes proceeding without correct approvals. IT Changes may not be authorised, reviewed and assessed for business impact by the correct business service owners. This could result in an unexpected impact to the Council's services if the IT Change fails or is scheduled at a time that is vital to business operations.	

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
a) The Technical Change Advisory Board meetings and the Customer Change Advisory Board meetings require documented terms of reference to explain their purpose, who should be invited and the roles and responsibilities of the attendees. **Action:** Recommendation accepted **Responsible Officer:** Head of Service Delivery (CSG)	**Partially Implemented** We examined *P0060 Terms of Reference for Technical CAB for the London Borough of Barnet v1.1* dated 22nd June 2016. The document was approved by the CSG Service Delivery Manager on 22nd June 2016, however evidence to show review by the Council is still outstanding. Implementation of this document is therefore still in progress. We examined *P0069 Terms of Reference for Customer CAB for the London Borough of Barnet v1.1* dated 17th June 2016. This document was reviewed with Council management and acceptance was confirmed via an email dated 17th June 2016. Implementation of this document is considered complete. **Revised implementation date:** 8 July 2016
b) Evidence of agreed decisions from the Advisory Board meetings should be attached to the relevant change record. **Action:** Recommendation accepted & completed **Responsible Officer:** Head of Service Delivery (CSG)	**Implemented** We examined changes *CHG0054545, CHG0055506 CHG0053692*. Agreed decisions and approvals were attached to the work notes for each change.

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
6. Expectations Management: *Control design*	
6.1 A lack of transparency and access to IT Service SLA information for IT services decreases the trust between parties and can create confusion over the nature and quality of service being provided.	
a) Publish the SLA and KPI definitions so that they are easily accessible and clear. Clarify Core Service Hours and Key Performance Indicators (KPIs) that are related to service quality. **Action:** (a) Recommendation accepted **Responsible Officer:** Head of Information Management	**Unconfirmed** Both Capita CSG and Council management have stated that the information was published to the LBB intranet site. Council management has advised that a Council incident (outside the control of Capita CSG), had led to the pages being removed. At the time of this review a request was in progress to restore the pages and we were therefore unable to confirm the status of this finding. Follow-up on this action will therefore be re-examined as part of the Phase 2 review. **Revised implementation date:** 28 October 2016
b) Communicate expected resolution timeframes to Council staff when they report incidents and keep them informed if the timeframe is exceeded. **Action:** Recommendation accepted & completed	**Implemented** We examined *P0049 The Major Incident Management Process* and *P0045 Incident Management Procedure for the London Borough of Barnet*.

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
Responsible Officer: Head of Service Delivery (CSG)	The document provides IT Service Desk staff guidance on how to prioritise and manage incidents. Page 7, Section 3.7 of the document states: "*The assignee also takes responsibility for updating the customer and changing the call status as it moves towards closure. At this point expectations should be conveyed to the user".*

Internal Audit
Information Technology Disaster Recovery
Follow-up June 2016

Executive Summary

An audit was held in March 2016 to review the appropriateness and effectiveness of the Council's IT Disaster Recovery arrangements. The review focussed on the obligations of Capita with respect to ITDR provision, the scope of the ITDR project for the secondary data centre, the governance of the ITDR programme and existing ITDR capabilities. The audit highlighted a number of areas for improvement, from which recommendations for improvement have been made.

This follow up review has considered progress against the recommendations made in the original report and The technical recovery capability that is currently in place as delivered by the project and what potentially this provides the council in terms of cover should an incident occur prior to the end of the project;. It should be noted that the ITDR project is scheduled to complete in mid-August and a review of ongoing, business as usual ITDR arrangements is scheduled to be undertaken in Q3.

We identified 10 action items for review that met the criteria for Phase 1. 30% of the actions have been completed, 50% are still in progress and 20% have not been completed. A summary of the outcome is shown in the table below:

Status	Description	Total
Implemented	Evidence provided to demonstrate that the action is complete	3
Partially Implemented	Evidence provided to show that progress has been made but the action is not yet complete	5
Not Implemented	No evidence seen of the action being progressed or completed	2

Detailed Status Updates

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
1. ITDR Governance	
a) Governance of BCM should formally include Capita staff who are responsible for ITDR. These individuals should be identified by Capita and then invited on a standing basis (Governance) **Action:** Recommendation accepted & completed **Responsible Officer:** IS Security Manager (CSG)	**Implemented** Capita staff, who are responsible for the ITDR programme have been identified for inclusion in the council's BCM steering committee.
b) The BCM quarterly meeting should include formal ITDR discussion we with respect to a) business alignment b) capability c) status d) issues e) residual risk **Action:** Recommendation accepted & completed **Responsible Officer:** Emergency Planning and	**Partially implemented** Capita have invited and have attended the BCM steering committee. However the meeting did not include any formal ITDR programme discussion. BCM team should add a standing ITDR agenda item to the steering committee. ***Revised implementation date: 31/08/2016***

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
Business Continuity Manager (LBB)	
c) Capita should immediately engage the Council management and agree the level of reporting information required with respect to the ITDR capability. This should include as a minimum a) ITDR capability in terms of IT services in scope, Recovery Time Objective (RTO), Recovery Point Objective (RPO) and capacity, b) residual risk, c) planned tests, d) the test results and remedial actions and d) ITDR capability changes. (Governance) **Action:** Recommendation accepted & completed **Responsible Officer:** Operations Manager (CSG)	**Not implemented** Please see 2.1b below. RTO's are still being reviewed with the council this cannot complete until they are agreed. ***Revised implementation date: 31/08/2016***
d) Management should update governance policies, terms of references and processes to reflect the above. (Governance) **Action:** Recommendation accepted &	**Not implemented** No update received from management for this recommendation. Governance policies, terms of references and processes can't be confirmed until reporting arrangements have been defined.

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
completed **Responsible Officer:** Emergency Planning and Business Continuity Manager (LBB)	***Revised implementation date: 31/08/2016***
2. Alignment of BCM recovery requirements with ITDR capability	
c) The programme teams should confirm who is responsible for reviewing the scope of the IT services included within ITDR. The responsible party should review the scope and the current ratings and engage Capita with respect to any required changes which should be provisioned as part of the ITDR project. (Business requirements) **Action:** Recommendation accepted **Responsible Officer:** Emergency Planning and Business Continuity Manager (LBB)	**Implemented** For the purposes of this action Capita are engaging with Jenny Obee.
d) Capita should immediately engage the Council to ensure that the recovery bandings, i.e.	**Partially Implemented**

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
platinum, gold, silver and bronze, are being delivered as per the contractual agreement. Where not, Capita should provision as part of the project. (Contract Specification) **Action:** Recommendation accepted & completed **Responsible Officer:** Operations Manager (CSG))	Capita have recently (complete June 2016) an analysis of the original schedule against the systems currently provisioned for by the project. At the time of the update Capita had not discussed the outcomes with LBB. The Capita analysis shows the following for 2011: • 32 as Platinum • 16 as Gold • 23 as Silver • 66 as Bronze • 43 unclassified (i.e. in this case do not require ITDR) The above numbers are reflected in the contract. It was also noted that a number of these entries were erroneous as they were for service components (e.g. Oracle) as opposed to IT services. Additionally these numbers include a number of 3rd party services not provided directly by Capita The Capita analysis shows that what has actually been provisioned (excluding 3rd parties) is as part of the project is as follows: • 52 as Platinum and Gold • 27 as Silver and Bronze • 25 as Unclassified The analysis notes that since 2011 58 additional services have been decommissioned It was also noted on interview, that systems that were introduced since 2011, did not include a formal request for ITDR from the council, however in a number of cases (e.g. Mosaic), Capita have provisioned anyway. The analysis underlines the necessity for the council and Capita to re-baseline the

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
	recovery requirements of IT services. ***Revised implementation date: 31/08/2016***
e) In line with the governance finding (Recommendation 2.1d *per report*) above, the BCM programme should engage with those in Capita responsible for ITDR on a defined and regular basis to ensure changes in recovery requirements are provisioned for. (Business requirements) **Action:** Recommendation accepted & completed **Responsible Officer:** Emergency Planning and Business Continuity Manager (LBB)	**Not implemented** As Capita and the council have not re-baselined this action is not possible. ***Revised implementation date: 31/08/2016***
3. ITDR planned technical recovery capability	
c) In line with the recovery requirements recommendation in the report (Recommendation 2.2b), Capita should immediately engage with the Council to ensure the required infrastructure is provided to meet recovery requirements and	**Partially completed** As per 2.1b, Capita have completed their initial analysis on what is currently covered by the ITDR programme against initial contract and are in the process of engaging the council.

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
expected user numbers. (Contract specification). **Action:** Recommendation accepted & completed **Responsible Officer:** Operations Manager (CSG)	As an update Capita have informed IA that the current ITDR project's provision for applications placed in silver and bronze categories cannot meet contractual recovery requirements with respect to Recovery Point Object (RPO, i.e data loss). The contractual requirements stands at 1 hour (i.e. if the system fails at 1200, it will be brought back to a state where it was at 1100, with an hours' worth of permanent data-loss), however the actual capability will lose up to 24 hours of data. It is recommended that the council take this into account when re-baselining. ***Revised implementation date: 31/08/2016***
d) The ITDR project should identify end to end IT service dependencies that should be taken into account in provisioning and planning. This may mean that IT services that are not currently in scope have to be provisioned to support ones that are in scope and have a critical dependency. It may also mean that IT services have to be promoted in terms of tiering to ensure successful recovery. (Proposed ITDR solution) **Action:** Recommendation accepted & completed	**Implemented** Capita have conducted an analysis of the applications in scope and identified interdependencies between applications.

Audit finding, date and recommendation (March 2016)	Audit follow-up status (June 2016)
Responsible officer: Applications team, CSG	
4. Interim IT Disaster Recovery	
c) Capita should immediately engage the Council and propose the most effective way of mitigating the risk in the interim period prior to ITDR being fully deployed by the project (Contract specification). **Action:** Recommendation accepted & completed **Responsible Officer:** ICT Director (CSG) Head of Information Management (LBB)	**Partially implemented** Capita have continued with the rollout of the ITDR programme. In terms of recoverability the following stands: • Gold and Platinum IT services have recovery infrastructure and currently replicating their data. • Silver and Bronze IT services have recovery infrastructure in place, however it does not allow for the recovery of data within contractual requirements • Partial recovery plans have been developed • The associated LAN/WAN project has not completed and the time of review would mean that approximately 40% of council users would not be able to access recovered services from their offices. • No testing has been carried out In this position Capita would stand a reasonable chance of recovering services but there is a risk this may not occur within contractual requirements due to the lack of testing and documentation. However requirements do not come into force until the project has delivered. The project is currently on track to complete (i.e. hand over to Business As Usual) in mid-August. ***Revised implementation date: 31/08/2016***

Internal Audit
2016-17 Street Scene Operations Review

Executive Summary

An audit, - Street Scene Operations Review – November 2015 report - was completed in 2015-16 to review the appropriateness and effectiveness of the Council's Street Scene Delivery Unit overall control environment, in particular around the recruitment of staff, the monitoring of sickness, the private use of Council vehicles and the commercial waste monitoring arrangements to prevent illicit payments stemming from the collection of commercial waste.

An audit - Trade Waste Income – January 2015 report - was completed in 2014-15 to review trade waste credit note and invoice processing arrangements.

New management who have started in Street Scene after the audits were completed to address governance issues have overseen the implementation of all recommendations. Owing to the seriousness of the weaknesses in controls that were identified during those audits, we conducted a detailed follow-up of priority 1 and priority 2 recommendations made in the above audits to assess their implementation status under new management. The scope of the audit was as follows:

Scope areas	Audit coverage
Follow-up of 2015-16 Street Scene Operations Review (Audit Report : Street Scene Operations Review – November 2015) - P1 recommendations All actions to mitigate the identified risks are and remain implemented.	Focussed on how priority 1 (P1) recommendations - made in the l audit 5 - which were found to be implemented at a strategic level when followed up in quarter 4 2015-16 had embedded in day to day operation in the Street Scene Delivery Unit and those which (10 recommendations)
Follow-up of 2015-16 Street Scene Operations Review (Audit Report : Street Scene Operations Review – November 2015) - P2 recommendations	Followed up priority 2 (P2) recommendations and actions made in the initial audit in November 2015. (8 recommendations)

Scope areas	Audit coverage
All actions to mitigate the identified risks are and remain implemented.	
Follow-up of the 2014-15 the Trade Waste Invoicing review (Audit Report: Trade Waste Income Management Letter – January 2015) All actions and processes to mitigate the identified risks have been implemented.	Followed up the trade waste credit note and invoicing recommendations made in the Trade Waste Management Letter - January 2015 (8 recommendations)
Trade Waste Implementation Plan Planned changes to trade waste delivery incorporate the necessary key controls to manage risks to tolerable levels.	Provided risk and control advice and guidance as part of the implementation of the Commercial Waste Transformation project reported to the Environment Committee 8 March 2016.

Status	Description	Total
Implemented	Evidence provided to demonstrate that the action is complete	16
Partially Implemented	Evidence provided to show that progress has been made but the action is not yet complete	7
Not Implemented	No evidence seen of the action being progressed or completed	2
Status review	Report on the current circumstances for a recommendation, in this instance a recommendation relating to the availability of resources	1
Total		**26**

Audit	Implemented	Partly implemented	Not implemented	Status Review	Total
Audit Report : Street Scene Operations Review – November 2015 (P1)	**8**	**2**	**0**	**0**	**10**
Audit Report : Street Scene Operations Review – November 2015 (P2)	**7**	**1**	**0**	**0**	**8**
Audit Report: Trade Waste Income Management Letter – January 2015	**1**	**4**	**2**	**1**	**8**
Total	**16**	**7**	**2**	**1**	**26**

Note: Four of the partly implemented recommendations and the 2 not implemented recommendations are attributable to the lack of credit note and sales invoice control checks required by the recommendations reported in the Trade Waste Income Management letter January 2015. These controls will be included in trade waste processes being redesigned as part of the Commercial Waste Transformation vision and project reported to the Environment Committee 8 March 2016. Internal Audit will be involved in the redesign of processes to ensure that the appropriate controls are embedded in trade waste income operations at the outset. The implementation of controls is therefore considered work in process.

We have made one medium priority (P2) recommendation to implement formal project management arrangements to ensure effective delivery of the Commercial Waste Transformation.

Detailed Status Updates

Audit finding, date and recommendation 1. Street Scene Operations Review (November 2015) – P1 recommendations	Audit follow-up status (June 2016)
1.1 Recruitment - Conflicts of Interest	
A process was not evident for central CSG HR to independently review application forms to identify and address personal interests and close relatives declared in application forms by applicants. This resulted in a breach of the "Employment of Relatives" policy paragraph 2.1 which states that officers should not be involved in the recruitment of 'close relatives' as defined in the Staff Code of Conduct. We also noted that in this case the members of the recruitment panel were not formally documented and recorded on the recruitment file at the time of the recruitment exercise for referral and scrutiny, where necessary. Paragraph 9 of the "Staff Code of Conduct" refers to the expectation that officers will declare conflicts of interest where they believe they exist. There is therefore no requirement for officers to formally declare at the start of the recruitment and in writing the non-existence of any conflicts of interest for referral for the avoidance of any doubt.	
Recommendation: a) CSG HR officers should review returned job application forms to identify, communicate and address any interest or close relatives declared on application forms. The action should ensure that the interview and evaluation panel is structured to ensure an unbiased objective assessment of the candidate for the role in line with the Employment of Relatives policy paragraph 2.1. **Action:** Recommendation accepted & completed	**Implemented** The Recruitment Declaration forms are now completed as part of the recruitment process in Street Scene. The completed Recruitment Declaration of Interest confirmed the non-existence of conflicts of interest in relation to the recruitment exercise and the allocation of the appropriate officers to interview and evaluation panel. The Recruitment Declaration of Interest form was signed by the Director as evidence of senior management review/challenge

Audit finding, date and recommendation 1. Street Scene Operations Review (November 2015) – P1 recommendations	Audit follow-up status (June 2016)
Responsible Officer: (a) – (d) Graeme Lennon, Human Resources Director Customer and Support Group(Capita) **Target date:** February 2016	
Recommendation: b) The Staff Code of Conduct should be updated to require officers involved in the interview, evaluation and selection of candidates to formally complete a recruitment declaration of interest form, for example in relation to "close relatives" as defined, similar to the requirement at paragraph 9.10 of the Code of Conduct to complete a procurement declaration of interest form at the start of each procurement exercise. **Action:** Recommendation accepted & completed **Responsible Officer:** (a) – (d) Human Resources Director Customer and Support Group(Capita) **Target date:** February 2016	**Implemented** The Staff Code of Conduct had been correctly updated. The Recruitment Declaration forms are now completed as part of the recruitment process in Street Scene. The completed Recruitment Declaration of Interest confirmed the non-existence of conflicts of interest in relation to the recruitment exercise and the allocation of the appropriate officers to interview and evaluation panel. The Recruitment Declaration of Interest form was signed by the Director as evidence of senior management review/challenge

Audit finding, date and recommendation 1. Street Scene Operations Review (November 2015) – P1 recommendations	Audit follow-up status (June 2016)
Recommendation: c) The recruitment declaration of interest form should formally record/confirm the existence or non-existence of conflicts which could compromise objective selection of a candidate, for example, where the candidate is a “close relative” as defined. This would prevent the lack of awareness of policy being raised as a defence for not declaring interests where necessary. **Action:** Recommendation accepted & completed **Responsible Officer:** (a) – (d) Human Resources Director Customer and Support Group(Capita) **Target date:** February 2016	**Implemented** The Recruitment Declaration forms are now completed as part of the recruitment process in Street Scene. The completed Recruitment Declaration of Interest confirmed the non-existence of conflicts of interest in relation to the recruitment exercise and the allocation of the appropriate officers to interview and evaluation panel. The Recruitment Declaration of Interest form was signed by the Director as evidence of senior management review/challenge

Audit finding, date and recommendation 1. Street Scene Operations Review (November 2015) – P1 recommendations	Audit follow-up status (June 2016)
Recommendation: d) The relevant Assistant Director/ Director should sign off the declaration as evidence of appropriate review **Action:** Recommendation accepted **Responsible Officer:** (a) – (d) Human Resources Director Customer and Support Group(Capita) **Target date:** February 2016	**Implemented** The Recruitment Declaration forms are now completed as part of the recruitment process in Street Scene. The completed Recruitment Declaration of Interest confirmed the non-existence of conflicts of interest in relation to the recruitment exercise and the allocation of the appropriate officers to interview and evaluation panel. The Recruitment Declaration of Interest form was signed by the Director as evidence of senior management review/challenge
1.2 Workforce Management –Governance Arrangements	
For absence reporting we noted that for 191 out of 206 instances (93%) of absence leave for the period 1 April 2014 to date there was no record of the “Return to Work” interview in the HR Core records provided to us. Of these, there were 57 instances of absence of 5 days or more. “Return to work interviews” should be conducted after every period of absence in order to identify the cause of the absence. We were informed of practices whereby staff had requested annual leave that had been refused due to a lack of alternative staff being available, then the requesting officer then calling in sick. If return to work interviews were being undertaken and recorded within Core as expected this would enable further investigation of this issue.	

Audit finding, date and recommendation 1. Street Scene Operations Review (November 2015) – P1 recommendations	Audit follow-up status (June 2016)
Recommendation: All sickness should be recorded in Core and records of return to work interviews and related issues should be recorded in HR Core after each period of absence. Where this is not possible a corporate Return to Work form should be completed, scanned and sent to HR to be held on the employee's file. **Action:** Recommendation accepted **Responsible Officer:** Street Scene Director **Target date:** December 2015	**Partly Implemented** Return to Work Interview forms are properly completed by supervisors where officers return from a period of sickness. The recommendation is considered partly implemented as the Return to Work Interview form is not available in HR Core so that it can be accessed centrally for referral/review, where necessary, consistently. **Future Action**: Recycling and Waste will use HR Core, the Councils recruitment and payroll system for sickness recording, including Return to Work Interviews, when the Recycling and Waste staff move to the same Terms and Conditions, when Unified Pay and Reward is implemented. **Revised Implementation Date**: 1 October 2016
1.3 Risk of Illicit Payments -Vehicle CCTV monitoring	
The Council's refuse collection vehicles are all fitted with CCTV cameras on the sides, front and rear of the vehicles to view operations around the vehicles. The camera recordings are not visible real time from a central location. Related recordings are only reviewed in response to incidents, for example attacks on drivers, resident complaints or enquiries by the Met Police. The records are not reviewed pro-actively to identify non-compliant behaviour such as identifying operatives taking monies for personal deliveries or identifying where cameras have been repositioned.	

Audit finding, date and recommendation 1. Street Scene Operations Review (November 2015) – P1 recommendations	Audit follow-up status (June 2016)
Recommendation: a. A process should be introduced and documented to review camera recordings pro-actively on a sample basis to ensure that cameras are operating correctly at all times and to identify non-compliant behaviour, such as accepting amounts for private collections from businesses with whom the Council does not have trade waste agreements or for identifying non-attendance at work. **Action:** Recommendation accepted **Responsible Officer:** Street Scene Director **Target date:** March 2016	**Implemented** The review of refuse vehicle CCTV recording / footage stemming from suspicious activity noted on refuse vehicle tracker reports has started. The refuse vehicle tracker reports are routinely reviewed pro-actively for suspicious activity as in line with the Street Scene Use of Tracker Information Systems procedure dated 7 June 2016.
Recommendation: b) The 'Data Protection Council Vehicle Mounted CCTV, Vehicle Tracking and Electronic Data Management Systems Policy' should be updated, in conjunction with the Council's Data Protection team, to facilitate the use of such pro-active monitoring. **Action:** Recommendation accepted **Responsible Officer:** Street Scene Director	**Implemented** The CCTV Policy has been updated to reflect the new approach to monitoring as follows: - the pro-active review of vehicle tracker monitoring reports and - the reviewing of refuse vehicle CCTV recordings/footage where this is considered appropriate, for instance, where the

Audit finding, date and recommendation 1. Street Scene Operations Review (November 2015) – P1 recommendations	Audit follow-up status (June 2016)
Target date: March 2016	review of vehicle tracker report information above shows suspicious activity indicating that a review of the camera recording is necessary.
1.4 Risk of Illicit Payments - Route rotation	
Operatives on collection routes are not subject to periodic route rotation. Management indicated that it was generally preferable to keep operatives on the same route to ensure smooth and effective operation and service delivery.	
Recommendation: Waste collection operatives should be rotated between collection crews periodically to prevent the development of rogue relationships with businesses on routes. **Action:** Recommendation accepted **Responsible Officer:** Street Scene Director **Target date:** February 2016	**<u>Implemented</u>** Evidence of the natural rotation of trade waste crews through absence was provided in line with the agreed action.
1.5 Refuse vehicle tracker monitoring	

Audit finding, date and recommendation 1. Street Scene Operations Review (November 2015) – P1 recommendations	Audit follow-up status (June 2016)
Recommendation: The vehicle tracker reports and vehicle CCTV camera recordings should be used together to optimise pro-active monitoring of movements **Action:** Recommendation accepted **Responsible Officer:** Head of Waste and Recycling **Target date:** March 2016	**Implemented** The review of refuse vehicle CCTV recording / footage stemming from suspicious activity noted on refuse vehicle tracker reports has started. The refuse vehicle tracker reports are routinely reviewed pro-actively for suspicious activity as in line with the Street Scene Use of Tracker Information Systems procedure dated 7 June 2016.
1.6 Risk Management (Mill Hill depot site security)	
Security did not undertake physical inspection of vehicles leaving or entering the site.	
Recommendation: Spot checks of people and vehicles entering and leaving the site should be introduced as should increase site patrols. **Action:** Recommendation accepted **Responsible Officer** Acting Facilities Manager CAPITA Customer and Support Group **Target date:** November 2015	**Partly Implemented** No further action since the last follow-up. Spot checks of vehicles entering and leaving the Mill Hill Depot site are still not done. **Further Action**: The Acting Facilities Manager, CSG will contact the Head of Estates for his initial approval for spot checks. Once agreed, The Acting Facilities Manager, CSG will ensure the message is passed onto managers operating at Mill Hill Depot and inform them this

Audit finding, date and recommendation 1. Street Scene Operations Review (November 2015) – P1 recommendations	Audit follow-up status (June 2016)
	message needs to be cascaded to staff. Spot checks will commence from Monday 1 August 2016 following communication of requirements to service managers. **Revised Implementation Date**: 1 August 2016

Audit finding, date and recommendation 2. Street Scene Operations Review (November 2015) – P2 recommendations	Audit follow-up status (June 2016)
2.1 Side Waste Policy	
A judgement-based approach is adopted in relation to side trade waste, in excess of the contractual amount on the crew sheet. If the excess is small, it will be taken. If it is considered excessive, it will be noted on the crew sheet and taken. The sheets are reviewed by the Collections team and where trends are noted an Enforcement Officer will be sent to assess whether the business requires an updated contract.	

Audit finding, date and recommendation 2. Street Scene Operations Review (November 2015) – P2 recommendations	Audit follow-up status (June 2016)
Recommendation: A complete formal policy / procedure on the treatment of Trade and Residential side waste should be approved by senior management, dated and subject to version control. The policy should document all aspects of the process to ensure a consistent approach to side waste identification, recording, collection and charging across collection crews and the Enforcement team **Action:** Recommendation accepted **Responsible Officer:** Street Scene Director **Target date:** February 2016	**Implemented** A Side Waste Policy has been approved and communicated.
2.2 Policies and procedures – staff use of Council fleet vehicles	
There was no evidence of the "Drivers Handbook", developed by the Transport Service, having been formally approved at Delivery Unit Senior Management Level and it was not subject to a version and formal change control process. The Handbook sets out the policy for the private use of Council fleet vehicles. The intention was that there should be no personal/private use other than travel between home and work. Officer understanding of whether and when the private use of Council vehicles was allowed varied confirming the need for clarification and communication of policy.	

Audit finding, date and recommendation 2. Street Scene Operations Review (November 2015) – P2 recommendations	Audit follow-up status (June 2016)
Recommendation: a) For the avoidance of any doubt, the Drivers Handbook should be updated to clarify the position on the private use of Council vehicles, for example, paragraph 5.1 should be updated to read as follows: "5.1 Council vehicles are provided for business use and must not be used for personal use." **Action:** (a) Recommendation accepted **Responsible Officer:** Street Scene Director **Target date:** February 2016	**Implemented** The Driver's Handbook has been updated and finalised and clarifies the rules around private use of Council Vehicles
Recommendation: b) The Driver's Handbook should be formally approved at Delivery Unit Senior Management Level and subject to version and formal change control process when reviewed and updated. **Action:** Recommendation accepted **Responsible Officer:** Street Scene Director	**Implemented** The updated Driver's Handbook was approved by Street Scene Senior Management Team.

Audit finding, date and recommendation 2. Street Scene Operations Review (November 2015) – P2 recommendations	Audit follow-up status (June 2016)
Target date: March 2016	
Recommendation: c) The updated Drivers Handbook should be circulated to the relevant Green spaces officers and operatives for review and sign-off. Records of sign-off should be retained centrally for referral. **Action:** Recommendation accepted **Responsible Officer:** Street Scene Director **Target date:** March 2016	**<u>Implemented</u>** A process has been implemented for: - the relevant officers to read the Driver Handbook stipulating that private use of vehicles is not allowed and - the sign-off the related declaration as to understanding its contents
2.3 Policy / procedures –fuel pump and fuel master key operation	
The responsible officer was not aware of a documented policy/procedure governing the use of the fuel pump, including the use of jerry cans or fuel keys, including the master fuel keys. The expectation is that the approaches for key processes are documented and communicated for clarity and for the avoidance of any doubt as to the requirements.	

Audit finding, date and recommendation 2. Street Scene Operations Review (November 2015) – P2 recommendations	Audit follow-up status (June 2016)
Recommendation: a) A formal policy governing fuel pump operation and fuel key issue and control at the Mill Hill Depot site should be documented for referral, approved by Senior Management and communicated, including to service responsible for site security. This should cover: 1. Control/security of fuel keys and particularly master keys for example the maintenance of usage logs/records (log of when taken, date taken, authorisation, reasons for use and date returned). It should also be clear on when master keys may be used. 2. The use of the fuel pumps to mitigate the risk of theft, including rules for filling jerry cans on site. **Action:** Recommendation accepted **Responsible Officer:** Street Scene Director **Target date:** ***February 2016***	**Implemented** The Fuel Management Policy has been drafted and approved. The policy addressed: - The control of fuel and master keys including the maintenance of usage logs - The maintenance of logs of fuel issued to storage/jerry cans and reconciled to Transport master reports. They also required the use of the Master key which itself was subject to additional controls in terms of access.
Recommendation b) The policies should be signed off as having been read by	**Implemented** The policy has been circulated to and read by all relevant officers

Audit finding, date and recommendation 2. Street Scene Operations Review (November 2015) – P2 recommendations	Audit follow-up status (June 2016)
staff and evidence of sign-off retained. **Action:** Recommendation accepted **Responsible Officer:** Street Scene Director **Target date:** March 2016	confirmed. The sign-off by the relevant officers confirming that they had read and understood the policy was retained for review.
2.4 PAYE for taxable benefit from private use of Council fleet vehicles	
We confirmed with CSG Payroll that there were no officers on the Barnet Council payroll being taxed for the benefit associated with the private use of Council vehicles. There were no PAYE adjustments for staff using Council vehicles for private use, for example travel between home and work. The view of HR was that HMRC would need to be informed about such private use.	
Recommendation Street Scene Management should refer the issue to the Council's Finance section and HB Public Law for review and confirmation of the position for communication to CSG Payroll as necessary. The Drivers Handbook should be updated to emphasise that	**Implemented** The issue around liability for PAYE on the private use of Council vehicles was resolved by Capita HR in consultation with HMRC. The decision was the private use of vehicles between home and work in the manner defined in the deriver's Handbook did not create a liability for PAYE. The responsible Service Manager indicated that the Drivers Handbook would be updated in the next review in 6 months.

Audit finding, date and recommendation 2. Street Scene Operations Review (November 2015) – P2 recommendations	Audit follow-up status (June 2016)
private use is not permissible and that the Council would be liable for PAYE on any such private use. **Action:** Recommendation accepted **Responsible Officer:** Street Scene Director **Target date:** March 2016	
2.5 Trade Waste Market share	
The officer interviewed indicated that a programme of greater enforcement was planned to identify Businesses without a formal agreement for the collection of trade waste which could potentially increase market share.	
Recommendation: The enforcement plan to identify businesses without a trade waste collection agreement/licence should be developed, approved and commenced. **Action:** Recommendation accepted **Responsible Officer:** Street Scene Director	**Partly implemented** The Street Scene Delivery Unit Enforcement Policy December 2015 was reviewed and approved at the Environment Committee 8 March 2016. Enforcement was also referred to in the Commercial Waste Transformation initiative reported to the Environment Committee on 8 March 2016. The Enforcement Policy through requiring the monitoring of duty of

Audit finding, date and recommendation 2. Street Scene Operations Review (November 2015) – P2 recommendations	Audit follow-up status (June 2016)
Target date: March 2016	care arrangements in businesses for the disposal of their commercial waste supports the "Business rebranding and expansion" priority referred to in the Commercial Waste Transformation initiative. A product called the "Dashboard" developed in consultation with Capita was completed and signed off during the week commencing 26 June 2016. The product allows the identification of potential businesses in the Borough not having the relevant Duty of Care Certificate which is required by all relevant businesses to confirm that they have the proper arrangements in place to dispose of their commercial waste through a licenced carrier. We understand that the "Dashboard" will start being used in 3 weeks after a data matching exercise has been undertaken. We were however not provided with an Enforcement Plan – as required by the recommendation - or any other Plan to show how the Enforcement Policy would be implemented in relation to increasing trade waste market share. The minutes of the decisions of the Environment Committee 8 March 2016 referred to a trial of the Street Scene enforcement approach but a detailed plan for delivery was not available for inspection. The development of a plan is therefore considered work in progress. **Further action:** The Enforcement Plan should be completed and approved.

Audit finding, date and recommendation 2. Street Scene Operations Review (November 2015) – P2 recommendations	Audit follow-up status (June 2016)
	Revised implementation date: 1 September 2016

Audit finding, date and recommendation 3. Trade Waste Income (January 2015)	Audit follow-up status (June 2016)
3.1 Approval and allocation of credit notes	
The allocation of trade waste credit notes to an invoice is not currently subject to secondary review once it has been authorised. Delays in authorising credit notes were an historic issue. It is not possible in Integra to track raised credit notes until they have been authorised / declined for monitoring purposes.	

Audit finding, date and recommendation 3. Trade Waste Income (January 2015)	Audit follow-up status (June 2016)
Recommendation: a) Management should investigate whether it is possible within Integra to make credit notes visible on the system when they have been raised but not yet authorised. **Action:** Recommendation accepted **Current Responsible Officer (started April 2016):** Interim Collections Services Manager **Target date:** March 2015	**Partly implemented** The responsible officer for raising credit notes in Integra was not able to generate a report of credit notes raised in the accounting system Integra which had not been authorised for monitoring long overdue credit notes where applicable. The monitoring of unauthorised credit notes was performed manually and successfully using an Excel spreadsheet. **Further action**: These controls will be included in trade waste processes being redesigned as part of the Commercial Waste Transformation vision and project reported to the Environment Committee 8 March 2016. Internal Audit will be involved in the redesign of processes to ensure that the appropriate controls are embedded in income operations at the outset. The implementation of controls is therefore considered work in process. Internal Audit will therefore be in a position to monitor implementation as part of our input to redesigned processes. **Revised implementation date**: 1 September 2016
Recommendation: b) Management should introduce a requirement for all	**Partly implemented** The allocations of the credit notes to invoices were done promptly.

Audit finding, date and recommendation 3. Trade Waste Income (January 2015)	Audit follow-up status (June 2016)
credit notes to be allocated to an invoice in a customer's account at the time they are authorised, and for this allocation to be subject to secondary review. **Action:** Recommendation accepted **Current Responsible Officer:** Interim Collections Services Manager **Target date:** March 2015	However the allocations were not subject to secondary review as required by the recommendation. Evidence of secondary checks undertaken was not available for our inspection. **Further action**: These controls will be included in trade waste processes being redesigned as part of the Commercial Waste Transformation vision and project reported to the Environment Committee 8 March 2016. Internal Audit will be involved in the redesign of processes to ensure that the appropriate controls are embedded in income operations at the outset. The implementation of controls is therefore considered work in process. Internal Audit will therefore be in a position to monitor implementation as part of our input to redesigned processes. **Revised implementation date**: 1 September 2016
3.2 Accuracy of trade waste charges	
We selected a sample of 25 trade waste invoices raised on Integra between 1 April 2014 and 31 October 2014 for accuracy. Of the 25 tested, we identified 8 incorrect invoices of which 2 had not been resolved at the time of the audit.	
Recommendation:	**Partly implemented**

Audit finding, date and recommendation 3. Trade Waste Income (January 2015)	Audit follow-up status (June 2016)
a) Management should introduce a requirement for a sample of invoices to be subject to secondary review before being raised on customer accounts. Management could review the error rate after 6 months and then consider reducing the sample size if the error rate is low. **Action:** Recommendation accepted **Current Responsible Officer:** Interim Collections Services Manager **Target date:** March 2015	Reviews/checks of invoices raised in Integra for errors were not performed as required by the recommendation. Upon testing a sample of six invoices issued between February 2016 and May 2016 we found that trade waste bins were charged at the correct rates and for the correct period. The checking process should ensure that this is the case consistently. **Further action**: These controls will be included in trade waste processes being redesigned as part of the Commercial Waste Transformation vision and project reported to the Environment Committee 8 March 2016. Internal Audit will be involved in the redesign of processes to ensure that the appropriate controls are embedded in income operations at the outset. The implementation of controls is therefore considered work in process. Internal Audit will therefore be in a position to monitor implementation as part of our input to redesigned processes. **Revised implementation date**: 1 September 2016
Recommendation: b) The collection rates in Integra should be reviewed by the Trade Waste Management Team when they are	**Partly implemented** Checks of the accuracy of trade waste collection rates in Integra were not performed

Audit finding, date and recommendation 3. Trade Waste Income (January 2015)	Audit follow-up status (June 2016)
annually entered into Integra by Finance to further ensure they are correct and consistent with rates published on the Council's website. **Action:** Recommendation accepted **Current Responsible Officer:** Interim Collections Services Manager **Target date: March 2015**	Upon testing a sample of six invoices issued between February 2016 and May 2016 we found that trade waste bins were charged at the correct rates and for the correct period. The checking process should ensure that this is the case consistently. **Further action**: These controls will be included in trade waste processes being redesigned as part of the Commercial Waste Transformation vision and project reported to the Environment Committee 8 March 2016. Internal Audit will be involved in the redesign of processes to ensure that the appropriate controls are embedded in income operations at the outset. The implementation of controls is therefore considered work in process. Internal Audit will therefore be in a position to monitor implementation as part of our input to redesigned processes. **Revised implementation date**: 1 September 2016
3.3 Roles and responsibilities within Trade Waste Management and CSG Finance	
At the time of the audit there was only one member of the Trade Waste team and one manager. This member of staff is responsible for the processing and recording of all invoices and cancellations relating to Trade Waste and when this member of staff is absent the manager will undertake these duties.	

Audit finding, date and recommendation 3. Trade Waste Income (January 2015)	Audit follow-up status (June 2016)
Improved procedures have been documented within Street Scene. However these do not currently include the Finance team in CSG's responsibilities.	
Recommendation: a) Management should review the current capacity of the Trade Waste Management function to ensure there is sufficient resource available to effectively meet customer demand and ensure key controls are operated including those to mitigate relevant fraud risks. **Action:** Recommendation accepted **Current Responsible Officer:**, Interim Collections Services Manager **Target date: March 2015 and ongoing**	**Status review** Previously when this audit was followed up in October 2015 as part of the Street Scene Operations Review, 3 officers were recruited to the Trade Waste team to support delivery. Management indicated that 2 of these officers were however never involved in Trade Waste and took on new work around bin deliveries, clinical waste and special collections acquired from other teams during 2015. One of the officers left in April 2016. Management indicated that the loss of the officer compromised overall capacity to increase income and develop innovative approaches to trade waste delivery. Management indicated that appointment to the role of Collection Service Innovation Assistant to replace an agency worker was imminent and that recruitment to the Collection Service Innovation Manager role to replace the current interim appointment would start shortly. The expectation is that management utilise the available resource optimally to deliver service priorities in line with budget and employ a risk based approach to inform resource allocation.

Audit finding, date and recommendation 3. Trade Waste Income (January 2015)	Audit follow-up status (June 2016)
	Advice: Resource implications need to be considered by Street Scene senior management as part of the Commercial Waste Transformation reported to the Environment Committee 8 March 2016.
Recommendation: b) The recently revised documentation of the trade waste invoicing processes should be updated to include the Finance team in CSG's functions. The procedure document should be agreed by the Trade Waste team and CSG Finance, and ultimately approved by the Street Scene Director and the Assistant Director of Finance at CSG. **Action:** Recommendation accepted **Responsible Officer:** Interim Collections Services Manager **Target date: March 2015**	**Implemented** The Trade Waste invoicing processes were documented and defined the responsibilities of the Trade Waste Team and CSG Finance clearly. These procedures were communicated to new staff in Trade Waste.
3.4 Accuracy and completeness of contract information	

Audit finding, date and recommendation 3. Trade Waste Income (January 2015)	Audit follow-up status (June 2016)
We selected a sample of 25 trade waste invoices raised on Integra between 1 April 2014 and 31 October 2014, testing to ensure that the information included on the invoice was consistent with an agreed contract. Of the 25 tested, we identified 2 invoices that did not agree back to an appropriate contract. These issues had not been resolved at the time of the audit.	
Recommendation: a) Customer information in Integra should be subject to secondary review at time of entry and periodically thereafter to ensure that data is accurate and complete and agrees back to the Trade Waste database. **Action:** Recommendation accepted **Current Responsible Officer:** Interim Collections Services Manager **Target date: March 2015**	**Not implemented** a and b: Secondary reviews of customer information in Integra to the Trade Waste database at the time of input and periodically thereafter were not performed as required by the recommendation. Our invoice testing confirmed 1/6 (17%) instances when the invoice detail in Integra did not agree to the Trade Waste Database and the signed contract, suggesting the need for secondary reviews. **Further action**: These controls will be included in trade waste processes being redesigned as part of the Commercial Waste Transformation vision and project reported to the Environment Committee 8 March 2016. Internal Audit will be involved in the redesign of processes to ensure that the appropriate controls are embedded in income operations at the outset. The implementation of controls is therefore considered work in process. Internal Audit will therefore be in a position to monitor implementation as part of our input to redesigned processes.

Audit finding, date and recommendation 3. Trade Waste Income (January 2015)	Audit follow-up status (June 2016)
	Revised implementation date: 1 September 2016
Recommendation: b) Management should consider a sample check being undertaken in advance of each monthly meeting with CSG Finance to provide assurance over accuracy on an ongoing basis. **Action:** Recommendation accepted **Current Responsible Officer:** Interim Collections Services Manager **Target date: March 2015**	**Not implemented** a and b: Secondary reviews of customer information in Integra to the Trade Waste database at the time of input and periodically thereafter were not performed. Our invoice testing confirmed 1/6 (17%) instances when the invoice detail in Integra did not agree to the Trade Waste Database and the signed contract, suggesting the need for secondary reviews. **Further action**: These controls will be included in trade waste processes being redesigned as part of the Commercial Waste Transformation vision and project reported to the Environment Committee 8 March 2016. Internal Audit will be involved in the redesign of processes to ensure that the appropriate controls are embedded in income operations at the outset. The implementation of controls is therefore considered work in process. Internal Audit will therefore be in a position to monitor implementation as part of our input to redesigned processes.

Audit finding, date and recommendation 3. Trade Waste Income (January 2015)	Audit follow-up status (June 2016)
	Revised implementation date: 1 September 2016

Audit finding, date and recommendation 4. Trade Waste Implementation Plan)	Audit follow-up status (June 2016)
4.1 Project Governance	
The Commercial Waste Transformation was referred to as a project in the related report to the Environment Committee 8 March 2016. The report stated the vision and approach to commercial waste transformation. Our expectation therefore was that the transformation would be managed and under formal Prince type project management arrangements. The interim Collections Services Manager (started in April 2016) indicated that delivery was not being formally managed as a project at this stage. Currently our understanding is that verbal updates are provided to the Director as part of day to day business as usual governance and that the Director was satisfied with general direction. A project plan was made available for inspection which referred to developing “project governance arrangements". The engagement of the relevant operational officers in the development of new commercial waste processes at workshops was observed. Internal Audit will also provide input as to key risks and control on an ongoing basis so that they are included and embedded din new arrangements at the start. **If** risks and issues are not identified escalated and addressed **then** there is generally an inherent risk that the transformation may not be implemented correctly or optimally so that the expected benefits are derived.	

Audit finding, date and recommendation 4. Trade Waste Implementation Plan)	Audit follow-up status (June 2016)
Recommendation Delivery of the Commercial Waste Transformation should be managed through accepted project management methodology and practice as stated in the Environment Committee Report. We suggest that project governance be established at the earliest stage using the Council's Corporate Project Management process but as a minimum: - clear project management roles, for example sponsor and user representatives and related escalation routes. - review of formal risk and issues logs, in particular risks identified in workshops, for instance, relating to specific trade waste processes and any dependencies which could impact delivery. - the development of an up to date Project Plan with a detailed tasks/steps for short term deliverables. - reporting arrangements for reporting key issues and risks and progress against project deliverables milestones. - a clear understanding of the expected benefits / improvements for later assessment after implementation as part of a benefits realisation exercise.	**Management response** Agreed, significant work has been undertaken during July 2016 to progress the project governance and project plan. A report detailing that has been drafted for Commissioning for mid July 2016. **Action**: Interim Collections Services Manager **Implementation Date**: 1 August 2016

5. Advisory reviews for management purposes

There was one advisory reviews or management letters undertaken by internal audit that do not give an assurance rating but nonetheless aid 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 Internal Audit's standard follow-up process and reported to Audit Committee accordingly.

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	Risk management

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	Re Operational Review Phase 1	Draft report
2	Contract Management Toolkit Compliance - Parking	Fieldwork in progress
3	Direct Payments	Fieldwork in progress
4	Looked After Children- Virtual Schools	Fieldwork in progress
5	Transformation projects	Fieldwork in progress
6	Insurance	Fieldwork in progress
7	Parks & Green Spaces - Health & Safety	Planning
8	Review of Barnet Group Internal Audit Plan and Reports	Planning
9	Re Invoicing	Planning
10	SWIFT to Mosaic Data Migration	Planning
11	IT Risk Diagnostic	Planning
12	Review of SPIRs process	Planning
13	Catering Traded Service	Planning
14	Estates Health and Safety	Planning
	Schools review	
15	Hamden Way (School review)	Draft report

7. Implementation of Internal Audit recommendations

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

Audit Title, Date and Recommendation	Deadline and Responsible Officer(s)	Outcomes of previous audit follow-up assessments	Audit follow-up assessment (28 July 2016)
1. Grant Income June 2015 **Grant Identification** Roles/arrangements for proactively 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:	Supported by Finance (Commissioning Group) Resources Director	Previously we followed up and reported: • Q4, 2015/16 – The recommendation was considered Partly Implemented as the following remained outstanding: *Evidence of implementation of the agreed process for the routine pro-active scanning for income grants by Delivery Units was not evident at the date of the follow-up. Since*	**Partly Implemented** Evidence of implementation of the agreed process for the routine pro-active scanning for income grants by Delivery Units was not evident at the date of the follow-up. When we are able to evidence the routine pro-active scanning for income grants across Delivery Units in line with Management Agreements and the completion of the relevant templates in the required format, we will be able to move the status to implemented.

Audit Title, Date and Recommendation	Deadline and Responsible Officer(s)	Outcomes of previous audit follow-up assessments	Audit follow-up assessment (28 July 2016)
(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 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.		*implementation of the new process for identifying grants only one form had been received by CSG from the Street Scene Delivery Unit for their review and scrutiny.* *Management Agreements for 2016-17 were still in the process of being drafted. We were informed that the responsibility for identifying grants would be included in the Management Agreements. Wording for inclusion in the Management Agreements defining the responsibility for horizon scanning had been agreed at 31 March 2016.* *When we are able to evidence the routine pro-active scanning for income grants across Delivery Units in line with Management Agreements and the completion of the relevant templates in the required format, we will be able to move the status to implemented.*	

Audit Title, Date and Recommendation	Deadline and Responsible Officer(s)	Outcomes of previous audit follow-up assessments	Audit follow-up assessment (28 July 2016)
b) 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 Team (SMT) standing agendas. c) All eligible grants for which applications will not be submitted should be reported to the Commissioning Group's Head of Finance sufficiently in advance of application deadlines, 5 working days as a minimum, to consider whether decisions not to apply were appropriate and challenge as necessary.			

Audit Title, Date and Recommendation	Deadline and Responsible Officer(s)	Outcomes of previous audit follow-up assessments	Audit follow-up assessment (28 July 2016)
	1 March 2016 Commercial Manager - Property and Infrastructure	Previously we followed up and reported: • Q4, 2015/16 – The recommendation was considered Partly Implemented as the following remained outstanding: *The vendor analysis report had been provided to the Delivery Unit procurement lead by CSG Procurement. At 30 March we had not received a response as to progress with updating the contract register in line with the vendor spend analysis report provided to them by CSG.*	**Partly implemented** The officer responsible for implementation has engaged with CSG Procurement (central), Re Finance and Re Service Managers to produce an up to date Re Contracts Register. Implementation is therefore still in progress. We have provided advice to the officer responsible to expedite implementation. .
2. Better Care Fund (BCF) and Section 75 (S75) agreement review December 2015 **Section 75 agreement formalities** Section 75 Agreement Schedules - defining the pooling and governance arrangements	February 2016 Head of Joint Commissioning, Barnet Clinical Commissioning Group and Barnet Council (Adults).	**Partly implemented** The signed and dated S75 agreements and variations to the agreements where applicable were provided for Section 75 Learning Disability Commissioning and Section 75 Learning Disability Campus Reprovision. The signed and dated S75	**Partly implemented** The S75 for Voluntary Services has been updated taking into account the audit points. The Voluntary Service agreement will be added to the updated overarching S75 when this is extended and agreed in July. The S75 Voluntary Services agreement had therefore still not been signed and dated at the date of follow up procedures.

Audit Title, Date and Recommendation	Deadline and Responsible Officer(s)	Outcomes of previous audit follow-up assessments	Audit follow-up assessment (28 July 2016)
unique/specific to the S75 initiative - should be prepared for each S75 initiative as addendums to the overarching agreement All S75 Agreements/Schedules and Variations held by the relevant officers should be: - up to date - dated and - signed by both partners, the Council/CCG. The revised S75 agreements should go to the appropriate Committee as advised by Governance.		agreement for Voluntary Services was not available for inspection. Once the signed and dated S75 Voluntary Services agreement is provided, the recommendation will be regarded as implemented.	Management confirmed that the S75 Voluntary Services agreement been revised and agreed by the Council and the CCG and that HB Public Law had been advised to execute the deed of variation and extension after which it would be signed and sealed (by the start of August). Once the signed and dated S75 Voluntary Services agreement is provided, the recommendation will be regarded as implemented.
3. Better Care Fund (BCF) and Section 75 (S75) agreement review December 2015 **Pooled fund / budget** The roles and names of the nominated pooled fund managers at the Council/CCG should be specified in all S75 Agreements. Changes should be specified in S75 contract variation schedules.	1 February 2016 Community & Wellbeing Assistant Director	**Party implemented** The new Section 75 Equipment agreement has been drafted and specifies the Pooled Fund Manager as the Care Quality Service Manager – Prevention and Wellbeing. The new S75 Equipment agreement still has to be signed and dated and once this is done the recommendation will be considered implemented.	**Party implemented** Management indicated that the S75 for Equipment has been agreed by Barnet Council and the Barnet Clinical Commissioning Group. The DPR was due to be signed in June 2016 and would be signed and dated by mid-July 2016. Management confirmed, that the S75 Equipment agreement been revised and agreed by the Council and the CCG and that HB Public Law had been advised to execute the deed of variation and extension after which it would be signed and sealed (by the start

Audit Title, Date and Recommendation	Deadline and Responsible Officer(s)	Outcomes of previous audit follow-up assessments	Audit follow-up assessment (28 July 2016)
			of August). Once the signed and dated S75 Equipment agreement is provided, the recommendation will be regarded as implemented.
4. Better Care Fund (BCF) and Section 75 (S75) agreement review December 2015 **Pooled fund reporting and governance structure (Financial and performance)** All S75 agreements should follow a similar format to serve as a comprehensive baseline for S75 governance and reporting, aiming to be as specific as possible about the financial and nonfinancial information to be submitted for review. Future S75 agreements should all have addendum Schedules which should set out the Terms of Reference for the Board/Group/Committee responsible for review, scrutiny and challenge of performance and financial information for that	1 February 2016 Head of Joint Commissioning Barnet CCG and LBB (Adults and Children's)	**Partly implemented** We found the following aspects had not been fully implemented: • We had not been provided with evidence to show that the terms of reference for the Joint Commissioning Executive Group had been added to each agreement as referred to in the recommendation, except for s75 LD Campus Reprovision and S75 LD Commissioning agreements, above • Management indicated that the preparation of the S75 variation agreement for Mental Health Service provision with the updated Outcomes and	**Partly implemented** Adults S75 agreements Management indicated that the S75 Mental Health Agreement had been drafted and escalated to Legal for review and was due to be signed shortly. The S75 Mental Health agreement had therefore still not been signed and dated at the date of follow up procedures. We had not been provided with evidence that the Section 75 Mental Health Agreement had been ben updated to include the JCEG ToR and that the related Outcomes and Milestones schedules had been added to the S75 Mental Health agreement in terms of the signed and dated variation to the agreement. In addition evidence was not provided to demonstrate that the JCEG ToR has been added to the S75 Voluntary Services agreement, S75 Equipment Services agreement and the S75 BCF agreement. For S75 BCF agreement, management indicated that the agreement had been signed and included the JCEG ToR. Evidence of implementation was requested but had not been provided to confirm implementation at the date of the report. .

Audit Title, Date and Recommendation	Deadline and Responsible Officer(s)	Outcomes of previous audit follow-up assessments	Audit follow-up assessment (28 July 2016)
S75 agreement. Overarching S75 agreements should be updated to reflect current roles, for example, not referring to the Director of People. Agreement Schedules should aim to define specific reporting requirements where appropriate for the S75 agreement, for example for the Looked After Children agreement the reporting of invoices charged to the Council for services under the agreement. All S75 agreements should define the reporting line to the Health and Well Being Board. All S75 agreements should include up to date Business Plans with related outcomes and milestone / performance measures and targets for referral. Any changes to S75 agreements/schedules should be subject to formal variation agreements.		Milestones schedule had started, had been escalated to Legal but was still in progress at the date of the review. • There was no evidence that the ToR of the JCEG had been added to the Section 75 Voluntary Services agreement in line with the agreed action. • The new Section 75 Equipment agreement has been drafted but still has to be signed and dated. We understand that the agreement will include the ToR of the Joint Commissioning Executive Group. • The delivery of S75 OPIC is now included as part of the S75 Better Care Fund (BCF) agreement. We inspected the S75 BCF agreement but could not evidence the inclusion of ToR for the Joint Commissioning Executive Group (JCEG) in line with	Children's S75 agreements – Memorandum of Understanding, Looked After Children, Occupational Therapy and Speech and Language Therapy

Audit Title, Date and Recommendation	Deadline and Responsible Officer(s)	Outcomes of previous audit follow-up assessments	Audit follow-up assessment (28 July 2016)
A repository should retain a complete chronological history of the agreements and variations and related DPRs from inception of the S75 agreement to date.		the agreed action. • Children's Memorandum of Understanding: There was no evidence of the ToR of the Joint Commissioning Executive Group (JCEG) being included agreement provided to us in line with the agreed action. • S75 Occupational Therapy: There was no evidence that the agreement provided to us included the JCEG ToR nor the monthly and quarterly contract review meetings described during the initial audit in line with the agreed action. • Section 75 Speech and Language Therapy (SLT): There was no evidence that the agreement provided to us included: ○ the JCEG ToR ○ the monthly and quarterly contract review meetings described during the initial audit.	No further action to report since the last Audit Committee. We had not been provided with evidence that the following had been added to/included in the S75 agreements: - ToR of the JCEG - relevant governance arrangements - relevant targets for outcomes and - reporting requirements The officers responsible for delivery at the time of the audit had left the Council. The requirements were made clear to the new responsible officer who undertook to expedite completion urgently.

Audit Title, Date and Recommendation	Deadline and Responsible Officer(s)	Outcomes of previous audit follow-up assessments	Audit follow-up assessment (28 July 2016)
		○ targets for locally defined outcomes in line with the agreed action • S75 Looked After Children: There was no evidence that the agreement provided to us included: ○ the JCEG ToR ○ the monthly and quarterly contract review meetings described during the initial audit. ○ financial reporting relating to invoice charges in line with the agreed action	
5. Contract Management - Registrars Inter-Authority Agreement March 2016 **Contract Management and Governance** a) The Council should introduce the contract management toolkit and utilise it to manage, monitor and drive performance of the Registrars contract;	31 May 2016 Partnership Relationship Manager	Not applicable – this is our first assessment of progress .	**Partly Implemented** We were informed that the SMB had not met since the time of the audit. We were, therefore, unable to verify whether meetings are minuted. A SMB meeting is planned for early July and management confirmed that formal minutes would be generated in line with this the recommendation. Whilst the risk and issues register had not been updated in line with the Contract Management Toolkit, we were informed that a Commercial Support Manager had recently commenced employment at the Council and would be responsible for updating the register

Audit Title, Date and Recommendation	Deadline and Responsible Officer(s)	Outcomes of previous audit follow-up assessments	Audit follow-up assessment (28 July 2016)
b) Management should ensure that the governance arrangements set out within the Inter-Authority Agreement are complied with in practice and that SMB meetings are minuted in order to note the discussions held and monitor any actions required.			accordingly to ensure this recommendation will be fully implemented in the near future. **Revised date for full implementation:** • 1 August 2016
6. Contract Management - Registrars Inter-Authority Agreement March 2016 **Risk and Issue Management** a) The Council should ensure that the risk management process set out within the Inter-Authority Agreement is complied with in practice; b) Management should utilise the risk and issues register templates within the Contract Toolkit and ensure that Registrars risks and issues are recorded, assessed, mitigated and managed. This information should then be	31 May 2016 Partnership Relationship Manager	Not applicable – this is our first assessment of progress	**Partly implemented** As reported above SMB meetings have not been held since the time of the audit. Management confirmed that the risk and issues register had not been updated in line with the Contract Toolkit; however, the recent Commercial Support Manager would be responsible for updating the register to ensure the recommendation is fully implemented in the near future. **Revised date for full implementation:** • 1 August 2016 .

Audit Title, Date and Recommendation	Deadline and Responsible Officer(s)	Outcomes of previous audit follow-up assessments	Audit follow-up assessment (28 July 2016)
regularly monitored and updated; and c) SMB meetings should be minuted so that discussions held and actions required in order to manage risks and issues are recorded and can therefore be monitored.			
7. Accounts Payable December 2015 **New Supplier Forms** b) A clear timetable should be agreed between the Council and CSG for the introduction of the e-form workflow system within Integra.	April 2016 Head of Exchequer, CSG	Not applicable – this is our first assessment of progress	**Partly implemented** Management indicated that an e-form for new suppliers has been developed and was undergoing final end user testing. The form is expected to be rolled out within the next month Revised implementation date: 19 August 2016.
8. Schemes of Delegation February 2016 **Changes to standing data** a) A report of changes to financial limits on Integra should be built and made available for staff use.	30 April 2016 Assistant Director of Finance, CSG	Not applicable – this is our first assessment of progress	**Partly implemented** Management indicated that an audit tool which tracks all amendments to users' access is available within the system. A report is now being developed to extract that information. The report will be run and reviewed on a monthly basis with effect from 1 September Revised implementation date: 1 September 2016..

Audit Title, Date and Recommendation	Deadline and Responsible Officer(s)	Outcomes of previous audit follow-up assessments	Audit follow-up assessment (28 July 2016)
b) A report of changes to financial limits on Integra should be run on a regular basis (at least quarterly). This report should be reviewed by a member of the Integra Finance Team to monitor the updates to limits and check limits correctly reflect changes to staff roles.			
9. Schemes of Delegation February 2016 **a) The Council should seek legal advice to confirm the implications of incorporating the Barnet Homes Scheme of Delegation into the Growth and Development Scheme of Delegation. If appropriate, the Barnet Homes Scheme of Delegation should be incorporated into the Growth and Development Scheme of Delegation or published alongside it on the website to ensure there is a complete document available to staff.**		Not applicable – this is our first assessment of progress	**Not implemented** Evidence had not been provided for updating the Environment and Barnet Homes Scheme of Delegation for the transfer of Street Scene Delivery Unit to Barnet Homes management
10. Schemes of Delegation	Environment Commissioning	Not applicable – this is our first assessment of progress	**Partly implemented**

Audit Title, Date and Recommendation	Deadline and Responsible Officer(s)	Outcomes of previous audit follow-up assessments	Audit follow-up assessment (28 July 2016)
February 2016 **Commissioning and Delivery Units** b) The Council should seek legal advice about the implications of incorporating the RE Scheme of Delegation into the Growth and Development Scheme of Delegation and the Environment Scheme of Delegation. If included, the schemes should be updated to ensure that RE's delegated powers are reflected accurately and consistently in both schemes.	Director		Evidence of implementation in relation to the Growth and Development Scheme of Delegation was provided. The provision of evidence showing implementation of the recommendation in relation to the Environment SoD was in progress. We are therefore unable to evidence the implementation of agreed actions at this stage for Environment.
11. Schemes of Delegation February 2016 **Commissioning and Delivery Units** c) The roles and responsibilities section in the management agreements should be updated to refer back to the Schemes of Delegation to	Environment Commissioning Director	Not applicable – this is our first assessment of progress	**Partly implemented** A response to our request for progress regarding implementation was not received for Delivery Units other than Family Services and Adult Social Care. , We were therefore unable to confirm how roles and responsibilities in Street Scene management agreement referred back to its Scheme of Delegation

Audit Title, Date and Recommendation	Deadline and Responsible Officer(s)	Outcomes of previous audit follow-up assessments	Audit follow-up assessment (28 July 2016)
ensure consistency.			
Menorah Foundation School Voluntary Funds The audit objective was to ensure that voluntary funds are administered as rigorously as public funds. Finding: In the previous audit report dated 24th April 2012 it was noted that the school was operating an Amenities fund and a Lunch account. The audit report stated that the funds had not been audited on an annual basis, and the level of accountability and stewardship was not the same standard as for the School's delegated budget. At the current audit, due to changes in staff, no accounting records could be found for these accounts. The current staff found that the bank account named 'Lunches account' was closed on 24th Jan 2014, and the balance was transferred to the main school account. The	School Business Manager (SBM) 8 April 2016	Not applicable – this is our first assessment of progress	**Not Implemented** Follow up audit visit 23 June 2016. The "Keeping Your Balance document" indicates that "Voluntary fund accounts must be certified by an auditor who is completely independent of the school". Our expectation was that income and withdrawals from all voluntary funds were subject to independent certification. We were not provided with evidence of certified accounts for voluntary funds called: - the Lunch Account and which was closed 24 January 2014. - the Amenities account. Furthermore related accounting records could not be located for both accounts for an assessment of the value of receipts and withdrawals. . We are therefore unable to provide any assurance on the completeness, accuracy and validity of transfers to and withdrawals from the accounts. The recommendation therefore remains at "not implemented". The Chair of Governors of Menorah Foundation indicated as follows as the accounts have been

Audit Title, Date and Recommendation	Deadline and Responsible Officer(s)	Outcomes of previous audit follow-up assessments	Audit follow-up assessment (28 July 2016)
'Amenities' bank account could not be identified.			closed: " ***On behalf of Menorah Foundation School I wish to advise that the school is going to take no further action regarding the unaudited Voluntary Funds accounts from 2012."*** The school has been advised that in future where applicable voluntary funds should be subject to independent certification. Internal Audit does not propose to follow up this recommendation again.

Implemented recommendations

The following recommendations that had previously been raised as a priority one have been reviewed and are now considered implemented.

Audit Title, Date and Recommendation
1. **Procurement -** November 2015- **Compliance with Contract Procedure Rules- Conflicts of interest**
2. **Procurement –** November 2015 **– Adults and Communities Contracts Register**
3. **Procurement -** November 2015- **Compliance with Contract Procedure Rules- Vendor creation and approval**
4. **Client Affairs-** December 2015**- Property Visits**
5. **Street Scene Operations Review (Joint Internal Audit & CAFT review)**- November 2015 - **Risk of Illicit Payments - Vehicle CCTV monitoring / Route rotation**
6. **Street Scene Operations Review (Joint Internal Audit & CAFT review)**- November 2015**- Refuse vehicle tracker monitoring**
7. **Street Scene Operations Review (Joint Internal Audit & CAFT review)**- November 2015**- Risk Management (CCTV and Mill Hill depot site security**)
8. **Better Care Fund (BCF) and Section 75 (S75) agreement review December -** 2015 Statement of Accounts
9. **Better Care Fund (BCF) and Section 75 (S75) agreement review-** December 2015**- S75 control self-assessment**
10. **Key Financial Systems - Teachers' Pensions-** March 2016**- Monthly reconciliation of payroll records to payment made to Teachers' Pension**
11. **Schemes of Delegation-** February 2016**- Changes to standing data, Controcc**
12. **Schemes of Delegation (SoD)-** February 2016**- Commissioning and Delivery Units** **- Growth & Development and Barnet Homes - Legal input to Growth and Development SoD update (Barnet Homes SoD in Growth and Development SoD)** **– Growth and Development and Re – Re SoD included in Growth and Development SoD**
13. **Schemes of Delegation –** February 2016 **– Commissioning and Delivery Units – SoDs updated for future changes in Council Structure**
14. **Schemes of Delegation –** February 2016 **– Family Services and Adults Social Care – Roles and responsibilities in Management Agreements agree to related SoD**
15. **Accounts Payable-** December 2015- **New supplier forms**
16. **Menorah Foundation –** February 2016 **– Purchasing, Governance and Banking (3 of 4 P1 recommendations implemented)**
17. **Hasmonean Primary School -** 31 March 2016 **– Budget monitoring, purchasing, contracts, income, banking, payroll and tax (all P1 recommendations implemented)**

8. Changes to internal audit reporting framework

In 2016/17 internal audit will align its reporting framework and associated scoring framework with the methodology applied across the Cross Council Assurance Service (CCAS) of which Barnet is a member. This is part of ongoing process of alignment and methodology improvements that have been facilitated through the framework. Key points as follows:

- A systematic points based scoring system will be used to determine aggregate assurance ratings for individual audits. Findings from each review will be assessed and a score applied based on the risk rating. The total number of points per the audit will determine the assurance rating (**see fig 8.1 below)**;

- Reports that are "Limited assurance" and "No assurance" will be reported to Audit Committee in line with current arrangements. A key point to note is that previously all reports that have a "high risk" finding were classed as "limited assurance." This may not necessary occur based on the revised scoring framework; and

- The revised system will assist in ensuring consistency in the application of overall assurance ratings for work performed.

Note: These changes have been reflected in the Audit Charter which can be seen in **Appendix 1** for reference.

Fig 8.1: Report classifications

The report classification is determined by allocating points to each of the findings included in the report. Note terminology change from "Satisfactory" to "Reasonable".

Definition of risk categories and assurance levels

Findings rating	Description
Critical 40 points per finding	Life threatening or multiple serious injuries or prolonged work place stress. Severe impact on morale & service performance. Mass strike actions etc Critical impact on the reputation or brand of the organisation which could threaten its future viability. Intense political and media scrutiny i.e. front-page headlines, TV. Possible criminal, or high profile, civil action against the Council, members or officers. Cessation of core activities, Strategies not consistent with government's agenda, trends show service is degraded. Failure of major Projects – elected Members & SMBs are required to intervene Major financial loss – Significant, material increase on project budget/cost. Statutory intervention triggered. Impact the whole Council; Critical breach in laws and regulations that could result in material fines or consequences
High 10 points per finding	Serious injuries or stressful experience requiring medical many workdays lost. Major impact on morale & performance of staff. Significant impact on the reputation or brand of the organisation; Scrutiny required by external agencies, Audit Commission etc. Unfavourable external media coverage. Noticeable impact on public opinion Significant disruption of core activities. Key targets missed, some services compromised. Management action required to overcome med – term difficulties High financial loss Significant increase on project budget/cost. Service budgets exceeded. Significant breach in laws and regulations resulting in significant fines and consequences
Medium 3 points per finding	Injuries or stress level requiring some medical treatment, potentially some workdays lost. Some impact on morale & performance of staff. Moderate impact on the reputation or brand of the organisation; Scrutiny required by internal committees or internal audit to prevent escalation. Probable limited unfavourable media coverage. Significant short-term disruption of non-core activities. Standing Orders occasionally not complied with, or services do not fully meet needs. Service action will be required. Medium financial loss - Small increase on project budget/cost. Handled within the team. Moderate breach in laws and regulations resulting in fines and consequences
Low 1 point per finding	Minor injuries or stress with no workdays lost or minimal medical treatment. No impact on staff morale Internal Review, unlikely to have impact on the corporate image. Minor impact on the reputation of the organisation Minor errors in systems/operations or processes requiring action or minor delay without impact on overall schedule. Handled within normal day to day routines. Minimal financial loss – Minimal effect on project budget/cost. Minor breach in laws and regulations with limited consequences
Advisory 0 points per finding	An observation that would help to improve the system or process being reviewed or align it to good practice seen elsewhere. Does not require a formal management response.

Level of assurance	Description
No 40 points or more	There are fundamental weaknesses in the control environment which jeopardise the achievement of key service objectives and could lead to significant risk of error, fraud, loss or reputational damage being suffered.
Limited 18– 39 points	There are a number of significant control weaknesses which could put the achievement of key service objectives at risk and result in error, fraud, loss or reputational damage. There are High recommendations indicating significant failings. Any Critical recommendations would need to be mitigated by significant strengths elsewhere.
Satisfactory 7– 17 points	An adequate control framework is in place but there are weaknesses which may put some service objectives at risk. There are Medium priority recommendations indicating weaknesses but these do not undermine the system's overall integrity. Any Critical recommendation will prevent this assessment, and any High recommendations would need to be mitigated by significant strengths elsewhere.
Substantial ✓✓✓ 6 points or less	There is a sound control environment with risks to key service objectives being reasonably managed. Any deficiencies identified are not cause for major concern. Recommendations will normally only be Advice and Best Practice.

9. Internal Audit effectiveness review

Performance Indicator	Target	End of Quarter 4
% of plan delivered	95%*	93%
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	 6% 44% 17% - 33%
Number / % of Priority 1 recommendations: • Implemented • Partly implemented • Not implemented • Unconfirmed • Status Review in quarter when due	90%	 59% 30% 9% 1% 1%

* Based on 95% complete of those due in quarter.

Key:

Target met
Target not met
N/A

Implementation of internal audit recommendations – as per section 3, 4 and 7 above, the progress of the 85 high priority recommendations due for implementation in quarter 1 is that 59% of recommendations have been fully implemented compared to a target of 90%. 30% have been partly implemented and 9% not implemented.

A summary of the status is as follows:

Status	**Number**	**%**
Implemented	50	59 %
Partly Implemented	25	30 %
Not implemented	8	9 %
Unconfirmed	1	1 %
Status Review	1	1 %
Total	**85**	**100**

10. Changes to our plan

Since the Internal Audit Plan was agreed in April 2015 there have been changes to audits originally planned for Q4 as follows:

Type	Audit Title	Reasons
Deferred	SPIR process	Deferred to Q3 2016/17 in light of changes and improvements to the process to be rolled out in Q1
Deferred	Estates: Health and Safety Compliance	Deferred to Q3 2016/17 due to the roll out of a comprehensive improvement programme
Deferred	St Margaret's Nursery school	Deferred to Quarter 3 owing to the Unified Pay Reward roll out and significant related communication in the school

11. Risk Management

The performance report for Quarter 4 was presented to the Performance and Contract Monitoring Committee on 31st May 2016 and can be found via the link below:

http://barnet.moderngov.co.uk/documents/s32129/Performance%20Monitoring%20Report%20Q4%20PCM%20FINAL.pdf

Appendix J to the report is the Quarter 4 corporate risk register.

A proposal to transfer the current Risk Management function from Assurance to the Performance Team in the Commissioning Group was made several months ago to senior management and arrangements have been put in place to manage this transition.

Alongside this transfer the Interim Chief Executive has commissioned a thorough review of the risk management across the organisation throughout the summer which will report back to Performance and Contract Monitoring at the beginning of September. This review provides a timely opportunity to put the organisation's approach to risk management under closer scrutiny, especially from Members, providing an opportunity to reflect again on current practice and implement more extensive improvements and changes to our Council-wide approach.

One of the proposed outcomes of the review is to have a revised set of risk registers, across the Council which include risk ratings, actions/ mitigation with clear action plans for each risk.

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