Report to: **Audit and Governance Committee, 20th March 2019**

Report of: **Head of Internal Audit Shared Service, Worcestershire Internal Audit Shared Service**

Subject: **2018/19 INTERNAL AUDIT PROGRESS REPORT TO 28th FEBRUARY 2019**

1. Recommendation

1.1 That the Committee note the report.

2. Background

2.1 To provide an update on Internal Audit's progress towards meeting its objectives as set out in the audit plan for 2018/2019 as approved by the Audit Committee on 21st March 2018.

2.2 The Council is required under Regulation 5 of the Accounts and Audit Regulations 2015 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".

3. Summary of Activity:

3.1 Progress in regard to 2018/19 Internal Audit Plan.

3.2 Progress continues to be made in regard to the 2018/19 plan with the following audits on-going as at the 28th February 2019 and progressing through the final stages of clearance or draft report:

- Council Tax
- NNDR
- Treasury Management
- Debtors
- Creditors

3.3 Fieldwork continues in regards to

- ICT
- Benefits
- Main Ledger
- Payroll
- Cemeteries and Crematorium
- Street Scene

3.4 Confirmation of the level of assurance and summary details of the outturns in each case will be provided for committee perusal when they have been finalised.

3.5 **Reports completed since the 19th December 2018 in regard to the 2018-19 Internal Audit Plan.**

3.6 Audit reports completed since the previous progress report meeting of 19th December 2018 include:

3.7 **GDPR**

3.8 The purpose of the review was to follow up on from the last audit conducted and ensure that the awareness of GDPR has flowed corporately and that the council is complying. It was also to check that the recommendations in the last audit have been considered and carried out. From the follow up audit it was identified that there are areas which will require more time and resource to implement.

3.9 The Council's Policy and Strategy Team are fully aware of the requirements of the GDPR and are working with service areas towards completing the remaining items on the action plan. There have been several recommendations made, further to the last audit, to assist with enhancing the existing action.

3.10 There were 1 'high', 3 'medium' and 1 'low' priority recommendations reported. The 'high' recommendation has been addressed, all three 'medium' recommendations are in progress in line with the agreed action plan, and the 'low' recommendation has been completed.

3.11 Further follow up will take place in the near future in regard to the management action plans.

Type of Audit: Hybrid Follow Up
Report issued: 14th January 2019
Assurance: N/a

3.12 **H&S – Operations Training Programme**

3.13 The review found the following areas of the system were working well:

- All personal files for staff at the depot are kept locked in a cabinet in an A to Z surname order, which makes it easier to locate information.
- The Learning Lounge is a robust system and includes a lot of features which are suitable and user friendly to hold training records.
- There is a suitable control in place for fraud investigations regarding accidents.

3.14 The review found the following areas of the system where controls could be strengthened:

- Record Keeping
- Corporate Inductions
- Active Monitoring
- First Aiders
- The Learning Lounge

3.15 There were 2 'high', 2 'medium' and 1 'low' priority recommendations reported.

Type of Audit: Full System
Report issued: 20th December 2018

Assurance: Limited

3.16 **Health and Safety Consultancy – BS18001 compliance**

3.17 The work was undertaken at the request of the Health and Safety Team after receiving a non-conformance notice as part of an external audit against the OHSAS 18001:2007 standards. The non-conformance was due to Worcester City Councils inability to evidence that regular and targeted audits had been completed to ensure compliance with the standards. As part of the external audit 28 days was given to provide a response that evidenced compliance and ensured Worcester City Council maintained the standard. The consultancy work formed part of the evidence supplied to the external auditor to evidence independent review.

3.18 A gap analysis was provided instead of recommendations to assist the Health and Safety Team with working towards corporate compliance and certification.

3.19 The result of the combined work of Health and Safety and the consultancy was that Worcester City Council was able to show compliance with the Standards and retain the full OHSAS 18001:2007 certificated standard.

Type of Review: Consultancy
Report issued: 17th December 2018
Assurance: N/a

3.20 A summary table is provided below of the finalised audits:

2018/19	
GDPR	N/a
Health & Safety – Operations Training Programme	Limited
Health & Safety Certification Consultancy	N/a

3.21 A rolling testing programme on Debtors and Creditors has been undertaken during quarter 2 and continued through quarter 3. Testing results so far do not indicate any new or emerging risks to be brought to the attention of Committee. The rolling testing programme results have been amalgamated and will be reported at the next Committee.

3.22 After a recent management investigation in the Trade Waste service it was found there had been immaterial financial loss and appropriate action has been taken to conclude the matter.

4. National Fraud Initiative (NFI)

4.1 The 2018/19 NFI upload of data took place during October 2018. Various data sets were required, for example, Payroll, Creditors, along with a host of others provided by Worcestershire Regulatory Services and Civica. WIASS can confirm that all the required data sets have been uploaded for Worcester City Council. A further data upload took place during December in regards to the single person discount and

electoral registration. WIASS continues to play a supporting role for all the Partners in regard to this exercise.

5. Follow-Up Audits

5.1 Where appropriate follow-up audit work has been undertaken e.g. Debtors, the results of which are compiled on an on-going basis and provided in summary form for information at Appendix 4. Any material exceptions arising from audit 'follow up' are reported to Audit Committee. Good progress, in the main, has been made in satisfying a number of the 'older' recommendations which are now seen to be satisfactorily implemented. In a minority of cases, where a further review is scheduled to take place in the area, any outstanding recommendations will be revisited as part of the review. During December it was reported that there was an exception to report in regard to Debtors 2017/18 concerning housing sundry debtor accounts. Since then a Finance Officer has met with Housing and agreed the process that they should be working to and confirmed with Malvern Hills District Council that they support it. All parties have agreed to have a combined monthly review to confirm that procedures are indeed being followed.

6. Risk Management

6.1 Embedding the revised risk process continues and Committee will be appraised of the key risk areas on a regular basis. The Pentana system continues to be developed and is used to capture and report on risk. Regular reporting has been established in regards to risk information with updates being brought before this Committee.

7. Appendices

7.1 **Appendix 1** shows the progress that has been made since 1st April 2018 to the 28th February 2019 towards delivering the Internal Audit Plan set for the year. As at 28th February 2019 a total of 297 days had been delivered against a target of 327 days for 2018/19.

7.2 **Appendix 2** shows the performance indicators for the service. These indicators were agreed by Audit Committee on the 21st March 2018.

7.3 **Appendix 3** shows the 'high' and 'medium' priority recommendations which have been reported.

7.4 **Appendix 4** provides the Committee with audit report 'Follow Up' actions that have been undertaken to monitor audit recommendation implementation progress by management.

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Background Papers: **None**

APPENDIX 1

Delivery against Internal Audit Plan for 2018/19 as at 28th February 2019

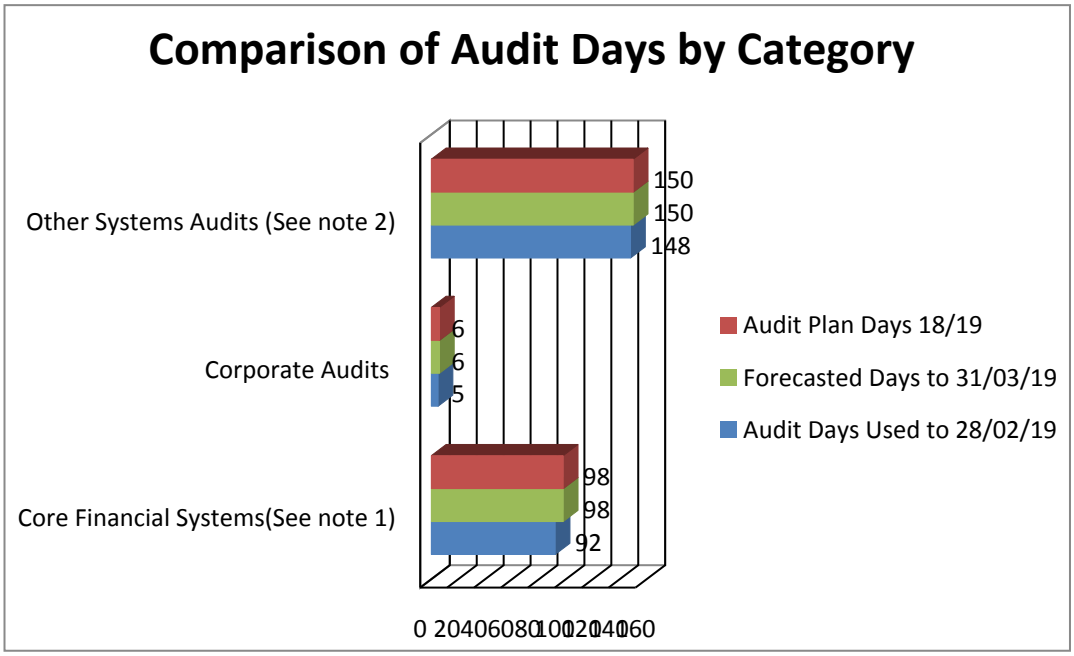
Audit Area	Original 2018/19 Plan Days	Forecasted days to the 31/03/19	AUDIT DAYS USED TO 28/02/19
Core Financial Systems (See note 1)	98	98	92
Corporate Audits	6	6	5
Other Systems Audits (See note 2)	150	150	148
Sub Total	**254**	**254**	**245**
Audit Management Meetings	30	30	21
Corporate Meetings / Reading	25	25	21
Annual Plans, Reports and Audit Committee support	18	18	10
Other chargeable (See note 3)	0	0	0
Sub Total	**73**	**73**	**52**
Total	**327**	**327**	**297**

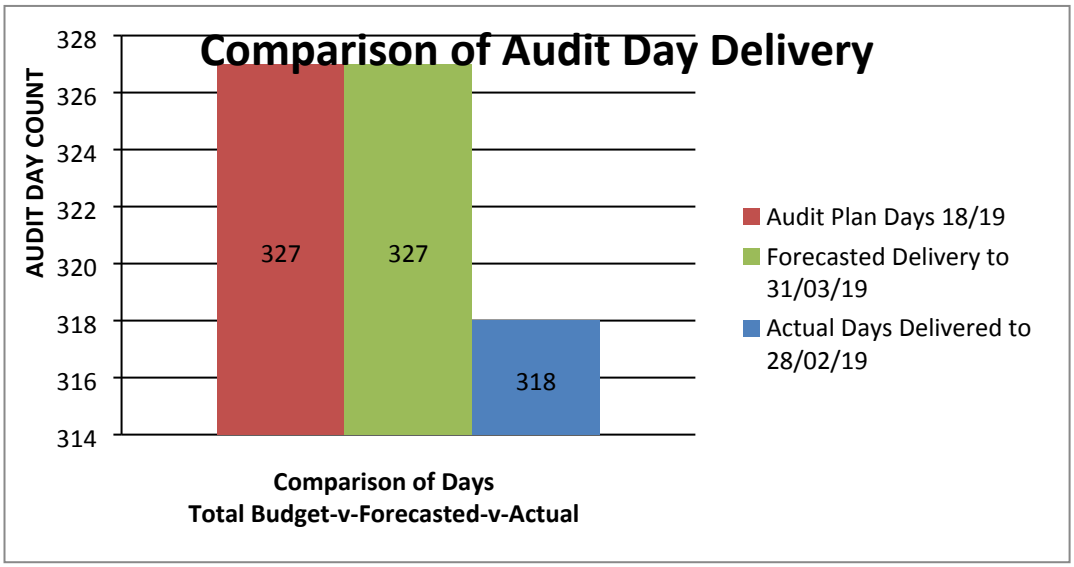
Audit days used are rounded to the nearest whole.

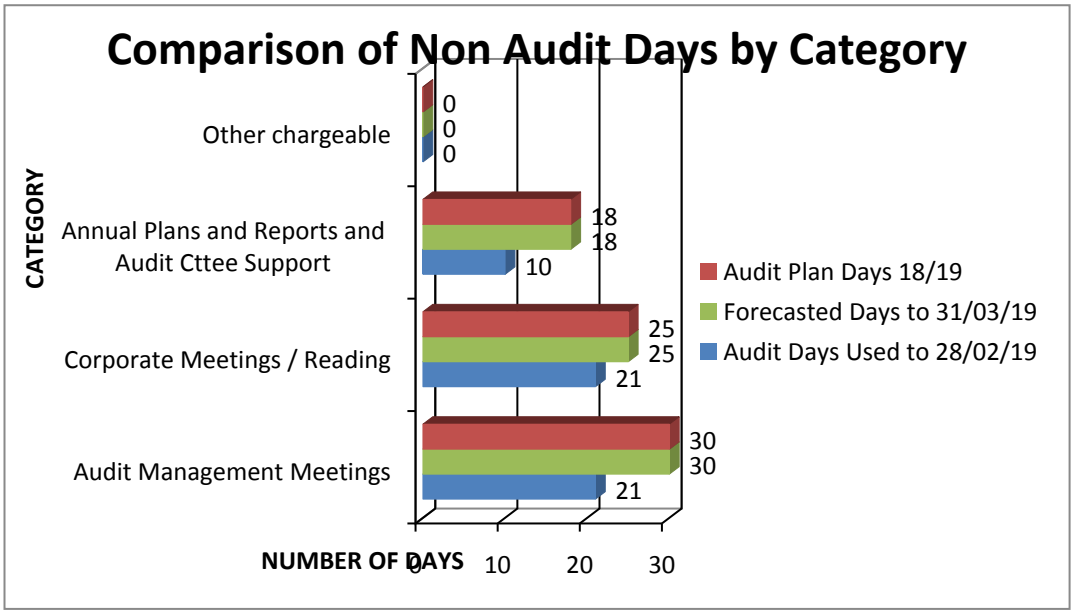
Note 1: This figure includes Quality Assurance monitoring work and the Revenues and Benefits Shared Service audit work undertaken. 'Core Financial Systems' are predominantly audited in quarters 3 and 4 in order to maximise the assurance provided for the Annual Governance Statement and Statement of Accounts. A rolling programme of testing has been introduced in 2018/19 the results of which will be reported in Q4.

Note 2: A number of the budgets in this section are 'on demand' (e.g. consultancy, investigations) so the requirements can fluctuate throughout the quarters. Over the last two quarters there has been a significant demand in regard to investigatory days for stage 2 complaints and other work. As a result there is an expectation that the original budget may be exceeded.

Note 3: IT issues which have led to interruptions in delivery and required resource to rectify are reflected in this figure.


Comparison of Audit Days by Category
Other Systems Audits (See note 2)
Corporate Audits
Core Financial Systems(See note 1)
150
150
148
6
6
5
98
98
92
0 20406080100120140160
Audit Plan Days 18/19
Forecasted Days to 31/03/19
Audit Days Used to 28/02/19


Comparison of Audit Day Delivery
AUDIT DAY COUNT
328
326
324
322
320
318
316
314
327
327
318
Comparison of Days
Total Budget-v-Forecasted-v-Actual
Audit Plan Days 18/19
Forecasted Delivery to 31/03/19
Actual Days Delivered to 28/02/19


Comparison of Non Audit Days by Category
CATEGORY
Other chargeable
Annual Plans and Reports and Audit Cttee Support
Corporate Meetings / Reading
Audit Management Meetings
0
0
0
18
18
10
25
25
21
30
30
21
NUMBER OF DAYS
0
10
20
30
Audit Plan Days 18/19
Forecasted Days to 31/03/19
Audit Days Used to 28/02/19

APPENDIX 2

Performance against Key Performance Indicators 2018-2019

The success or otherwise of the Internal Audit Shared Service will be measured against some of the following key performance indicators for 2018/19. Other key performance indicators link to overall governance requirements of Worcester City Council e.g. KPI 4 to 6. The 2018/19 position will be populated on a cumulative basis throughout the year.

WIASS operates within, and conforms to, the Public Sector Internal Audit Standards (as amended).

	KPI	Trend/Target requirement	2018/19 Position (as at 28th February 2019)	Frequency of Reporting
Operational				
1	No. of audits achieved during the year	Per target	Target = 12 (minimum) Delivered = 5 5 @ draft 6 in progress	When Audit Committee convene
2	Percentage of Plan delivered	>90% of agreed annual plan	91%	When Audit Committee convene
3	Service productivity	Positive direction year on year (Annual target 74%)	68%*	When Audit Committee convene
Monitoring & Governance				
4	No. of 'high' priority recommendations	Downward (minimal)	4	When Audit Committee convene
5	No. of 'moderate' or below assurances	Downward (minimal)	2	When Audit Committee convene
6	'Follow Up' results	Management action plan implementation date exceeded (nil)	0	When Audit Committee convene
Customer Satisfaction				
7	No. of customers who assess the service as 'excellent'	Upward (increasing)	1 returned as 'Good'	When Audit Committee convene

* Below target figure due to 4 new starters in April 2018. Training and mentoring has continued resulting in a positive trend in the productivity figure rising from 58% at the end of Q2 to 68% at the end of Q3.

APPENDIX 3

'HIGH' AND 'MEDIUM' PRIORITY RECOMMENDATIONS 2018/19

Ref.	Priority	Finding	Risk	Recommendation	Management Response and Action Plan
Audit: GDPR					
Overview: Hybrid Follow Up					
Assurance: N/a					
1	High	**Privacy Impact Assessments** Evidence has found that the introduction to the Privacy Impact Assessment form(s) is overdue.	The risk here is that if Privacy Impact Assessments are not undertaken during the initial scoping stage of projects, procurements, service delivery redesigns/changes it could lead to the organisation embedding non-compliant systems and working practises leading to increased financial costs and reputational damage.	It is recommended that the deadline is reconsidered for the completion of the Privacy Impact Assessment forms and a procedure agreed to introduce Privacy Impact Assessments as a mandatory requirement during the initial scoping stage of any project, procurement or service delivery redesign.	**Responsible Manager:** Team Manager – Corporate Projects and Transformation. **Implementation date:** 31st January 2019 A requirement to consider data protection impacts will be added to the project approval documentation
2	Medium	**Consent** **Photographs** From the testing it was evidenced that compliant photo consent forms	There is a risk associated with the	It is accepted that a pragmatic approach is	**Responsible Manager:** Communications Team Manager **Implementation date:** 31st March 2019 The communications service will

Ref.	Priority	Finding	Risk	Recommendation	Management Response and Action Plan
		are being used when taking new photos. However, historical photos lacking the enhanced consent requirements under GDPR are still being used depending on service needs and that these photos are not being chased for consent if used.	use of old photographs that are used without consent for marketing purposes potentially leading to, financial implications if leaflets, posters or other methods of promoting needed to be re-drafted as well as reputational damage through the media and in general if a complaint is lodged with the Information Commissioning Office.	required in order to transition the current arrangements for stock images in regard to marketing, events and communications. Existing photos to be phased out and replaced with appropriate compliant consented images over time. Old photos to be deleted immediately and transition to fully compliant and consented images within 6 months. All new photos must require the appropriate consent to prevent any potential financial implications or reputational damage.	review it's library of stock images and ensure that a plan is in place to phase out by March 2020 relevant images that are not covered by consent
3	Medium	**GDPR training** From the testing of the training log that was provided by People Services, it was identified that across the organisation not all staff completed the GDPR training and there was a little confusion as to who had already undergone GDPR training via other means.	There is a risk of reputational damage to the organisation as a whole if the mandatory training is not completed by staff potentially leading to breaches in the GDPR.	It is recommended that a clear protocol is established to ensure in future that mandatory training is taken by all staff regardless of the provider and recorded.	**Responsible Manager:** Head of Service, Human Resources & OD **Implementation date:** 31st March 2019 A record of training will form part of the Council's training plan for all staff and be monitored regularly by people services. Regular reviews will be undertaken and recorded.

Ref.	Priority	Finding	Risk	Recommendation	Management Response and Action Plan
4	Medium	**<u>Information Audit</u>** **<u>Delayed and outstanding Information Audit Registers</u>** From evidence found, not all information audit Registers were complete and signed off by the appropriate Head of Service or Deputy Director at the time of audit. This delay has impacted all aspects of the GDPR project and in the Council achieving compliance within the required timescales.	There is a risk to the Council of achieving compliance with The GDPR if the information audit registers are not completed as information could remain unidentified and retained longer that the business need and legal basis for holding potentially leading to damage to the reputation of the organisation, financial implications and ultimately resulting in the Council being non-compliant with The GDPR	It is recommended that copies of registers are obtained.	**Responsible Manager:** Deputy Director Commissioning and Delivery **Implementation date:** All registers are currently up to date with the exception of the newly transferred museums service which is under consideration. Updating of the registers is an ongoing process with responsibility resting with the individual service areas. Therefore, it is not considered to be an ongoing risk as identified at the time of the audit work.
Audit: Health and Safety					
Overview: Full System Audit					
Assurance: Limited					
1	High	**Record Keeping** When testing the current training records the following findings were found: -	Insufficient training records leading to a risk of having poor control over keeping training information	a) It is recommended to use the learning lounge for all primary records to allow monitoring per person(s).	**Responsible Manager:** Head of Operation Services Environmental Operations Projects Manager **Implementation date:** By April 2019

Ref.	Priority	Finding	Risk	Recommendation	Management Response and Action Plan
		1.) Leavers - There are names of staff that have left the organisation still on file at the depot and not being passed on to people services for appropriate recording. **2.) Record keeping - Training log sample testing –** After conducting testing on a sample size of 35 staff training records, it was identified that an individual had no manual training records in the training filing cabinet. 11 out of the 35 manual staff records tested at random were leavers and it was also difficult to identify when staff and agency staff had last received training and when they are next due to receive training. It was not easy to identify whether some documents had expired and staff are non-compliant. Training records e.g. corporate inductions and certification are not sufficient to accurately indicate the current position of all staff training should competency be challenged or to ensure that retraining is occurring.	up-to-date and relevant. There is also risk that the information is non-compliant and potential breach of legislation. Risk of knowledge gap due to poor communication between HR and management at the depot potentially leading to personnel operating machinery, etc. without the current certificates and relevant training.	b) It is recommended to consider that training and personnel record requirements are established for future reference between Operations and People Services and a timely update of training requirements is undertaken to ensure the workforce is fully compliant with legislative requirements and competent to use machinery thus ensuring all H&S requirements are complied with and documented. c) It is recommended to establish a control to ensure that when employees leave the organisation that all information is given to People Services to store rather than having the personal information of leavers being stored at the depot. d)If it is decided that documents are to be kept through a hard copy then an additional recommendation is to consider having a monthly FTE (Full Time Equivalent) report sent	a) H&S records- People Services Team Leader is lead manager for establishing the Learning Lounge as a means of centralised record keeping of all training. b) Will be building the Learning Lounge to ensure that all training records including induction, ongoing training and refresher training are recorded and provide automatic reminders when needed. Records will be assigned to each job role and will be established for agency workers as well as permanent staff. Environmental Operational Services (EOS) will agree job categories and packs and handbooks to be created for each role. Learning Lounge to be up and running by the end of March. Packs to be created by the end of March. Training of employees on risk assessments and safe operating procedures will continue using manual documents until Learning Lounge is updated to accept these records. c) All records will be checked and leavers' records will be passed to People Services. By end of financial year we will have cleansed all

Ref.	Priority	Finding	Risk	Recommendation	Management Response and Action Plan
				between people Services and the depot to confirm leavers, new starters and any changes to skills learnt to enhance communication levels.	records to ensure leavers are removed. d) There will be no hard copy records kept at the depot from April 2019 except for training on risk assessments and safe operating procedures as described in b).
2	High	**Corporate Inductions** It was identified that since May 2018 there has been no corporate health and safety inductions carried out at both the six ways depot and the Guildhall creating a risk of employees not following the correct protocol and some information that is meant to be passed on from a corporate perspective being missed. Although there are slides available on the learning lounge, staff at the depot that do not have access through a computer will miss this particular method of training which causes a barrier to their individual learning plans.	Staff that do not receive relevant and timely training potentially leading to a breach of legalisation, risk of injury or even death in service.	a) Mandatory training for each post has been identified and an induction programme should form part of this process. b) It is also recommended to start to introduce, for new starters who work at six ways depot, access to a computer on a particular date to complete a mandatory corporate induction online. Part of this recommendation is to also include agency staff to ensure that the site is fully compliant.	**Responsible Manager:** Head of Operation Services **Implementation date:** By April 2019 a) A face to face induction process is in place for all new employees, this is undertaken by the line manager (usually the supervisor) and there is an induction form used for this purpose. As above we will be building comprehensive sets of H&S documentation by post along with service handbooks for all members of staff. b) There are computers available at the depot for staff to undertake mandatory H&S training. We are about to pilot an i-pad at the depot to see if this makes it more accessible. Induction process will be reviewed and updated and in place from April 2019.

Ref.	Priority	Finding	Risk	Recommendation	Management Response and Action Plan
3	Medium	**<u>Active Monitoring</u>** From the assessment carried out, There is little proactive action being undertaken to assist with the identification of potential trends and subsequent training being deployed that would reduce the risk of reoccurrence.	There is a risk that accidents are repeating as there is no active monitoring occurring that can be evidenced potentially leading to a breach of legalisation, risk of injury or even death in service.	a) Using the data held it is recommended to start proactively looking at trends to see what areas of the depot accidents are occurring. Training plans for refresher training sessions for areas that seem more vulnerable to be formulated and deployed on a priority basis to reduce accident levels.	**Responsible Manager:** Head of Operation Services **Implementation date:** January 2019 a) Proactive accident and near miss monitoring will be regularly undertaken through a monthly report to the EOS management team from January 2019. This will assist in identifying training needs, review of risk assessments, safe operating procedures etc.
4	Medium	**First Aiders** Following the research carried out it was identified that the first aiders document which is available to staff at the depot is not including an expiry date for staff, which means there is a risk that the first aiders being shown may have a first aid course certificate which may have expired. Although there is a control in place regarding the training process and who fits in the yearly plan to undertake a first aid course, there is no date mentioned on the first aid sheet that the staff view, to state how recent the document is, although there is version control.	There is a risk that the first aiders' qualifications have expired meaning that they are not compliant to carry out first aid on staff potentially leading to a breach of legislation.	a) It is recommended that that there is clear indication on the document to show it is current version e.g. review date, version control, expiry date. b) It is also recommended that First Aiders and Fire Wardens are clearly identified throughout the site should there be an emergency situation and that their training is updated in a timely manner.	**Responsible Manager:** Environmental Operations Projects Manager **Implementation date:** Before end of December 2018 a) The document is already version controlled via the H & S Document Management database. Date will be added to notice displayed in buildings. NB First Aid and Fire Warden training will captured through the LL from April 2019. b) Both first aiders and fire wardens are already identified on the notices displayed on information boards. There is an

Ref.	Priority	Finding	Risk	Recommendation	Management Response and Action Plan
		Fire Wardens/ Trainers Although there is information regarding the procedures in place in case of a fire, there is no information around for staff or visitors to know who the Fire Wardens on site are.	In case of an emergency and a fire there is a risk that staff do not know who the fire wardens are or who to report to.		evacuation procedure which the trained fire wardens follow and are responsible in checking the building in an emergency. Training will be refreshed through the Learning Lounge as above.
end					

APPENDIX 4

Audit Report Follow Up Programme.

Audit	Year	Date Final Audit Report Issued	Service Area	Assurance	Number of High, Medium and Low priority Recommendations	FOLLOW UP		
						1st	2nd	3rd
						High and Medium Priorities 6mths after final report issued as long as implementation date has passed	High and Medium Priorities still outstanding 3mths after previous follow up as long as implementation date has passed	
2017/18								
Debtors	2017/ 18	28th June 2018	Finance	Moderate	The audit report made 1 high and 1 medium priority recommendations in relation to establishing protocol and authorisation signatories.	Follow up on the 31st October found that both recommendations were ongoing and had not been satisfied. This has been **escalated to the Head of Finance.**	Although reported as an exception, with the intervention this audit has now been satisfied. **No further follow up required.**	
2018/19								
Tourism Strategy	2018/ 19	7th October 2018	Economic Development	Moderate	The audit report made 1 high and 2 medium priority recommendations in relation to budget monitoring, action plan review and tourism marketing.	High priority recommendation has been satisfied in regard to budget monitoring. **Follow up planned for September 2019** to coincide with the completion of		

Audit	Year	Date Final Audit Report Issued	Service Area	Assurance	Number of High, Medium and Low priority Recommendations	FOLLOW UP		
						1st	2nd	3rd
						the implementation plan.		
H&S Operations	2018/ 19	20th December 2018	Cleaner Greener	Limited	The audit reported 2 'high', 2 'medium' and 1 'low' priority recommendations. Recommendations included; to review how training documents are kept, to consider going electronic through the learning lounge, to introduce mandatory training for each post, to update all first aider records so the site is compliant and to pro-actively look for near misses to help understand how to improve.	**Follow up to be undertaken in April 2019.**		
end								

Conclusion:

IA considers, overall, progress is being made by the respective managers and services with regard to the implementation of their action plans against reported Internal Audit recommendations. Although there are a couple of audits whereby work continues it is considered that there are legitimate reasons why this is the case (for example continuing development, or proposed system changes) or, non material risk items. Core financial audits are followed up as part of the annual audits.