Bath & North East Somerset Council		
MEETING:	Corporate Audit Committee	
MEETING DATE:	24th November 2022	**AGENDA ITEM NUMBER**
TITLE:	Internal Audit – Update Report	
WARD:	ALL	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Appendix 1 - Audit Reviews Position Statement (2022/23) Appendix 2 – Follow-Up Reviews Appendix 3 – Exception Reports for Audit Reviews with No or Limited Assurance		

1 THE ISSUE

1.1 This report is to provide an update on the work of the Internal Audit team and progress made in delivering the Annual Audit Assurance Plan 2022/23 which was presented and approved by the Committee on 22nd April 2022.

2 RECOMMENDATION

2.1 The Corporate Audit Committee notes the progress in delivery of the 2022/23 Annual Audit Assurance Plan and approves the proposed amendment to the Audit Plan 2022/23.

3 THE REPORT

3.1 The Annual Internal Audit Plan for 2022/23 was presented to the Corporate Audit Committee on the 22nd April 2022.

3.2 INTERNAL AUDIT WORK UPDATE

3.2.1 Internal Audit Plan – Half Year Review

3.2.2 This report summarises the work of the Internal Audit team during 2022/23, this includes planned and unplanned reviews from the 2022/23 audit plan along with carried forward work from 2021/22 and associated work to support the internal control framework.

3.2.3 The 2022/23 Internal Audit Plan approved in April 2022 recorded 34 areas to audit and provide assurance to management, the Audit Committee and Council. Appendix 1 records progress to 30th September 2022.

3.2.4 During the year there has been a reduction in resources available with two of the three Audit Managers in the Team's structure leaving our employment and we have not been able to recruit replacements based on market conditions. A restructure is therefore being considered to re-align resources for 2023/24.

3.2.5 Along with unplanned work this has impacted on the delivery of the 2022/23 plan and it has therefore been necessary to review the plan and inform the Committee that 3 audit reviews will not start this financial year following a risk assessment of the resources available. These reviews are Revenue Estate Asset Utilisation; GLL Contract Management; and Income Management - Collection & Reconciliation of Service Provision Income. These have been highlighted in red in Appendix 1 and Committee is being asked to approve this amendment to the Internal Audit Plan.

3.2.6 **Internal Audit Plan Work 2021/22 (Reports Published in 2022/23) -** As at 31st March 2022, twelve Audit Reviews were still work in progress or at/or near report writing stage. The work on these reviews has now been fully completed and those with limited or no assurance are reported at Appendix 3.

3.2.7 **Internal Audit Plan Work 2022/23** - In relation to the 2022/23 plan ten of the areas for audit are at report stage and another eight audits are recorded as 'Work-In Progress'. In addition to that we have contacted management and agreed scope and start dates for another five reviews.

3.2.8 For the ten reported audits, six were 'Assurance Reports' – four were assigned a Level 3 'Reasonable Assurance' or above rating and the remaining two audit reports were assigned a Level 2 'Limited Assurance' rating which require reporting to the Committee and are detailed at Appendix 3.

3.2.9 In addition to the formal reviews within the 2022/23 plan a summary of other work carried out in the year is detailed below -

3.2.10 **Grant Certification Work –** During April the Internal Audit team is required to carry out a significant amount of grant certification work. Twenty-four grant certification reviews had been completed up to the end of September. This generally relates to funding received from WECA and government departments.

3.2.11 **National Fraud Initiative** - The data for NFI 2022/23 is currently being prepared and submitted. In addition to co-ordinating the submission of data sets the audit service will also help review matched data records and liaise with Officers within services who have been tasked with reviewing data matching reports provided by the Cabinet Office.

3.2.12 **Investigations, Whistleblowing & Unplanned Work** – Internal Audit have responded to reports of financial irregularity which require advice/ investigation, including an unplanned Internal Audit review of cash handling / banking at the 3 One Stop Shops. This review included providing advice to the Team Leaders on the review and updating of the One Stop Shop Cash Control Procedures used for staff guidance and training purposes.

3.2.13 For the first 6 months of 2022/23, there have not been any whistleblowing cases reported to Internal Audit which have highlighted dangerous, illegal or unethical activity by Council Officers or Members that required investigation. Internal Audit have provided advice to two service areas where potential wrongdoing by individuals was identified through their systems of internal control. One case is being investigated by the Council's One West Investigation Service and the other has been referred to an employment agency for their investigation.

3.2.14 **Follow-Up Reviews -** The Internal Audit team have carried out 8 Audit 'Follow-Up reviews to ensure sufficient action has been taken to manage the internal control risks identified and reported. The 'Follow-Ups are recorded in the table at Appendix 2 – a simple RAG rating has been used to indicate Internal Audit's assessment as at the date of the 'Follow-Up' activity.

3.2.15 In addition to the 8 'Follow-Up reviews Members of the Committee will be aware that the Director of Regeneration and Housing attended the 14th July 2022 meeting to provide an update of progress related to the 2020/21 Property Compliance Internal Audit which was assessed as Level 2 'Limited Assurance'.

3.2.16 For reference it was agreed by the Committee that the Director of Regeneration and Housing would attend the March 2023 scheduled meeting to provide a further update on progress on improving the property compliance function.

3.2.17 Finally as reported at previous Committee meetings the Internal Audit team are required to be assessed independently every 5 years on our professional standards. This review is planned to take place in the next month and will involve interviews with the Chair of the Audit Committee, the independent co-opted Member and key officers including the Chief Finance Officer.

4 STATUTORY CONSIDERATIONS

4.1 There are no specific statutory considerations related to this report. Accounts & Audit Regulations set out the expectations of provision of an Internal Audit service. This is supported by S151 of the Local Government Act and CIFPA Codes of Practice and the IIA professional standards for delivery of an adequate Internal Audit Service.

5 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

5.1 There are no direct resource implications relevant to this report.

6 RISK MANAGEMENT

6.1 A proportionate risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision-making risk management guidance. Significant risks to the council arising from an ineffective Internal Audit Service include lack of internal control, failures of governance and weak risk management. Specific risks include supplementary External Audit Fees, undetected fraud and inadequate coverage of risks arising from COVID-19.

Internal Audit assists the council in identifying risks, improvement areas and recommending good practice.

6.2 The Corporate Audit Committee has specific responsibility for ensuring the Council's Risk Management and Financial Governance framework is robust and effective.

7 EQUALITIES

7.1 A proportionate equalities impact assessment has been carried out using corporate guidelines and no significant issues have been identified.

8 CLIMATE CHANGE

8.1 There are no direct climate change implications related to this report.

9 OTHER OPTIONS CONSIDERED

9.1 No other options to consider related to this report.

10 CONSULTATION

10.1 The Council's Section 151 Officer has had the opportunity to input to this report and has cleared it for publication.

Contact person	*Andy Cox (01225 477316) Jeff Wring (01225 477323)*
Background papers	*Reports to Corporate Audit Committee –14th July 2022 - PROPERTY COMPLIANCE INTERNAL AUDIT REPORT 2021 – UPDATE; 22nd April 2022 – INTERNAL AUDIT PLAN - 2022/2023*.
Please contact the report author if you need to access this report in an alternative format	

Audit Reviews Position Statement (as at 30th September 2022) Appendix 1

Audit Ref	Topic	Status	Assurance Level	Recommendations	
				Made	Agreed
22-001B	Payroll - Monthly Payroll Processing				
22-002B	SEND (Input into Education Health Care Plan)				
22-003B	Highway Structures - Risk Management				
22-004B	Payroll (Service Based Review)- Timesheet generated payments	WIP			
22-005B	S106 - Use of funding within timescales	Final	2	5	5
22-006B	Covid19 - Restrictions - Business Grants	Briefing Report	N/A	N/A	N/A
22-007B	IT - User education and awareness	WIP			
22-008B	Transport Projects - Cycle Schemes	Briefing Report	N/A	N/A	N/A
22-009B	Direct Payments (Adults)				
22-010B	Direct Packages / Payments (Children)				
22-011B	IT - Risk Management	Final	3	5	5
22-012B	Highways - Street Works	Final	4	2	2
22-013B	Main Accounting Systems Interfaces	WIP			
22-014B	Covid19 - Adult Social Care Grant Funding Management	WIP			
22-015B	Heritage – Income Collection & Banking				
22-016B	IT - Software Asset Management				
22-017B	APF - Cyber Essentials	Final - Briefing Report	4	N/A	N/A
22-018B	Debt Management - Corporate Policy	WIP			
22-019B	Brokerage Service & Block Contracts - Contract Management				
22-020B	Alternative Education Provision	Final	4	5	5
22-021B	IT -Service Level Management – Performance Measures	Final - Briefing Report	N/A	N/A	N/A
22-022B	Community Equipment (Asset Management)	Draft	2	6	
22-023B	Revenue Estate - Asset Utilisation				
22-024B	Creditor Payments - Data Analytics (Inc use of Meridian) & Late Payments Liability	WIP			
22-025B	LADO (Local Authority Designated Officer) - Statutory Responsibilities	Draft	5	2	
22-026B	APF - System Access Controls				
22-027B	Income Management - Collection & Reconciliation of Service Provision Income				
22-028B	IT - Secure configuration (Servers and Systems)				
22-029B	Health Safety & Wellbeing - Managing the Risks	WIP			
22-030B	Ecological Emergency				
22-031B	Council Tax & NNDR - Exemptions / Discounts / Relief	WIP			
22-032B	APF - Pensions Governance - New Pension Regulations				
22-033B	GLL Contract Management - Governance				
22-034B	IT - Change Management	WIP			

Appendix 2 – Follow-Up Reviews

Audit Report	Reported Assurance Level	Summary of Follow-Up findings
19-002B Avon Pension Fund COP14 Data Protection	4 Substantial Assurance	Green - All 3 recommendations implemented in full or part
20-022B Council Tax Liability (Billing & Refunds)	3 Reasonable Assurance	Green – All 5 recommendations implemented
20-025B Avon Pension Fund COP 14 Pensions Governance	4 Substantial Assurance	Green - All 3 recommendations implemented in full or part
20-028B Housing Benefit Processing Claims (Overpayments)	4 Substantial Assurance	Green - 2 recommendations implemented
21-003B Adult Social Care – Supplier Relief Scheme	4 Substantial Assurance	Green - 2 recommendations implemented
21-006B Clean Air Zone (Income & Interfaces)	4 Substantial Assurance	Green - All 6 recommendations implemented
21-014B Joint Agency Panel	Briefing Report	Green – 5 of 9 recommendations implemented and 4 linked to current external JAP review reporting in December 2022
20-015B Avon Pension Fund Risk Management	4 Substantial Assurance	Amber – management have requested additional time to implement 3 recommendations– revised implementation date of 31/12/2022 agreed based on recent appointment of a new Governance & Risk Officer
21-017B Community Resource Centre & Extra Care Housing Schemes	3 Reasonable Assurance	Amber – Management have requested additional time to implement the audit recommendations. All should be implemented by April 2023.

Appendix 3 – Exception Reports – Audit Reviews with No or Limited Assurance

Audit	Background	High Risk Weaknesses	Agreed Actions
Health Safety & Wellbeing – Managing the Risks **AUDIT OPINION – LEVEL 2 – LIMITED ASSURANCE**	On the back of the 2020/21 Property Compliance Review an audit of 'Health Safety & Wellbeing - Managing the Risks' was programmed. This was a high-level review of the arrangements in place to ensure that significant HS&W risks both Corporate (generic employer responsibilities), and specific Service provision (including commissioned services) risks were being identified, clearly defined, recorded and then effectively monitored (i.e. implementation of related actions / internal controls). In particular, the focus was on the role of the Council's Health, Safety and Wellbeing Team in ensuring the risk profile of the organisation is being assessed to determine the greatest risks and how these risks are managed, monitored and reported (including providing assurances to the Health, Safety & Wellbeing Steering Committee).	**Documenting HSWB risks** The Council does not currently maintain an effective framework to document and monitor HSWB risks. Through their liaison and support with the individual service areas across the Council, including work around compliance audits and inspections, the HSWB Team maintain and improve their awareness of the key HSWB risks faced by services. However, risk registers are not being maintained at Director, Service / Team level to assist and evidence the management of risks and help inform the corporate body of current risk exposure. If risk registers were maintained, it would assist in the maintenance of high-level risk dashboard(s) for management / monitoring purposes	a) Chief Operating Officer to ensure that Directorate Risk Registers are in place by 30/6/22 and being maintained. Officer Corporate Risk Management Group will help ensure that Corporate and Directorate risk registers regularly reviewed / updated. Directorate Risk Registers raised with Cabinet at Informal Cabinet meeting held on 3/5/22 (as part of a broader risk management discussion). Cabinet Members were requested to discuss risk registers with directors at their 1- 1s. b) The HSWB team will review the Directorate Risk Registers and create a HSWB dashboard. The HSWB team will review the control measures in place and align HSWB Business Partners to work with Directors at regular intervals to record progress on HSWB Dashboard and present to HSWB Committee. Health and Safety Risks that are identified by the Directorate / Service / Project / Corporate Risk Registers will be presented to the HSWB Steering Committee as a standard agenda item and supported with reports by CRMG. c) The HSWB team will support and propose KPI's that could be developed for the monitoring of managing H&S risks on risk registers, and ensure these are pro-actively monitored and included as regular discussion with Directors. d) An annual HSWB audit plan will be determined which gives consideration to HSWB risks and consideration determined by Directorate / Service /

			Project / Corporate Risk Registers and will be monitored accordingly.
		Membership of HSWB Steering Committee A review of the membership of the committee identified 'reporting officers' attending even if briefings/ updates were note being reported to the meeting. Plus, a reporting officer had not been identified / assigned from Children's Services and therefore HSWB risks and compliance reports for Children Services had not been submitted.	Director of People & Policy (CB) and HSWB Team Manager (TC) will amend Steering Committee membership to include core and reporting officers and establish clear work plan covering strategy and development and review of risk registers and service reports.
		Monitoring & Reporting of Key HSWB Risks A review of the current reporting arrangements to the HSWB Steering Committee identified that whilst comprehensive and detailed reports are provided from the three key/ identified key reporting services, the format and content of the current reporting is considered low level, i.e. operationally focused. High level risk monitoring reporting was not being compiled / presented to enable Committee members to monitor risk management across services and the organisation to enable them to focus on areas assessed as higher risk and needing attention.	Dashboard(s) are: 1) Periodically reviewed (at least quarterly) by the HSWB Team in liaison with individual service areas/ risk owners, to ensure it accurately reflects the current compliance status/ risk rating based on: •Recent data from KPI reporting. •Known issues and impacts affecting compliance. • Results of audits and inspections. • Impact of actual controls in place and progression of planned controls. 2) Presented as a standing agenda item to the HSWB Steering Group at every meeting for review, scrutiny and challenge. The HSWB Team Manager should invite reporting officers/ risk owners to explain risks/ issues requiring attention and action plans where necessary, i.e. where risk scores are high, or the committee has diarised a request to review and revisit progress against previously reported actions.

Audit	Background	High Risk Weaknesses	Agreed Actions
IT Audit - Capacity and Availability **AUDIT OPINION – LEVEL 2 – LIMITED ASSURANCE**	Capacity and availability management are the IT Infrastructure Library (ITIL®) names for two of the ICT service management practices that ensure organisations have sufficient ICT systems and services, available when users need them, and that performance meets users' needs. **Capacity and performance** Aims to match the business, service, and component capacity of IT to the organisation's demand for ICT resources. **Availability** Ensures that availability targets for ICT services, components and resources are measured and achieved, and that they match or exceed the current and future agreed needs of the business in a cost-effective manner.	**Performance, Capacity and Availability monitoring** The daily tasks workbook is focused on server operations. It does not include network infrastructure (routers, switches), network links, firewalls, operation of the Uninterruptable Power Supply (UPS) or the new laptop fleet	Implement monitoring tools for the network and other infrastructure components and set up a daily monitoring procedure like (or integrated with) the Servers and Networks team daily checks. IT Services have software (MicroTik's 'The Dude' and OpManager) that are capable of monitoring the performance of network devices. Prioritise the business-critical systems and services for performance, capacity, and availability monitoring
		Service trends and changing business needs There is no formal process to identify and review the availability and capacity implications of IT service trends and changing business needs	Establish processes to analyse the availability and capacity implications for annual trends in consumption of ICT services and where new solutions and business changes are introduced. Create availability and capacity plans to deliver required ICT service levels and changes in consumption and demand. Recognise adverse capacity and availability impacts in the IT Services risk register and agree mitigations with the affected Business System Owners

Audit	Background	High Risk Weaknesses	Agreed Actions
IT Audit – Incident Response **AUDIT OPINION – LEVEL 2 – LIMITED ASSURANCE**	For cyber security and incident response related IT audit reviews it is not considered appropriate to report individual weaknesses and action plans within the public domain. However, it can be reported that action has / is being take including having a Cyber Security Operational Group in place to coordinate and oversee operational focussed cyber security related activity; and the Group is overseeing improvements required to respond to a cyber incident.	Not Reported	Not Reported
S106 – Use of Funding **AUDIT OPINION –LEVEL 2 – LIMITED ASSURANCE**	The key planning tools for securing developer contributions to be used to provide infrastructure to support development and mitigate the impact of development are through Community Infrastructure Levy (CIL) or previously Section 106 legal agreements used to address site specific impacts arising from individual developments. The report on *S106 – Use of Funding* was discussed by the Head of Audit & Assurance with the Director of Sustainable Communities and Head of Planning and separately with the Council's Chief Operating Officer. It was considered very important that senior management took the necessary co-ordinating action to	**Failure to maintain an accurate Central Record of S106 Committed / Actual Spend / Balances Held.** The Council's financial system Agresso was being relied upon however Agresso could not provide full explanatory details of the committed / actual spend activities linked with projects aligned to individual S106 agreements and the timescales for using the balances held. Therefore, it was concluded that a comprehensive S106 record was not being maintained by the Council even though a suitable computer system (Exacom) is available for use. The potential implications were: 1) Significant sums on the balance sheet become time barred and subject to repayment to the developer. 2) Funding committed / spent do not meet the	Heads of each responsible Service to take charge of their own projects on Exacom so that they can accurately track and update their spend for their own projects. This will enable the S106 Monitoring Officer in Planning Service to effectively monitor S106 timely spend.

	ensure all relevant Heads of Service deployed the required resources to update and maintain Exacom S106 records. This audit and the implementation of actions will be subject to a 'follow-up' in Q1 2023/24.	criteria set out in the S106 – again making funds potentially repayable. 3) Waste of resources when having to compile information when required to respond to individual S106 enquiries	
		Failure of assigned Officers to fulfil to maintain Exacom System data The 'Planning Obligations / CIL Spend Protocol' approved in June 2018 is not being adhered to in terms of recording of up to date committed and actual spend data. Based on this, Exacom does not provide an accurate, up to date position statement in terms of: committed / actual spend sums; details of the associated projects; and current unallocated balances held against each S106 agreement.	Head of Planning and Planning Monitoring Officer to work with Heads of Service and assigned Officers to improve Exacom record keeping which will in turn help ensure adherence to the 'Planning Obligations / CIL Spend Protocol'
		Failure to monitor S106 spend timescales An effective system to monitor balances and spend timescales was not in place to ensure funds were being committed (with planned completion date) / spent. Currently the responsibility to monitor balances for individual cases is with the individual service spend manager(s). A sample of 22 S106 agreements identified • 15 (68%) totalling £604,337 had incorrect 'spend by' dates recorded in Exacom. • 7 (32%) totalling £369,672 had reached their spend by date outlined in the S106 agreement. In one case it was identified that £56,095 was being returned to the developer.	Once Exacom is being used to maintain accurate records (through joint working between the Officers in the Service areas and Project Finance) the Planning Monitoring Officer will flag any unallocated/unspent money especially when nearing S106 spend deadlines.

Audit	Background	High Risk Weaknesses	Agreed Actions
Community Equipment Store **AUDIT OPINION – LEVEL 2 – LIMITED ASSURANCE**	In May 2021, the Cabinet Member for Adult Services & Council House Building approved a decision to bring the Community Equipment Service in-house. The Service was transferred in-house from Sirona Care & Health Community Interest Company. The service provides equipment to clients of the Council and NHS Bath Swindon Wiltshire Integrated Care Board under a pooled budget arrangement. There is an annual budget of £675,000 to operate the service. The objective of the audit was to focus on the operation of the main store based in Radstock. The Community Equipment Store is now being managed by the Regeneration & Housing Service based on the Housing Team who manage the Disabled Facilities grants and the minor adaptations service within the Council. Management of this Service have been very positive in terms of planned actions related to the Internal Audit and steps have already been taken to improve access controls to the store and to implement the stock scanning system. The agreed actions based on the Internal Audit Report will be followed-up un 2023/24.	**<u>Failure to Manage Stock (minimum, re-order, and maximum Stock levels)</u>** At the time of the audit, minimum, re-order and maximum levels of stock had not been agreed and monitored to inform decision making when purchasing stock items.	The data that has been collected in relation to the purchasing, receipt and issuing of stock items should be analysed to enable minimum, re-order, and maximum stock levels to be determined.

Audit	Background	High Risk Weaknesses	Agreed Actions
		Failure to Control Movement of Stock It was found that the stock levels recorded on the Elms2 system were not correct. This was due to prescribers collecting the equipment from the store without requesting the equipment on via Elms2 beforehand and requesting the equipment after removing it from the store. This means that for a period of time the Elms2 stock system will show a larger inventory of stock than is actually the case.	Access to the Community Equipment Store should be restricted to the Community Equipment Team and all other staff / visitors entering the room should be supervised. Documentation must be immediately completed by 'authorised' personnel to record all stock movements and this documentation must follow a process to ensure that stock records (Elms2) are updated accurately and within a reasonable time period. The Community Equipment Manager should implement the remote scanning system to help maintain accurate stock records.