Worcester
CITY COUNCIL

Report to: **Audit and Governance Committee, 6th December 2023**

Report of: **Interim Audit Team Leader, Worcestershire Internal Audit Shared Service**

Subject: **INTERNAL AUDIT PROGRESS REPORT FOR 2023/24**

1. Recommendations

1.1 That the Committee notes the report of progress against the 2023/24 Audit Plan; and

1.2 Agree the proposed revisions to the Plan.

2. Background

2.1 The Council is required under Regulation 6 of the Accounts and Audit Regulations 2018 to "maintain in accordance with proper practices an adequate and effective system of internal audit of its accounting records and of its system of internal control".

2.2 This report provides an update on Internal Audit's progress towards meeting its objectives as set out in the audit plan for 2023/24.

3. Summary of Activity:

3.1 A rolling testing programme on Debtors, Creditors and Payroll has been taking place during Q1 and Q2. Further testing in planned through Q3 with the results reported before Committee in Q4.

3.2 Twelve reviews were at planning, testing, clearance or draft report stage and four had been finalised as of 27 October 2023.

3.3 Follow up work has been continuing as part of the core financial and ICT reviews.

4. 2022/23 Internal Audit Plan Residual Reports

4.1 There has been one 2022/23 audit report finalised since the last progress report:

- Performance Measures (Quality Assurance)

4.2 The following reviews are at draft report stage awaiting final management sign off:

- Council Tax
- NNDR
- Benefits
- ICT
- Project Management

5. 2023/24 Internal Audit Plan

5.1 The Internal Audit Plan for 2023/24 approved by this committee was based upon a resource allocation of 300 productive days, as agreed with the Council's section 151 officer. Since this time, several pressures have been placed upon the service that have affected and will affect its ability to complete the annual audit plan. These include the loss of key personnel (Head of Service and Audit Team Leader). As a result, productive days have been reduced by 60 from 300 to 240 days.

5.2 The Interim Audit Team Leader and S151 officer have reviewed the current status of the plan and considered whether the number of planned audits can be reduced, or specific audits deferred, if it is prudent to do so from a risk assurance perspective.

5.3 As a result of this exercised it is proposed to defer the following audits to 2024/25:

- **Project Management (10 days)**
  Rationale: Previous review has only recently been finalised. Deferred to allow embedding of actions.
- **GDPR (Rolling Plan) (8 days)**
  Rationale: Original focus was on data retention; retention policies/procedures are currently being reviewed. Deferred to allow completion.
- **Stores (10 days)(low levels of stock**
  Rationale: low risk/de minimis.
- **Guildhall Risk Assessments & Safe Working Practices (10 days)**
  Rationale: This is an ongoing arrangement.
- **Town Fund (11 days**)
  Rationale: This is subject to external review and assurance.
- **IT Audit (Information Management & Cloud Services (6 days)**
  Rationale: Deferred due to allow resourcing.

5.4 The remaining balance of 5 days is derived from reductions in the scope of existing audits within the plan.

5.5 Audits that have commenced and are currently at planning, testing, clearance or draft report stage include:

- Procurement (Museums) (Clearance)
- Debtors
- Creditors
- Payroll
- Asset Ownership
- Grants (Incl. Members Grants, Home for Ukraine)
- Worcester Regulatory Services

5.6 There have been three 2023/24 audit reports finalised since the last progress report:

- Treasury Management (Substantial)
- Performance Data (Quality Assurance)
- Bereavement Services (Reasonable)

5.7 As work on the audits indicated above is classed as on-going or awaiting a management response a final 'Assurance' level will be assigned on completion along with the appropriate report being brought before the next available Committee.

5.8 Critical review audits are designed to add value to an evolving Service area. Depending on the transformation that a Service is experiencing at the time of a scheduled review a decision is made regarding the audit approach. Where there is significant change taking place due to transformation, restructuring, significant legislative updates or a comparison required a critical review approach will be used. To assist the service area to move forward, challenge areas will be identified using audit review techniques. The percentage of critical reviews will be confirmed as part of the overall outturn figure for the audit programme. To date, no critical review audits have been undertaken during 2023/24.

6. National Fraud Initiative (NFI)

6.1 WIASS provided a supporting role for all the Partners regarding the NFI exercise. All the 2022/23 data sets were uploaded by the deadlines and the matches received. Investigations regarding matches are being undertaken by the relevant Service area with appropriate action taken. Further uploads will be required for November 2023 onwards.

7. Follow-Up Audits

7.1 Follow up reviews are an integral part of the audit process. There is a rolling programme of review that is undertaken to ensure that there is progress with the implementation of the agreed action plans. The outcomes of the follow up reviews are reported in full at Appendix 3, where applicable, so the general direction of travel and the risk exposure can be considered by Committee. Any material exceptions arising from audit 'follow up' will be brought to the attention of the Audit Committee. There are no material exceptions to report.

8. Risk Management

8.1 Embedding the risk process continues and Committee will be appraised of the key risk areas on a regular basis. The Pentana system continues to be used to capture and report on risk.

Regular reporting has been established regarding risk information with updates being brought before this Committee as well as being presented before the Policy and Resources Committee. Risk registers are now well established for Services and are complemented by the corporate risk register. Key risks are also discussed at CMT level for business resilience and planning purposes.

9. Independence

9.1 WIASS delivers the audit programme in conformance with the International Standards for the Professional Practice of Internal Auditing (ISPPIA) as published by the Institute of Internal Auditors. WIASS recognise there are other review functions providing other sources of assurance (both internally and externally) over aspects of the Council's operations. Where possible WIASS will seek to place reliance on such work thus increasing the internal audit overall coverage. WIASS confirms it acts independently in its role as internal audit and applies safeguards where there is any potential for conflict of interest.

10. Appendices

10.1 Appendix 1 shows a summary of days delivered for the 2023/24 Internal Audit Plan. The figures are for the period 1 April 2023 to 27 October 2023.

10.2 Appendix 2 shows the progress and delivery against the indicative plan for 2023/24.

10.3 Appendix 3 provides the Committee with the 'Follow Up' audit report confirming recommendation implementation progress by management and identifying any exceptions.

10.4 Appendix 4 provides the Committee with copies of the finalised reports for 2022/23 and 2023/24.

Ward(s): **All**

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Background Papers: **None**

APPENDIX 1

Delivery against Internal Audit Plan for 2023/24 on 27 October 2023

Planned Days	Audit Budgets 2023/24	Actual Days Used 2023/24
Financials	53	13
Corporate Work	53	19
Systems Audits (Note 1)	124	71
Sub total	**230**	**103**
Audit management meetings Corporate meetings / reading Annual plans, reports and Audit Committee support	70	17
Sub total	**70**	**17**
Other chargeable (Note 2)	0	0
TOTAL Audit Days	**300**	**120**

Audit days used are rounded to the nearest whole.

Note 1:
'Systems Audits' include budgets which are used throughout the year as well as those budgets which are used for specific events (e.g. investigations/NFI Administration) on a draw down basis therefore the amount of days used can fluctuate across the quarters and can result in budgets not being fully used or being overspent due to additional resource being required.

Note 2:
'Other chargeable' days equate to times where there has been, for example, significant disruption to the IT provision resulting in lost productivity.

APPENDIX 2

Audit Area	Corporate Link	Risk Register link	Indicative Date	2023/24 Days	Current Position	Notes
Financial Services						
Debtors (incl advance payments)	Underpins City Plan requirements	CRK-002a	Rolling Programme	10	Testing underway	Light touch
Main Ledger/Budget Monitor/Bank Rec	Underpins City Plan requirements	CRK-002a	Rolling Programme	9	To commence Q3	Light touch
Creditors#	Underpins City Plan requirements	CRK-002a	Rolling Programme	0	Testing underway	Incl. in MHDC plan
Payroll	Underpins City Plan requirements	CRK-002a	Rolling Programme	10	Testing underway	Light touch
Treasury Management	Underpins City Plan requirements	CRK-002a	Rolling Programme	4	Completed	Light touch
Sub Total				33		
Council Tax*	Underpins City Plan requirements	FS-SRK-007	Q3	6	To commence Q4	partner split budget
Benefits*	Underpins City Plan requirements	FS-SRK-007	Q3	8	To commence Q4	partner split budget
NNDR*	Underpins City Plan requirements	FS-SRK-007	Q3	6	To commence Q4	partner split budget
TOTAL				53		
Corporate (incl CP&S)						
(IT Audit) Information Management & Cloud Services	Underpins City Plan requirements	CRK-012	Q2, Q4	6	Proposed deferred	South Worcestershire Focus
Project Management	Underpins City Plan requirements	HoS	Q3	10	Proposed deferred	PM leaving & embedding of new system
Asset Ownership	Sustaining and Improving our Assets	CRK-018	Q3	8	Testing underway	Phones – linking to piece of work Strategy are to do

Audit Area	**Corporate Link**	**Risk Register link**	**Indicative Date**	**2023/24 Days**	**Current Position**	Notes
Performance Data	Underpins City Plan requirements	HoS	Q1	5	Completed	Source data assurance
GDPR (Rolling Plan)	Underpins everything	HoS	Q4	8	Proposed deferred	
Grants (Incl. Member Grants, Homes for Ukraine)	Stronger and Connected Communities	CRK-002a	Rolling Programme	10	Planning stage	£2k Member grants, adhoc grant requirements
Disabled Facilities Grants (limited scope - grant issue sign off)	Stronger and Connected Communities	Statutory requirement for the provision of grant	Q2		Working with Millbrook & Worcestershire County Council	Annual requirement
SUB TOTAL				53		
Other Systems Audits						
Community						
Car parking	Stronger and Connected Communities	CS-SRK-004	Q4	15	To commence Q4	Cttee Chair Request
Operations						
Bereavement Services	Stronger and Connected Communities	CS-SRK-022	Q1	15	Completed	Full process and compliance check
Stores	Underpins City Plan requirements	HoS	Q2/Q3	10	Proposed deferred	Use, wastage & process
Training Records Hybrid Follow Up	Underpins City Plan requirements	OP-SRK-006	Q3/Q4	5	To commence Q4	Health and Safety link
Museums						
Procurement	Sustaining and Improving our Assets	MS-SRK-001	Q1 -Q4	10	Clearance Stage	Full process and compliance check
Legal, Democratic incl. Guildhall						
Guildhall Risk Assessments & Safe Working Practices	Sustaining and Improving our Assets	HoS	Q4	10	Proposed deferred	Critical friend to assist embedding

Audit Area	Corporate Link	Risk Register link	Indicative Date	2023/24 Days	Current Position	Notes
Strategic Housing						
Benefit Recharging	Stronger and Connected Communities	SH-SRK-026	Q2	9	To commence Q4	Maximise income from temp. accomm. claims
Economic Development and Planning						
Towns Fund	Sustaining and Improving our Assets	CRK-005	Q4	11	Proposed deferred	Delivery/management
Other Operational Work						
Contingency, advisory, consultancy (incl. H&S), fraud and enquiry and investigations incl. NFI	N/a	N/a	Q1 -Q4	19	Ongoing requirement	
Completion of prior year's audits	N/a	N/a	Q1 -Q3	8	Complete	
Report Follow Up (previous reviews)	N/a	N/a	Q1 -Q4	12	Ongoing requirement	
SUB TOTAL				124		
TOTAL				177		
Support budget incl: all meetings, annual planning, reports, committee support	N/a	N/a	Q1 -Q4	70	Ongoing requirement	
TOTAL				70		
TOTAL CHARGEABLE				300		

APPENDIX 3

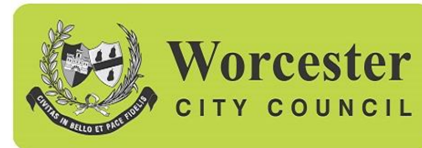
Follow Up Reporting During 2023/24

Since the last Committee Progress Report the follow ups have been part of the annualised core financial and ICT reviews. These form part of the audits and are not reported separately. There were no material exceptions to report regarding these follow up areas.

APPENDIX 4

Residual 2022/23 and 2023/24 Audit Reports

Worcestershire Internal Audit Shared Service



Internal Audit Report

Data Quality – Success Measures 2022-23

17th October 2023

Distribution:

To: Deputy Director, Policy and Strategy
Strategy, Performance and Development Officer

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1. Introduction

1.1 The audit of the Data Quality - Performance Measures was carried out in accordance with the Worcestershire Internal Audit Shared Service Audit Plan for Worcester City Council for 2022/23 as approved by the Audit Committee on 23rd March 2022. The audit looked at the quality of the data in relation to Performance Measures as operated by Worcester City Council.

1.2 Performance measures are linked to the following priorities:

- Enhancing and sustaining our beautiful city for future generations -
- stronger and Connected Communities
- A prosperous city
- Committed People

1.3 There was no risk on the Corporate Risk Register relevant to this review.

1.4 This review was undertaken during the months of September 2022 and April 2023

2. Audit Scope and objective

2.1. This review has been undertaken to provide assurance on the quality of the data provided for the reporting of Performance Measures.

2.2. Four performance measures were selected for testing across four service areas.

3. Detailed Findings and Recommendations

Ref	Performance Measure	Comments
Ci – PI - 001	**City Services** % of household waste recycled and composted	**Data** Reported on Pentana for Quarter 1 2022/23 Actual 37.1% against a target of 39% The data is received from Worcestershire County Council in the form of a spreadsheet. This will include details taken from weighbridge tickets and total weight. Any adjustments for unfit recycling are also included. **Process/Review** Once the spreadsheet is received from County Council. The information is manually transferred on the spreadsheet held within the service. The last month of each quarter is estimated taking into account, last year's performance as the figures received from County Council are not received until after the Committee Report is produced. Once County Council send the figures for the last month, they are entered on the Service Spreadsheet which will calculate the actual for the quarter. This usually has a minimal impact on the recycling percentage originally reported, dependant on how accurate the estimate was. **Reporting** The estimated figure is reported to committee. At the time of the review, the actual figures were not being recorded.

		Note 1
PS-PI-005	**Major Planning applications** PI Description (Speed) (P151) Major Planning Applications (Speed) (or within such extended period as has been agreed in writing between the applicant and the LPA)	**Data** Reported for Quarter 3 2022/23 on Pentana was 30/39 To get the interim quarter figure. Information is pulled through from the DEF system using the PS1/2 returns (the data sent to DLUHC). This is an estimate, and the published data can be slightly different, but it gives an indication for the scorecard. **Process/Review** From the DEF system, select PS1/PS2 report entering the dates required. View PS2 for the results. Results for Quarter 3 showed 6 Approved 0 within 13 weeks and 4 within agreed time. total 6/4 for the quarter. These reports are submitted quarterly by the Development Manager to DLUHC. In the meantime, the figures are estimated (replicated like the live tables) and the rolling 2-year figures are reported on Pentana. The estimated figures will be a quarter behind. Estimated live tables for the rolling 2-year period shows 39 major decisions and 7 cases within 13 weeks and 23 cases extra time totalling 30 (7+23) this works out to be 76.90% and recorded on Pentana is 77%. There were no written procedures. However, there is resilience within the team to carry out the reporting. **Reporting** The figures are estimated (replicated like the live tables) and the rolling 2-year figures are reported on Pentana. Once the figures are recorded on the Government website (Table P151a) they are checked against the estimated and will record on Pentana the actual percentage. At the time of the review the actual figures had not been entered onto Pentana. Actual figure for Quarter 3 is 75.7% therefore, there is a minimal variance between the actual and estimated figure. **Note 2**

HCPI 025	**Homeless prevention** % of successful homelessness preventions Percentage of homelessness approaches where their homelessness has been prevented for households that are owed a duty.	**Data** The data has been taken from the HCLICK report within the Jigsaw system. **Process/Review** Recreated Q1 01/04/2022 - 30/06/2022 Downloaded the readable version. Filter dates and cases closed in prevention. This came to a total of 90 cases. Further filter applied to remove unsuccessful prevention and only keep those where accommodation had been secured. This came to 46 cases. This was 1 extra to what had been reported on Pentana (45 cases) and was due to a case being corrected manually after the report had been produced. Recreated Q4 01/01/2022 - 31/03/2022 HCLIC figures 49/87 cases Recorded on Pentana 48/85 cases. The differences could be explained by the Strategic Housing Officer and figures on Pentana are correct. This is due to updates on live applications since the original report was issued. Recreated Quarter 3 01/10/2022 - 31/12/2022 Retested process - Downloaded readable version. Filtered dates and cases closed in prevention (secured accommodation 6 months, 12mths or more and secured existing accommodation 12 months or more) removed unsuccessful prevention and only reported cases where accommodation has been secured. Came to 38 cases out of 81 cases. This was 2 less cases than initially reported. Quarter 3 2022/23 Discrepancies. 1. Customer withdrew application on 9/11/22. They then reapproached in January 2023 and case was reopened (rather than making a new case). 2. A case may have been deleted – This will need to be investigated especially as cases fall under Housing retention policy. There were no written procedures and minimal resilience within the team to carry out the reporting.

		Reporting A copy of the Quarter 3 report used to report the data on Pentana had been saved. Therefore, this could be referred to in order to verify the accuracy of the data reported at that time. On all occasions when a new report was created for the various reporting period the data was slightly out. Other than for 1 case there was a satisfactory explanation for the variance. **Note 3**
HR -P1-001	**Sickness Absence (average Days)**	**Data** The Data originates from the information recorded by Goodshape and subsequently from Frontier. **Process/Review** Logon to Goodshape monthly to put off Sickness absences for the previous month. Manually delete any records to avoid duplication and where the sickness has rolled over to another month. Once the data has been cleansed the information is sent to Frontier who will input it into Chris 21. Data was re-created from the Original Q1 sickness worksheets referred to as 'Data Dump'. This information is then pulled through the spreadsheet using pivot tables to gain the average number of days. During the re-creation of the figures for Quarter 1 2022/23. There was a discrepancy, but this was explained, and Internal Audit were satisfied with the explanation. **Reporting** The information is transposed from the reports into pivot tables to work out the FTE average sickness for reporting. The FTE data is run every month and used to update the figures every quarter. Therefore, the average FTE Q is based on actual people rather than the posts. **Note 4**

Note 1 The data is reliant on third party information. This is then collated into a spreadsheet manually. The figures reported could not be verified as the spreadsheet had been updated with actual figures since the information was reported and recorded on Pentana**.** Only estimated figures are reported to Committee. The performance description does not advise that the information is calculated using 3rd party data and it is not clear when reporting to committee that the information is based on data provided by a third party.

Note 2 The title of the performance measure does not reflect this is an estimated rolling 2-year figure. There is a note on Pentana dated 4th August 2022 that refers to current Government figures are 80% to March. This is an error and should state 60%.

Note 3 There was no written procedures and minimal resilience within the team to carry out the reporting.

Note 4 While there are written procedures for Officers to follow to create the data reported for reporting. Training was still required to do this. The data is originating from a 3rd party. However, it is likely that the Service would notice if there was a discrepancy with the data.

4. Overall Conclusion

Waste

The review did not identify any issues with the quality of the data when walking through the process. However, the figures could not be replicated as the information is overwritten on the spreadsheet once updated information comes in from County. The data has been calculated in line with the agreed formula. Due to the timing of committee only estimates can be provided. This is made clear within the committee report. However, it would be useful for the actual to be presented to committee the following quarter to highlight any variance. Targets vary as they only run garden waste 9 months of the year, relevant to seasonal needs. There was an influx of waste during the pandemic due to people have a clear out within their homes and gardens. There is one other senior officer that could carry out this reporting in the event of the absence of the Officer, it would be advisable for a more detailed proforma template form detailing how the measure is calculated, information used is retained corporately or by the service for resilience.

Planning

This was a new measure introduced in 2022/23. The description doesn't reflect that the measure is based over a rolling 2-year period. The 60% target is a statutory target. The figures are taken from the DEF system for reporting and are reported as estimated to committee before the Government figures are published. The note on Pentana suggested that data was corrected with the government figures but there was no note what the revised figure was. There is no process note or description to record how to pull off these figures. it would be advisable for a more detailed proforma template form detailing how the measure is calculated, information used is retained corporately or by the service for resilience.

Housing

The data from the report at the time of reporting the KPI was correct. However, both times when the report was re-created it showed a variance in the number of cases. There were satisfactory explanations apart from 1 case which requires further investigation. The lead was unable to provide the reports used for the KPI and referred to another staff member. There is resilience within the team, but it would be advisable for a more detailed proforma template form detailing how the measure is calculated, where the data is extracted from and retained by the service for resilience.

Sickness

There are no issues with the data reported and these could be replicated with further explanation. While there are procedures, training is still required to carry out this task in order to work through the process to pull off the KPI's. It would be advisable for details of any alterations to the reports i.e., deletion of employees where the sickness rolls over to be kept in the event of a challenge. The performance measure on Pentana does not include the formula, therefore, it would be advisable for a proforma template form detailing how the measure is calculated is retained for resilience Especially as the data originated from a 3rd party and is manipulated in order to get the information needed for reporting.

Overall

Out of the four performance measures reviewed, two could be verified.

Only 1 performance measure had procedures held by the service on how to create the figures and there was no or minimal information on Pentana under the description.

For consistency, resilience, reference and in the event of a challenge a performance measures template or more detailed information recorded on Pentana advising of information such as the exact process to obtain the data, the systems used, names of reports, any formula's and possibly a worked example would be beneficial.

The review found it was not always the named lead on Pentana that is pulling off and verifying data used for reporting.

The performance measure should accurately describe what is being reported, especially for measures for example, where figures are estimated or cover a period such as a rolling 2 year.

Where spreadsheets are used to provide performance measure data there is a risk that due to a lack of resources spreadsheets may become out of date and therefore not useful for producing success measures. Where the data could change, the services should consider retaining a snapshot of the data used for reporting in the event of a challenge.

There is trust in information provided by third parties and for transparency when reporting, it should be made clear that the data is obtained from a third party.

Management Response – Deputy Director, Policy & Strategy
Actions General comments and trends regarding data quality arrangements for performance measures have been noted by the Deputy Director, Policy and Strategy and reported to Corporate Management Team.

Raise awareness of the Data Quality Policy for Performance Information and Data Quality principles in the Managing Director's bulletin, through training and as part of the Service Planning process.

Include additional details in Service Plan template 2024/25 for review of existing Performance Indicators (completed).

Make changes and add updates to performance measure on Ideagen as directed by Lead Officers / Service Managers (completed).

Officers Responsible
Deputy Director, Policy, and Strategy.

Strategy, Performance and Development Officer.

Implementation Date

16th October 2023 (Presented to Corporate Management Team)

Q3/Q4 2023/24 (Ongoing Works)

5. Independence and Ethics:

- WIASS confirms that in relation to this review there were no significant facts or matters that impacted on our independence as Internal Auditors that we are required to report.

- WIASS conforms with the Institute of Internal Auditors Public Sector Internal Audit Standards as amended and confirms that we are independent and able to express an objective opinion in relation to this review.
- WIASS confirm that policies and procedures have been implemented to meet the IIA Ethical Standards.
- Prior to and at the time of the audit no non-audit or audit related services have been undertaken for the Council within this area of review.

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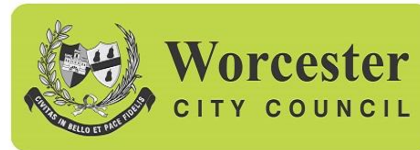
Worcestershire Internal Audit Shared Service



Internal Audit Report

Bereavements Service 2023-24

3rd October 2023

Distribution:

To: Head of City Services
Business Development Manager (Bereavement)

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6. Introduction

1.1 The audit of the Bereavements Service was carried out in accordance with the Worcestershire Internal Audit Shared Service Audit Plan for Worcester City Council for 2023/24 as approved by the Audit and Governance Committee on 22nd March 2023. The audit was a risk-based systems audit of the Bereavements Service as operated by Worcester City Council.

1.2 The objective and scope of this review were agreed after discussions with the Business Development Manager (Bereavements) The findings and recommendations were discussed at service level of management as these were service risks and not corporate risks.

1.3 This review relates to the Worcester City Council theme of stronger and connected communities.

1.4 There were no risks on the Corporate Risk register relevant to this review. The risks on the Service Risk Register relevant to this review were:

- CS-SRK-022 – Arrangements for Funeral/Cremation Services.

- CS-SRK-014 – Cremators.
- CS-SRK-002 – Cemetery and Crematorium Service Delivery Resilience.

1.5 There are controls in place to remove the risk of fraud.

1.6 This review was undertaken during the months of May and June.

7. Audit Scope and objective

7.1. The objective of this audit was to provide assurance that the service is operating with robust controls in place to ensure that policy, procedure, and service management are operating efficiently with due regard to continuous improvement and legal/statutory requirements.

7.2. The scope covered:

- Processes effectively achieve objectives, statutory and legal requirements. Procedural notes accurately reflect legal processes and staff are following procedures and breaches are resolved.
- There is robust training on service delivery, reviewed at regular intervals.
- Service management is effectively providing continuous improvement and business resilience.
- Legal and statutory requirements for documentation are fulfilled. There are robust controls in place to ensure compliance.

7.3. This testing covered the period from 1st November 2022 to 14th June 2023.

7.4. This was a 'back to basics' review, all processes of the service have been considered.

8. Audit Opinion and Executive Summary

8.1. From the audit work carried out we have given an opinion of **reasonable assurance** over the control environment in this area. The level of assurance has been calculated using a methodology that is applied to all Worcestershire Internal Audit Shared Service audits and has been defined in the "Definition of Audit Opinion Levels of Assurance" table in

Appendix A. However, it should be noted that statements of assurance levels are based on information provided at the time of the audit.

8.2. We have given an opinion of **reasonable assurance** in this area because there is a sound system of controls however testing has identified some weaknesses in controls.

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

- The service has robust controls around cremation applications ensuring it is legally compliant, acting diligently to ensure that it can deliver a service.
- Good customer service, sensitivity and core values are kept at the heart of the service ensuring the utmost respect for customers.
- There is good risk awareness. Potential impacts to the service are thoroughly assessed, plans are in place to ensure business continuity.
- The service is aware of its current limitations and is undergoing reviews to assess the opportunities available to it.

8.4. It is noted, regarding third party authentication, that the service has previously initiated communication and acted to the greatest extent of its control to ensure the service is able to deliver with confidence and compliance.

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

	Priority (see Appendix B)	**Section 4 Recommendation number**
Training Records and Compliance	**Medium**	**1**
Fireproof Documentation Storage	**Medium**	**2**
Procedural Records and Reviews	**Low**	**3**
Business Continuity Plan – Loss of Cremators	**Low**	**4**

9. Detailed Findings and Recommendations

The issues identified during the audit have been set out in the table below along with the related risks, recommendations, management responses and action plan. The issues identified have been prioritised according to their significance / severity. The definitions for high, medium and low priority are set out in the "Definition of Priority of Recommendations" table in Appendix B.

Ref.	Priority	Finding	Risk	Recommendation	Management Response and Action Plan
New matters arising					
1	M	**Training and Compliance** The service meets legislative requirements for training in crematorium and burial operations however council requirements are not being met. Not all mandatory council training is carried out within the Learning Lounge, however, at the time of the audit there was no evidence of training completion via alternative methods.	Non-compliance with council mandated policy and procedure. Risk of legal action from or against employees if training is not provided and serious incidents result. Reputational damage	Relevant training courses should be completed by staff, to ensure compliance, understanding and sign off. If there are problems with Staff access to computers, then other ways of delivering the training should be considered.	**Responsible Manager:** Business Development Manager (Bereavement) **Implementation Date:** Jan 2024 All staff prompted to check learning lounge and complete all mandatory training. All office staff now up to date 4 of the 6 outdoor staff now up to date. 2 require IT support which is in hand.

2	M	**Fireproof Documentation Storage** The service currently has no fireproof storage for documentation.	Destruction of key documentation leading to inefficiencies and inability to provide service. Assurance could not be provided over legal compliance regarding sign off. Heightened risk due to cremators and gas lines.	The service should procure fireproof documentation storage.	**Responsible Manager:** Operational Supervisor (Bereavement) **Implementation Date:** Jan 2024 To seek suitable fireproof storage for any sensitive documentation.
3	L	**Procedural Records and Reviews** Not all procedures on file reflect current service procedures in practise. There is no structured plan for the review of procedures. The procedures for 1st, 2nd and 3rd line checks are not recorded. Multiple procedures for cleaning have now been consolidated into one	Inefficiencies in working practises. Inconsistencies among staff performing procedures. Confusion among staff. Reputational damage	A review should ensure that procedures kept on file reflect current working practises. Dates for review should be added to each procedure as well as the business continuity plan, with a change log and updated upon completion of each review.	**Responsible Manager:** Operational Supervisor (Bereavement) **Implementation Date:** Jan 2024 To create procedure for statutory papers office checking system.

		procedure. The working files currently do not reflect this one procedure. The uniform log on file is not current, however an updated log is held elsewhere.		A paper copy of the service's business continuity plan should be made available in the event of IT or power infrastructure failure. Line check procedures to include process for managing high risk errors.	To consolidate any duplicate versions of policy's'/ procedure and date stamp. All risk now in online shared registers.
4	L	**Business Continuity Plan – Loss of Cremators** A dedicated plan for the loss of one or all cremators is in place but not recorded in written format.	Lack of clarity in actions required upon loss of cremators.	The business continuity plan should be amended to include the plan for the loss of cremators.	**Responsible Manager:** Business Development Manager (Bereavement) **Implementation Date:** Jan 2024 To add a section in BCP covering this that will include provision of mobile cremators or diversion to another local facility.

- **5. Independence and Ethics:**

- WIASS confirms that in relation to this review there were no significant facts or matters that impacted on our independence as Internal Auditors that we are required to report.
- WIASS conforms with the Institute of Internal Auditors Public Sector Internal Audit Standards as amended and confirms that we are independent and are able to express an objective opinion in relation to this review.
- WIASS confirm that policies and procedures have been implemented in order to meet the IIA Ethical Standards.
- Prior to and at the time of the audit no non-audit or audit related services have been undertaken for the Council within this area of review.

Adrian Howe
Interim Audit Team Leader
Adrian.howe@worcester.gov.uk

- # APPENDIX A

Definition of Audit Opinion Levels of Assurance

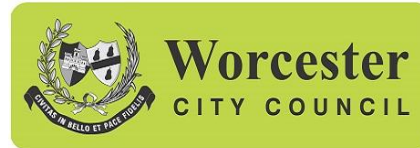
Opinion	Definition
Substantial Assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited
Reasonable Assurance	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.
Limited Assurance	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.
No Assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.

- # APPENDIX B

Definition of Priority of Recommendations

Priority	Definition
H	Fundamental control weaknesses that present a significant material risk to the function or system objectives and requires immediate attention by Senior Management.
M	Other control weaknesses where there are some controls in place but there are issues with parts of the control that need to be addressed by Management within the area of review.
L	Issues of best practise where some improvement can be made.

Worcestershire Internal Audit Shared Service



Final Internal Audit Report

Light Touch Treasury Management 2023-24

Date 2nd October 2023

Distribution:

To: Accountant
Head of Finance

CC: Director of Finance and Resources (S151 Officer)

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4. Opinion and Executive Summary 33
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10. Introduction

1.1 The light touch review of the Treasury Management system was carried out in accordance with the Worcestershire Internal Audit Shared Service Audit Plan for Worcester City Council for 2023/24 as approved by the Audit and Governance Committee on 22nd March 2023.

1.2 A full review of Treasury Management was carried out in 2021/22.

1.3 This review does not relate directly to the Councils five themes but does underpin them as the system is used for the investing of funds to achieve additional income from interest received.

1.4 There were no service or corporate risks identified which were relevant to this review.

1.5 There is a potential for fraud within this area with the fraudulent transfer of funds if controls are not working properly.

1.6 This review was undertaken during the month of September 2023.

11. Reasoning for the Light Touch Audit

11.1. There has not been any change to the key responsible officer for this area.

11.2. The last three years audits have given the following assurance:

Year	**Assurance**
2022/23	Light Touch (Full Assurance)
2021/22	Full Audit (Full Assurance)
2020/21	Light Touch Audit (Full Assurance)

12. Audit Scope

12.1. A sample of transactions from 1st April 2023 to 9th September 2023 were tested to ensure that.

- The investment could be traced out and back into the Council's bank account.
- Investments were made in line with the Treasury Management Policy/Strategy.
- Investments were authorised and interest had been correctly calculated and received.

13. Opinion and Executive Summary

4.1. If any major control/risk issues had been highlighted during the testing, then this would have been reported at the time.

4.2. From the audit work carried out we have given an opinion of 'substantial' over the control environment in this area. The level of assurance has been calculated using a methodology that is applied to all Worcestershire Internal Audit Shared Service audits and has been defined in the "Definition of Audit Opinion Levels of Assurance" table in Appendix A. However, it should be noted that statements of assurance levels are based on information provided at the time of the audit.

4.3. We have given an opinion of 'substantial' assurance in this area because there is generally a sound system of internal control with controls working as expected.

5. Independence and Ethics:

- WIASS confirms that in relation to this review there were no significant facts or matters that impacted on our independence as Internal Auditors that we are required to report.
- WIASS conforms with the Institute of Internal Auditors Public Sector Internal Audit Standards as amended and confirms that we are independent and able to express an objective opinion in relation to this review.
- WIASS confirm that policies and procedures have been implemented to meet the IIA Ethical Standards.
- Prior to and at the time of the audit no non-audit or audit related services have been undertaken for the Council within this area of review.

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- **APPENDIX B**

Definition of Priority of Recommendations

Priority	Definition
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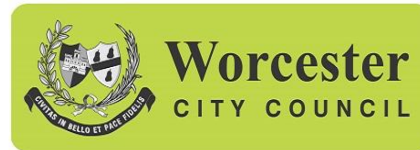
L	Issues of best practise where some improvement can be made.

Worcestershire Internal Audit Shared Service



Internal Audit Report

Performance Measures – Data Quality 2023-24

17th October 2023

Distribution:

To: Deputy Director, Policy and Strategy
Strategy, Performance and Development Officer

Contents

1. Introduction 38
2. Audit Scope and objective 38
3. Detailed Findings and Recommendations 39
4. Overall Conclusion 42
5. Independence and Ethics: 43

14. Introduction

1.1 The audit of Performance Measures - Data Quality, was carried out in accordance with the Worcestershire Internal Audit Shared Service Audit Plan for Worcester City Council for 2023/24 as approved by the Audit and Governance Committee on 22nd March 2023. The audit tested the data quality of the Performance Measures, as operated by Worcester City Council.

1.2 The following performance measures were tested for data quality:

- Ci-PI-016: % Of Street Assessed as Excellent or Acceptable Across Four Main Place.
- LS-PI-001: Active Participation at Leisure Centres
- MS-PI-005: Admissions and Commercial Income from City Museums

1.3 There were no Corporate Risk Register entries relevant to this review.

1.4 This review was undertaken during the months of May, June and July 2023.

15. Audit Scope and objective

15.1. The objective of this audit was to provide assurance that the quality of data reported under performance measures are accurate.

15.2. Three performance measures were selected.

15.3. This reviewed covered the period from April 2022 to March 2023.

16. Detailed Findings and Recommendations

Ref	Performance Measure	Findings and Recommendations	Service Managers Response
Ci-PI-016	**City Services** % Of Street Assessed as Excellent or Acceptable Across Four Main Place	**Findings** The assessors' forms (source data) are not retained. Data from these forms is input into an Excel spreadsheet that has been tested, however testing was not able to provide assurance that data had been entered correctly from the source data. Errors in Excel formulas cell ranges meant results reported to Pentana/Ideagen did not capture all the available data. This however did not impact the overall results as the graded brackets were large enough to accommodate any variance. **Recommendations** Retain the assessors' forms (source data) in an appropriate format to the service. Review the Performance Indicator Results Spreadsheet to ensure all data is captured within formula cell ranges.	**Action 1** Completed assessment sheets stored for 15 months, removed on a rolling basis. **Manager Responsible** Environmental Operations Team Manager (Street Scene) **Implementation Date** Implemented as of July 2023/24 **Action 2** Excel Spreadsheet formula corrected to include all data cells. **Manager Responsible** Environmental Operations Team Manager (Street Scene) **Implementation Date**

			Implemented as of July 2023/24
LS-PI-001	**Contracts and Leisure Team** Active Participation at Leisure Centres	**Findings** Data provided for this performance measure is received from a third party. The Pentana/Ideagen description does not reflect this. **Recommendations** The Pentana/Ideagen description should make explicit any third-party data reported.	**Action 1** The description on Pentana/Ideagen is to be updated to specify third-party origins of data. **Manager Responsible** Contracts and Performance Manager **Implementation Date** Implemented as of July 2023/24
MS-PI-005	**Museum Services** Admissions and Commercial Income from City Museums	**Findings** Café income has not been consistently reported. In quarters 1 and 4 of 2022/23, one or more cafes income has been omitted. Income from both cafes for quarter 2 has been reported with the addition of the museum and art gallery café quarter 1 figures. Checks against reported café income from third parties are not performed. Testing revealed an error in the reported income totals. It is unknown if café income includes vatable goods. The Pentana/Ideagen performance indicator description makes no reference to third party provision of data included within the reported figures. **Recommendations** Corrections should be made to the reported data held on Pentana/Ideagen to ensure accuracy. Future reporting must be consistent and include both cafes.	**Action 1** Adjustment of the internal monthly PI collection spreadsheet to make the combined figure for transferring to Pentana/Ideagen clear. When data is received late and thus has been omitted from Pentana/Ideagen reporting, this should be noted. **Manager Responsible** Museums Manager **Implementation Date** Implemented as of July 2023/24

		Basic checks should be performed to ensure the accuracy of third-party data. The Pentana/Ideagen description should make explicit any third-party data reported.	**Action 2** Quarterly income reports from cafes to be checked for accuracy and adjusted as needed. Discussion with café licensees to ensure VATable goods are reported correctly to enable accurate calculation of the licence fee. **Manager Responsible** Museums Audiences Manager **Implementation Date** December 2023/24 **Action 3** PI description to be updated to reference third party information. **Officer Responsible** Strategy, Performance and Development Officer **Implementation Date** Implemented as of October 2023/24
Management Response – Deputy Director, Policy & Strategy			

Actions

General comments and trends regarding data quality arrangements for performance measures have been noted by the Deputy Director, Policy and Strategy and reported to Corporate Management Team.

Raise awareness of the Data Quality Policy for Performance Information and Data Quality principles in the Managing Director's bulletin, through training and as part of the Service Planning process.

Include additional details in Service Plan template 2024/25 for review of existing Performance Indicators (completed).

Make changes and add updates to performance measure on Ideagen as directed by Lead Officers / Service Managers (completed).

Officers Responsible
Deputy Director, Policy, and Strategy.

Strategy, Performance and Development Officer.

Implementation Date

16th October 2023 (Presented to Corporate Management Team)

Q3/Q4 2023/24 (Ongoing Works)

17. Overall Conclusion

Assurance can be given that 2 of the 3 tested performance measures are accurate, despite minor errors, these were '% of

Street Assessed as Excellent or Acceptable Across Four Main Place' and 'Active Participation at Leisure Centres'. Assurance cannot be given over the accuracy of 'Admissions and Commercial Income from City Museums' at this time.

- **5. Independence and Ethics:**

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