Southend-on-Sea Borough Council

Agenda Item No.

12

Report of the Chief Executive

to

Audit Committee

on

28 June 2017

Report prepared by: Linda Everard, Head of Internal Audit

Head of Internal Audit Annual Report 2016/17

Executive Councillor – Councillor Moring

A Part 1 Public Agenda Item

1. Purpose of Report

1.1 To provide for the 2016/17 financial year:

- the rationale for and an audit opinion on the adequacy and effectiveness of Southend-on-Sea Borough Council's (the Council's) risk management, control and governance processes
- a statement on conformance with the UK Public Sector Internal Audit Standards (the Standards) and the results of the Quality Assurance and Improvement Programme.

2. Recommendation

2.1 The Audit Committee accepts the Head of Internal Audit's Annual Report for 2016/17.

3. Background

3.1 The Head of Internal Audit's Annual Report and Opinion provides the Council with an independent source of evidence regarding both the design of its risk management, control and governance framework and how well it has operated throughout the year.

3.2 The opinion is predominantly based upon the audit work performed during the year as set out in the risk based Audit Plan agreed with the Corporate Management Team and the Audit Committee.

3.3 As outlined in the Internal Audit Charter, audit coverage is determined by prioritising the significance of Council's activities to its ability to deliver its Aims and Objectives. This is done:

- using a combination of Internal Audit and management risk assessments (including those set out in risk registers)
- in consultation with Directors, Deputy Chief Executive's and the Chief Executive, to ensure work is focused on key risks.

3.4 Quarterly meetings are then held with the Chief Executive and the Deputy Chief Executives to:

- reflect on the original risk profile and work planned
- determine whether any changes are required to it or the Audit Plan.

3.5 Organisationally, this reflects a very mature approach to operating an internal audit function.

3.6 All individual audit reports are discussed with the relevant Group Managers, Directors and Deputy Chief Executives / Chief Executive before being finalised.

3.7 The opinion and summary findings from audit reviews are reported to the Corporate Management Team and the Audit Committee throughout the year.

4 Head of Internal Audit Opinion for the year ended 31 March 2017

4.1 ***As discussed with senior management, it would be timely to undertake a review of the Council's governance and assurance framework to ensure it remains fit for purpose and supports the delivery of service objectives across the Council. This is particularly the case for the organisational processes that enable any business to be managed effectively. The work completed to develop the understanding of risk management, and planned to fully integrate this into the governance framework, should help with this significantly.***

This, in conjunction with the planned training on "How it Works, A guide for managers to help the Council run effectively", will help those managers or team leaders who do not:

- ***fully understand the objectives of and risks relating to the services they are delivering***
- ***obtain appropriate evidence that these processes are designed and / or being applied properly by their staff, consistently throughout the year.***

Particular consideration needs to be given to ensuring clarity around roles and responsibilities where processes or activities cross team, service, departmental or organisational boundaries. Without clear accountabilities, processes may not operate as efficiently and effectively as possible.

Further work is required in order to ensure that performance management processes designed to monitor that actions arising from audits are implemented properly and in a timely manner, are effective.

Internal Audit continues to work proactively with services to help ensure that action plans arising from children's, adults or domestic homicide case reviews or inspections are SMART[1] and address the cause of the issue not the symptom. Developing a more corporate approach to training staff in these skills and / or ensuring such support is consistently available in such circumstances would be beneficial.

Otherwise the design and operation of the Council's risk management, control and governance framework continues to be satisfactory.

---

[1] Specific, Measureable, Attainable, Relevant, Timely

4.2 The basis for forming this opinion is an assessment of:

- the design and operation of the underpinning governance and assurance framework
- the range of individual opinions arising from risk based and other audit assignments that have been reported during the year taking into account the relative significance of these areas
- whether management properly implement actions arising from audit work completed, to mitigate identified control risks within reasonable timescales.

4.3 The Head of Internal Audit has not reviewed all risks and assurances relating to the Council's activities in coming to her opinion.

5. Supporting Commentary

5.1 **Appendix 1** summarises the audit opinions issued this year.

5.2 The following paragraphs then:

- summarise findings from all the work completed this year
- highlight the key areas requiring improvement
- also includes findings from other relevant sources (e.g. independent inspections) that have been used to support the overall opinion.

5.3 Where necessary, actions have been agreed with services to improve the arrangements where the more serious control issues were identified during the audits.

Overarching Theme

5.4 Governance comprises the arrangements put in place to ensure that the intended outcomes for stakeholders are defined and achieved. In the public sector, it involves both governing bodies and individuals trying to achieve their entity's objectives while acting in the public interest at all times.

Source: International Framework, Good Governance in the Public Sector

5.5 The overall aim of good governance is to ensure that resources are directed in accordance with agreed policy and according to priorities, that there is sound and inclusive decision making and that there is clear accountability for the use of those resources in order to achieve desired outcomes for service users and communities.

Source: Delivering Good Governance in Local Government: Framework

5.6 In order to deliver this, there is a need to have a clear constitutional framework and corporate plan, an appropriate an organisational structure and culture with good ethical standards as well as a set of process that manage business delivery. Appropriate assurance is then required that these processes are fit for purpose and applied effectively and consistently throughout the organisation.

5.7 Audit opinions are one, independent barometer of how well these arrangements are operating, from the work of the Audit Committee to setting and managing the delivery of individual's performance targets (i.e. the golden thread). The profile of audit opinions over recent years indicates that some elements of this framework need to be revisited to see whether they are still fit for purpose and appropriately resourced.

5.8 This is particularly the case with regards to the design and operation of the business management processes and the work of the Audit Committee, which has not been assess for some years now. Given the significant changes at senior management level over the last year, this is an opportune time to undertake this work. The remainder of this report should be read within this context.

Managing the Business

5.9 The Council had a working **Business Continuity Plan** (BCP) and Incident Management Strategy (IMS), which were broadly in line with the requirements of ISO 22301. However, Emergency Planning (EP) was handled separately meaning there was no clear linkage between both plans. Very limited staff resources were available to maintain these documents and supporting processes.

5.10 Each departmental BCP lead was required to maintain a Business Impact Assessment (BIA). The template used contained the key information expected. Not all BIAs had been recently updated or tested and the central BCP database had not been updated since May 2015.

5.11 The corporate, desktop Operation Meltdown exercise tested the resilience of the BCP but did not include the IMS. The results from this were used to enhance the BCP and promote the use of BIA templates within departments.

5.12 A fixed term contractor started in November 2016 to progress this work, which included:

- updating the BCP, then getting it formally approved with the IMS before testing them both
- fully implementing the recommendations arising from Operation Meltdown, where they were still relevant
- organising corporate wide testing of BIAs using different scenarios and training on the BCP and IMS.

5.13 Overall, the Council's **Corporate Procurement Strategy and Toolkit** were fit for purpose, consistent within themselves and the other elements of the contract management framework. The Strategy was clear and concise containing those elements of any business strategy that would expect to be seen. Action was still required to set up the Procurement Review Board in accordance with the role stipulated in the Contract Procedure Rules. Each objective within it was accompanied by a set of key performance indicators that should provide meaningful measures of the successful, or otherwise, implementation of the contract management framework.

5.14 This new approach reflected a move to a more modern procurement function that uses technology to assist with the procurement process enabling the Corporate Procurement Team to have greater influence over the procurement behaviours within the Council. The main area where further work was still required, involved developing a critical services, supplies and works Contracts Register with appropriate exit strategies where none exist.

5.15 Overall, the arrangements for identifying, recording and monitoring **corporate or strategic risks** were good and in compliance with the Council's Risk Management Strategy and Toolkit. The level of understanding about how to apply this was also sound.

5.16 This process was not being applied as well or consistently at **service** level, thus reducing the assurance available that these **risk**s were being properly documented and communicated and as a result, efficiently and effectively mitigated or managed.

5.17 A programme of work was subsequently delivered providing practical feedback and support on the issues arising from the audit, with the aim of ensuring:

- there is a consistent understanding of what good risk management looks like in a live and practical sense at all levels of the Council
- the guidance clearly reflects future requirements and therefore supports officers in their roles and responsibilities
- the quality of risk identification, analysis, management and communication is improved
- the risk management framework is developed in a proportionate, practical way, focussing on adding value and minimising the investment of resources required to support the service and corporate process.

5.18 The key messages fed back to the Corporate Management Team in March 2017 having completed this additional work were that:

- there was a strong understanding of risks being faced by individual Directors, but that this was not effectively captured within the formal Risk Management Framework (the Framework)
- the Framework met good practice, but it was inconsistently applied and therefore, there was still work to do to embed it
- there was embedded performance management throughout the organisation, but no link between this activity and the risk registers
- there was a discipline around the production of the Corporate Risk Register, but the value of the process was not optimised
- the Framework was not overly onerous on management, but there was a perception of bureaucracy
- a good infrastructure of people resources existed to support implementation, but there was an over reliance on them in terms of responsibility for risk
- the Framework and approach should focus on horizon scanning and the cascade of the emerging risk to the relevant parts of the business as well as developing criteria to help facilitate efficient escalation of risks
- there were gaps in assurance and insufficient evidence of the management of impact for some risks, despite the regular update and reporting.

5.19 A final programme of work will be delivered throughout 2017/18, to help fully integrate the Framework into the Council's governance arrangements. This seeks:

- in the short term, to ensure that the risks captured at the corporate level are refreshed
- in the medium term, to support the Council in strengthening the risks captured at an operational level within services and changing the perception and language around risk

- in the longer term, to help align strategic and operational planning processes, with the analysis of risk being a central driver at each stage of the process.

5.20 The effective management of risk within significant **corporate projects** was also considered. The projects reviewed were A Better Start, Airport Business Park, Better Queensway and the Integrated Pioneer Programme.

5.21 The Council led projects were not consistently applying its **risk management** approach as set out in Risk Management Strategy and Toolkit. Nevertheless, there was evidence of a good level of understanding with regards to the risks the projects were facing.

5.22 Significant projects were expected to report monthly into the Corporate Delivery Board although this did not happen consistently for all these projects. It was also unclear whether these project risks were always being included in relevant service risk registers.

5.23 There was a need to formally document the role and objectives of the Corporate Delivery Board as well as the methodology for including or excluding a project from its agenda. However, projects were added and removed from its work programme during 2015/16 indicating some on-going review of what needed to go to it.

5.24 Better use could have been made of risk, to more effectively drive the Corporate Delivery Board's agenda in this regard. Better links needed to be made between highlight reports and the supporting project risk registers, with the focus being on Council rather than partnership risks.

Service Delivery Risks

5.25 A key objective for Internal Audit is to give a view on whether the Council's risk management and control processes are robust enough to enable services to effectively contribute to the delivery of its corporate aims and objectives.

5.26 The remainder of the report therefore, structures the audits undertaken of services areas under the corporate aims they help deliver so this connection can be made.

SAFE

5.27 The Resource Allocation System used to **assess an individual's personal budget** had not been maintained and key elements of it were out of date.

5.28 However, all personal budget assessments were subject to management review, with management approval required of those valued up to £185 per week. Personal budgets over this were subject to review and approval by the Finance Authorisation Panel (the Panel). There was a need to adopt a more consistent approach to recording the management challenge of personal budgets proposed by caseworkers. However, there was consistent evidence of robust challenge regarding cases referred to the Panel.

5.29 Action was required to ensure that annual reviews occurred for everyone with a personal budget, as there was evidence that a number were overdue.

5.30 An Adult Social Care Transformation Project was scheduled to take place in 2017 that would include a fundamental review of the process for assessing personal budgets.

5.31 The Community Safety Partnership commissioned the first **Domestic Homicide Review** in 2014. This involved Children's Services, the Integrated Youth Support Service and Public Health producing an Independent Management Review (IMR) with actions to be taken to address any issues identified.

5.32 On review, there was a need to:

- improve the process for developing action plans so that they were SMART and addressed the cause of the issue not the symptom
- provide some guidance and or training on how to do this more effectively in future
- develop a more cohesive and robust process across the partners for:
  - monitoring and that agreed actions were implemented, both properly (by challenging the supporting evidence) and in a timely manner
  - reporting on progress made to appropriate levels of management within each organisation as well as the partnership.

5.33 The Council's arrangements for **financially monitoring** how **direct payments** were used needed to be better defined and updated to reflect more recent legislation. The roles and responsibilities of the Department for People's Finance Team (Payments), and Locality Assessment and Review Teams within this process also needed to be clarified.

5.34 The direct payment agreements required extending to ensure expectations were clear as to how the money was to be used. Carers awarding a one off payment should also be required to complete an agreement.

5.35 For adult direct payments, a comprehensive monitoring form had been developed capturing the key checks required to confirm they were being appropriately managed but it was not being used. Therefore, a systematic approach still had to be implemented for:

- reviewing the quarterly returns and associated documents submitted as well as challenging and holding to account clients that fail to submit a return
- confirming client contributions were made and surplus funds clawed back if necessary.

5.36 Action had been taken to target and follow up non-returns over the last financial year as a priority.

5.37 There was a systematic process in place to monitor children's direct payment returns. Work was underway to introduce independent management checks into the process, risk assess the level of monitoring to confirm it was still appropriate and automate the process more.

5.38 During the audit, procedures were amended to make clear that relevant Director approval was required, before deviating from any aspect of the monitoring arrangements. This was to be formalised in a revised policy document to replace 'Self Directed Support, Best Practice Guidance'.

5.39 Work was underway to restrict the Department for People's Finance Team (Payments) access to records on IT systems used, where potential interests had been declared.

5.40 Internal Audit worked collaboratively with Children's Services assess whether opportunities identified to strengthen arrangements to prevent **child sexual exploitation** had been formed into a robust **action plan** and implemented in a timely manner. This helped the service ensure that actions were SMART and addressed the cause of the problem, not just a symptom.

5.41 The Project Board involved in the **Social Care IT Case Management System contract procurement** had undertaken an initial options appraisal and an Options Appraisal Authorisation Form had been completed. However, this had not explained how the decision to use a Framework Agreement was made. Stakeholders were involved in preparing the service specification and evaluating whether submissions met their requirements. However, there was no evidence that the specification or evaluation questions had been signed off by the Project Board.

5.42 The key elements expected of a good practice procurement process, had taken place when the Social Care IT Case Management System contract was let, within budget. However, there were instances where best practice guidance and the Council's Contract Procedure Rules had not been followed or insufficient evidence was retained to confirm compliance. Most of the issues related to the way in which the tender process was conducted by a member of staff who has now left the Council.

5.43 The opportunity was being taken to amend the Procurement Toolkit to further clarify expectations in a few areas. A quarterly check was also being introduced of completed procurements to confirm that all relevant documentation had been retained.

5.44 Further negotiation was being undertaken around one aspect of the contract to try to improve the terms, regarding the cost of optional software modules going forward.

5.45 In July / August 2016, an assessment was made of whether good **project management** processes had been established to support the implementation of the **Social Care IT Case Management System**. At this stage, elements of good project planning were in place but there was scope to strengthen the overall process.

5.46 Action was required to:

- produce a more complete and better defined project plan, as well as monitor it regularly to ensure it remained on track to deliver within the agreed timeframe and budget
- better integrate and monitor other project activities, which had an impact on the operation of the Social Care IT Case Management System, and therefore the delivery of this project
- monitor benefit realisation, finalise the testing strategy and ensure risks were discussed at each Project Board meeting
- agree a clear set of business readiness activities including up-skilling the IT helpdesk and user-guides with the services areas, and track this within the project plan.

5.47 At the end of 2016, officers decided to:

- review the status of the project
- revise the project delivery plan accordingly to provide time to fully complete the design and system testing before implementation.

5.48 Therefore, the additional audit work planned on this project was postponed until 2017/18.

5.49 The work required to adequately strengthen the arrangements for making **direct payments** to those with **Mental Health** difficulties, was not complete. The original system weaknesses were identified in the summer of 2014 and then added to in the summer of 2015. As at October 2016, twelve of the sixteen agreed actions remained outstanding.

5.50 As a result, action was still required to:

- document the manner in which the Council wants to work with South Essex Partnership University NHS Foundation Trust (SEPT) and Vibrance on a day to day basis and establish robust contract management processes for both of these arrangements
- agree with SEPT, which officers are authorised to independently authorise care packages before their submission for approval
- define the checks to be completed and by whom, before a care package is input into Care First (the social care IT case management system)
- set out that new care providers will not be added to the list provided to clients, until they have been vetted and approved by the Council
- develop a report that highlights instances where a staff member has entered and authorised a care package on Care First, so its validity could be independently confirmed
- produce procedure notes on the process to be followed when approving a care package on Care First, which includes the checks to be undertaken by a senior, independent officer
- improve the Finance Authorisation Meeting's Panel Decision Sheet to provide greater clarify over what within the referral form from SEPT, has been approved by the Panel
- formalise reporting and claw back arrangements for surplus funds on client accounts held by Vibrance and improve the content, quality and regularity of management and performance reports received from Vibrance.

5.51 Some progress had been made in addressing the actions contained in the original **Licensing** report. As a result:

- all licenses were being checked by the Regulatory Services Manager, with additional spot checks being carried by the Group Manager every six months
- historical parked licensing debts were being proactively chased and more regular liaison with the Accounts Receivable team was helping to manage current debts more effectively.

5.52 A target was to be set for completing the review of the older parked debt so a decision could be made about writing off uncollectable debts.

5.53 Action was still required to:

- reconcile the Licencing team's records of debt due with the corporate record of income received via the cash receipting system for the whole of 2016/17
- equip the Licencing team with the skills and management information required, so that this reconciliation could be completed each day from the 1 April 2017.

5.54 All the actions agreed relating to the **Traffic Management Schemes implemented by Traffic Regulation Orders** (TROs) audit had been fully implemented. Staff were using ParkMap to access details of what TROs should be in place and reporting any exceptions. This automatically updated the Asset Management system linked to it. There was more formal evidencing of the checks undertaken as part of the inspection and all these documents were being independently checked.

5.55 A traffic management scheme policy and protocol had been approved, with amended criteria for assessing requests for Traffic Management and Safety schemes. Reports to the Traffic and Parking Working Party more clearly set out:

- the rationale for progressing or not, with schemes
- what action if any is required regarding each scheme reported to it.

5.56 In collaboration with Children's Services:

- opportunities were identified to further strengthen the arrangements for producing **safeguarding performance indicators**. The service was also going to consider whether the current suite of indicators were still required and if so, confirm who they should be reported to
- challenge was provided on the draft action plan produced following the **Ofsted inspection of services for children in need of help and protection and looked after children**. Again, this was to help ensure actions were SMART and addressed the cause of the problem, not just a symptom.

5.57 In May 2016, **Ofsted** gave an overall judgement that services for children in need of help and protection and looked after children, require improvement to be good.

CLEAN

5.58 No work undertaken this year, although reviews were initially planned.

HEALTHY

5.59 The responsibility for **commissioning public health services for 0 to 5 year olds** was transferred to the Council from NHS England in October 2015. Overall, the process was well managed. The contract was agreed in line with the NHS model, and was finalised prior to the Council's involvement.

5.60 Public Health regularly monitored key performance indicators at Directorate Management Team meetings. The on-going arrangements for monitoring the commissioning of 0 to 5 year public health services were also appropriate. Regular contract monitoring meetings were held, which covered key performance and contractual areas. Action points (“recovery plans") emanate from the meetings and issues were followed up in the next meeting.

5.61 Overall, there was clarity as to accountability in strategic terms, for **the Drug and Alcohol Commissioning Team** between the Council and the Southend Community Safety Partnership Priority Leadership Group (CSP PLG). The roles and responsibilities for the DACT and the CSP PLG as well as the DACT's contract monitoring arrangements were clearly documented, understood and operating in practice.

5.62 Aspects of what the service was required to deliver and the performance measures that were expected appeared in various Council and partnership documents. However, there was no one overarching service plan that pulled them all together. Progress and performance was monitored on a regular basis. However, some actions were monitored informally and completion could not necessarily be fully demonstrated. Developing and monitoring a DACT level service plan would address these issues.

5.63 The absence of formal risk management controls may have meant that management do not have all information required to make effective decisions.

5.64 Overall, the Council was discharging its regulatory duties effectively with regard to the **protection of the local population's health**. The policy, procedure and working arrangements framework were good and complied with recognised good practice guidance. Public Health tracked expenditure when an incident occurred to be able to potentially reclaim monies from the relevant health body, as part of a risk share agreement.

5.65 Increased reporting to Members and Senior Management would provide greater assurance regarding the work that the Director of Public Health and Public Health team had carried out with regard to health protection.

5.66 Satisfactory progress had been made to strengthen the process for ensuring that:

- action plans developed to address issues raised by **Ofsted inspections of schools, Private Voluntary Independent settings, Children's Centres and the Council's Children's Social Care Services** were implemented in a timely manner
- "Statements of Action" effectively drove the schools to make prompt, significant improvements.

5.67 Further work was underway to:

- update the Improving Learning Together Policy to provide further guidance on developing and managing all post-Ofsted inspection action plans and Statements of Action
- develop a system which provides:
  - evidence that all actions emanating from post Ofsted inspection action plans, are being monitored and implemented
  - regular reports for senior management on the progress made in completing outstanding actions.

5.68 Limited progress had been made in implementing the actions agreed in the original **Forum Governance Arrangements** report. Therefore, action was still required to:

- clarify and document the legal and accounting arrangements for a party to withdraw from the partnership / company
- formally get Board agreement on the basis of apportioning shared running costs and the method for calculating each
- obtain more formal feedback from Councillors serving as directors on the Board, on the actions undertaken by them whilst representing the Council in this capacity, which may also be an issue for other such arrangements

- get Financial Regulations amended to explicitly require segregation of duties in respect of ordering, receiving and paying for goods and services.

5.69 However, the arrangements for rotating the company treasure role had been clarified satisfactorily and a broad range of information on the performance and operation of the Forum building was being regularly and formally reported upon. This would be enhanced by including information on compliance with Financial Regulations and progress made in delivering the original intended benefits from the new library.

5.70 The Council is a one-third owner of the Southend-on-Sea Forum Management Limited (SoSFML), so can only persuade not direct. Nevertheless, given the basic nature of the governance issues outstanding, it needed to assess the organisational risk to it, should SoSFML not agree to put such arrangements in place.

PROSPEROUS

5.71 As at February 2017, the arrangements established to manage the **Airport Business Park project** were sound and appropriately documented. Two Boards had been established, with appropriate terms of reference, one taking a strategic role whilst the other focused on the operational delivery of the project. Meetings were minuted, actions required defined and then followed up to ensure they were delivered. The Council's Project Manager also provided regular, informal feedback to key senior officers every other week.

5.72 More formal highlight reporting needed to be developed at all levels in the governance structure. These reports needed to cover key project control areas of time, cost, quality, scope, changes, risks, and benefits.

5.73 The Airport Business Park Phase 1 Business Case, dated 11th January 2016, set out the planned benefits of the project, at a high level. These were tangible deliverables, which in some instances, were quantifiable. Further work was needed to produce detailed benefit profiles for the project, benefits management strategies or plans. The operational arrangements for managing delivery of expected project benefits also needed to be more clearly defined.

5.74 Overall, project planning was good, included the information expected and was being appropriately reported upon to key senior officers and the two Boards. A draft dependency log was in place, but it did not contain fields to capture all of the required information, nor had it been fully completed in order to ensure project dependencies were fully monitored and managed.

5.75 Given the change in overall management of the **Better Queensway project** in the latter part of 2016, some work was undertaken with the service to review project governance. A robust approach had been adopted to engaging key stakeholders for the current phase of the project. Opportunities to improve other aspects of project governance were going to be addressed by adopting the same approach as was already being used for the Airport Business Park project.

5.76 The Council's **Housing Allocation** Policy (the Policy) was largely in line with the current guidance available from the Department of Communities and Local Government (DCLG). It required clarification in a few areas. Comprehensive procedure notes then needed to be produced in order to ensure it is applied consistently.

5.77 A review was to be undertaken to establish whether the IT software in place had the ability to enable effective monitoring of applications progress through the

process. If this was not possible, alternatives were to be explored. Performance information was being developed that would enable management to monitor whether timescales within the allocations process, as set out in the Policy, were being met.

5.78 Focused, management checks were going to be introduced into key stages within the process to provide assurance that procedures are adhered to and consistently applied. This will ensure appeals are dealt with by an independent officer in line with Policy requirements.

5.79 Direct Lets were undertaken in line with the relevant policies with good supporting documentation available to support them. Finally, the Council was to define the performance information required from South Essex Homes to enable it to be satisfied that the allocations work undertaken meets its expectations.

5.80 The majority of **Purchasing Card (P-Card) expenditure** was not supported by receipts or other appropriate evidence. Action was being taken to strengthen these arrangements to enable the Council to:

- be better placed to detect errors or fraud in relation to this expenditure
- challenge the validity of any spend and reclaim all VAT it is entitled to because it is properly coded
- ensure that relevant Council policies were being adhered to (e.g. when reclaiming expenses)
- check that areas of spend protected by specialist gatekeepers (e.g. ICT equipment) are not being bypassed
- deal appropriately with staff who persistently fail to provide the evidence required in support of expenditure incurred.

5.81 Officers were also exploring:

- whether the P-Card IT system could be developed so that receipts and supporting evidence can be saved on it instead of elsewhere
- what kind of management information / reports could be produced from the system.

5.82 No issues were found with **Right to Buy** cases reviewed, due to the experience of the staff undertaking the work rather than the Council clearly defining the tasks to be completed and evidenced, when processing applications. Therefore, the checklist currently used was to be developed further so it:

- defined the tasks to be completed, including the independent checks required to confirm the work had been undertaken properly
- evidenced when each task is completed.

5.83 Legal Services processed all 2015/16 sales within the required 12 month period, bar one where the buyer delayed the process. South Essex Homes was notified promptly once sales completed, allowing the rent account to be adjusted in good time. Appropriate charges were being put on properties sold, thus protecting the Council's interest should they be resold within certain timeframes. Legal Services also confirmed charges were registered with the Land Registry, although evidence of this was not seen.

5.84 Suitable checks were undertaken to ensure buyers legal representatives were appropriately qualified and registered with a relevant regulatory body, who

require members to comply with Money Laundering Regulations. Going forward, the Counter Fraud and Investigations Directorate will complete financial checks for cash purchases in line with those undertaken by financial services, including lenders.

5.85 Opening correspondence with legal representatives was to be amended to request details of the bank account any funds were to be transferred from. This was so it could be confirmed the money was coming from an appropriate source at the start of the process.

5.86 Some progress had been made to address the issues raised in the original **Southend Adult Community College** report (June 2013). However, further work was still required to adequately strengthen its financial and governance controls so they provided an effective framework for financial planning, accountability and safeguarding public funds.

5.87 The main governance documents and policies were in place and broadly in line with the recommended requirements. But a Finance Department Operation Manual was still being produced and the Financial Regulations and the Debt Collection and Recovery Strategy required amending.

5.88 Good progress has been made in improving the format and presentation of management accounting information. However, better financial reporting was required of purchases made without a requisition or order and debt collection. A graphical trend analysis was needed to support management accounts information and independent reviews were required to confirm that reconciliations were being properly completed.

5.89 The private funds account had been appropriately closed and relevant, supporting evidence was available to support payroll and expense forms tested. But, better processes were still required to ensure:

- alternative quotes are always obtained in compliance with Contract Procedure Rules and VAT invoices are obtained
- budget holders confirm their budget position each quarterly and the on-going need for and accuracy of direct debits on their account
- temporarily postponed debt collection arrangements are challenged by senior management and assets are all security marked, recorded on the asset register and checked annually.

5.90 The 2016/17 **Schools Audit Programme** focused on revisiting schools to assess whether they had implemented the actions agreed, to improve the adequacy and effectiveness of their finance, management and governance arrangements. Of the 14 schools revisited, ten had satisfactorily implemented most or all of the agreed actions. Four still required further work to more fully address the issues identified in the original audits.

5.91 Whilst the new and very innovative **Education Board** was being established, some supportive challenge was provided to management as the governance arrangements developed. Overall, these arrangements were sound.

5.92 It was possible to certify that grant terms and conditions had been met for the following **grant claims**:

- South East Essex Local Growth Fund
- Highways Maintenance Challenge Fund
- Local Transport Capital Block Funding

- Disabled Facilities Grant
- A127 Corridor Growth Scheme.

5.93 The Expanded **Troubled Families Programme, Payments by Results (PBR) Scheme for Local Authorities** returns continued to be audited. All claims audited this year had an unqualified audit opinion. The protocols agreed with the service for producing evidence to support the claims, along with the continued independent review of sample claims by the Group Manager to complement Internal Audit's examination of claims work, operated well and the process remains a collaborative one.

EXCELLENT

5.94 Further work was required to ensure that **payments made for works under the Highways NEC3 Term Service Contract** (let from 1st April 2015), were accurate and properly authorised in line with Contract Procedure Rules / Financial Regulations. Initially, it was identified that:

- work was procured in line with defined good practice processes established by the Department for Place when the contract was let
- officers had authorised works orders above their approved limit and segregation of duties could not be demonstrated between the assessment, approval and checking of works done
- evidence was not available to confirm the sample payments were appropriate and accurate, as the arrangements and accountabilities for doing this were not clearly understood by officers.

5.95 Subsequently:

- approved delegated authorities were established for authorising works orders within the Insights Symology system, which interfaces with the contractor's systems and is used to instruct the contractor to undertake work
- officers were:
  - required to post inspect 10% of all works, with Symology automatically generating the sample works to be inspected
  - reminded of their responsibilities for signing off and confirming charges for works they notify to the contractor.

5.96 A further audit has been scheduled in 2017/18 to confirm the above improvements have been effectively implemented and the processes for procuring work and making payments are now robust.

5.97 The key elements expected of a good practice procurement process, had taken place and the **St Helen's Roman Catholic School** works contract with AW Hardy was let was within budget which was £1,982,110. Nevertheless, non-compliance with legislation, the Council's Contract Procedure Rules and proper procurement practice was identified in the letting of this contract. Most of the issues related to the way in which the tender process was conducted. Nevertheless, the project was delivered successfully, in time and on budget.

5.98 Stakeholders were appropriately involved in preparing the service specification, evaluating whether submissions met their requirements and at the build stage of the project.

5.99 Many of the issues identified will be dealt with going forward, by the requirement to involve the Corporate Procurement team in any procurement over £25k. However, where appropriate, action was being taken to strengthen the Property, Regeneration and Strategic Projects team's arrangements by providing staff with additional guidance and training in respect of good procurement practice.

5.100 The **Section 75 Agreement** and supporting Terms of Reference for the **Southend Equipment Service** needed to be updated to reflect the current requirements of all parties and a process established to ensure they are subject to regular review. Proper performance arrangements also needed to be established for the service that involved regular reporting to all partners against agreed targets. A more equitable basis for funding the service was being sought.

5.101 Further work will be undertaken to establish how the Council records and monitors the currency and quality of all "agreements" it has with others to provide, buy in or share services, including Section 75 Partnership Agreements.

5.102 The foundations were in place for managing **cyber security** across the Council. However, the restructuring of departments during 2016 had led to some **governance** issues being identified. This was not assessed as having a significant operational impact in the short term. However, there was a need to formalise roles, clarify accountabilities and responsibilities, and update policies in line with the latest government guidance in order to obtained greater assurance over the effectiveness of these arrangements. More detailed analysis and management of risk was also required.

5.103 The technical documentation setting out how to deal with cyber security was in line with best practice and processes were maturing. Operational issues around data protection were handled to a satisfactory level. Further development of such activities as information handling and information asset registers will increase the overall assurance over cyber security across the Council.

5.104 A Corporate Information Security Policy (the Policy) was in place which covered **IT data security**, reflected good practice guidance and was supported by appropriate, associated policies. However, some of them needed updating and better links were required between all these policies. This suite of policies should be stored together on the intranet for ease of reference by staff.

5.105 Information sharing protocols existed which covered the legal requirements for the effective control of data and helped ensure that shared data was securely managed. If additional resources could be obtained, a cost benefit analysis was to be undertaken and an assessment of risk, before deciding whether to implement an appropriate data classification scheme or not. Overall, the Council procedures for dealing with data breaches were robust.

5.106 Network access security was in place along with device encryption and two factor remote access authentication. The possibility of introducing a system to identify unsuccessful log-on attempts to determine unauthorised activity and also provide trend analysis was also being explored. Further work was required to improve the arrangements for dealing with penetration test vulnerabilities in a timely manner and implement the backup strategy. Overall, access to the IT suite was satisfactorily controlled, as was its environment.

5.107 Disposal procedures were in place that ensured that data is cleansed and reports are provided to evidence this.

5.108 With regards to **IT Infrastructure and Asset Management**, the hardware asset register needed to be updated so that it is a complete and accurate record of what the Council owns, which was not the case. It then needed to be refreshed at least annually to ensure it remains so. However, the software asset register was largely satisfactory although it still needed to contain additional information regarding licensing arrangements (e.g. type and numbers of).

5.109 Procedure notes and flowcharts were available to demonstrate the asset management processes operating within the Council. However, these would be better formalised into a single, accessible policy. Assets awaiting deployment or disposal were found to be held securely. The condition and performance of key assets (i.e. key software packages and physical servers) were checked on a daily basis and issues were followed up satisfactorily when identified.

5.110 A formal **Third Party Hosting** Policy (the Policy) had been established which defined the:

- circumstances under which third party hosting may be considered
- minimum IT Data Security and Information Governance requirements that must be met before new contracts can be let.

5.111 Action had been taken to identify all existing third-party hosted contracts and obtain any additional information necessary, to evidence that these contracts remain compliant with the new Policy. The Information Governance Meeting had been briefed on the updated standards and has a standard agenda item to consider new third party hosted contracts.

5.112 Better arrangements were being established to ensure that:

- both Information Governance and ICT are consistently informed of proposed contracts over £25k in value, where a third party will host the Council's data
- the proposal is vetted by both parties before a recommendation for approval is made to the Council's Senior Information Risk Owner for sign off.

5.113 A process was being created to train contract managers in their responsibilities regarding on-going contract management.

5.114 Outstanding information was required in order to finalise the action plan to Policy and Resources Scrutiny Committee's final **Welfare Reform report**, approved by Cabinet in July 2014. Further work was still required to:

- integrate the action plan into Corporate Services performance management framework so it is routinely monitored by senior management and Members
- update the action plan to include clear measurable outcomes and timescales for pledges six to eight and individual monitoring arrangements for all pledges.

KEY FINANCIAL SYSTEMS

5.115 A few **key financial controls** were reviewed to ensure they:

- were designed to prevent and / or detect material financial errors
- had been in place during 2016/17 and therefore, could be relied when producing the Council's Statement of Accounts.

5.116 No significant issues were identified that could potentially generate material errors in the Statement of Accounts. Action was being taken to:

- reassess the process for getting assurance that invoices raised accurately reflect the requests received from services
- confirm regularly that only appropriate staff have user permissions in Agresso that allow them to authorise journals
- ensure there is sufficient resilience within the Accountancy section so that reconciliations between key financial systems can always be undertaken in a timely manner.

5.117 The **Social Care Debt** Policy and Strategy had been extended and included sufficient information around the escalation of cases and exemption of charges. Further clarity was required to ensure management expectations are clear to staff when:

- agreeing and monitoring Payment Plans as well as managing and monitoring parked debt
- referring cases to colleagues, as potential safeguarding, financial abuse and fraud concerns have been identified.

5.118 Staff were regularly encouraged to identify problem cases to management. Direction given on how to deal with them was documented and followed up to ensure actions were taken. This will now be supplemented by a regular and systematic review of a selection of cases picked at random from the aged debt report. The aim being to confirm staff are applying the required monitoring process and when they pause the recovery process, the reason for it is appropriate.

5.119 The service had also developed a better understanding the debt profile, although an age debt analysis would also be beneficial. As such, the risk associated with collecting certain types of debt and where to focus resources for optimum return, was more clearly understood.

IMPLEMENTING ACTION PLANS

5.120 Internal Audit input agreed actions into Covalent once the audit report is issued. Services then used this to monitor their implementation. Internal Audit only revisits and retests action plans where a partial or minimal assurance opinion was given. Management close down other action plans once they are satisfied the issues identified have been properly dealt with.

5.121 There were instances this year, when services were reporting that all actions had been dealt with but this proved not to be the case when it was re-audited. Some reports had also not been progressed as well as they might have been. Further work will be done with services during 2017/18, to strengthen these arrangements.

Conclusion

5.122 As reported last year, an important source of evidence that service, process and systems are operating as they should, is obtained through targeted and proportionate management checks, linked to an understanding of and assessment of risk. Managers need to be clear on the checks needed to ensure that these controls are adequate and effective.

6. Compliance with Professional Standards

Head of Internal Audit Opinion

6.1 ***The in-house service has substantially conformed to the relevant professional standards throughout the year.***

6.2 ***I have obtained assurance from external suppliers regarding their conformance with relevant professional standards, but have not independently confirmed this with regards to audit work completed at the Council.***

Resourcing

6.3 In July 2015, the Council decided to undertake a service review of the Internal Audit Service so permanent recruitment was stopped. All subsequent vacancies were covered by:

- resources bought in through framework contracts with external suppliers
- agency or casual staff and staff on short term contracts.

6.4 BDO was appointed to complete the service review, which occurred during January / February 2016. It was concluded in August 2016 at which time permission to recruit and rebuild the in-house team was granted. By this time, the combined in-house team of nine auditor posts was carrying seven vacancies, one of which has been covered by a long term contractor. The Head of Internal Audit also continued to cover the contract manager role.

6.5 This reduced management capacity has had a significant impact on its ability to deliver:

- all audit reports in a timely manner
- an annual programme of work that would provide some assurance that there are appropriate arrangements in place to manage the key risks within the more significant Council services / activities (as agreed when discussing the audit risk assessment / assurance statements) over a three / four year period.

6.6 Recruitment of permanent staff commenced in January 2017. However, the remainder of the report needs to be considered within this context.

Audit Plan 2016/17

6.7 The target was to deliver 100% of the Audit Plan by the June Audit Committee meeting. As at 16th June, a draft report has been produced for 82 out of the 87 (94%) audits undertaken this year (including schools). 71 reviews (82%) have been completed. All outstanding audits will now be included in the 2017/18 Audit Plan.

6.8 **Appendix 2** shows the final status of the Audit Plan which is a comparison of actual audit work completed against work planned at the start of the year.

Other Performance Indicators

6.9 The service stopped reporting on its productivity during the year as it was no longer a relevant indicator, given the service was predominately being bought in from external suppliers. However, sickness absence remained very low at 1.49 days per FTE compared to a target of less than 5 days per FTE for in-house staff.

6.10 The service revised its approach to obtaining feedback from stakeholders at the conclusion of audits so it focused more on obtaining evidence of compliance with some of the less tangible elements of the UK Public Sector Internal Audit Standards (the Standards). During the year, 13 officers were interviewed. The key message from the surveys was the need for there to be a more seamless service regardless of whether work is undertaken by the in-house team or contracted in resources. Nevertheless, the response to the question "Do *you think internal audit adds value to the Council?*" was 96%. **Appendix 3** summarises the final survey results relating to the Council's 2016/17 audits.

6.11 External Audit confirmed that it could rely on Internal Audit's work where it was relevant to its audit of the Council's Statement of Accounts.

Service Management Arrangements

6.12 An assessment was also completed of the team's compliance with Castle Point Borough Council's governance arrangements requirements as set out in the Manager Assurance Statements (which are not dissimilar to those used by the Council). This highlighted some areas where they should be strengthened and actions are in hand to address this (refer Appendix 5 below).

Quality and Improvement Programme

6.13 I can confirm that I have maintained an appropriate Quality and Improvement Programme (QAIP) during the year for the in-house team or work undertaken by contractors when being managed by the in-house team. As required by the Standards, this consisted of:

- on-going supervision and review of individual audit assignments completed by in-house staff or contractors working to in-house staff
- reporting on a limited set of performance targets to the Audit Committee each quarter (for all work done including that of the external supplier)
- undertaking a self assessment which evaluates conformance with the Standards.

6.14 I have received assurance from the external suppliers that where they have undertaken work using their own audit approach, this is also compliant with the Standards.

6.15 Due to resource constraints, there have been no independent file reviews of in-house staff or contractors work completed this year.

6.16 **Appendix 4** summarises the results of the annual self assessment of the team's compliance with the Standards. **Appendix 5** sets out the actions the team plans to take over the coming year to improve its working arrangements, which includes:

- organising the independent external assessment of the combined services compliance with professional standards which must be completed before 31 March 2018, and then refreshing the audit approach / Audit Manual accordingly
- destroying all audit files that fall outside the data retention policy period.

6.17 Senior management has chosen not to implement the Standard relating to the appointment and removal of the Head of Internal Audit as the Council's normal HR practices would already mitigate this perceived potential risk.

Other Disclosures

6.18 As required by the Standards, I can confirm that the Internal Audit service has:

- operated in a manner that maintains its organisational independence throughout the year
- been able to determine the scope of reviews, perform the work and report on its findings without interference neither has there been any inappropriate resource limitations imposed upon it.

7. Issues for the Annual Governance Statement

7.1 No issues have come to my attention this year, other than those already disclosed, that I believe need including in the Council's Annual Governance Statement.

8. Corporate Implications

8.1 Contribution to Council's Aims and Priorities

Audit work contributed to the delivery of all Council Aims and Priorities

8.2 Financial Implications

The Audit Plan was delivered within the approved resource budget.

8.3 Legal Implications

The Council is required, by the Accounts and Audit Regulations 2015 (the Regulations) Section 5, to undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance. The Standards require that the Head of Internal Audit to report on compliance with this annually to the Audit Committee. This report satisfies this requirement.

8.4 People and Property Implications

People issues that were relevant to delivering the Audit Plan were raised in the quarterly progress reports.

8.5 Consultation

All terms of reference and draft reports were discussed with the relevant Directors / Deputy Chief Executives / Chief Executive before being finalised. This annual report has also been presented to and discussed with senior management.

8.6 Equalities Impact Assessment

The relevance of equality and diversity was considered during the initial planning stage of every audit before the Terms of Reference were agreed.

8.7 Risk Assessment

Failure to operate a robust assurance process (which incorporates the internal audit function) increases the risk that there are inadequacies in the risk management, control and governance processes which may impact of the Council's ability to deliver its corporate objectives.

8.8 Value for Money

Opportunities to improve value for money in the delivery of services were identified during some reviews and recommendations made as appropriate.

Internal Audit periodically undertakes a service review to assess whether its costs remain competitive.

8.9 Community Safety Implications and Environmental Impact

These issues were only considered if relevant to a specific audit review.

9. Background Papers

- The Accounts and Audit Regulations 2015
- UK Public Sector Internal Audit Standards
- CIPFA: Local Government Application Note for the UK Public Sector Internal Audit Standards
- CIPFA: The Role of the Head of Internal Audit in Public Service Organisations 2010
- CIPFA: Audit Committee, Practical Guidance for Local Authorities and Police 2013

10. Appendices

Appendix 1	Assurance Summary 2016/17
Appendix 2	Internal Audit Plan 2016/17 as at 16th June 2017
Appendix 3	Stakeholder Surveys, Compliance with Professional Standards
Appendix 4	Summary Assessment of Compliance with UK Public Sector Internal Audit Standards 2016/17
Appendix 5	Compliance with the UK Public Sector Internal Audit Standards 2016/17 Action Plan