BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Date: 22nd July 2020

THE INTERNAL AUDIT PROGRESS REPORT OF THE HEAD OF THE INTERNAL AUDIT SHARED SERVICE ~ WORCESTERSHIRE INTERNAL AUDIT SHARED SERVICE.

Relevant Portfolio Holder	Councillor Geoff Denaro
Portfolio Holder Consulted	Yes
Relevant Head of Service	Chris Forrester, Financial and Customer Services
Ward(s) Affected	All Wards
Ward Councillor(s) Consulted	No
Key Decision / Non-Key Decision	Non–Key Decision

1. SUMMARY OF PROPOSALS

1.1 To present:

- the monitoring report of internal audit work for 2020/21 and residual 2019/20 work.

2. RECOMMENDATIONS

2.1 **The Committee is asked to note the report.**

3. KEY ISSUES

Financial Implications

3.1 There are no direct financial implications arising out of this report.

Legal Implications

3.2 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".

Service / Operational Implications

3.3 The involvement of Members in progress monitoring is considered to be an important facet of good corporate governance, contributing to the internal control assurance given in the Council's Annual Governance Statement.

3.4 This section of the report provides commentary on Internal Audit's performance for the period 01st April 2020 to 30th June 2020 against the performance indicators agreed for the service.

3.5 Summary Dashboard:

Total reviews planned for 2020/21:	13 minimum	
Reviews finalised to date for 2020/21:	0	
Assurance of 'moderate' or below:	0	
Reviews currently awaiting final sign off:	1	
Reviews ongoing:	3	
Reviews to be commenced (Q2 to 4):	14	
Number of 'High' Priority recommendations reported to date:		0
Satisfied 'High' priority recommendations to date:		0
Productivity:	50% (against targeted 74%)	
Overall plan delivery to date:	10% (against target >90%)	

2019/20 AUDIT REPORTS ISSUED/COMPLETED SINCE THE LAST PROGRESS REPORT (5th March 2020):

3.6 In summary they are:

- Safeguarding
- Debtors
- Creditors
- NNDR
- Main Ledger
- Health & Safety (Hybrid follow up)
- Worcestershire Regulatory Services
- Benefits (Draft)
- IT (Draft)
- Business Continuity (Draft)

Reports finalised	7
'High' priority recommendations reported	1
'Medium' priority recommendations reported	8
'Low' priority recommendation reported	3
'Moderate' or above assurances	6
'Limited' or below assurances	Nil

Full reports are contained at Appendix 3. Health and Safety Hybrid findings have already been reported to Committee and are not included in the above figures.

All 'limited' assurance reviews go before CMT for full consideration.

3.7 2020/21 AUDITS ONGOING AS AT 30th June 2020

Audits progressing through clearance or draft report awaiting management sign off stage include:

- Orb

Audits progressing through testing stage included:

- Health and Safety
- Use of Agency and Consultants
- Creditors (rolling review)

The summary outcome of the above reviews will be reported to Committee in due course when they have been completed and management have confirmed an action plan.

A rolling testing programme on Debtors and Creditors is undertaken during quarters 1 to 3 inclusive. The rolling testing programme results will be amalgamated as at the end of quarter 3 and formal audit reports issued during quarter 4.

The 2020/21 plan will reflect the delayed start and certain lesser risk reviews may need to be rolled to next years plan. Priority will be given to potentially higher risk areas e.g. limited assurance audits. As we return to the new normal the impact of restrictions of the COVID-19 lockdown on the plan will be closely managed as the year progresses. The plan for 2020/21 will therefore remain very flexible but the core financial areas of the business will be considered and reported on and there is sufficient coverage for the Head of Internal Audit to provide an overall opinion. Committee will be regularly informed of developments throughout the year and any variations to the plan will be overseen by the Executive Director and s151 Officer.

3.8 AUDIT DAYS

Appendix 1 shows that progress continues to be made towards delivering the Internal Audit Plan and achieving the targets set for the year. As at 30th June 2020 a total of 24 days had been delivered against a target of 230 days for 2020/21.

Appendix 2 shows the performance indicators for the service. These indicators were agreed by the Audit, Standards and Governance Committee on the 5th March 2020 for 2020/21.

Appendix 3 provides copies of the reports that have been completed and final reports issued.

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

3.9 OTHER KEY AUDIT WORK

Much internal audit work is carried out "behind the scenes" but is not always the subject of a formal report. Productive audit time is accurately recorded against the service or function as appropriate. Examples include:

- Governance for example assisting with the Annual Government Statement

- Risk management
- Transformation review providing support as a critical review
- Dissemination of information regarding potential fraud cases likely to affect the Council
- Drawing managers' attention to specific audit or risk issues
- Audit advice and commentary
- Internal audit recommendations: follow up review to analyse progress
- Day to day audit support and advice for example control implications, etc.
- Networking with audit colleagues in other Councils on professional points of practice
- National Fraud Initiative over view.
- Investigations

3.10 **National Fraud Initiative**

There has been on going work undertaken in regard to the National Fraud Initiative. This year is the 2 yearly cycle of data extraction and uploading to enable matches to be reported. Worcestershire Internal Audit Shared Service (WIASS) has a coordinating role in regard to this investigative exercise in Bromsgrove District Council. The data requirements were uploaded during October and December 2018 with any queries dealt with accordingly. Potential matches have been returned to the Authority for investigation. A further upload of Council Tax single person data and Elections was completed in January 2020. WIASS have a watching brief in regards to these uploads. A further substantial upload of data is due to take place in December 2020.

3.11 **Monitoring**

To ensure the delivery of the 2020/21 plan and any revision required there is close and continual monitoring of the plan delivery, forecasted requirements of resource – v – actual delivery, and where necessary, additional resource will be secured to assist with the overall Service demands. The Head of Internal Audit Shared Service remains confident his team will be able to provide the required coverage for the year over the authority's core financial systems, as well as the revised plan for other systems which have been deemed to be 'high' and 'medium' risk. Due to changing circumstances and the impact of the COVID-19 pandemic a variation in the plan will be required. This will be agreed on a risk priority basis with the s151 Officer as the year progresses. With any adjustment to the plan there will remain comprehensive audit coverage for 2020/21.

3.12 **Quality Assurance Improvement Plan**

3.13 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. Further improvements may be identified through the self assessment process which is due to be carried out by the end of August 2020 and will be reported to Committee.

3.14 **Customer / Equalities and Diversity Implications**

There are no implications arising out of this report.

3.15 WIASS is committed to providing an audit function which conforms to the Public Sector Internal Audit Standards (as amended). 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 we will seek to place reliance on such work thus reducing the internal audit coverage as required.

3.16 WIASS confirms it acts independently in its role and provision of internal audit.

4. RISK MANAGEMENT

The main risks associated with the details included in this report are:

- failure to complete the planned programme of audit work for the financial year; and,
- the continuous provision of an internal audit service is not maintained.

5. APPENDICES

Appendix 1 ~ Internal Audit Plan delivery 2020/21
Appendix 2 ~ Plan position and key performance indicators 2020/21
Appendix 3 ~ Finalised audit reports including definitions
Appendix 4 ~ Finalised 'follow-up' reports.

6. BACKGROUND PAPERS

Individual internal audit reports are held by Internal Audit.

7. KEY

N/a

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BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Date: 22nd July 2020

APPENDIX 1

Delivery against Internal Audit Plan for 2020/21
1st April 2020 to 30th June 2020

Audit Area	2020/21 Total Planned Days	Forecasted days to the 30th September 2020	Actual Days Used to the 30th June 2020
Core Financial Systems (see note 1)	60	6	4
Corporate Audits	66	28	13
Other Systems Audits (see note 2)	68	35	2
SUB TOTAL	**194**	**69**	**19**
Audit Management Meetings	15	8	3
Corporate Meetings / Reading	5	3	1
Annual Plans, Reports and Committee Support	16	8	1
Other chargeable (see note 3)			
SUB TOTAL	**36**	**19**	**5**
TOTAL	**230**	**88**	**24**

Notes:

Audit days used are rounded to the nearest whole.

Note 1: Core Financial Systems are audited predominantly in quarters 3 and 4 in order to maximise the assurance provided for Annual Governance Statement and Statement of Accounts but not interfere with year end. A rolling programme has also been introduced for Debtors and Creditors to maximise coverage and sample size. The results will be reported during Q4.

Note 2: A number of the budgets in this section are 'on demand' (e.g. consultancy, investigations) so the demand can fluctuate throughout the quarters.

Note 3: 'Other chargeable' days equate to times where there has been, for example, significant disruption to the IT provision resulting in lost productivity.

* Where the forecasted days are less than the planned days for the year this reflects the adjustments that have been made to the plan during the year.

BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Date: 22nd July 2020

APPENDIX 2

Audit Plan Position as at the 30th June 2020

Audit Area	Planned days 2020/21	Proposed Review	Current Position and indicative delivery date		Assurance
Accountancy & Finance Systems					
Debtors	9	Full	To commence	Q3/4	
Main Ledger/Budget monitoring/bank rec	10	Full	To commence	Q3/4	
Creditors	9	Full	Rolling review commenced	Q3/4	
Treasury Management	6	Full	To commence	Q2	
Council Tax	8	Full	To commence	Q3/4	
Benefits	10	Full	To commence	Q3/4	
NNDR	8	Full	To commence	Q3/4	
SUB TOTAL	**60**				
Corporate					
IT	8	Full	To commence	Q4	
Risk Management	6	Critical Friend Support	To commence	Q1/ 4	
Health and Safety	7	Limited Focus	Testing commenced	Q1/ 2	
Procurement	8	Full	To commence	Q4	
GDPR	8	Limited Focus	To commence	Q4	
Orb	9	Full	Clearance	Q1	
Use of Agency & Consultants	9	Full	Planning	Q2	
Projects	11	Critical Friend	To commence	Q4	
SUB TOTAL	**66**				
System / Management Arrangements					
Refuse Service Scalability	6	Limited Scope	To commence	Q4	
Markets	10	Limited Scope	To commence	Q2	
Worcester Regulatory Services	10	Limited Scope	To commence	Q4	
Advisory and Consultancy	10	Pull Down Budget	Q1 – Q4		N/a
Fraud and Investigations inc. NFI	10	Pull Down Budget	Q1 – Q4		N/a
Completion of prior years work	8	Pull Down Budget	Q1 – Q4		N/a
Report follow up	10	Pull Down Budget	Q1 – Q4		N/a
Statement of Internal Control	4	Pull Down Budget	Q1 – Q4		N/a
SUB TOTAL	**68**				

BROMSGROVE DISTRICT COUNCIL

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Date: 22nd July 2020

General				
Audit Management Meetings	15	Pull Down Budget	Q1 – Q4	N/a
Corporate Meetings/Reading	5	Pull Down Budget	Q1 – Q4	N/a
Reports, Annual Plans and Committee Support	16	Pull Down Budget	Q1 – Q4	N/a
SUB TOTAL	**36**			
PLAN TOTAL	**230**			

Performance against Key Performance Indicators 2020-2021

The success or otherwise of the Internal Audit Shared Service will be measured against some of the following key performance indicators for 2020/21. Other key performance indicators link to overall governance requirements of Bromsgrove District Council e.g. KPI 4. The position will be reported on a cumulative basis throughout the year.

	KPI	Trend/Target requirement	2020/21 Position (as at 30th June 2020)		Frequency of Reporting
Operational					
1	No. of audits achieved during the year	Per target	Target = Minimum 13 Delivered = Nil to date	😐	When Audit Committee convene
2	Percentage of Plan delivered	>90% of agreed annual plan	10%	😟	When Audit Committee convene
3	Service productivity	Positive direction year on year (Annual target 74%)	50%	😟	When Audit Committee convene
Monitoring & Governance					
4	No. of 'high' priority recommendations	Downward (minimal)	0 (2019/20 = 9)	😐	When Audit Committee convene
5	No. of moderate or below assurances	Downward (minimal)	0 (2019/20 = 7)	😐	When Audit Committee convene
6	'Follow Up' results	Management action plan implementation date exceeded (nil)	Nil to report	🙂	When Audit Committee convene
Customer Satisfaction					
7	No. of customers who assess the service as 'excellent'	Upward (increasing)	Nil returns to date	😐	When Audit Committee convene

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

APPENDIX 3

2019/20 Residual Audit Reports.

Appendices A & B are indicated below and are applied to all reports. To save duplication these have been produced once, listed below and removed from the reports.

APPENDIX A

Definition of Audit Opinion Levels of Assurance

Opinion	Definition
Full Assurance	The system of internal control meets the organisation's objectives; all of the expected system controls tested are in place and are operating effectively. No specific follow up review will be undertaken; follow up will be undertaken as part of the next planned review of the system.
Significant Assurance	There is a generally sound system of internal control in place designed to meet the organisation's objectives. However isolated weaknesses in the design of controls or inconsistent application of controls in a small number of areas put the achievement of a limited number of system objectives at risk. Follow up of medium priority recommendations only will be undertaken after 6 months; follow up of low priority recommendations will be undertaken as part of the next planned review of the system.
Moderate Assurance	The system of control is generally sound however some of the expected controls are not in place and / or are not operating effectively therefore increasing the risk that the system will not meet it's objectives. Assurance can only be given over the effectiveness of controls within some areas of the system. Follow up of high and medium priority recommendations only will be undertaken after 3 to 6 months; follow up of low priority recommendations will be undertaken as part of the next planned review of the system.
Limited Assurance	Weaknesses in the design and / or inconsistent application of controls put the achievement of the organisation's objectives at risk in many of the areas reviewed. Assurance is limited to the few areas of the system where controls are in place and are operating effectively. Follow up of high and medium priority recommendations only will be undertaken after 3 months; follow up of low priority recommendations will be undertaken as part of the next planned review of the system.
No Assurance	No assurance can be given on the system of internal control as significant weaknesses in the design and / or operation of key controls could result or have resulted in failure to achieve the organisation's objectives in the area reviewed. Follow up of high and medium priority recommendations only will be undertaken after 3 months; follow up of low priority recommendations will be undertaken as part of the next planned review of the system.

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

APPENDIX B

Definition of Priority of Recommendations

Priority	Definition
H	Control weakness that has or is likely to have a significant impact upon the achievement of key system, function or process objectives. Immediate implementation of the agreed recommendation is essential in order to provide satisfactory control of the serious risk(s) the system is exposed to.
M	Control weakness that has or is likely to have a medium impact upon the achievement of key system, function or process objectives. Implementation of the agreed recommendation within 3 to 6 months is important in order to provide satisfactory control of the risk(s) the system is exposed to.
L	Control weakness that has a low impact upon the achievement of key system, function or process objectives. Implementation of the agreed recommendation is desirable as it will improve overall control within the system.

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Worcestershire Internal Audit Shared Service

Final Internal Audit Report

Safeguarding - Children 2019/20
(Evidence to Support the Section 11 Audit Return)

5th March 2020

Distribution:

To: Head of Community and Housing Services
Head of Transformation, Organisational Development and Digital Services
Human Resources & Development Manager
Cc: Chief Executive
Executive Director and Deputy Chief Executive
Executive Director and Section 151 Officer

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Contents

1. Introduction

1.1. The audit of the safeguarding of children was carried out in accordance with the Worcestershire Internal Audit Shared Service Audit Plan for Redditch Borough Council and Bromsgrove District Council for 2019/20 as approved at the Audit, Governance and Standards Committee and the Audit, Standards and Governance Committee on 29th July 2019 and 18th July 2019 respectively. The audit was a risk based systems audit of the safeguarding of children as operated by Redditch Borough Council and Bromsgrove District Council.

1.2. The strategic purpose that this Underpins is Keep my Place Safe and Looking Good

1.3 There are no risks recorded on the corporate register in relation to this review.

The following entries on the service risk register are relevant to this review:

- COM 3 – Safeguarding – Inadequate child and adult protection systems/process

1.4 Statutory guidance included within the Working Together to Safeguard Children (2013) document requires local Safeguarding Children's Boards to gather data to assess whether partners are fulfilling their statutory obligations under section 11 of the Children Act 2004. The Worcestershire Safeguarding Children's Board, (now known as the Worcestershire Safeguarding Children's Partnership), requires that such a self-assessment should be made every two years. The section 11 'audit' for Redditch Borough Council and Bromsgrove District Council was last completed and submitted to the Worcestershire Safeguarding Children Board by the Head of Community Services on behalf of both Councils in February 2018.

1.5 This review was undertaken during the months of September and October 2019. .

2. Audit Scope and objective

2.1. This review has been undertaken to provide assurance that;

- The evidence stated in support of the last Section 11 audit response return is relevant, reliable and up to date.
- Critically review the procedures relating to the recruitment of staff and volunteers for those related to DBS (Disclosure and Barring Service) please place in full requirements including the renewal process and the decision making as to when DBS are appropriate and at what level. (**See Section 5 below**)

2.2. The scope covered:

- The most recent Section 11 assessment undertaken.
- Policy and procedures for DBS checks and renewals in relation to safeguarding.

2.3. This reviewed covered the last completed Section 11 assessment and DBS check procedures in place at the time of the audit and incorporated a critical friend review of the procedures relating to the recruitment of staff and volunteers for those related to DBS requirements including the renewal process and the decision making as to when DBS are appropriate and at what level.

2.4 This review did not provide sufficient evidence to give absolute assurance that the Council is meeting its Legislative and Regulatory duties and responsibilities in relation to safeguarding.

3. Audit Opinion and Executive Summary

3.1. From the audit work carried out we have given an opinion of **moderate 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.

3.2. We have given an opinion of **moderate assurance** in this area because there is a sound system of control in place but that some of the expected controls are not in place and / or are not operating effectively therefore assurance can only be given over the effectiveness of controls within some areas of the system.

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

- The Council has formally documented its Safeguarding Policy and procedures and these are made accessible to office based staff and Members via the Orb. The Safeguarding Policy includes named designated Safeguarding Advisers to act as safeguarding leads.
- Experienced Safeguarding Leads.
- Knowledge, pro-activeness and involvement of the Community Safety Team in educating children and advising where they can seek help in relation to maltreatment and abuse.
- The safeguarding awareness, knowledge and procedures within the Family Support Service.

3.4 The audit has identified through the last Section 11 Return, areas for improvement which include the need to retain evidence which should be retained in an easy accessible file. This will assist with future completion of the Section 11 Audit Response and will allow it to be presented within a timely manner if requested by Worcestershire County Council or as part of a serious case review.

Due to the number of employees, members, volunteers and agency workers within Bromsgrove District Council and Redditch Borough Council, it would be advisable to review the number of safeguarding leads to ensure there is sufficient availability, knowledge and presence within both authorities. The Safeguard Lead has responded to this advising that it is felt that there are sufficient safeguarding leads for BDC and RBC. The primary role of the safeguard lead within RBC and BDC is to discuss, provide advice/guidance and support referrals as appropriate to children's services. All leads are shared managers so whilst their primary offices are in RBC they do work from Parkside and are accessible at all times by phone. The 3 Leads operate a rota for cover so one Lead is always on duty plus the Deputy Chief Executive is the strategic lead.

Due to the consequences to a child of child neglect the authority must not become complacent and must ensure they have robust processes in place including training records to deliver, co-ordinate, monitor and record safeguarding training to staff. A good awareness of safeguarding concerns within all service areas of Bromsgrove and Redditch is important in order to identify trends and implement or change policy when required.

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

	Priority (see Appendix B)	**Section 4 Recommendation number**
Safeguarding Training & Monitoring of the Training	**High**	**1**
Commissioned Services	**Medium**	**2**
Safeguarding Policy April 2019	**Medium**	**3**
Whistleblowing	**Medium**	**4**
Literature	**Low**	**5**
Knowledge Sharing	**Low**	**6**

3.6 There were some areas of the system that audit have challenged Management on:

Challenge	Section 5 Challenge number
DBS Checks	1

4 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 – From the review of the evidence supporting the Section 11 Audit - Return Completed February 2018					
1	H	**Training and Monitoring** The manual safeguarding training records held and referred to within the section 11 was incomplete. Therefore there was no up to date record that evidenced staff that do not receive the net consent training including operational staff, agency staff and volunteers, had been trained. The training record shows that staff have been reminded that their safeguarding training is outstanding. However	Lack of Co-ordination and recording of training could result in staff not completing training and lead to incorrect procedures being followed. Resulting in vulnerable children not been given the correct and necessary help, which has the potential to lead to reputational damage for the authorities.	To ensure there is a clear Corporate Safeguarding training plan in place for each year. A review of the safeguarding training record and establish a protocol to ensure that where mandatory training is required its completion is monitored and timely	**Responsible Manager** Head of Community and Housing Services **Action** To review and improve the training record to ensure it is up to date with the ability to set up reminders including escalation to Managers

		there is no evidence that this has been addressed and no feedback from Managers are received. The results from the net consent training identified that 43% of staff incorrectly answered the question 'Which one of the following is not one of our safeguard leads'. A further report showed that the read time for this training took 50.23% of staff less than 1 minute. The training provided by Worcestershire Safeguarding Children's Board which provided more in depth training for those staff with more regular contact with children was withdrawn in March 2019 and no suitable alternative training has been identified. No evidence of specific training in relation to Safer Recruitment. There is no mention of safeguarding in the Bromsgrove Induction Policy or Guidelines for Managers dated 2005 found on the Orb. However, a new Corporate Induction handbook is		reminders are issued and followed up for non-completion. Procedures for the provision of regular fresher training should be established. Send out a communication to staff reminding them of who the safe guard leads within Redditch Borough Council and Bromsgrove District Council are. If feasible, request that the consent the staff agree to which confirms they have understood the safeguarding training is moved to the end of the training so that the presentation has to be read and test completed before they can agree their understanding. Source and implement suitable training for those staff dealing with vulnerable children on a regular basis. Review the purpose and process of the Safeguard log as it is not capturing referrals across all services including housing and no output is	**Implementation Date** 31st October 2020 **Action** To identify replacement training resources for staff who are in regular contact with children. **Implementation Date** 31st May 2020 **Action** If possible to make changes to Net consent as recommended. **Implementation Date** 31st May 2020 **Action** Re-run the results of the net consent safeguarding testing to determine if staff are still getting the question relating to who the safeguarding leads are wrong and if so, appropriate action to be taken. **Implementation Date**

		in the process of being developed for both authorities.		being recorded. Review what Safer Recruitment training is in place and if this training is being rolled out and effective. Liaise with Human Resources as to when the induction handbook is likely to be finalised and published.	30th September 2020 **Action** To review the safeguarding log and determine an appropriate process for recording referrals from all services including the housing service. **Implementation Date** 31st July 2020 **Management Response / Action** New Induction booklet on track to be launched Spring 2020. New starters have access to the system currently and will continue to trigger the launch of the safeguarding awareness training via Netconsent. **Responsible Manager** Human Resources and Development Manager **Implementation Date** 30th June 2020

					Action Explore options for safer recruitment training **Responsible Manager** Head of Community & Housing Services / Human Resources and Development Manager **Implementation Date** 30th June 2020
2	M	**Commissioned Services** The audit identified a lack of evidence to support the responses within the Section 11 Audit return with regards to commissioned services which states that safeguarding requirements built into commissioned services, tenders and specifications. **(**RBC) At the time of the audit the Rubicon Leisure safeguarding policy for safeguarding Children is still in draft stage and waiting approval. However, the Senior Safeguard Lead advised that as staff are RBC employees they were all following the RBC policy	Where responses in the section 11 self-assessment documents cannot be adequately supported there is an increased risk that any assurance placed on such responses could be misplaced or not found if the senior safeguarding lead is not present.	Ensure that an agreed and approved safeguarding policy for Rubicon for safeguarding children is in place and that both leisure safeguarding contracts are being monitored on a regular basis. Review the procedure for new contracts in relation to safeguarding requirements. To retain evidence for the responses given in the Section 11 that can be accessed within an organised folder or	**Responsible Manager** Head of Community & Housing Services / Business Development Manager **Management Response** Rubicon Safeguarding Policy in place and safeguarding included on contract monitoring agendas **Implementation Date** Action completed 30th November 2019 **Action**

		whilst their own policy was being developed as part of the mobilisation plan. (BDC) No written evidence provided that the Bromsgrove Sports and Leisure Centre Contract has been monitored over the last year. However, a safeguarding agenda item has been added to agenda's from 15th November 2019 and monitoring of this contract is now taking place with evidence that a current issue is being monitored.		hyperlinked to the documents and produced within a timely manner if requested.	Agree a process with the procurement team to ensure that safeguarding requirements are included within relevant contracts. **Implementation Date** 30th April 2020 **Action** Evidence for future Section 11 audits to recorded electronically **Implementation date** to be determined by date of next S11 audit
3	M	**Safeguarding Policy April 2019** The response within the last Section 11 return suggests that the policy is promoted to all staff via the in house safeguarding group. The Orb and team brief. From the evidence received. It appears that the last in house safeguarding meeting was held in September 2018. There is still an old version of the safeguarding policy displayed on	Due to 2 policies showing on the Orb. Staff could refer to the out of date policy which has the potential to follow an incorrect procedure. Where responses in the section 11 self-assessment documents cannot be adequately supported there is an increased risk that any assurance placed on such	Update the old version on the Orb or remove. Ensure that any changes to the Safeguard Policy are communicated within a timely manner to staff and evidenced. To retain evidence for the responses given in the Section 11 that can be	**Responsible Manager** Head of Community & Housing Services **Action** 1. Policy listed under the Corporate section of the Orb removed 2. Annual update to the

		the Orb under the Corporate Policy Section. The Section 11 completed Feb 18 states the policy as evidence that there is a named senior board member. However there is no mention to the board member within the policy. Other documentation could have been referred to in order to evidence this standard.	responses could be misplaced or not found especially if the senior safeguarding lead is not present. .	accessed within an organised folder or hyperlinked to the documents and produced within a timely manner if requested.	Safeguarding Policy promoted on Team Brief 3. Evidence quoted for future Section 11 audits to be cross referenced for accuracy and recorded electronically. **Implementation Date** Action point 1 completed November 2019 Action point 2 – 31st May 2020 Action Point 3 – to be determined by date of next S11 audit
4	M	**Whistleblowing** There is no mention of whistle blowing within the training on Net Consent. The Joint Whistleblowing policy dated June 2017 for Bromsgrove District Council and Redditch Borough Council is not on the Orb for staff to refer to.	Risk of potential reputational risk if the authority is unable to evidence the response within the Section 11 Self-Assessment.	Review the content of the basic safeguarding awareness training on net consent and include a reference to the Whistleblowing Policy. Make available on the Orb the June 2017 Whistleblowing Policy for both Bromsgrove & Redditch staff to refer to.	**Responsible Manager** Head of Community & Housing Services **Management Response / Action** The training on whistleblowing in the S11 audit refers to corporate training rather than it being included within the safeguarding training.

					A copy of the Joint Whistleblowing Policy 2017 to put on the Orb for staff to refer to **Implementation Date** 31st March 2020
5	L	**Literature** Safeguarding literature found on notice boards at both Redditch and Bromsgrove displayed out of date information. The up to date literature was available on the Orb.	By displaying out of date literature. There is a potential risk that staff may not follow the correct procedure which could delay vulnerable children not been given the correct and necessary help, which has the potential to lead to reputational damage for the authorities.	Remove all out of date posters, leaflets on notice boards within the Town Hall and Parkside (and anywhere else they may be used such as the depots, children centres, locality offices). Replace with up to date literature.	**Responsible Manager** Head of Community & Housing Services **Management Response / Action Plan** Literature updated at all sites **Implementation Date** Completed end of January 2020
6	L	**Knowledge sharing** The safeguard log held and assessed by the safeguarding leads shows 2 safeguarding issues were raised in 2018 and 6 have been recorded in 2019. No output has been recorded against these.	That knowledge sharing and lessons learnt are not formally shared across the organisation potentially leading to missed opportunities of better staff awareness and action.	The discussion of the Internal Safeguarding Group should be formally documented and include reference to reporting lines. Consider if there is sufficient	**Responsible Manager** Head of Community & Housing Service **Action Plan** Safeguarding Log themes and

		Lack of evidence as to what safeguarding communication has been sent to staff.	Where responses in the section 11 self-assessment documents cannot be adequately supported there is an increased risk that any assurance placed on such responses could be misplaced or not found especially if the senior safeguarding lead is not present.	safeguard leads within both authorities.	lessons learnt to be discussed at Safeguarding Group. Key representatives from the Internal Safeguarding Group to act as additional communication links between the staff and Safeguarding Leads. **Implementation Date** 31st March 2020

5 Critical Review Challenge

The challenges identified during the review have been set out in the table below along with the related risks and management action plan.

Ref.	Current Position	Challenge	Risk	Management Response and Action Plan
1	**DBS Checks** There is awareness by management within Bromsgrove District Council and Redditch Borough Council that DBS checks are required for staff that regularly come into contact with vulnerable families and children and the DBS check is carried out during the recruitment process. The application form also asks if the candidate has any	**Renewal of DBS Checks** It is the responsibility of the employer/volunteering organisation (bearing in mind their legal and other regulatory obligations) to determine if a DBS check is needed, what level of check and workforce(s) may be applicable, and how frequently checks are updated on their staff and volunteers. If an employer / organisation require their employees to have their Disclosure Certificates renewed after a set number of years that is their decision.	Current Staff may have undisclosed convictions which may put vulnerable people at risk of harm, leading to reputational damage.	**Responsible Manager** Human Resources and Development Manager **Management Response / Action** Service Managers to work with HR to determine level of risk relating to post requiring DBS check and appropriateness of renewal HR Adviser to work with service areas to support **30th September 2020**

	unspent convictions. No records have been provided which detail which posts require DBS checks and records with volunteer's certificates and information. Each post will have documentation to support the job vacancy and any additional requirements such as DBS checks. There is no process in place for renewing DBS checks. However, mangers will ask staff in periodic meetings if there have been any changes in their DBS Status. Mangers can refer to HR for any guidance and support if a potential safeguarding issue arises and it is likely that an action plan will be put in place for the employee if there is cause for concern. There is a cost associated with DBS checks. **Recruitment and Selection Procedures**	The authorities need to consider the risk for not carrying out DBC checks during the recruitment process for roles that have contact with Vulnerable Adults, Families and children and ensure any reasons clearly documented for any decisions to not carry out the DBS check. The risk should also be considered whether a further check after a set number of years is required bearing in mind that DBS Disclosure Certificate carries no fixed period of validity and is only valid on the date of issue. The authority should ensure that there are robust procedures in place to mitigate any risk should there be a change to the employee's circumstance that would have an impact on their job role and potentially put an adult or child at risk of harm and reputational damage to the authorities.	Potential for reputational damage if the authority cannot evidence the justification to what is stated on the Section 11	

	There is no reference within the Recruitment, Selection and Employment Policy for Bromsgrove District Council regarding DBS checks (policy on the Orb not dated). The date on the Recruitment and Selection policy for RBC is November 2012 and there is no evidence that this has been reviewed or updated and refers to CBS check which was superseded by DBS checks. The HR policies do not make reference for staff to refer to the safeguarding policy recruitment section which contains the Safer Recruiting Policy and Procedures and no evidence that staff who are involved in the recruitment process have received training. Therefore there is lack of evidence that safer recruitment has been embedded via HR policy and Procedures.	Retain evidence that the Safer Recruiting Process is embedded within the recruitment process for both authorities.		

Overall Conclusion (Critical Friend)

This shared service is delivered by Redditch Borough Council and is a statutory requirement.

Managers are responsible for identifying if DBS checks are required for the vacant post and this is discussed and agreed with HR.

The Authorities need to ensure that their recruitment policies are reviewed and updated regularly to include the policy for DBS checks and ensure that the policy makes reference to the Safeguarding Policy which refers to Safer Recruiting Procedures. A decision needs to be made by the authority as to whether to carry out any renewals of DBS checks and any policy decisions should be documented and retained for future reference on a shared drive.

There is still a potential risk for the authorities even if a DBS is carried out. Therefore there needs to be robust procedures in place to manage any change in employee circumstance that could impact on their job role or that could be a risk to others or themselves.

6. 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.

Andy Bromage
Head of Internal Audit Shared Services

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Internal Audit Shared Service

Final Internal Audit Report

Sundry Debtors 2019/20

10th March 2020

Distribution:

To: Financial Support Manager

CC: Executive Director Finance and Resources (S151 officer)

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

1. Introduction

1.1. A light touch review of Sundry Debtors was carried out in accordance with the Worcestershire Internal Audit Shared Service Audit Plan for Bromsgrove District Council for 2019/20 as approved at the Audit, Standards and Governance Committee on 30th July 2019.

1.2. This review does not relate directly to the Councils Strategic Purposes but does underpin them as the system is used for the raising of invoices for the collection of Sundry Income.

1.3. There were no risks on the corporate or Service risk register relevant to this review.

1.4. The testing in relation to this review was undertaken during the months of April 2019 to December 2019 and reviewed during January 2020.

2. Reasoning for Light Touch Audit

2.1. There has been no recent or planned change in the system used or the key responsible officer for this area.

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

Year	Assurance (Please see Appendix A)
2018/19	Significant
2017/18	Significant
2016/17	Significant

3. Audit Scope

3.1. Testing of 90 Debtors invoices randomly selected across the period was undertaken to ensure that:

- Invoices were raised for items that are reasonable for the council to charge for

- Invoice clearly states the name and contact details in case of query
- Invoices clearly stated the Debtors name and reference, goods/services supplied, charge and VAT amounts
- The charges applied are in accordance with the Council's scale of fees and charges

3.2. The five highest gross value aged debtors where selected in bias and tested to ensure that the debts had been chased in line with the Council's Debt Management Policy. It was found that debts where being chased where appropriate (a number of these debts are in line with Housing Benefits and as such can be sensitive) however the chasing was not always systematic.

3.3. Debtor Write Off was tested to ensure appropriate authorisation had been given. Papers for April, May and June where provided with authorisation, however the authorised papers for July to December had been misplaced. A total of £11218.78 debt has been written off in the period.

4. Audit Opinion and Executive Summary

4.1. If any major control/risk issues had been highlighted during the testing this would have been reported at the time. An interim report was issued in August 2019 in regard to incorrect charges for naming and numbering of new premises. Further testing in this area found that the charges had been corrected going forward. The missing authorised papers for debtor write off were reported verbally to CMT on the 14th January 2020.

4.2. From the audit work carried out we have given an opinion of **significant 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.

4.3. We have given an opinion of **significant assurance** in this area because there is a reasonably sound system of internal control in place and our testing in relation to the controls at 3.1 above found that incorrect charges had been used in relation to the Naming and Numbering of New Premises (as per the interim report of August 2019), and that in relation to the controls at 3.3 above found that records of authorisation of Debtor Write Off is have been misplaced.

5. 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
1	M	**Debtor Write Off** The electronic sheets of debts to be written off are printed and manually authorised. Manual authorisation sheets for July-Dec 2019 have been misplaced.	Potential for financial loss.	If the current process of debt write off is to continue then the manual authorisation sheets are to be scanned and held electronically. Going forward, any new system to consider system authorisation of write offs.	All records of write offs are now scanned and held electronically so evidence of write off authorisation will be fully available **Responsible Manager:** Financial Support Manager **Implementation date:** Implemented

6. 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 to 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.

Andy Bromage
Head of Internal Audit Shared Services

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Worcestershire Internal Audit Shared Service

Final Internal Audit Report

Creditors 2019/20

26th February 2020

Distribution:

To: Financial Services Manager
Senior Payments Officer

CC: Executive Director Finance and Resources (S151 officer)
Senior Accounting Technician

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

1. Introduction

1.1 The audit of the Creditors system was carried out in accordance with the Worcestershire Internal Audit Shared Service Audit Plan for Redditch Borough Council and Bromsgrove District Council for 2019/20 as approved by the Audit and Governance Committee on 29th July 2019 and the Audit, Standards and Governance Committee on 30th July 2019.

1.2 This review does not relate directly to the Councils Strategic Purposes but does underpin them as the system is used for the purchasing of goods/services.

1.3 There were no risks on the corporate or service risk registers relevant to this review.

1.4 Performance Indicators for this area are:

- The average percentage of Standard suppliers' payments (30 days).
  - As at November 2019 Bromsgrove District Council was 84.1%

1.5 The testing in relation to this review was undertaken during the months of April 2019 to December 2019 and was reviewed in January 2020.

2. Reasoning for the Light Touch Review

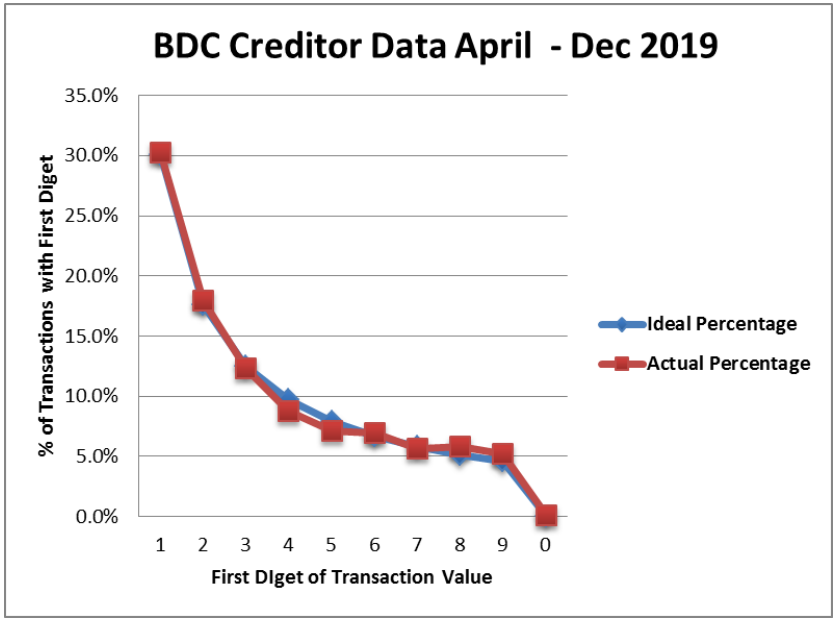
2.1 There has been no recent or planned change in the system used or the key responsible officer for this area.

2.2 The last three years audits have given the following assurance:

Bromsgrove District Council;

Year	Assurance (Please see Appendix A)
2018/19	Significant
2017/18	Significant
2016/17	Moderate This was due to a specific control of orders not being raised prior to the goods being ordered and therefore this control was included in this review.

2.3 There were no significant issues highlighted by using Benford's Law to analyse the Creditors data. **(Appendix B)**



NB: Within the data 33 transactions were for £100,000 or more, which represented 43% of the total value.

3. Audit Scope

3.1 Testing was undertaken to ensure that:

- Invoices were addressed to the Council
- The goods/services were in line with that expected for use by the Council
- The Purchase Order has been raised prior to the supply of the goods/services
- The payment has been made within 30 days of the Tax Point
- There was segregation of duties between the officer raising and authorising the order
- Authorisation levels had been adhered to
- Where applicable the VAT number is valid

3.2 The review covered the period from 1st April 2019 to 31st December 2019.

3.3 90 creditors' transactions for Bromsgrove District Council were selected across this period. The sample was biased to ensure that items over £100,000 were included and then the remainder were randomly selected using a random number generator.

4. Audit Opinion and Executive Summary

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

4.2 From the audit work carried out we have given an opinion of **significant assurance for both Councils** 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 in respect of the specific audit scope as stated in 3.1 above.

4.3 We have given an opinion of **significant assurance** in this area because there is a reasonably sound system of internal control in place and our testing in relation to the controls at 3.1 above found that in one of the transactions tested it was authorised by a person without the necessary authorisation level. Please see 5 below for recommendation.

5. 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 C.

Ref.	Priority	Finding	Risk	Recommendation	Management Response and Action Plan
New matters arising					
1	M	**Authorisation of transaction** One transaction for Bromsgrove District Council was not authorised by a person of appropriate level.	Potential for financial loss.	With the current system, to implement procedures that ensure that incorrect authorisation of invoices cannot occur. Within the new system, to ensure that system parameters will not allow the incorrect authorisation of invoices	**Responsible Manager:** Senior Payments Officer **Management action:** Efin has now been updated to prevent this occurring in the future **Implementation date:** 26/02/2020

6. 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 to 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.

Andy Bromage
Head of Internal Audit Shared Services

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Worcestershire Internal Audit Shared Service

Internal Audit Report

NNDR 2019/20

11th March 2020

Distribution:

To: Financial Support Services Manager
Assistant Financial Support Manager
Cc: Executive Director, Finance & Resources and Section 151 Officer
Chief Executive

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Contents

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

1. Introduction

1.1 The audit of the NNDR system was carried out in accordance with the Worcestershire Internal Audit Shared Service Audit Plan for Redditch Borough Council and Bromsgrove District Council for 2019/20 as approved by the Audit, Governance and Standards Committee and the Audit, Standards and Governance Committee at the meeting held on 29th July 2019 and 30th July 2019 respectively. The audit was a risk based systems audit of the NNDR system as operated by Redditch Borough Council and Bromsgrove District Council.

1.2 The audit relates to the following from the Corporate Plan for each Authority:

- Bromsgrove District Council Key Priorities 2017-20 – Financial Stability, with the Strategic Purpose “Help me to be financially independent”
- Redditch Borough Council Strategic Purposes - "Help me to be financially independent" and “Help me run a successful business”

1.3 The following entries on the Corporate Risk Register for Redditch Borough Council and Bromsgrove District Council are relevant to this review:

- Lack of robust financial accounting and monitoring arrangements
- IT systems and infrastructure has a major failure

The following entries on the service risk register are relevant to this review:

- CUS 20: RBC Data Protection
- CUS 21: BDC Data Protection
- CUS 23: RBC Failure to meet audit requirements
- CUS 24: BDC Failure to meet audit requirements 2017/18
- CUS 25: RBC Failure to meet audit requirements

1.4 This review was undertaken during the months of December 2019 and January 2020.

2. Audit Scope and objective

2.1 The audit provided assurance that the NNDR process is maximising all income using appropriate and timely recovery methods where necessary and that bad debt is being closely managed.

2.2 The scope covered the following:

- A review of the updated position in relation to the 2018/19 audit recommendations.
- Debt recovery procedures are followed in a timely manner to ensure that income is maximised.
- The correct protocol is being followed with regards to first and any subsequent reminders and appropriate suppression is being managed.
- Collection rates and recovery success are monitored and are within acceptable levels.
- Write Offs are being administered and appropriate procedures are followed when identified.
- There is regular performance monitoring and reporting.

2.3 This review did not cover:

- Registration processes
- Identification of new dwellings

3. Audit Opinion and Executive Summary

3.1 From the audit work carried out we have given an opinion of **significant 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.

3.2 We have given an opinion of **significant assurance** in this area because there is a generally sound system of internal control in place but that our testing has identified isolated weaknesses in the design of controls and / or inconsistent application of controls in a small number of areas. There are three areas that were highlighted during the previous audit relating to website pages, forms and relief and

exemption reviews. Audit notes that there is ongoing work in each of these areas and implementation dates have not yet been reached therefore they will be revisited at the next review.

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

- Debt recovery processes for current year NNDR debt are followed in an accurate and timely manner, ensuring that income is maximised.
- Write Offs are being correctly administered and all of the appropriate procedures are being followed.

3.4 It was highlighted during testing that the performance measures available via the dashboard could be re-purposed to improve on their output, relevance and usefulness. Discussions are taking place to this effect with the aim of having a new set of performance measures by the start of 2020/21 to provide management information with which the service can develop.

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

	Priority (see Appendix B)	Section 4 Recommendation number
Recovery of Prior Year and Aged NNDR Debt	**Medium**	**1**

4. 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	**Recovery of Prior Year and Aged NNDR Debt** Audit testing on random accounts with varying recovery stages showed that current year recovery was prompt, accurate and reasonable with the appropriate costs added where necessary. Testing identified that although recovery relating to previous years was being undertaken - and new attempts to recover aged debt were evidenced in the majority of cases reviewed - there were delays found in recovery being moved to the next stage including following the return of debt from the bailiff due to the resource to pursue further recovery attempts or to establish write offs being limited, leading to debt stagnation.	Adverse collection rates and loss of potential income to the authority due to limited recovery on aged debt leading to reputational damage and financial hardship.	An options paper and clear policy is formulated as to how the Councils will handle aged NNDR debt and the way it is managed going forward to maximise income and enable timely action.	**Management Response:** A review of resources for recovery of Council Tax and Non-Domestic rates will be completed within the first 6 months of 2020. As part of this review there will be a challenge to the existing Recovery Policy and Debt Collection strategies. This review will ensure that more thorough guidance is provided to teams in relation to actions for collection of debt, methods of enforcement and where applicable write off. **Responsible Manager:** Financial Services Support Manager

					Implementation Date: 30 September 2020

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 to 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.

Andy Bromage
Head of Internal Audit Shared Services

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Worcestershire Internal Audit Shared Service

Final Internal Audit Report

Worcestershire Regulatory Services (Stray Dog Service) - 2019/20

14th April 2020

Distribution:

To: Technical Services Manager
Head of Regulatory Services
Executive Director (S151 Officer)

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Contents

1. Introduction

1.1 The audit of the Stray Dog Service was carried out in accordance with the Worcestershire Internal Audit Shared Service Audit Plan for Bromsgrove District Council for 2019/20 as approved at the Audit, Standards and Governance Committee on 18th July 2019. The audit was a risk based systems audit of the Stray Dog Service as operated by Bromsgrove District Council.

1.2 There were no strategic risks appropriate to this review.

1.3 The following Service Risks were relevant to this review:

- Issues with the Worcestershire Regulatory Services database system

1.4 This review was under taken by Matt Wooldridge during the month of February. .

2. Audit Scope and objective

2.1 This review has been undertaken to provide assurance that the process surrounding the management and recharging of costs associated with stray dogs are well documented, transparent and accurate.

2.2 The scope covered:

- Stray dog information is accurately recorded
- Fees are accurately calculated and recharged
- Reconciliations for the kennels/contractors used and payments made
- Potential continuity issues and conflicts of interest have been considered and documented.

2.3 This reviewed covered the period from April 2019 to February 2020.

2.4 This review did not cover:

- An independent review of the contracts in place
- The geographical logistics of the dog warden service.

3. Audit Opinion and Executive Summary

3.1 From the audit work carried out we have given an opinion of **significant 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.

3.2 We have given an opinion of **significant assurance** in this area because there is a generally sound system of internal control in place designed to meet the organisation's objectives. However isolated weaknesses in the design of controls or inconsistent application of controls in a small number of areas put the achievement of a limited number of system objectives at risk.

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

- The Idox Solutions Database contained reportable information for the evidencing of key performance indicators
- There was an understanding of the trajectory of the service and the issues faced
- Evidence of the development requirements of the Idox Solutions Software
- Financial procedures in place including reconciliations for the recording and payment/receipt of the Worcestershire Partners and additional contracts for Authorities outside of Worcestershire.

3.4 There is an emerging risk of which there is awareness by the Technical Services Manager in regard to a potential conflict of interests if Dog Wardens were to licence kennels used for the kennelling of stray dogs. This is not currently an active conflict as licensing of the kennels currently used for the housing of stray dogs is completed by an Officer outside of the stray dog process, however this may become an issue following Dog Wardens acquiring the relevant qualifications under the new legislation that comes into force during 2021, it is advised therefore that appropriate procedures are documented to allow the avoidance of any conflict of interest to continue in future.

3.5 Additionally there is an ongoing system issue that does not allow a time to be input to the Idox Solutions system when recording stray dog cases however this has been raised with the vendor prior to the audit and therefore is included for note only.

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

	Priority (see Appendix B)	**Section 4 Recommendation number**
Contract Continuity	**Medium**	**1**
Contractor Reconciliations	**Medium**	**2**
Idox Solutions Narrative	**Low**	**3**

4. 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	Clearance meeting discussion points
New matters arising					
1	M	**Contract Continuity** Testing identified that all kennels used had a contract in place. However a number of contracts had expired and are operating under a month extension (that had been accepted by all contractors at the time of audit) whilst procurement for new contracts continued. There is potential for there to be a further requirement to extend again on a month by month basis until the procurement process is completed.	Service continuity is affected if a contractor refuses an additional extension prior to successful procurement of new contracts.	It is accepted that a number of charitable organisations and commercial businesses exists in relation to stray dogs and there is a number which could be used during a continuity issue. However continuity could be further improved by ensuring the procurement process is actioned and completed in preparation for the end dates of any current contracts. Additionally any other kennels that could potentially be used in a continuity event are documented as part of service continuity arrangements.	**Responsible Manager:** Technical Services Manager (WRS) **Management Response:** The recommendation to commence the procurement process in good time is accepted and will be actioned when the contracts are next due to be tendered. In relation to maintaining a list of potential kennels, this is not considered of value. Geographical remit of WRS changes and businesses willing to work with us change depending on date and reason. With the vast number of potential kennelling facilities that are available within our current operating range, it would be a

					considerable task that would not be useful at the time we required the information collated. There is no intention to undertake this part of the recommendation. **Implementation Date:** October 2022 (ahead of expiry of contract February 2023)
2	M	**Contractor Reconciliations** Reconciliations are performed for costs and charges for all stray dog cases for the contracts undertaken on behalf of Authorities outside of Worcestershire. In addition to this charges are verified for veterinary services received by the Senior Dog Warden prior to invoices being passed for payment. However there is no periodic reconciliation for charges received in relation to stray dogs from within Worcestershire for kennelling and out of hour collections. It is understood there is some mitigation of risk in place in the form of the reconciliations completed for the external contracts as mentioned above as the contractor used for kennelling dogs and the out of hours service	Errors/fraud not identified on contractor invoices prior to being passed for payment.	Periodic/random reconciliations are performed on charges received in relation to Worcestershire stray dogs so that potential discrepancies are identified and reported back to the relevant contractor.	**Responsible Manager:** Technical Services Manager (WRS) **Management Response:** The recommendation is accepted and periodic random checks will be made on charges received. **Implementation Date:** 1st June 2020 (to enable new processes and contracts to bed down and account for issues raised by COVID-19)

		is the same for all stray dogs regardless of location and therefore discrepancies may be picked up on invoices in relation to these external contract charges.			
3	L	**Idox Solutions Narrative** Testing showed that all relevant information was recorded on the account to allow the discharging off the service and both Dog Wardens and the Technical Service Manager were aware of ongoing cases including difficulties within more complex cases. However an increase in the amount and quality of narrative and therefore justification of decisions made would be beneficial when reviewing individual stray dog cases and to justify decisions if challenged.	Unable to justify decisions if challenged due to lack of descriptive narrative on the database (transparency). Lack of clear audit trail.	Staff are reminded of the importance of including all relevant information that does not conform to a defined field within the narrative box to allow easier review and justification of decisions made.	**Responsible Manager:** Technical Services Manager (WRS) **Management Response:** It is accepted that an improvement in the quality of the information recorded would benefit the service. A reminder to all staff to ensure appropriate level of detail is provided on case records. This will be audited with a view to identify training requirements or action. **Implementation Date:** 1st April 2020

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

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.

Andy Bromage
Head of Internal Audit Shared Services

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Appendix 4

Finalised 'Follow-Up' Reports

Worcestershire Internal Audit Shared Service

Final Internal Audit Report

Health and Safety Follow Up 2019/20

17th February 2020

Distribution:
To: Director of Finance and Resources
Head of Transformation
Human Resources and Development Manager

CC: Senior Health and Safety Advisor
Chief Executive

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Contents

1. Introduction

1.1 The Health & Safety follow-up was carried out in accordance with the Worcestershire Internal Audit Shared Service Audit Plan for Redditch Borough Council for 2019/20 as approved by the Audit and Governance Committee on 20th March 2019. The audit was a follow up of the Health & Safety Audit 2018/19.

1.2 This area is fundamental in the achievement of all 5 themes contained in the Worcester City Plan 2016-2021.

1.3 The following entries on the corporate risk register were relevant to the original review:

- COR19 – Non Compliance with Health and Safety legislation

The following entries on the service risk register were relevant to the original review:

- COR19 – Non Compliance with Health and Safety legislation

1.4 This follow up was undertaken during the months of January and February 2020.

2. Audit Scope and objective

2.1 The original review gave **Limited Assurance** over the control environment and covered:

- Review of action plan
- Financial Analysis and Review of the training budget
- Health and Safety Documents
- Planning and development
- Training
- Communication of Health and Safety information
- Risk Assessments and Risk Management
- Fire Safety Risk Assessment and Risk Management
- Active and Re-active Monitoring and review of Health and Safety Statistics and information
- Corporate Health and Safety advice and support

2.2 This follow up has concentrated on the actions taken by management to address the findings of the 2018/19 audit.

3. Executive Summary

3.1 The original review gave **Limited Assurance** and found that controls could be strengthened in the following areas:

	Priority (see Appendix B)
Policies	High
Manager IOSH training	High
Fire Risk Assessments Action Plan	High
Fire Alarms and Drills	High
Action Plan update	Medium
Financial Analysis and Training budget:	Medium
Induction Process	Medium
Bespoke health and safety training	Medium
Risk Assessments	Medium

3.2. This follow-up has sought evidence, explanations and information in order to assess the progress against the Management action plan in relation to the above control areas. The results of this follow up can be seen in Section 5.

4. Conclusion - Current Position statement

Health and Safety have made good progress in addressing the recommendations made during the Health & Safety 2018/19 Internal Audit. Bespoke in house training has been developed for health and safety including risk assessment training for managers with scope to expand this to include a Health and Safety Induction and Manual handling.

There remains an outstanding risk as the Fire Risk Assessments throughout the council need to be fully completed however there is a programme in place for the completion of these. In addition there is no evidence that regular fire alarm testing is taking place and a full

programme of fire drills has not been completed. Whilst we are aware that there is a programme in place for alarm testing and fire drills, work needs to be undertaken to ensure these are being completed and completion is documented.

5. Detailed Findings, Recommendations and Updated Position

The issues identified during the 2018/19 Health and Safety audit have been set out in the table below along with the related recommendations, management responses and action plan and actions taken up to the time of the follow-up. The issues identified were 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.

Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
1 High	**Policies** **The Orb** Testing of the policies on the orb found that: - • There are policies missing i.e. the Fire Safety Policy. • There is no version control on the policies from a version/review date perspective. • There is no evidence to show if the documents on the orb is the same	**The Orb** Effective working practice is established to ensure policies are uniform and are uploaded on the orb in a timely manner for both Councils at the same time to prevent any knowledge gaps. All policies must have a version control associated and a review date prominently displayed.	**Responsible Manager:** **HR Manager** Approval process is currently under review which will potentially change the delegation which will stream line the process and the activation and communication of policies. **Implementation date:** April 2019		**In Progress** Health and Safety statement of intent and Health and Safety Manual have been developed, both documents have been approved by the both Council Leaders and have been published on the Orb. The policies detail version control and the date of publishing. The Health and Safety statement of intent details the Councils' commitment to a 'Plan Do check Act' approach to health and Safety. The Health and Safety Manual is an all-

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
	document that was written in 2011. • Using the Orb it is easy to access Health and Safety policies but regarding fire procedures, training and other areas it is more difficult to navigate through.	There must be an established forum e.g. Orb, notice board, providing ease of use and access to information.	Review of notice boards will be undertaken including review of electronic notice boards Section was cleared down in Sept/Oct 18 April 2019		encompassing manual which details: - Organisation structure and responsibilities, - Health and Safety Management Governance. - Specific Health and Safety Arrangements including fire precautions, first aid at work and lone working. Noticeboards are still in place however information held on these has been reduced. No funding is currently available for rolling screens however information is updated to Orb to ensure staff are aware of changes to policies/procedures. Council wide decision taken to continue with the orange high vis, some areas have introduced green for first aiders. Details of first aiders are held centrally and courses are made available to them. Further work to be undertaken to display first aider notice to include photos and locations.
2 High	**Manager IOSH training** The findings indicate that: • There is no review date. • There is no expiry date. • Managers may not have attended the allocated training slot.	Establish a mandatory requirement for IOSH training and issue reminders when completed training is set to expire.	**Responsible Manager: Health and Safety Officer / HR** Accepts taking on part of the risk, as does not believe need to commit to IOSH Managing Safely as a mandatory course, as there are alternative routes that could be taken.		**Complete** There is no requirement to make IOSH a mandatory course. CMT have given approval for internal risk assessment training to be delivered by the Senior Health and Safety advisor. The training will be delivered to frontline managers, however IOSH training will be provided where required.

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
			Suggestions to improve include: - • Identify the right people who would require the training (likely front line managers) • Develop an in-house course, which could take one day, which delivers: 1.) Broad introduction to health and safety law and how it applies to both councils 2.) Accident and incident investigation 3.) Risk assessment • To go down the route of getting approval / endorsement from IOSH • This would not require IOSH to be paid to come in and present each time Regarding ensuring this detail is tracked and reviewed, that is not difficult to achieve. I would then		

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
			suggest refresher on a three year basis. **Implementation date:** February 2019		
3 High	**Fire Risk Assessments Action Plan** The findings are that: - • According to the 2014 action plan there are a number of items incomplete especially regarding housing. • There are no public buildings such as Parkside in Bromsgrove and Town Hall in Redditch mentioned within the 2014 action plan. • There is a sheet being filled in by housing and a sheet being filled in by place partnership. • There is a high risk item set in 2016 which was not complete as of 11th June 2018. Review date stated mentions 2019. • Risk assessments are not being completed frequently.	To update the 2014 action plan to include all public buildings for both councils and to ensure that it is up to date to mirror the actual fire risk assessments that have been filled in. It is recommended to have regular meetings regarding the process on the action plan to ensure controls are in place and to create an audit trail through the minutes. To ensure 'high risk' items are updated and dealt with in as a priority and it a timely manner.	**Responsible Manager: Senior Contracts Manager** An IT system has been sourced and will be part of the asset management system implementation that Senior Contracts Manager is leading on and will enable better maintenance of records and data. Public buildings will be managed centrally. Budget bid for dedicated system linking to PPL transfer in-house. **HR& OD Manager** **Facilities Management** - **Property Services** - **Place Partnership** - **Housing** **Implementation date:** Bromsgrove to review in October/November 2019.		**In Progress** Ridge have now been contracted to complete the Council's Fire Risk Assessments. There is a programme in place to complete baseline assessments across the council; once these are completed the plan will change to a risk based approach.

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
			Place Partnership will no longer be carrying out this work post 31st march 2019. It is therefore intended that processes and procedures will be established as part of the Officer in Charge process to ensure that all fire safety checks are carried out in a timely and compliant way by the transfer date. It is also intended that all officers with responsibility for FRAs will review risk assessment and action plans and training will be delivered where required. Health checks are currently being carried out in the Housing Schemes and new FRAs being developed for High Risk Housing		
4 High	**Fire Alarms** There is no consistency in how often the test is carried out. In August 2017 for instance it	To ensure a control is in place at both councils to carry out a weekly fire	**Responsible Manager: Facilities Management** - Property Management – BDC		**In Progress** Weekly tests are being completed.

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
	was noticeable that the test was only carried out once; there is also other occasion during the year of 2017 where tests have been infrequent. **Fire Drills : - Bromsgrove District Council** For the Bromsgrove District Council Depot evidence suggests that the latest fire drill was completed on 23/5/2014. The follow up should have been completed in November 2014. This did not occur and is non-compliant. At the Parkside site the evidence provided shows that the last live fire drill was performed in October 2017. This should have been followed up in April 2018. This is now non-compliant.	alarm test and record it to comply within British Standards 5839. If a test is not completed on a weekly basis then there needs to be justification to support why it was not carried out in case a fire officer visits the site and questions it. Redditch Borough Council and Bromsgrove District Council need to establish a requirement to complete a fire test regularly to remain within compliance for fire safety regulations. It is recommended that both depots start to commence fire drills within a 6 month window to ensure that they are compliant and regiment the evacuation process for any fire Marshalls. A process to be established where a designated fire warden is	- Place Partnership – RBC **Implementation date:** BDC – Implemented RBC – April 2019 To create a sub group to work through recommendations and give a clear plan by April 2019. Group to feature Health and Safety Advisor, Facilities and be supported by Claire Felton and Guy Revans. This group will also review officer behaviour through fire drills to ensure compliance. To deliver fire drills at all sites in Dec-18.		Fire evacuation drills will happen over a phased period across all locations once completed these will take place on a risk basis, i.e. some locations may only complete one a year however other such as children's centres will have these more frequently. Fire wardens are made aware of their responsibilities during training. Evacuation procedures are being reviewed by RIDGE as part of their Fire Risk Assessments and local site management is then required to establish plans based upon recommendations therein. Contractors are provided with a site induction on arrival.

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
		located next to one of the fire exits to ensure no unauthorised personnel re-enter the building until safe to do so. Better planning to ensure that the fire alarms are tested on time and that the key is available and not moved. A process is established to ensure all contractors sign a register when coming to work on site and that they have basic induction training to know where the fire evacuation point is. It is recommended to have a systematic approach to ensuring all documentation is up-to-date at all times so that if departments change locations this does not impact on obtaining an assurance that everyone has left the building.	To provide audit trail moving forwards, to be implemented immediately.		

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
5 Medium	**Action Plan Update** Testing of the health and safety action plan found: - • There is no version control within the action plan to state when it was last edited or modified. • There is a lot of information which has a narrative as 'Out Of date' and no comments as to why the action is out of date or what has been put in its place. • The target deadline date has been not been adhered to since the end of 2014. • There are target dates in place but none of the targets set have been completed. • The recommendations from the fire risk assessment and management perspective have not been completed according to the action plan. • There is no tab specifically for 'Planning and Development'. There is no evidence of a planning and development within the action plan scope for the	The action plan should be treated as a key management tool driving the development of H&S and must be regularly updated with a systematic approach to enable a clear indication of progress. A version control must also be included and priorities need to be established e.g. fire risk assessments and management perspective. To focus on getting any work 'Out of date' completed and to include a new tab saying 'Planning and development' as well as to include High/Medium/Low priority to assist the planning structure.	**Responsible Manager: HR Manager** Work will be actioned to combine all H&S Audits into a definitive action plan **Implementation date: April 2019** Whilst a large amount of work has been taken from the 2014 action plan. An ambulation of plans will take place and used to go forward from April 2019.		**Complete** Action plan is regularly reviewed and monitored; progress towards implementation is reported to the Health, Safety and Wellbeing Committee and the Audit and Governance Committee.

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
	technological and innovative factors of the business.				
6 Medium	**Financial Analysis and Training budget:** • There is no centralised finance code dedicated for Health and Safety. • There is no system in place for showing value for money is being achieved on spend. • The budget was overspent on a couple of occasions at both Bromsgrove District Council and Redditch Borough Council.	To improve overview of the training budget use. To consider using cost centres for the training budget and Health and Safety to improve corporate oversight of expenditure.	**Responsible Manager: HR Manager in conjunction with Finance Director.** There is a current review of corporate training budgets and the separation of H&S training in readiness for 2019/20. **Implementation date: April 2019**		**Complete** Review of budgets completed, a decision has been taken to provide bespoke in house training in most instances. External training courses will only be provided where there is a specific need.
7 Medium	**Induction Process** The findings from the testing showed that: - • No corporate training has been completed on a scheduled basis and there is evidence to show that even under the presumption that training was being carried out on a monthly basis there is no evidence that can prove this. • Inductions have not been completed for a while; there	**Training** Design into the new HR training system to leaver's dates, start dates and a review date to enable local monitoring regarding the training from both a corporate and service level perspective leading to better communication between local departments and Human Resources.	**Responsible Manager: HR Manager** **Implementation date:** Looking at corporate induction process and currently under review. Consideration being given to hard copy and interactive learning. Full review to be undertaken which is		**In Progress** A review of the corporate induction process is currently being undertaken

AUDIT, STANDARDS AND GOVERNANCE COMMITTEE

Original Ref./ Priority	Original Finding	Original Recommendation	Original Management Response and Action Plan		Position as at 29th January 2020 1st Follow up
	is no review date or location included to state Redditch Borough Council or Bromsgrove District Council. • There are blank entries and 'n' showing in the attendance of the training throughout the training document with no comments as to what was done to get staff on the training. • No training has happened since 2017 due to limited resources. • There is no information being passed on to Human Resources from local teams to confirm what training that has been completed.	To establish exception reporting to ensure comment are included in any fields that are blank or show 'n' on the training attendance. The frequency of induction training to be established. Introduce self-serve training systems through e-learning and ensure all new employees complete mandatory induction training within 30 days. Probationary periods should not be signed off if mandatory training has not been satisfactorily completed. Existing staff to have mandatory training requirements identified for their roles and reported on an exceptions basis.	currently underway. **July 2019**		
8 Medium	**Bespoke health and safety training** • There is no systematic approach in reference to how the training is being recorded.	**Be-Spoke training** To develop further the 2014 action plan to ensure all training is completed and recorded in a timely manner.	**Responsible Manager: HR Manager** Continue to review and explore how training can be monitored and recorded on		**In Progress** A new system is being introduced later this year which will encompass the HR system, functionality of this may allow for training to be recorded and allow for prompts highlighting that

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	• There are dates in place for training for both supervisors and team leaders, but there is no evidence that training took place or who attended the training sessions. • There is no review date in place for any training that was completed. • There is no information that the employee in question still currently works for the Council.	Consider what the new system can provide in order to establish record integrity in regards to the current workforce training requirements, how it is reported and how potential training gaps can be identified.	the HR 21 system. By the end of the first financial quarter we will have a better understanding of the budgets allocation and the spend on training and training records. **Implementation date: July 2019**		training needs are to be reviewed after a given time period.

6. 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 to 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.

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