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DATE: 28 February 2023

AUDIT SUB-COMMITTEE INFORMATION BRIEFING

Meeting to be held on Wednesday 8 March 2023

QUESTIONS ON THE INFORMATION BRIEFING

The Briefing comprises:

Members and Co-opted Members have been provided with advanced copies of the briefing via email. The briefing is also available on the Council website at the following link:

http://cds.bromley.gov.uk/ieListMeetings.aspx?CId=559&Year=0

Printed copies of the briefing are available upon request by contacting Steve Wood on 020 8313 4316 or by e-mail at stephen.wood@bromley.gov.uk.

Copies of the documents referred to above can be obtained from www.bromley.gov.uk/meetings

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FINAL INTERNAL AUDIT REPORT

CHIEF EXECUTIVE'S DIRECTORATE

Capital Strategy – Planning and Monitoring

Draft Issued to:	**Head of Corporate Finance and Accounting**
	Principal Accountant
Final Issued to:	**Director of Finance and S151**
	Head of Corporate Finance and Accounting
	Principal Accountant
Prepared by:	**Senior Internal Auditor (Mazars LLP)**
Reviewed by:	**Manager (Mazars LLP)**
	Partner (Mazars LLP)
Date of Issue:	**23 November 2022**
	04 January 2023 (Revised Draft)
	18 January 2023 (Final)
Report No.:	**CEX/03/2022**

INTRODUCTION

1. This report sets out the results of our internal audit of Capital Strategy Planning and Monitoring. The audit was carried out as part of the work specified in the 2022-2023 Internal Audit Plan.
2. A Capital Strategy is an overarching document that sets the policy framework for developing, managing and monitoring the Council's capital investment. The Strategy should focus on the core principles that underpin the Council's capital programme and align with the priorities set out in the Council Plan and other key Council strategies.
3. A Capital Strategy aims to ensure the Council's investment in capital projects is sound and supports the delivery of its corporate objectives. The requirement to have an annual Capital Strategy approved by Council became mandatory in 2019/20 as part of the update to the Chartered Institute of Public Finance and Accountancy (CIPFA) Prudential Code for Capital Finance in Local Authorities (the Prudential Code).
4. We would like to thank the Principal Accountant, the Head of Corporate Finance and Accounting and any other staff contacted during this review for their cooperation.

AUDIT SCOPE

5. The original scope of the audit was outlined in the terms of reference issued in September 2022.
6. The controls in place to mitigate the impact of the key risk areas were examined. The audit included an interview with the Principal Accountant, a review of relevant documentation, data analysis, and a review of related procedures and processes.
7. The following were considered to be the key risks to the process:
   - Where the process for producing the Council's capital programme is inadequate, there is a risk that the Programme will not sufficiently assist in achieving corporate objectives, resulting in criticism of the Council and public dissatisfaction;
   - Available financial resources are not used effectively, failing to obtain value for money; and
   - Where Capital projects result in high costs incurred by the Council, there is a risk that future savings may have to be made elsewhere.

AUDIT OPINION

8. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Reasonable Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
-	3	3

SUMMARY OF FINDINGS

9. Below are examples of controls noted to be in place and working effectively based on the audit testing conducted. In addition, where we have identified issues, we have also highlighted these below:

- We reviewed the Council's latest Capital Strategy 2022-26, approved by Full Council in February 2022 and confirmed that it includes information on the following:
    - *Capital Expenditure:* Plans and future scheme proposals are set out for consideration, detailing the background of each new proposed scheme and providing financial information on current schemes in the programme.
    - *Investments:* Details of investment and growth funds have been set out to help support the achievement of sustainable savings and income.

- *Treasury Management:* Reference to the Treasury Management Strategy is made throughout the Capital Strategy, specifically referencing the policy for borrowing and the investment of balances. It also directs readers to the standalone Treasury Strategy to read in conjunction with the Capital Strategy. We reviewed the latest Treasury Management Annual Investment Strategy 2022/23 & Quarter 3 Performance 2021/22 report, presented and approved by Council in February 2022 and confirmed that it reports and monitors the Council's prudential indicators.

Further, as set out in the appendices to the Capital Strategy report, information on variations to the programme with rationale, financing statement and investment funds are set out. However, we noted that the report is not designed and set out in the form of a corporate company document, as seen with the Treasury Management Strategy. Further, it does not contain sections that align with sector best practice, identified from inspecting common themes within Capital Strategies from other local authorities, and which would be useful to both Council and external stakeholders (*see issue 5 in the detailed findings section).*

- The CIPFA Prudential Code 2017 introduced the setting and revising of a Capital Strategy. This requirement became mandatory in 2019/20. The Prudential Code laid out the following requirements:
  - *Governance Procedure – 'the setting and revising of the capital strategy and prudential indicators will be done by the same body'.* We reviewed February & March Council minutes from 2019 to 2022. We confirmed that the setting and revising of the Capital Strategy and review and approval of prudential indicators are ratified by the Council. We also noted a clear governance structure for reviewing and approving the Capital Strategy and associated Programme (see below).
  - *Determining a Capital Strategy – 'the Capital Strategy should demonstrate that the Council takes capital expenditure and investment decisions in line with service objectives'.* We noted a clear reference to the Council's overall priorities and objectives as part of the Corporate Strategy. Per the Capital Strategy, *"The primary concern is to ensure that capital investment provides value for money and matches the Council's overall priorities as set out in the Corporate Strategy"*. Further, *"The Council's Capital Programme is intended to maintain and improve the quality of life in the borough and help meet its overall priorities as set out in its Corporate Strategy (Making Bromley Even Better), and with a four-year plan, assists the longer-term planning for capital expenditure and the use of resources to finance it"*. However, the exact objectives and priorities the Capital Strategy will help deliver have not been explicitly set out (*see Issue no. 5 in the detailed findings section).*
  - *Prudence & Affordability – 'each local authority should ensure that all its capital, investment (and any borrowing) is prudent and sustainable'.* The Strategy sets out the capital available, current investments and proposed investments. We noted, via inspection of the Capital Financing statement and discussions with the Principal Accountant, that the Council is not borrowing funds to finance schemes as it is 'in a cash surplus position following capital receipts'. However, the Strategy acknowledges that surplus funds have been falling and estimates the value of surplus/deficit up to 2027-28, to the extent that it will have to start considering external borrowing. Further, the Capital Strategy references and links to the Treasury Management Strategy, which details capital expenditure, borrowing needs and affordability. The Council's capital expenditure plans are the key driver of treasury management

activity. The output of the capital expenditure plans is reflected in the prudential indicators, designed to assist members' overview and confirm capital expenditure plans.

- The 2022/23 Capital Programme was presented to the Executive on 9 February 2022 and subsequently to Full Council on 28 February 2022. The Capital Strategy report is produced from discussions between the Director of Finance, the Head of Finance Corporate and the Principal Accountant for Capital, Treasury and Insurance. The report is then scrutinised by the relevant portfolio Committee (Executive, Resources and Contracts) and then presented to the Executive for approval at their public meeting. Once approved, it is then presented at Full Council at their next meeting.
- The process followed for the submission of capital bids, as part of the annual capital bidding process, requires bids to be submitted using standardised bid forms:

  Each year, an internal memo is sent to all Chief Officers. This memo sets out the required information and deadlines and explicitly states the mechanism for submission; a standardised bid form and CR2 form. We obtained and reviewed the internal memo sent to Chief Officers on 5 October 2021 as part of the annual Capital Review Programme. The memo sets out the following:

  - Its purpose;
  - Why it's important to plan;
  - What is required to be submitted for a bid to be assessed,
  - Specific guidance on completing the bid and CR2 forms and
  - Respective deadlines.

  The memo also states that bids must demonstrate how the proposed schemes meet the objectives of the Council's various plans and strategies, such as its Corporate Strategy, Corporate Operating Principles, Portfolio/Service Plans and Asset Management Plan. A service area (e.g., Housing) will propose a scheme which delivers one or more of the priorities of the Council.

  We selected a sample of ten capital bids from the Capital Programme spanning from Q3 2020/21 to Q1 2022/23 to ascertain whether bids had been submitted using standardised forms and templates and whether the information documented was complete.

  Of the ten cases, only five could evidence a completed bid form, with all necessary information completed and documented. However, for these five samples, no associated CR2 forms were evidenced. This has been discussed further in the detailed findings section of the report *(see Issue 1 in the detailed findings section).*
- Through discussions with the Principal Accountant, we identified the following process followed for the assessment and approval of submitted bids:

- *Screening*: The Director of Finance, the Head of Finance Corporate and the Principal Accountant for Capital, Treasury and Insurance initially discuss and review affordability and assess whether all relevant details have been supplied. Viable bids then go through scrutiny.
- *Scrutiny*: Detailed scrutiny is undertaken by COE (Chief Officers Executive). The majority of scrutiny is not based on scorecards but on discussions (normally verbal) between elected Members who represent the community of the area they serve, supported by Officers who provide technical expertise. Bids will be assessed against the criteria outlined in the CR2 form. However, there will also be discussions of how well the bid fits with the Council's Corporate Strategy and whether a bid is 'likely to work in practice'.
- *Finance Committee and Policy Development Scrutiny (PDS):* Bids are then presented to an initial Finance Committee for assessment, specifically to assess whether funding has been considered and is available. Bids are put forward to the relevant PDS Committee for further scrutiny.
- *Executive Committee*: As a final stage, bids are put forward to the Executive via PDS, which will then either approve the bid (which will result in it being added to the Capital Programme), send the bid back for further work and development (after which it will be represented at a later meeting) or, refuse the bid.

From our sample of ten capital bids, we ascertained whether decision-making and/or the rationale had been documented at the 'screening' and 'scrutiny' stages above. In respect of this testing, evidence was provided to support that the bids, with the relevant information, are always subject to scrutiny at the relevant Committee before being accepted. There is sufficient assurance that bids are being appropriately scrutinised at an appropriate level before being accepted. However, the process to follow is not formally documented and outlined. This has been discussed further in the detailed findings section of the report (*see Issue 1 in the detailed findings section).*

We also found that in respect of the two above processes, there is no standing documented policy/procedure in place for the submission and assessment of capital bids outlining the key stages in the process, roles and responsibilities and decision-making authority (*see Issue 2 in the detailed findings section).*

- Amendments to the Capital Programme will follow the same process of initial capital bids, being put forward to the relevant PDS Committee for scrutiny and then to the Executive for approval/comment. We selected a sample of ten amendments made to schemes spanning from Q3 2020/21 to Q2 2021/22. We confirmed that in all ten cases, the Council's Executive reviewed and approved the proposed amendments.
- The Capital Programme indicates how it will be financed and sets out the available resources for the entire programme period, 2022-26. One of the appendices attached to the report is a Capital Financing statement that goes beyond 2025-26 to 2027-28. It sets out the estimated available financing resources. The report also outlines the required financing and financing available up to 2025-26, in line with the programme period.

  In generating aspects of the data contained within the Financing Statement, assumptions have been made to estimate the impact on financial resources in future years. From this data, the shortfall is also outlined and thus, where contributions may be needed from external

sources or the Council's revenue budget. The report also details the value of internal reserves, noting expected fluctuations throughout the years and where gaps may arise.

Our review of the report and associated Capital Financing statement noted that any assumptions made had been outlined, making it clear to readers. However, in line with best practice, no sensitivity analysis has been performed on the assumptions and the impact this may have on financial resources (*see Issue 3 in the detailed findings section).*

- The Principal Accountant indicated that, as part of the bidding process, bidders are required to set out the financial considerations of the bid. This includes:
    - providing granular capital cost information year by year throughout the duration of the scheme;
    - setting out any potential external funding, such as government grants.

  Financing is agreed and scrutinised as part of the bid process and subsequent approval by the Executive. The CR2 form (also required) requires bidders to distinguish between capital and revenue costs. This information is recorded when the successful bid is added to the Capital Programme. The Principal Accountant informed us that obtaining capital grants would normally be the responsibility of the service making a bid that relies on one or more capital grants.

  From our previously selected sample of ten capital bids, we assessed whether the financing of bids had been set out and, where applicable, capital grants had been obtained. As mentioned above, of the ten samples selected, only five could evidence a completed bid form. As part of the completed forms, we confirmed that financing requirements were set out, broken down year by year. We also confirmed that analysis of any potential external financing was provided, such as any capital grants.

  We also reviewed the past four Capital Monitoring workbooks spanning from Q2 2021/22 to Q1 2022/23, used to compile the quarterly Capital Monitoring reports, and noted that each scheme is listed with a distinction between the external and internal funding assigned to each scheme.

- A Capital report is presented to the Executive for Q4, which is an outturn report and reconciles the latest approved capital budget with the actual spending to date. This includes variance analysis between estimated and actual spending, including granular detail on the methods of financing used during the year.

  We reviewed four quarterly monitoring reports, which comprise all 2021-22 FY reports. We noted that all contain clear and granular information on the capital budget, considering any current variations. Accompanying the monitoring reports are sources of financing to fund the programme each year. However, the periodic analysis of current spending for Q1-Q3 is not included in the quarterly reports (*see Issue 4 in the detailed findings section).*

- The Principal Accountant depicted the following process for reporting capital monitoring information, with scrutiny taking place before it reaches the Executive Committee:

- Each PDS Committee receives a report on capital projects within their area, which will normally have been pre-scrutinised by the relevant Senior Leadership Team. The Principal Accountant is responsible for compiling reports sent to the relevant PDS Committees.
- Additionally, the PDS Committee for Executive Resource & Contracts (ERC) scrutinises the whole Council report, which summarises the contents of the PDS reports, contextualises them and raises whole-programme issues. This report is then formally presented to the Executive for approval at their public meeting.
- These reports are quarterly for all Committees and the Executive. The Q3 report also includes the Capital Strategy and, as previously mentioned, the Q4 report details outturn position.

As part of the above process, we confirmed that the Principal Accountant holds 'capital monitoring' meetings attended by budget holders/managers, who are asked to:

- Review the Capital Monitoring workbook sent to them;
- Reporting on the progress of the schemes, and
- Highlight any errors or apparent discrepancies they notice.

This process assists in checking accuracy against the financial systems and against the knowledge of those involved in delivering the schemes. We obtained evidence of the covering email sent by the Principal Accountant to budget holders setting out the various actions required and by when. This is then further developed in any follow-up meetings arranged as needed. We then also obtained evidence of specific communication with individual budget holders and meetings held with the Culture & Regeneration and Traffic & Parking teams during Q1 2022/23 to confirm operating effectiveness.

- To assess the accuracy and completeness of the data reported in the quarterly monitoring reports, the Principal Accountant indicated that reconciliations are performed between the reports run from the financial systems containing source data and the data contained in the workbook used to compile the quarterly monitoring reports.

  We obtained and reviewed the last four quarterly monitoring workbooks from Q2 2021/22 to Q1 2022/23. We noted that for the past two quarters, Q1 2022/23 and Q4 2021/22, reconciliations were performed between the source data and data set out for the monitoring reports. However, no formal reconciliations are recorded in the Q2 and Q3 2021/22 workbooks (*see Issue 6 in the detailed findings section).*

  We also confirmed that as part of accuracy checks, the Head of Corporate Finance and Accounting would review and scrutinise the report prepared by the Principal Accountant before being circulated. We obtained email evidence of this scrutiny on the Q4 2021/22 and Q1 2022/23 reports, demonstrating the review performed.

- The Local Government Act 2003 requires local authorities to have regard to CIFPA's Prudential Code when determining how much money it can afford to borrow. To demonstrate that the Council has fulfilled these objectives, the Prudential Code sets out the following indicators that must be set and monitored each year:
    - Estimates of Capital Expenditure
    - Estimates of Capital Financing Requirement
    - Gross debt and the Capital Financing Requirement
    - Operational Boundary for External Debt
    - Authorised Limit for External Debt
    - The ratio of Financing Costs to Net Revenue Streams
    - Debt Limits

  For clarification, the Council is required by statute to agree and publish prudential indicators, primarily to confirm that the Council's capital expenditure plans are affordable and sustainable. Per the Treasury Management Strategy, we confirmed there are five indicators in place:
    - Capital Expenditure
    - Capital Financing Requirement
    - Minimum Revenue Provision
    - Core Funds and Expected Investment Balances
    - Affordability (Ratio of Financing Costs to Net Revenue Streams)

  As stated earlier, via inspection of the Capital Financing statement and discussions with the Principal Accountant, the Council does not have any external debt. Thus, the debt indicators do not apply.

  We reviewed the Treasury Management Strategy 2022-23 and the minutes for the Full Council meetings held in Q3 spanning from 2019 to 2022. We confirmed that in each instance, the Council agreed to the prudential indicators set out in the Treasury Management Strategy for the Programme's current and future years.

10. The findings of this report and an assessment of the risk associated with any control weaknesses identified are detailed in the Detailed Findings / Management Action Plan. Any management recommendations are prioritised in line with the criteria set within Appendix B.

APPENDIX A
DETAILED FINDINGS / MANAGEMENT ACTION PLAN

No.	Finding	Risk	Recommendation and Priority	Management Response	Agreed Timescale and Responsible Manager
1	Documenting of Bid/Scheme Information We selected a sample of ten capital scheme bids ranging from Q3 2020/21 to Q1 2022/23, and £0.1m to £14.6m in value. Our testing noted that of the ten bids selected: - Five could evidence a completed bid form, with all necessary information completed and documented. - The Principal Accountant informed us that for two of the ten samples, no formal bid was submitted, and the Executive ratified inclusion. We were also informed by management that schemes are often considered outside of the annual capital bidding process, so for some schemes, there will not be a bid document as such, only a preliminary Committee/Executive report asking for a scheme to be given an outline approval/progress to a further report to approve capital spend.	If a standardised bid process is not followed, there is a risk of inconsistencies, failure to compare and contrast bids effectively and, ultimately, poor decision making with regard to materially significant financial resources. This could lead to further adverse financial consequences. The potential consequences of this risk will become greater as the Council's resources	Management should: - Formalise its bid submission process and ensure all bids part of the annual capital bidding process are submitted using the current standardised bid form and CR2 form. This should be saved within a centralised file management system to ensure ease of access and maintenance of bid file history. - Document how a bid was assessed, outlining the factors considered in the discussions and document who was involved in assessing the bid and putting forward the proposal for approval. Where several discussions are held at several layers (and thus become difficult to document), management should at least ensure it records dates,	This should be looked at as part of the preparation for the next cycle of capital bids, that is, at the end of 2023. At this stage, the Principal Accountant should consider the system about to be used to see what can be done to improve record keeping and standardising the submissions process. Similarly, notes of the review process should be made during this round, with a view to improving templates and guidance for the following round.	December 2023 - Principal Accountant

	- Where a completed bid form had been evidenced, no associated CR2 form had been provided/evidenced. - No evidence was provided for the remaining three samples. For our sample of ten bids, no information/evidence was provided when assessing whether bids had been scored individually by a specific team/officer or assessed in line with a defined criteria. The rationale behind decision-making at the 'screening' and 'scrutiny' stages was not documented. The Principal Accountant informed us that 'decisions are often based on what best aligns with current values rather than on a scorecard system. The decision-making is represented either by a set of minutes or, in the case of some meetings, no minutes at all, often for confidentiality reasons'. So, a bid may be discussed at several layers and still not leave a detailed written record.	are increasingly stretched.	attendees, an overview of the discussion and any key decisions made during the meetings. This will allow management to maintain and evidence a file history at the assessment stage. **Priority 2**		
2	<u>Capital Bidding - Policies and Procedures</u> Through discussions with the Principal Accountant, we identified and reviewed the process for the origination and submission of capital bids and the subsequent assessment and approval of those bids.	Council staff are unaware or lack understanding of the capital bid process that is followed, including what they are responsible for	Management should compile standing policy and procedure document(s) which sets outs: - The end-to-end capital bid process from origination to	Policy and standard documents for the end-to-end process already exist; the issue is the various alternative routes to submission.	September 2023 - Principal Accountant

	While management informed us of the process, we found no documented policy/procedure that states the end-to-end process. Further, no guidance is provided on schemes considered outside the annual capital bidding process and the process to be followed. Therefore, there is no complete and up-to-date guidance for staff to refer to, outlining the key stages in the end-to-end process, such as how bids are to be submitted and assessed, roles and responsibilities, and decision-making authority. As noted earlier in this report, while we confirmed that an internal memo is sent to the Chief Officer that sets out what is required in respect of the submission of bids, this memo does not compensate for not having an approved and comprehensive bidding policy.	and how bids are assessed, leading to inconsistencies when handling and processing bids. This could result in poor decision making. Potential conflicts of interest are not identified and are unclear how to proceed with potential conflicts which could arise when processing, assessing and approving bids.	approval, split into distinct and logical sections - Roles and responsibilities - Decision-making authority - How bids are considered outside the annual capital bidding process - How to identify and handle any potential conflicts of interest - Any other relevant information about the process This should be approved by senior management and subsequently reviewed and updated at an appropriate frequency to ensure it reflects current practice. This should be circulated and made available to all relevant staff. **Priority 2**	However, it would be good practice for the Principal Accountant and his team to double check how and where this is recorded, update such guidance to incorporate the main "alternative routes" and get senior management approval.	
3	<u>Sensitivity Analysis</u> Our review of the four quarterly Capital Monitoring reports for 2021/22 FY noted that assumptions had been made as part of the Capital Financing statement, which sets out the different sources of finance available and the impact on these resources as a result of the current Capital Programme and the estimated value of future programmes.	The Council is unable to identify in advance and prepare for potential capital shortfalls due to potential adverse scenarios and therefore is unable to fund future capital	Management should perform sensitivity analysis of assumptions made within the Capital Financing statement and document within quarterly Monitoring reports, which reflects sector best practices.	We accept this comment as fair and as being potentially useful, except to add that, as all projects are ultimately proposed by experts, the process relies on those experts to perform such analysis as part of	December 2023 - Principal Accountant

	These assumptions include the following: ○ The annual value of new capital schemes; ○ Timing and value of capital receipts; ○ The current approved programme, and ○ Internal borrowing. While these assumptions have been explicitly stated within the Capital Financing statement, no sensitivity analysis has been performed. For example, an analysis of plausible scenarios that could occur, such as current programme costs increasing by 5% or capital receipts achieving 5% less than the estimated value, has not been performed. Therefore, the impact on financial resources has not been considered.	schemes due to insufficient funds in place and/or at the right time. As a result of the current uncertain economic environment, the Council is not prudent in making capital investment and financing decisions, which could lead to an unsustainable capital programme and failure to meet strategic objectives.	Management should identify plausible but adverse scenarios at appropriate intervals, e.g., 5%/10%/20% increase in costs/decrease in capital receipts and analyse the impact on financial resources, allowing to identify where shortfalls may occur and outline contingency actions should the scenario crystalise. **Priority 2**	preparing their detailed business case. Principal Accountant and team to develop a simple, re-usable Excel model that can flex budgets for options appraisals. This could then be either performed on submitted bids as part of a challenge and scrutiny process or requested from bidders as part of the bids process. Obviously, the success of any such strategy depends on the experts submitting their bids doing so with sufficient detail and rigour. Have typically already provided input.	
4	<u>Actual Spend Monitoring</u> We noted that the Q4 Monitoring Report is an outturn report as this is a report produced after the programme year is complete and documents the final budget approved for the year alongside actual spending.	A lack of oversight in identifying and analysing variations or potential future variations in spending. This could result in the	To provide further transparency, management should consider reporting figures on actual spending to date for the current year in each quarterly Capital Monitoring report presented to the Executive. As reflected in the	The Principal Accountant and team are minded to do this - indeed, this is already reported at sub-Executive level (PDS committees) but whether it happens or not will ultimately depend on	December 2023 - Principal Accountant

	However, no analysis of spend to date, split by scheme/portfolio in quarters one to three, is provided in the reports. Our review of the Q1, Q2 and Q3 Capital Monitoring report presented to the Executive for the FY 2021/22 noted that analysis of actual spending to date of the current Capital Programme is not included. While this information is included in the Capital Monitoring workbooks and reports to PDS Committees, which are used to compile the quarterly Monitoring reports to the Executive, this information is not included in the report to the Executive itself.	Executive's inability to challenge the cause for such variations.	reports to the PDS Committees, this data should be split by scheme/portfolio to allow the Executive to identify the spending to date and comparison to the budget. **Priority 3**	appetite from the target audience, i.e. Exec. Suggest putting summary figures into Q1 23/24 Exec report (the Q4 report is outturn and so already includes actuals) and seeing what response the inevitably longer report gets - perhaps an extra appendix.	
5	<u>Capital Strategy Report</u> We obtained and reviewed the latest Capital Strategy report 2022-26 and noted that the document is not in the form of a formal 'published' report as seen with the Council's Treasury Management Strategy. Although we confirmed that the key components of the Capital Strategy are reflected within, there is a lack of structure with no table of contents providing ease of navigation for readers. There are also no sections which include the following:	Committees and other readers of the Capital Strategy report cannot navigate and grasp the Capital Strategy in a convenient and timely manner which may impair decision-making ability at the Committee level. The Capital Strategy report presented to Committee and made available in	Management should review and update its Capital Strategy to reflect a 'published', easy to navigate and user-friendly report. A table of contents should be inserted, and sections within the report should be set out logically and incorporate the sections noted within the observation box. Management should review published Capital Strategy reports of other local Council bodies available in the public domain to gain an insight into how a Capital Strategy report can be compiled	This does not fit well with the format of the report as published, which is a 5-8 page narrative report with appendices, written to a standard format specified by Exec and Democratic Services. We will review the work of other authorities - one alternative would be to publish the key points, once approved, as part of a revamped “Capital Booklet”,	December 2023 - Principal Accountant

	- Formal Introduction: which gives residents, Councillors and other stakeholders an overview of why, where and how the Council intends to spend capital on providing services and meeting the Council's wider strategic aims; - Council Plan/Objectives: identify and explicitly set out what strategic objectives the strategy will help to deliver; - Governance Arrangements: setting out who does what and when; - Other Strategies relevant to Capital Strategy and how they feed in. - Where appropriate, thematic information relevant to the programme and investment to give readers context - Key Strategic Risks and Mitigation of the Capital Programme We also noted that some standalone appendices accompany the main Capital Strategy report, containing key information that makes it difficult to locate and navigate.	the public domain does not align with sector best practices and may result in stakeholders outside of the Council not being able to digest the information presented and associated reputational risk.	and the nature of sections included within the report. **Priority 3**	largely for internal consumption.	

6	<u>Data Reconciliations</u> To ascertain the completeness and accuracy of data reported within the quarterly Capital Monitoring reports, we obtained four quarterly Capital Monitoring workbooks (which are used to compile the reports) spanning from Q2 2021/22 to Q1 2022/23 to confirm whether reconciliations are being performed between source data and the data reported within the reports. We noted that for the past two quarters, Q1 2022/23 and Q4 2021/2022, reconciliations were performed between the source data obtained via reports from the financial system and the data set out for the monitoring reports. However, no reconciliations were performed in the Q2 and Q3 2021/2022 workbooks. The Principal Accountant informed us that while accuracy checks will have been made, they were not formally documented.	Incomplete and/or inaccurate data is compiled and reported to Committees, resulting in potential ineffective monitoring and decisions made.	Management should ensure and continue to perform automated reconciliations between data in the quarterly Capital Monitoring reports and source documentation to ensure the completeness and accuracy of the information being reported to Committees. **Priority 3**	As noted, this process has now begun. We will endeavour to continue and improve it. Ongoing process, constantly looking for improvements.	Implemented – Capital Accountant

APPENDIX B

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

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REDACTED

FINAL INTERNAL AUDIT REPORT

CHIEF EXECUTIVE DEPARTMENT

CASH AND BANK

Issued to: Assistant Director, Exchequer Services
Revenues and Benefit Manager
Head of Financial Systems
Head of Corporate Finance and Accounting
Director of Finance (Final report only)

Prepared by: Trainee Auditor

Reviewed by: Head of Audit and Assurance

Date of Issue: 07 February 2023

Report No.: CEX/02/2022

CASH AND BANK

INTRODUCTION

1. This report sets out the results of our audit of Cash and Bank. The audit was carried out as part of the work specified in the six-monthly Internal Audit Plan for 2022-23, agreed by the Audit and Risk Management Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. The objective of the audit was to review the effectiveness of controls in place to ensure income is received, allocated and banked accurately and intact.
3. We would like to thank all staff contacted during this review for their help and co-operation.

AUDIT SCOPE

4. The original scope of the audit was outlined in the Terms of Reference and subsequently we tested the following key risks:

- Theft or loss of income through fraud or error, which may also create reputational damage
- Errors are made in recording and processing of income
- There are delays in processing and recording of income

AUDIT OPINION

5. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Substantial Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

CASH AND BANK

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
0	1	3

SUMMARY OF FINDINGS

6. The audit has identified the following controls in place and working as expected:
   - Income received via bank, cheques, telephone, internet and cash is recorded and processed accurately and intact.
   - KPIs are reviewed monthly by the Revenues and Benefits Manager and review of the outcomes for September identified that performance is meeting targets.
   - The policies and procedures for cashiers are held at the Cashier's Office and readily available to staff.

7. Management should consider the key findings summarised as follows:
   - Corporate Finance Team is currently not undertaking any reconciliation on income received by the Council.

8. We would like to thank all staff contacted for their help and cooperation during the audit.
9. The Management Action Plan is set out in Appendix A and Appendix B defines the audit opinion and recommendation ratings.

REDACTED

CASH AND BANK

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

1. Reconciliation of income	
Finding Corporate Finance Team is currently not undertaking any reconciliation on the income received by the Council. Council's Senior Accountant has advised that this is due to operational issues and the function is planning to implement reconciliations by the end of January 2023. As part of the audit, we also examined other measures that function had had taken to mitigate the risks in the absence of income reconciliation and did not find them robust in highlighting errors or exceptions in the received income. **Risk** Errors, exceptions and discrepancies may not be identified, investigated and rectified timely.	
Recommendation The Head of Finance and Accounting should set a clear timescale for completing the reconciliation, ensuring that procedures are drawn up and that there are sufficient staff trained to cover the reconciliation in the event that the responsible officer is absent.	**Rating** **Priority 2**
Management Response and Accountable Manager The reconciliation process has been delayed in 2022/23 owing to prolonged staff absences and the implementation of the Council's new finance system – the latter has meant that the cash income reconciliation process is completely new and consequently it has taken some time to understand the underlying processes and implement the reconciliation. Accountable Manager: Senior Accountant – Technical & Control	**Agreed timescale** January 2023 onwards

CASH AND BANK

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

2. Delay in banking – Sites A and B kiosk cheques	
Finding Our sample testing of five cheques received at the Sites A and B identified that four were banked with a delay of eight to ten working days. We are awaiting a response from the Council's Exchequer contractor regarding the possible reasons for this. **Risk** Any delay in processing cheques may increase the risk that there are insufficient funds in the client's account to honour the cheque.	
Recommendation The Assistant Director, Exchequer Services should discuss the banking arrangements with the Council's Exchequer contractor for Site A / Site B and investigate the reason for the delay in banking, to identify if any measures can be implemented to improve timeliness of banking.	**Rating** Priority 3
Management Response and Accountable Manager The receipts from the Council's Exchequer contractor's Site A (previously Site B) office are collected by their cash collection contractor who should then deposit them with the Bank's Cash Centre on the following working day. The Council's Exchequer contractor contacted their cash collection contractor regarding the delays in banking and they advised that any delays would be at the Bank's Cash Centre end. The cash collection contractor confirmed that they would be able to provide a Proof of Deposit for any days under question and this has been requested. Once this is received the delays will be discussed with the bank. Assistant Director, Exchequer Services	**Agreed timescale** 28/02/23

CASH AND BANK

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

3. Money Laundering Policy	
Finding Council's Exchequer contractor's Cashier Function did not have access to the Council's Anti-Money Laundering Policy. As per the contracted service requirements, the Council's Exchequer contractor's Cashier Function should ensure that appropriate officers attend Money Laundering Training and that procedures are put in place to ensure they comply with the regulations specifically with regard to identification procedures. We also noted that the Council's Exchequer contractor's 'Cashiers Anti-Money Laundering Awareness Training' document provides incorrect guidance on contacting the Council's Head of Audit for reporting any cash payments over £5,000; this is no longer aligned with Money Laundering roles and responsibilities within the Council. **Risk** All legal obligations, safeguards and reporting arrangements may not be complied with.	
Recommendation The Assistant Director, Exchequer Services should review the Council's Anti-Money Laundering Policy and ensure that the Council's Exchequer contractor's relevant processes and procedures align.	**Rating** Priority 3
Management Response and Accountable Manager Council's Exchequer contractor have been provided with the Council's Anti-Money Laundering Policy and a review of their processes will be conducted to ensure they align. Assistant Director, Exchequer Services	**Agreed timescale** 28/02/23

An annual review of the Council's Exchequer contractor's procedures will be carried out and refresher training for its employees will also be scheduled. F & A Council's Exchequer contractor's Service Delivery Manager	28/02/23

4. Keys	
Finding We noted that the keys for storing Bromley kiosk's float can be accessed by any staff working there without restriction. **Risk** Inability to investigate and identify the responsible person in case of missing or lost Bromley kiosk float.	
Recommendation The Assistant Director, Exchequer Services should liaise with the Council's Exchequer contractor and ensure that this money is kept securely.	**Rating** Priority 3
Management Response and Accountable Manager Agreed Council's Exchequer contractor's F & A Service Delivery Manager	**Agreed timescale** 28/02/23

OPINION DEFINITIONS **APPENDIX B**

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

REDACTED

INTERNAL AUDIT FINAL REPORT

Place

NET ZERO

Issued to: Director of Environment and Public Protection
Assistant Director- Carbon Management and Greenspace
Head of Finance-Environment & Community Services and Chief Executive Department

Prepared by: Principal Auditor

Reviewed by: Head of Audit and Assurance

Date of Issue: 07/02/2023

Report No.: PLA/07/2022

NET ZERO

INTRODUCTION

1. This report sets out the results of our audit of Net Zero. The audit was carried out as part of the work specified in the 2022-23 Internal Audit Plan agreed by the Audit and Risk Management Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. In June 2019, the United Kingdom became the first major economy to pass a law to bring all Greenhouse Gas (GHG) emissions to Net Zero by 2050. In response a Council Motion on 15th July 2019 unanimously approved a ten-year plan to ensure that the council will have Net Zero carbon emissions by 2029. This target applies to LBB's organisational emissions only (i.e. those which are directly within the Council's control). The Net Zero Action Plan charts the planned activities of LBB in reducing the organisational emissions to achieve Net Zero by 2029". The Council's Net Zero carbon target is now 2027 which was revised from 2029 at the Full Council meeting on 28th Feb 2022.
3. We would like to thank everyone contacted during this review for their help and co-operation.

AUDIT SCOPE

4. The original scope of the audit was outlined in the Terms of Reference issued on 09/09/2022.
5. We identified the following key risks:
    - Failure to achieve Net Zero organisational emissions by 2027 due to inadequate planning
    - Actions do not align to available funding
    - Failure to embed Net Zero in business as usual meaning that changes are not sustainable

NET ZERO

AUDIT OPINION

6. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Reasonable	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
0	**3**	**0**

SUMMARY OF FINDINGS

7. We observed some areas of good practice and sound controls:

- Failure to adapt the borough and Council services to our changing climate is included as a risk in both the LBB corporate risk register and Environment & Community Services (ECS) Risk Register. Management have identified existing controls which are in place and further actions to mitigate the climate change risk and they are listed on the risk registers. Most existing controls were satisfactorily evidenced and areas where further action is required, are listed in Recommendation 3.
- The Net Zero plan is the Council's key response to reducing its emissions. The plan is comprehensive and includes its scope, approach, actions, and targets for delivery of the key initiatives, enabling factors and implementation strategy to achieve Net Zero.
- Performance against the Net Zero target is monitored, measured, and reported by the Carbon Management Team.
- The initiative to upgrade all street lighting to LED is almost complete with the last few remaining.

- The procurement of 100% renewable energy that allows the Council to credibly report zero emissions for its electricity consumption is the most impactful solution for reducing most of the Council's scope 1 and 2 emissions and is therefore paramount to achieving the 2027 Net Zero target. The Greater London Authority and London Councils are currently developing a pan-London renewable PPA procurement option that would allow all London boroughs to access renewable energy in such a way as to achieve zero emissions on electricity use. The Carbon Programme manager advised that once available the council will consider procuring its electricity through the renewable PPA procurement option.
- There are no annual targets within the Net Zero plan, progress is measured against the 2018/19 baseline year and the Net Zero target. The data requirements are understood, and controls are in place to ensure relevance, completeness, accuracy, and timeliness of data capture.
- Progress of the Net Zero plan is reported in the Annual performance report which is presented to the Environment PDS committee, and it is also published on the Council's website.

8. Our review highlighted the following areas for further development:

- Some information recorded on both Corporate and ECS risk registers for the climate change risk is out of date.
- Reducing emissions for the Council owned buildings is one of the four key initiatives prioritised in the Net Zero plan. The energy used by council buildings (electricity & gas) accounts for 54.2% of the Council's emissions for 2021/22, reduction of these emissions is fundamental to achievement of its Net Zero ambition. Possible relocation of the Council HQ is planned however the carbon impact of this proposal has not been assessed.
- In addition to monitoring, measuring, and reporting the performance against the Council's Net Zero target, the Carbon Management Team also identifies and develops business cases for new initiatives and coordinates the initiatives already included in the Net Zero plan. In discussions, the Carbon Programme Manager stated that the Carbon Management Team lacks capacity to drive resource intensive initiatives.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

9. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised, together with management's responses and timescales for implementation. Appendix B details the definition of the audit assurance and priority ratings.

DETAILED FINDINGS AND ACTION PLAN

1. *Resources*	
Finding In addition to monitoring, measuring, and reporting the performance against the Council's Net Zero target, the Carbon Management Team also identifies and develops business cases for new initiatives and coordinates the initiatives already included in the Net Zero plan. The Carbon Management Team previously had 3 Full Time Equivalent officers. Currently the team consists of a Carbon Programme Manager, supported by a part time Strategic commissioning officer whose key responsibility is supporting offsetting activities which includes advice on carbon reduction in council owned buildings in parks and a graduate trainee. In discussions, the Carbon Programme Manager stated that the Carbon Management Team lacks capacity to keep driving resource intensive initiatives. For example, a Council-wide Green Recovery Working Group (GRWG) has been established to build back greener, following the COVID-19 pandemic. The remit of the GRWG is to bring services together to identify further opportunities for environmental improvement. The Carbon Programme Manager informed that currently the GRWG meetings are paused as the Carbon Management Team has not had sufficient resources to keep driving the GRWG forward. No additional resources have been identified to deliver the revised target for Net Zero for scope 1 and 2 emissions from 2029 to 2027. The Carbon Programme Manager is due to leave the Council at the end of January 2023 which will further reduce the resources within the Carbon Management Team. **Risk** Required actions do not align to available resources.	
Recommendation: Management should review the actions required to deliver net zero and ensure that these can be delivered with existing available skills and resources, or alternative resourcing strategies developed.	**Rating** Priority 2

Management Response and Accountable Manager	Agreed timescale
Management is in the process of reviewing resourcing for the delivery of the Net Zero Carbon Action Plan and the council's wider policy commitments to carbon related projects.	
There are currently two vacant posts in the Carbon Management Team – the Carbon Programme Manager and the Environmental Programme Officer posts. The job titles and JD/PS for these posts are currently under review to ensure that they best meet the resourcing needs of the carbon programme. Once reviewed and agreed, it is intended to recruit to both posts, with recruitment activity commencing by the end of April 2023.	April 2023
Additionally, management are reviewing the availability of other sources of funding, such as the Carbon Neutral Fund and external grant funding, for the creation of posts to deliver specific projects that fall within the remit of the carbon management team (e.g. electrification of fleet within Scope 3 emissions).	Ongoing
Accountable Manager: Assistant Director, Carbon Management and Greenspace	

2. *Building emissions*	
Finding Reducing emissions for Council owned buildings is one of the four key initiatives prioritised in the Net Zero plan. The energy used in Council buildings (electricity & gas) accounts for 54.2% of the Council's emissions for 2021/22, reduction of these emissions is fundamental to achievement of its Net Zero ambition. Initiatives to reduce these emissions were dependent on the outcome of the Operational Property review. The recommendations from this review were agreed by Executive on 30/11/22 which included formal adoption of the Operational Estate Strategy and agreement for officers to progress various workstreams included in the report. The Strategic Objective 1 of the Operational Estate Strategy includes the commitment to rationalise the estate used for the delivery of Council services through co-location or reconfiguration of retained assets to reduce their carbon impact. One of the workstreams agreed was to relocate the Council's Headquarters to a new site. Following the formal announcement of the possible relocation, we contacted the Carbon Programme Manager to ascertain what impact the move will have on the Council's emissions from its buildings for both electricity & gas. He said that the carbon impact of the move has not yet been assessed. Following our meeting, he has requested the energy usage and carbon emissions information for the proposed new Headquarters but has not yet received this. **Risk** Failure to achieve Net Zero organisational emissions by 2027 due to inadequate planning.	
Recommendation The emissions for the proposed new Headquarters should be assessed to ascertain the Carbon impact of the move. Based on the outcome of this assessment the Net Zero plan should be reviewed and changed as required. The Programme Board should ensure that carbon impacts are assessed when decisions concerning the office move are made.	**Rating** Priority 2

Management Response and Accountable Manager	Agreed timescale
Information to support the assessment of the impact of the proposed move of the council's headquarters on the Net Zero Carbon Action Plan has been requested from the Programme Lead and will be reviewed by the Carbon Management Team once received, with this information informing any changes that then need to be made to the Net Zero Action Plan. The Programme Board (led by the Director for Environment and Public Protection) will be provided with the assessment information to inform future decision making. Accountable Manager: Director, Environment & Public Protection / Assistant Director Carbon Management & Greenspace	July 2023

3. *Risk registers*

Finding

Some information recorded on both the Corporate and ECS risk registers for the climate change risk is out of date or not reflective of the current situation.

- One of the existing controls noted on the Risk register is the 'Adoption of adaptations best practice as identified through London Climate Change Partnership, UK Climate Impacts Programme, and the Local Adaptation Advisory Panel'. The Carbon Programme Manager informed that this not in place yet and the Carbon Management Team are currently developing a briefing note to support the case for an adaptation strategy. Whilst some Council departments are delivering services to adapt to the changing weather (e.g. flood risks) there does not appear to be an umbrella strategy in place to bring everything together in a joined-up fashion.

- Another existing control on the Risk register is that a Council-wide Green Recovery Working Group (GRWG) has been established to build back greener, following the COVID-19 pandemic. The remit of the GRWG is to bring services together to identify further opportunities for environmental improvement. The Carbon Programme Manager informed that currently the GRWG meetings are paused as the Carbon Management Team has not had sufficient resources to keep driving the GRWG forward.

- One further action required noted on the Corporate Risk register as at 20/09/22 is the 'Roll out of Carbon Literacy Training to all staff to assist in the identification of climate change risks and opportunities at an individual, team and service level.' The Carbon Programme Manager advised that the Carbon Management Team delivered an online Climate Change staff webinar on 11th Nov 2021 attended at the time by 400 staff. The webinar was recorded and is still available on LBB's intranet site for all staff to watch. Currently no further training is planned.

Risk

Failure to achieve Net Zero organisational emissions by 2027 due to inadequate risk management.

Recommendation	**Rating**
Management should review and update the Climate Change risk on both Corporate and ECS risk registers to ensure that controls and actions listed accurately reflect the current arrangements in place, or additional actions required.	Priority 2
Management Response and Accountable Manager	**Agreed timescale**
The corporate and departmental risk registers will be reviewed to ensure that mitigations are appropriate and deliverable within existing policy and available resources. Accountable Manager: Assistant Director, Carbon Management and Greenspace	July 2023

OPINION DEFINITIONS

APPENDIX B

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

REDACTED

INTERNAL AUDIT FINAL REPORT

PEOPLE/CHIEF EXECUTIVES DEPARTMENT

PRE-PAID CARDS (Children's)

Issued to: Interim Director of Adult Services
Assistant Director of Integrated Commissioning
Head of Service Community Living Commissioning
Senior Commissioning Officer

Director of Children's Services
Assistant Director, Children's Social Care
Assistant Director, Children's Social Care
Head of Service (CLA and Care Leavers)
Head of Service Referral and Assessment
Head of Permanency Service and DCT
Group Manager Leaving Care
Group Manager Specialist Support and Disabilities
Head of Service 0-25 Service, Children and Young People with Disabilities
Assistant Director, Exchequer Services

Prepared by: Principal Auditor

Reviewed by: **Head of Audit and Assurance**

Date of Issue: **09 January 2023**

Report No.: **PEO/04/2021**

REVIEW OF PRE-PAID CARDS (Children's)

INTRODUCTION

1. This report sets out the results of our audit of the pre-paid cards within Children's Services. The audit was carried out as part of the work specified in the 2020-21 Internal Audit Plan agreed by the Section 151 Officer and Audit Sub-Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. The pre-paid cards solution for Bromley council is provided by a contractor. The prepaid cards contract aims to support the expansion of the use of direct payments to increased number of clients accessing community support to respond to their assessed needs, improving how money is disbursed to young people in Leaving Care and more effective management of money for people with no recourse to public funds**.**
3. We would like to thank everyone contacted during this review for their help and co-operation.

AUDIT SCOPE

4. The original scope of the audit was outlined in the Terms of Reference issued on 14/03/2022.
5. We identified the following key risks:
   - The pre-paid card contract and specification do not align to the London Borough of Bromley's service needs or are not an effective means of service delivery
   - Funds are loaded incorrectly, leading to overpayments or service users unable to pay for their care or other needs
   - Cards are used fraudulently, or funds are spent inappropriately

REVIEW OF PRE-PAID CARDS (Children's)

AUDIT OPINION

6. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Reasonable Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
0	**5**	**0**

SUMMARY OF FINDINGS

7. We observed some areas of good practice and sound controls:

- The contract is a comprehensive document that clearly sets out Council/provider roles and responsibilities together with service requirements in a logical order.
- Quarterly Prepaid Card Programme Contract Monitoring Meetings are held with the contractor. The meetings are attended by the LBB contract owner, Senior commissioner and Head of Strategy and Performance Adult services and contractor representative. An agenda and the Prepaid Card KPI Pack produced by the contractor is circulated prior to the contract monitoring meeting and minutes of these meeting are retained.

REVIEW OF PRE-PAID CARDS (Children's)

- To ensure that access rights to the prepaid card portal is adequately controlled we requested a report of all users with access to portal to review that access rights correspond with officers' roles and responsibilities and access is removed promptly when officers leave. Access rights of officers responsible for setting up, authorising, and allocating the cards in audit sample for the Leaving Care, Children with Disability and NRPF team were checked and found to be satisfactory to their roles and responsibilities. No cases of officers not being removed after they have left LBB were noted.

8. Our review highlighted the following areas for further development:

- 3 of 11 KPIs relate to clients and their card transactional activities. This information is available within the contractor's portal and should be reviewed by the service teams. No evidence of service teams reviewing these KPIs was seen.
- Once an officer is set up on the contractor's portal, there is no process to periodically review their roles, responsibilities, and access rights to ensure that their level of access corresponds to their role within the process and any access accounts that are no longer required are deactivated.
- The documented pre-paid card process for each of the three services using the cards was missing some key elements of the process, these have been explained in the detailed findings below.
- The monitoring of expenditure for Direct Payment cards for both children services and adult services has been paused. It was noted that the Exchequer team has not communicated this change to the Direct Payment teams.
- The contractual obligation to complete necessary checks on clients before requesting a prepaid card are not evidenced by NRPF team.
- Whist reviewing a sample of invoices for the contractor, their payment date could not be confirmed on the Financial system. The senior commissioner who is responsible for reviewing invoices said that there has been ongoing delay in payments since moving to the Financial system and the contractor has been chasing outstanding payments.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

9. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised, together with management's responses and timescales for implementation. Appendix B details the definition of the audit assurance and priority ratings.

DETAILED FINDINGS AND ACTION PLAN

1. *Performance management*	
Finding Quarterly Prepaid Card Programme Contract Monitoring Meeting are held with the contractor. The meetings are attended by the contract owner, Senior commissioner and Head of Strategy and Performance Adult services. An agenda and the Prepaid Card KPI pack produced by the contractor is circulated prior to the contract monitoring meeting. We compared the KPIs in the contract to the information provided by the contractor in their KPI pack for Q1, Q2, Q3 and Q4 of 2021-22. The KPI packs did not include sufficient information to support 3 of 11 KPIs. On enquiry the contractor advised that these 3 KPIs relate to individual client's and their card transactional activities, scheme budgets and care package allowances. The contractor does not access this data in line with General Data Protection Regulation (GDPR) however the required information is available within the contractor's portal and LBB officers can check if the KPIs are met. The Senior Commissioning Officer further advised that the 3 KPIs not included in the KPI pack relate to automatic functions that are set up on the online portal and are actioned the moment LBB officer makes the request. The commissioning officers already generate reports that check on these activities collectively however no evidence of these KPIs being reviewed by the service teams was evidenced. **Risk** Key performance indicators to assess the achievement of contract objectives are not tracked as the required data is not available which impacts on the ability to adequately performance measure the contract delivery. Deficiencies in performance may not be identified or addressed.	
Recommendation KPIs relating to individual client transactions should be reviewed by the service teams before the Quarterly Prepaid Card Programme Contract Monitoring Meeting to ensure issues can be discussed and resolved with the contractor. Going forward management should consider and agree information required and responsibility for performance monitoring at the time of contract negotiations.	**Rating** **Priority 2**

Management Response and Accountable Manager	Agreed timescale
To work with colleagues in children and adult services, as we are a 0-25 service the provision of pre-paid cards spans both services. As detailed, this should be prior to the Quarterly Prepaid Card Programme Contract Monitoring Meeting. Accountable Manager: Head of Service 0-25 Service, Children and Young People with Disabilities	February 2023
Monitoring information required is emailed to the contract lead prior to the meetings to use at the Quarterly Prepaid Card Programme Contract Monitoring Meeting. Accountable Manager: Senior Commissioning Officer	April 2023

2. *Roles and Responsibilities*

Finding

Once an officer is set up on the contractor's portal, there is no process to periodically review their roles, responsibilities, and access rights to ensure that their level of access corresponds to their role within the process and any access accounts that are no longer required are deactivated.

Risk

Access to system is poorly controlled which may lead to misappropriation of funds.

Recommendation	Rating
Management should set up a process to periodically review the access rights of officers in their teams to ensure that the level of access corresponds to their role within the process and any access accounts that are no longer required are deactivated.	Priority 2

Management Response and Accountable Manager	Agreed timescale
To link in with above standard, to periodically review the access rights of officers. An immediate review of access rights will be actioned. Accountable Manager: Head of Service 0-25 Service, Children and Young People with Disabilities	January 2023
Dedicated IT support has been agreed between the commissioning team and the Councils IT contractor systems support. They are in the process of finalising the specific tasks and functions that they are going to support and associated costs. Accountable Manager: Senior Commissioning Officer	February 2023

3. Procedure notes

Finding

We reviewed the procedures for setting up, authorising, and allocating cards for the Leaving Care and Children with Disability teams. The procedure note for NRPF was not provided and hence could not be reviewed. The Head of Service Referral and Assessment responsible for NRPF advised that their procedure note is being updated and hence they did not provide it for review.

The procedures for the Leaving Care team and Children with Disability team did not cover how the receipt of the prepaid card by the cardholder will be acknowledged, particularly the ones sent out via post. Funds should only be loaded onto the pre-paid card once the receipt of the card is confirmed by the service user. They have also not been reviewed and updated to reflect the changes to the process since the pandemic and move to the care management system.

Risk

Lack of clear guidance leading to poor governance and use of prepaid cards.

DETAILED FINDINGS AND ACTION PLAN

Recommendation	**Rating**
Procedures for the governance and use of prepaid cards should be updated to reflect any changes to the process since the pandemic and move to the care management system. They should be made available to the respective services teams. The procedure note should include the name of the owner, published date and review date.	Priority 2
Management Response and Accountable Manager	**Agreed timescale**
To link with children and adult colleagues to review the procedure reflects the change to the care management system. We understand an activation process is required which would ensure no fraudulent activity can take place. Accountable Manager: Head of Service 0-25 Service, Children and Young People with Disabilities	End of January 2023
NRPF updated procedures will be completed by the 27/01/23. This will incorporate management authorisation for issuing a card and will also incorporate where in the care management system this will be recorded. Accountable Manager: Head of Service, Children Services	End of January 2023
Finance officers are very clear that they do not load money on to cards until they have received notification from the worker that the card has been received by the young person. This has been done via email and not hitherto recorded. Moving forwards the email communication will be saved with the card details for audit purposes. The finance officer will implement this process. Accountable Manager: Head of Service Children Looked After & Care Leavers	Completed 01/12/2022

4. Monitoring of expenditure on prepaid card	
Finding We tested for sampled prepaid cards that the purchases were made for agreed purposes and adequate monitoring was being done by the service. There is no requirement for expenditure monitoring for Leaving Care and NRPF cards. Monitoring of expenditure for Direct Payment cards for both children's and adults services and should be completed by the Exchequer Services contractor. On enquiry we were informed by the Exchequer Services contractor's Service Delivery Manager that direct payment monitoring has not been undertaken as payment processing and query resolutions has taken priority over all monitoring. The Contract and Operations Manager (Exchequer) confirmed that the monitoring has been paused. We discussed this with the Interim Group Manager who was not aware that the monitoring has been paused. She stated that there has been no communication from the Exchequer team on the matter. Sample testing of pre-paid cards for Children with Disabilities did evidence some cash withdrawals and, without further monitoring or receipts, we are unable to provide assurance that this money was spent in accordance with its intended purpose. **Risk** Loss of funds due to fraud.	
Recommendation Management should ensure that the monitoring for both children's and adults services receiving direct payments is undertaken to ensure funds are being spent on the assessed needs of the direct payment client. Whilst The Exchequer Services contractor are unable to do it, the service should agree and implement an interim approach.	**Rating** **Priority 2**
Management Response and Accountable Manager To discuss with contract holder, how this can be managed going forward. Accountable Manager: Head of Service 0-25 Service, Children and Young People with Disabilities	**Agreed timescale** January 2023

The Pandemic and subsequent issues caused by the implementation of the case management system and financial modules meant that the monitoring had to be paused. This will be recommenced in January 2023 (16/1/2023) for both children and adult services. Accountable Manager: Assistant Director, Exchequer Services/Service Delivery Director (The Exchequer Services contractor)	January 2023

5. Completion and retention of documents	
Finding As part of the set-up process for prepaid cards, it is a contract requirement that a 'Know Your Customer' (KYC) form is completed by the client. As part of testing, the KYC form could not be located for the two sampled prepaid cards issued to NRPF client. The completion of contractual obligation to do necessary checks on client before requesting a prepaid card was therefore not evidenced. **Risk** Loss of funds due to fraud.	
Recommendation Management should ensure that the documents to confirm a client's identity are duly completed and retained.	**Rating** Priority 2
Management Response and Accountable Manager This action has been completed. We have reviewed the "Know Your Customer" form and confirm there is a specific section for NRPF families. This form has been retrospectively completed on all open NRPF cases (where they have not been completed) and new forms will be completed at the point of new cards being issued. Cards will not be issued without a completed form. Accountable Manager: Head of Service, Children Services	**Agreed timescale** Completed.

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

REDACTED

INTERNAL AUDIT FINAL REPORT

PUBLIC HEALTH DIRECTORATE

PUBLIC HEALTH COVID-19 RESPONSE – LESSONS LEARNED

Issued to: Director of Public Health
Consultant in Public Health
Director of Finance (final report only)

Prepared by: Principal Auditor

Reviewed by: Head of Audit and Assurance

Date of Issue: 25 January 2023

Report No.: PH/01/2022

INTRODUCTION

1. This report sets out the results of our audit of the lessons learned from the Public Health Covid-19 response. The audit was carried out as part of the work specified in the 2022-23 Internal Audit Plan. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. The Covid-19 pandemic resulted in Local Authorities needing to respond immediately to challenges which they had not faced before. In Bromley a local Covid-19 Outbreak Control Plan was put in place which provided the framework for coordinating the borough multi-agency response to COVID-19 pandemic. Key areas of work which the Public Health team undertook during the pandemic were:

    - Surveillance
    - Outbreak management
    - Covid-19 clinical response service
    - Local contact tracing service
    - Community testing service
    - Vaccination
    - Prevention /Communication and engagement

3. We would like to thank everyone contacted during this review for their help and co-operation.

AUDIT SCOPE

4. The original scope of the audit was outlined in the Terms of Reference issued on 25 August 2022.
5. We identified the following key risks:
    - Lessons learned from the Council's Public Health response to the Covid-19 pandemic have not been identified

- Lessons learned have not been prioritised and assessed, including the availability of resources within the Council and services provided by external stakeholders

- Measures to improve the Council's Public Health response have not been tested and implemented, meaning that the Council is unprepared for a future pandemic.

AUDIT OPINION

6. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Reasonable Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
0	**2**	**1**

SUMMARY OF FINDINGS

7. Our audit identified areas of good practice and sound controls as set out below:

- Within the Public Health Directorate, initial lessons learned were identified and addressed promptly by the Directorate during the course of the Covid-19 pandemic. This resulted in it being adequately resourced and prepared to deal with the Public Health response, both as the Covid-19 pandemic progressed and in the event of a further pandemic emergency in the future.

- Care Home Managers were complimentary about the support received from Public Health, as part of the multi-disciplinary Bromley Care Settings Support group, throughout the Covid-19 pandemic. The joint working to support care settings resulted in the recognition of a National 'Care and Health Integration Award'.

- The report written by the Director of Public Health on Public Health management of the Covid-19 pandemic identified lessons learned from management of the pandemic and prioritised three key lessons for the future for the London Borough of Bromley. The report was presented to the Health & Wellbeing Board and the Council's Adult Care and Health Policy Development and Scrutiny Committee. From our testing of a sample of data and information contained in the report we were able to confirm its robustness and accuracy. The principle of identifying three key lessons for the future arose from a peer review process led by the Association of Directors of Public Health across London.

- Separately, as part of the Council's preparedness for the UK Covid-19 Inquiry, interviews were arranged by Public Health officers and took place with key officers throughout the Council who were involved in providing the Council's response during the Covid-19 pandemic. Questions included those about the Council's level of preparedness pre-pandemic and governance and decision making. These interviews, which took place in 2022, also identified lessons learned, some of which related to individual Directorates and some which had a Council-wide focus.

8. Our audit review has, however, identified the following areas which we would like to bring to management's attention:

- We were unable to find evidence that the three key lessons learned for the future for the Council, prioritised in the Director of Public Health's report, have been actioned and tested for adequacy across the Council. Ownership and responsibility for this has not been assigned.

- We did not see evidence that each of the lessons learned suggested in interviews by key officers had been evaluated and either accepted or rejected. Examples included creating a guide for future pandemics with key people and 'steps' to do it efficiently and efficiently, having a bank of staff for a response team incident and keeping a database on this information and consideration of a proper wellbeing programme for everyone who worked on the Covid-19 response programme.

- Officers from Public Health interviewed key officers in the Council who were involved in providing the Council's response but one interview did not take place and so it is not known what, if any, suggestions of lessons learned were identified by that key officer.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

9. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised, together with management's responses and timescales for implementation. Appendix B details the definition of the audit assurance and priority ratings.

PUBLIC HEALTH COVID-19 RESPONSE – LESSONS LEARNED

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

1. Lessons learned not actioned or tested across the Council	
Finding Following the Covid-19 pandemic, the Director of Public Health wrote a report on Public Health management of the Covid-19 pandemic. This was based on the Bromley Outbreak Management Plan. It was presented to the Health and Wellbeing Board and the Adult Care and Health Policy Development and Scrutiny Committee in June 2022. Lessons learned had already been discussed at an Association of Directors of Public Health meeting and there was a lot of commonality between the Public Health teams, but some were quite specific to individual areas. The report written by the Council's Director of Public Health identified three key lessons or developments that should be retained as a priority for the future in Bromley. These were: 1.Re-energise whole Council approach, including partners i.e. whole system approach to address any health protection issues. 2.Ensure flexibility of the workforce through training, development, recruitment. 3.Maintain communications and local networks established for rapid information sharing and community engagement. We were unable however to find evidence that the three key lessons learned for the future for the Council, as prioritised in the Director of Public Health's report, have been actioned and tested for adequacy across the Council. Ownership and responsibility for this has not been assigned. **Risk** There is a risk that the Council is not adequately prepared for a future pandemic.	
Recommendation The Council implements the three key lessons for the future highlighted in the Director of Public Health's report on Public Health management of the Covid-19 pandemic and tests them for adequacy, to ensure that the Council is	**Rating** **Priority 2**

prepared for a future pandemic. This should be addressed by creating a more detailed supporting action plan with responsibilities assigned and resources addressed.	
Management Response and Accountable Manager Regarding the three key lessons for the future highlighted in the Director of Public Health's report: 1. This has been taken forward through our join partnership working, mainly through the Health and Well-Being Board One Bromley Executive and Borough Officers Group. 2. Further discussions and planning to take place with the Training and Development Team. 3. This has been maintained through various mechanisms as in point 1. In addition, through the South East London Integrated Care Board and the South East London Directors of Public Health group. Accountable Manager : The Director of Public Health.	**Agreed timescale** On-going 1 June 2023 On-going

PUBLIC HEALTH COVID-19 RESPONSE – LESSONS LEARNED

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

2. Evaluating all suggestions of lessons learned	
Finding During their interviews for the Council's preparations for the UK Covid-19 Inquiry, key officers including Directors, suggested lessons learned. In some instances, those suggested lessons learned e.g. creating a guide for future pandemics with key people and 'steps' to do it efficiently and effectively, aligned with the three overarching lessons learned and identified for the future. We did not however see evidence that other suggestions made by key officers in interviews in response to the 'lessons learned' question, been evaluated subsequently and either taken forward by the Council or individual departments as separate actions or rejected. Examples included 'Create a guide for future pandemics with key people and 'steps' to do it efficiently and efficiently', 'to have a bank of staff for a response team incident and keep a database on this information' and 'a proper wellbeing programme put in place for everyone who worked on the Covid-19 response programme'. We are aware from a discussion with Public Health that there is a protocol, agreed at Chief Officers Executive meeting on 1 November 2022, for appropriate Directors to check the accuracy and completeness of evidence and respond to a Rule 9 request (written request for evidence) received by the Council from the UK Covid-19 Inquiry. Our finding in this report is however outside of that protocol and relates purely to the risk of lessons learned not being actioned internally. **Risk** Useful suggestions which could help to improve the Council's response in future may not be taken forward, resulting in the loss of key learning opportunities and a less effective and efficient response if another pandemic occurred in the future.	
Recommendation Public Health provide COE with the strengths and areas for development, identified by individuals through the interviews conducted by Public Health for the Council's response to the Covid-19 Inquiry. COE can then evaluate and implement them where appropriate. This is to ensure that the Council is prepared for a future pandemic.	**Rating** Priority 2
Management Response and Accountable Manager Director of Public Health will present to COE the strengths and areas for development as recommended above.	**Agreed timescale** 1 April 2023

PUBLIC HEALTH COVID-19 RESPONSE – LESSONS LEARNED

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

3. Stakeholder interviews	
Finding As part of the Council's preparations for the UK Covid-19 Inquiry, officers from Public Health held interviews with key officers in the Council who were involved in providing the Council's response to the Covid-19 pandemic. We did not see transcripts of one of the interviews with key officers because, although arranged, it did not take place and so it is not known what, if any, suggestions of lessons learned were identified by that key officer. Interviews had not taken place with Members or external partners to identify lessons learned. We noted however that Members had welcomed the Director of Public Health's 'Management of Covid-19 Pandemic' report when it was presented to the Health & Wellbeing Board and Adult Care and Health Policy Development and Scrutiny Committee in June 2022. Members had been informed about the Director of Public Health's three key lessons for the future for the London Borough of Bromley and we are not aware of any consequent issues raised by them. **Risk** Lessons learned may not be identified and therefore key learning opportunities to help the Council to prepare for a future pandemic may be missed.	
Recommendation Public Health ensure that suggestions of lessons learned are obtained from: (i) the key officer who has not yet provided them, and (ii) that any suggested lessons learned are fed into the evaluation exercise outlined in recommendation 2 above.	**Rating** Priority 3
Management Response and Accountable Manager The key officer has been asked by Public Health for suggested lessons learned but has not provided them.	**Agreed timescale** Risk accepted.

APPENDIX B

OPINION DEFINITIONS

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

REDACTED

INTERNAL AUDIT FINAL REPORT

PEOPLE DEPARTMENT

QUALITY ASSURANCE FRAMEWORK – CHILDREN'S

Issued to:	**Director of Children, Education and Families** **Head of Service, Quality Improvement**
Cc (Final only)	**Assistant Director, Strategy, Performance and Corporate Transformation** **Head of Finance, Children, Education and Families**
Prepared by:	**Principal Auditor**
Reviewed by:	**Head of Audit and Assurance**
Date of Issue:	**6th February 2023**
Report No:	**PEO/06/2022**

QUALITY ASSURANCE FRAMEWORK – CHILDREN'S

INTRODUCTION

1. This report sets out the results of our audit of the Quality Assurance Framework of Children's Social Care. The audit was carried out as part of the work specified in the six-monthly Internal Audit Plan for 2022-23, agreed by the Audit and Risk Management Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. The function of the Quality Improvement service is to:-
    - deliver a comprehensive quality assurance programme 'system of control', identifying strengths and areas for development across the services which make up the Department
    - ensure compliance with legislation such as the Children and Families Act 2014 and the Ofsted ILACS (Inspecting Local Authority Children's Services) framework element of 'knowing about the quality and impact of social work practice in your local authority'
    - ensure that lessons learned from workstreams, including Practice Assurance Stocktakes and Practice Reviews, are embedded in service delivery.
3. This function supports the Making Bromley Even Better ambition for 'children and young people to grow up, thrive and have the best life chances in families who flourish and are happy to call Bromley home'.
4. The objective of the audit was to review the effectiveness of the arrangements in place to assure quality of practice and a safe service.
5. We would like to thank all staff contacted during this review for their help and co-operation.

AUDIT SCOPE

6. The original scope of the audit was outlined in the Terms of Reference issued on 5th August 2022. During our fieldwork, we reviewed and tested the following key risks:-

QUALITY ASSURANCE FRAMEWORK – CHILDREN'S

- Effective oversight of Quality Assurance workstreams (Governance) is not maintained. Roles and responsibilities are not clearly defined or undertaken by staff with sufficient skills, leadership and practice knowledge. The service is unable to demonstrate how it assesses, monitors and, where required, improves the quality and safety of service
- If Quality Assurance work is insufficiently robust, poor quality practice may not be identified and inadequate services may be delivered to residents
- If recommendations/best practice to improve outcomes for service users are not disseminated, embedded and followed up, practice improvements may not be sustained.

AUDIT OPINION

7. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Reasonable Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
0	**2**	**1**

QUALITY ASSURANCE FRAMEWORK – CHILDREN'S

SUMMARY OF FINDINGS

8. At the time of the fieldwork, the Quality Assurance Framework was undergoing a refresh. This was a result of the Quality Improvement service having identified areas which were not fully working as desired. Amendments made include elevating the minimum tier of staff undertaking Performance Reviews from Team Leader to Group Manager.

9. Our testing was against the Framework in place at the time of the fieldwork. In October, we had sight of the refreshed Framework which was approved in September 2022. At the time of reporting, launch was imminent. The Framework contains provision for 'review in six months (March 2023) by the Group Manager to the Performance Improvement Board and annually thereafter', to ensure that it remains live. We have considered the contents of the new Framework when making our recommendations.

10. The Performance Improvement Board is an established Group, with attendees including the Director of Children, Education and Families and the Chief Executive. It is empowered to oversee and determine action for continuous improvement, innovation and consistency of high-quality practice and service delivery. During the last year, both a new Independent Chair and Quality Assurance Group Manager have been appointed.

11. Our fieldwork highlighted a number of key strengths. We found that the Quality Assurance Framework and Timetable incorporate both internal and externally commissioned workstreams. There is a robust reporting mechanism to the Performance Improvement Board encompassing further independent challenge by the Chair. These layers of scrutiny provide Senior Management with clear sight of strengths and areas of good practice, together with areas for development.

12. Thematic findings are disseminated, in detail, to staff through the 'Getting to Excellence' training seminars which take place approximately every six weeks. We noted that both the trajectory to Excellence and the links between the Practice Standards and the Quality Assurance Framework to monitor services for quality and effectiveness, were reinforced via this medium.

13. The majority of templates used for the Quality Improvement process invite the reviewer to comment on strengths or excellent practice identified, and these have been well used. We also noted that overarching reports include commentary on strengths identified.

14. Our audit review has, however, identified the following areas which we would like to bring to management's attention:

QUALITY ASSURANCE FRAMEWORK – CHILDREN'S

- Return rates of the Practice Reviews were low for some cycles, with one service sampled seeing a return of 64% 'in time' and a second service seeing a return of just 15%. For Practice Reviews which had been graded overall as 'Requires Improvement' or 'Inadequate', there was not a clear line of sight to ensure that the Practice Review Improvement Meeting (PRIM) had taken place or that actions recorded had been followed up through the supervision process.

  We acknowledge that the Quality Improvement service had identified both of these areas as gaps and have strengthened the process as part of the September 2022 Framework refresh.

- The main data repository, for documentation which cannot be held in the Social Care Management System, is a restricted access section of the 'Shared' drive. The file management system is ad hoc in nature, both in terms of file structure (high level and sub structure), and the actual documentation held. We could not establish a full audit trail for the workstreams from this data source. It is, however, acknowledged that further material is held in personal E mail boxes.

- Whilst not every section of the Practice Review forms will be relevant for each case sampled, evidence as to whether each section had been considered for inclusion/exclusion was inconsistent, with no formal process in place.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

15. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised, together with management's responses and timescales for implementation. Appendix B details the definition of the audit assurance and priority ratings.

QUALITY ASSURANCE FRAMEWORK – CHILDREN'S

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

1. Quality Assurance Framework – Considerations for six month review
Finding During our testing of the Practice Review process, we found that:- - Return rates of the Practice Reviews were low for some cycles, with one service sampled seeing a return of 64% 'in time' and a second service seeing a return of just 15%. - For Practice Reviews which had been graded overall as 'Requires Improvement' or 'Inadequate', there was not a clear line of sight to ensure that the Practice Review Improvement Meeting had taken place or that actions recorded had been followed up through the supervision process. This includes those that had been regraded during the moderation process. We acknowledge that the Quality Improvement service had identified both of these areas as gaps and have strengthened the process as part of the September 2022 refresh. As part of the refreshed process, 25 Practice Reviews are to be carried out for each service/theme reviewed, this being the number of staff in the revised tiers of Management undertaking the reviews. We reviewed the Quality Assurance Frameworks for a selection of local authorities as available in the public domain. We observed that one Framework stated 'Members have oversight of QA Activity' and they provided a 'Practice Assurance Stocktake Report' on 7th February 2022 to their Safeguarding Sub (Community & Children's Services) Committee. Whilst we acknowledge that this is not a statutory requirement and service areas report separately to the Children, Education and Families Committee, we recommend consideration is given to an annual Quality Assurance Information Briefing. **Risk** Insufficient return of Practice Reviews, lack of a robust follow through process for actions for 'Requires Improvement' or 'Inadequate, and an insufficient initial sample size leaves the Quality Improvement process at risk of :-

(i) lack of critical mass on which to base an opinion as to the quality of service provided (ii) inability to demonstrate that recommendations/desired improvements have been followed through to conclusion and embedded.	
Recommendation We recommend that as part of the initial six month review of the September 2022 Quality Assurance Framework Refresh, consideration is given to: - (i) Mechanisms for ensuring that Practice Reviews are being completed within time to provide a sufficient base on which to provide an opinion as to the quality of work across the service. (ii) Mechanisms for ensuring that actions and recommendations resulting from 'Requires Improvement' or 'Inadequate' gradings, together with those emanating from overarching Practice Assurance Stocktakes and Practice Review reports, are followed through until closure. (iii) Whether a static sample size of 25 provides a sufficient cohort on which to base an opinion as to the quality of service. (iv) Providing an annual Quality Assurance Information Briefing to the Children, Education and Families Policy Development and Scrutiny Committee. (v) Whilst there is clear evidence of the Quality Assurance Timetable's oversight at both Director and Assistant Director level and it forms part of verbal discussions at the Performance Improvement Board, it is recommended, for good practice, that the document itself forms part of the Board's standing agenda items.	**Rating** Priority 2

QUALITY ASSURANCE FRAMEWORK – CHILDREN'S

APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

Management Response and Accountable Manager	**Agreed timescale**
The recommendations are agreed and viable. We have adjusted to ensure a greater compliance with returns of Practice Reviews to timescale as set out in actions below. We are in our Ofsted inspection window and have presently increased our audit coverage to reflect inspection preparations and the cycle will then be reviewed post-inspection. Because of this, the actions below reflect current adjusted practice on the basis we do not know exactly when we will undergo our regulatory inspection. The recommendations will further strengthen our oversight of continuous improvement. The QAF has been through recent amendments and now addresses the lines of accountability in 'closing the loop' of actions and learning from practice review and practice assurance stocktake cycles. **Actions** (i) Practice Reviews are now completed by Group Managers, Heads of Service, Assistant Directors and the Director CEF. Any exemptions have to be authorised at Assistant Director level and time extensions are not given. These reviews are now completed on a monthly basis. The Director CEF addresses any failures to submit a completed practice review to timescale. **(QA Lead Manager / Director CEF)** (ii) A moderation meeting is held by the QA Lead Manager with the Head of Service and Team Manager to ensure that agreed actions from Practice Reviews with an inadequate or RI outcome are tracked through to completion. **(QA Lead Manager)**	(i) End Jan 2023 (ii) End Feb 2023

HOS will record on children's records when all moderated actions from practice reviews have been completed and this record will be shared with the QA Lead Manager for tracked oversight. **(All HOS / QA Lead Manager)**	End Feb 2023
The terms of reference of the Performance Improvement Board will be updated to set out how recommendations from QA work including Practice Reviews and Practice Assurance Stocktakes will be followed through the Board to final sign off. **(QA Lead Manager)**	End Feb 2023
Sign off that actions have been completed will be incorporated as a standing agenda item at Performance Improvement Board. **(QA Lead Manager / Director CEF)**	End Feb 2023
(iii) On a monthly basis there are now 25 internal Practice Reviews completed, 50 case audits completed by external consultants and up to 100 dip sample audits completed by team managers to ensure full coverage upon which to establish information about the quality of service across the Department. **(QA Lead Manager / Head of Service Quality Improvement)**	(iii) End Feb 2023
(iv) The Director of Children, Education and Families should give consideration with SLT, Portfolio Holder and PDS Chairperson as to whether an annual report concerning QA activity and its framework should be part of Members scrutiny on the PDS Committee cycle. **(Director CEF)**	(iv) End March 2023
(v) The QA timetable will be a standing agenda item at each Performance Improvement Board and latest iteration made available to all board members as part of board papers. **(Director CEF / QA Lead Manager)**	(v) End Feb 2023

All iterations within a calendar year will be saved and stored in Sharepoint to ensure ready access to the evolution of the QA timetable. **(QA Lead Manager / HOS Quality Improvement)**	End Feb 2023
Meetings held by senior managers to establish and agree the QA timetable will have minutes and those minutes stored on Sharepoint to ensure ready access so that the methodology can be evidenced and tracked. **(QA Lead Manager / Head of Service Quality Improvement)**	End Mar 2023

2. Strategic File Management

Finding

We were advised that in addition to the Social Care Case Management system, the main data repository for the Quality Assurance process is a restricted access section of the Shared drive. We reviewed the contents of this as part of the initial fieldwork for the audit. We found the system to be ad hoc in nature, both in terms of file structure (high level and sub structure), and the actual documentation held.

We could not establish that all relevant documentation had been uploaded to the system and a full audit trail could not be determined from this data source. It is, however, acknowledged that further material is held in personal E mail boxes.

We noted during the testing that, whilst the majority of Practice Reviews were completed via the template held on the Social Care Case Management System, bespoke forms, held outside of the system are still required on occasion. Whilst the Case Management System contains a workflow of 'alerts' to the Team Leader and Head of Service, the system for those held outside of the system remains manual. It could not be evidenced through the filing system that the eight forms in the sample for audits completed outside the system had been seen by the Team Manager or Head of Service.

Risk

Lack of a full audit trail could lead to the overall opinion as to the quality of work in Children's Social Care being based on insufficient or inaccurate data and is therefore not robust.

Recommendation	Rating
We recommend that:- (i) The contents of the Shared drive and individual E mail boxes are reviewed, realigned and standardised to ensure that a full audit trail is available. File naming conventions and contents should be agreed. Going forward, Sharepoint should be the repository for documentation which cannot be held on the Social Care Case Management system.	Priority 2

(ii) Team Leader and Head of Service sign off of Practice Reviews completed on bespoke forms outside of the Social Care Case Management system off is included in the filing system.	
Management Response and Accountable Manager The findings are agreed. Recommendation ii is partially viable on the basis that information recorded in auditing work is not always suitable to be stored on children's individual social care records and have implemented a process change to evidence this recommendation that is most consistent with what the Department considers is in children's best interests regarding information stored on their personal records. **Actions** (i) File naming conventions and contents should be agreed with written guidance if necessary. **(QA Lead Manager)** Sharepoint should be the repository moving forward and relevant Shared drive material transferred. Any Sharepoint training need will be taken forwards with the IT Tutor, Workforce Development to ensure all who would need to use this Sharepoint are fully trained. **(HOS Quality Improvement / QA Lead Manager)** Email correspondence that is relevant and evidences methodology and the auditing/practice review process should all be moved and stored in the agreed filing conventions on Sharepoint, and stored for all future cycles in Sharepoint. **(HOS Quality Improvement / QA Lead Manager)**	**Agreed timescale** (i) End March 2023 End April 2023 End April 2023 for each cycle

(ii) The QA Lead Manager will complete a case note on each case file where a Practice Review has been completed to set out the date of the Practice Review, key findings and actions. The team manager and HOS will then evidence tracking and completion through social work supervision records. **(QI Lead Manager and all HOS)**	(ii) End March 2023

3. Practice Review Forms – Standardisation of completion	
Finding We noted during testing that the completed Practice Review forms on the Social Care Case File Management varied in terms of the sections completed. Additionally, there were examples of forms where although sections had been graded, the specific questions had been marked 'Not Applicable'. Whilst we accept that not every section will be relevant for each review, we recommend that a standardised process is implemented for recording where sections of the Practice Review Form are not applicable, and therefore should not be graded, to provide a robust audit trail that all sections of the form have been considered. We noted that discussion with the Practitioner is at the heart of both the Practice Review and the Practice Assurance Stocktake process. From a review of the documentation held, it could not be established definitively that the Practitioner had been involved, although this is clearly the intention as stated in the guidance. We noted that one non standard Practice Review Form does not provide the option for the reviewer to bullet point examples of 'Excellent Practice'. **Risk** Without a standardised approach to form completion, there is a risk that assumptions may be made when completing the forms leading to inconsistencies and oversights.	
Recommendation We recommend that:- (i) A standardised process is implemented for recording where sections of the Practice Review Form are not applicable, and therefore should not be graded, to provide a robust audit trail that all sections of the form have been considered.	**Rating** Priority 3

(ii) For absolute clarity, we recommend that it is confirmed in each Practice Review that the Social Worker has been involved and the outcome of the Practice Review discussed with them. (iii) Non standard/bespoke Practice Review Forms are reviewed and amended to ensure that the option to bullet point examples of Excellent Practice is included.	
Management Response and Accountable Manager The recommendations are agreed and viable. **Actions** (i) Guidance will be issued by the QA Lead Manager to ensure all completing practice reviews are recording any sections that are not applicable as such. **(QA Lead Manager)** (ii) All staff completing Practice Reviews have been issued guidance that the involvement of the Social Worker must be captured and the outcome discussed with them. If this is not possible, the Practice Reviewer must set out who was involved and the reasons why the Social Worker was unable to take part. **(QA Lead Manager)** (iii) All audit templates, including Practice Review forms, now include a space for exemplars of excellent practice to be recorded. **(QA Lead Manager / HOS Quality Improvement)**	**Agreed timescale** (i) Guidance issued in Dec 2022 (ii) Guidance issued in Dec 2022 (iii) Completed in Dec 2022

OPINION DEFINITIONS

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

REDACTED

FINAL INTERNAL AUDIT REPORT

EDUCATION DEPARTMENT

REVIEW OF EDGEBURY PRIMARY SCHOOL

Issued to:	**Headteacher** **School Business Manager** **Chair of Governors (Final report only)** **Director of Education (Final report only)** **Head of Finance, Children Education and Families (Final report only)**
Prepared by:	**Trainee Auditor**
Reviewed by:	**Principal Auditor** **Head of Audit and Assurance**
Date of Issue:	**06 December 2022**
Report No.:	**PEO/08/2022**

REVIEW OF EDGEBURY PRIMARY SCHOOL

INTRODUCTION

1. This report sets out the results of our audit of Edgebury Primary School. The audit was carried out as part of the work specified in the six-monthly Internal Audit Plan for 2022-23, agreed by the Audit and Risk Management Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. The Pre-Audit Questionnaire filled by the School Business Manager (SBM) forms part of the audit review as a self-assessment. As such the questionnaire, completed by the SBM, was certified by the Headteacher and the Chair of Governors to give adequate assurance that the return was representative of current working arrangements.
3. We would like to thank all staff contacted during this review for their help and co-operation.

AUDIT SCOPE

4. The original scope of the audit was outlined in the Terms of Reference.

5. We examined the key risks in the areas set out below:
   - **Financial Management Information** including budget monitoring, financial reports and returns to London Borough of Bromley
   - **Primary accounting documentation** including payments, contracts, voluntary funds and bank reconciliations
   - **Asset control**
   - **Governance arrangements** including financial delegation, governor minutes, budget approval and business interests

6. The fieldwork was undertaken during a two-day visit to the school.

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AUDIT OPINION

7. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Reasonable Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
1	3	2

SUMMARY OF FINDINGS

8. We found that controls are in place and working well for utilisation of reports from the Financial Management System (FMS) to support the financial management of school, management of purchasing card and governance arrangements including budget approval. However, the school should consider the key findings summarised below and set out in detail in Appendix A:

- 16 IT assets were missing at the time of the audit. The School Business Manager (SBM) informed us that these assets were taken by staff without signing a loan card during covid and have not been returned, and the school is unable to locate these assets.
- Audit testing of 20 payments from the bank history identified issues related to raising purchase orders, checking invoices, authorisation in the payment process, sourcing quotations for expenditure over £5,000 and use of school funds.
- IR35 assessments had not been completed for the payments made to individuals that we sampled.

- Declaration of interest forms completed by the Governors and staff with financial/ procurement responsibility had not been completed for the academic year 2021/22.

9. We did not review the procedures to collect income and banking arrangements at this audit.

10. Although the responsibility for cyber security and backup of school systems has been passed to the IT provider, the risk remains with the school and given recent ransomware attacks on education establishments the threat is topical and should be reviewed as a priority. The school needs to be aware of cyber security threat, assign a school lead to be responsible and ensure that the risks are effectively managed. We have sent a cyber security self- assessment questionnaire to the school to focus a discussion on these issues.

11. We would like to thank all staff at the school for their help and cooperation during the audit.

12. The Management Action Plan is set out in Appendix A and Appendix B defines the audit opinion and recommendation rating.

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APPENDIX A

DETAILED FINDINGS AND ACTION PLAN

1. Missing IT assets	
Finding The school had 16 missing IT assets - 10 laptops (1 HP, 1 Dell, 7 Lenovo, 1 Tactus Geobook), 5 ipad minis and 1 ipad. As recorded in the school's IT asset register, the total value of 13 of the missing devices was £4213, excluding the cost of replacing 3 devices (1 Apple iPad, 1 Tactus Geobook and 1 Dell laptop) which were originally received for free from DfE. The school has a process of loaning devices to staff whereby they are expected to sign a loan (orange) card before taking the device. The School Business Manager (SBM) informed us that staff took these devices without signing a loan (orange) card during covid and have not returned them. These devices were identified as missing during the school review of the IT asset register on 24 June 2021. The SBM stated that "the school did amnesty and checked with the existing and former staff but could not locate these devices. These devices were disabled by the school's IT Contract Technician in November 2021 to ensure they were blocked for use outside and have agreed to be written off by the Governors at the finance committee meeting held on 6th July 2022." **Risk** Financial loss to school. Unauthorised access and misuse of the school's and students' personal information which can have significant personal, financial and reputational consequences.	
Recommendation The school should follow its procedure of issuing a loan (orange) card when loaning assets to staff in all circumstances and keep a record of all loans. The school should remove any future missing IT assets from the system immediately, after reasonable initial enquiries. The school should review its procedure for securing its IT assets, restricting the access to designated officers. These officers should then issue IT assets and keep a record of them.	**Rating** **Priority 1**

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Management Response and Accountable Manager	**Agreed timescale**
The school has started an asset loan book within the business office (loan book managed by the Office Manager, KM and SBM, KP.) Any extra assets borrowed will need to be requested via the business office and where authorised: signed for and a return date set at time of borrowing The Office Manager and SBM will monitor the asset loan book and return dates The Head Teacher has advised all staff of the asset loan book protocol and that all assets are issued via the school business office Missing assets will be removed promptly (after initial enquiries) and the action dated and authorised by HT/DHT so that audit trail can be maintained	Now operational

2. Expenditure process
Finding We reviewed a sample of twenty payments made between 1 May 2021 and 31 May 2022 and identified the following issues: • For six payments, a purchase order was not raised. • For five payments, three officers were not involved in the purchase process. Only two officers authorised the order and invoice. • One invoice had the date printed incorrectly as the previous year's date. • One invoice did not have a VAT registration however VAT had been charged and paid. • For three payments over £5,000, three quotes were not obtained and there were no associated waivers to justify this. The school offered an explanation advising that for two of these samples they had used the regular supplier for the school trip and the reading scheme; and for the third

sample, they used a supplier they had engaged with before who was offering a discount. None of these were reported to the finance committee as set out in the Financial Regulations for Schools 2020 and the school's Finance Policy.

The Financial Regulations for Schools 2020 section 5.5.3 sets out: "In order to ensure best value, at least three competitive quotes must be obtained in writing or via authorised e-mail where costs exceed £5,000. Where this is not practical to do so, the reasons must be submitted to the Finance Committee and/or governing body, in writing."

- There was no authorised signatory list. On occasions, initials were used to authorise the invoices or BACS payments.
- The bank mandate had not been dated.
- For weekly BACS payments for the suppliers, the SBM uses her login to upload pending payments on the banking portal and sends the printout to the Assistant Head Teacher (AHT) for authorisation. Once it has been authorised by the AHT, the SBM uses the AHT's login to authorise these payments online. We discussed the associated risks with the school, who has agreed to address it.

School funds of £129.07 were used to purchase food items for a staff leaving party.

Risk

Unauthorised expenditure may be incurred by the school.
The school may not be able to reclaim VAT, resulting into financial loss.
Shared logins increase the risk of unauthorised access and loss/ misuse of associated data as transparency and accountability are reduced.
Misuse of the money received from the government for pupils learning and development and reputational damage to the school.

Recommendation	Rating
Purchase orders should be raised as the expenditure is committed and should be authorised timely.	Priority 2

At least three authorised signatories should be involved in the purchasing process. Separation of duties should be evidenced for the expenditure process including checking and authorising the invoices. Invoices should be checked for any errors or inaccuracies before payment. The school should pay VAT invoices only if the VAT registration is printed on them. The school cannot reclaim the VAT in the absence of a valid VAT invoice. Three competitive quotes must be obtained for expenses exceeding £5,000. Any alternative arrangements and deviation from the agreed process should be formally recorded and submitted to the Finance Committee and/or governing body, in writing. An authorised signatories list should be prepared including the initials/ short signatures for verification purposes. Bank mandate should be dated to allow authorisation in the relevant timeframe. Officers should not share logins and passwords amongst the members of staff. Segregation of duties evidence accountability and ownership, accurate representation of actions taken and helps in avoiding fraudulent payments. School funds should only be used for educational purposes.	
Management Response and Accountable Manager A new School Business Manager is in place. Office and Finance Staff have been reminded of following the ordering protocol which will involve three officers There are now three staff involved in the purchasing process: Requisition / Order Goods received and invoice checked Payment An authorised signatory list will be created The SBM and Head Teacher recognise the need for three quotes as stated in the Finance Handbook Financial trans-actors have been directed to only use their own log ins for BACS and other finance actions Staff have been directed to ensure VAT registration number is present on invoice where VAT is requested Bank mandate is to be dated	**Agreed timescale** Now operational

The spending comment regarding non-education purposes is acknowledged	

3. Payment to individuals & HMRC regulations (IR35)	
Finding Eleven payments were made to three individuals between 1 May 2021 and 31 May 2022, who were not members of staff. An online HMRC assessment (IR35) had not been completed for any of the three individuals. **Risk** Financial penalty for non-compliance with HMRC Regulations (IR35).	
Recommendation The procedure to engage off-payroll staff must be implemented to ensure compliance with IR35 regulations for all current and future procurement and payments. For any payments to named individuals the school should complete the online questionnaire on the HMRC website to establish payroll /self-employment status. Since April 2021, this assessment must be given to the individual to be engaged. For school purposes the assessment should be retained, dated, and certified to support payment to a named individual.	**Rating** Priority 2
Management Response and Accountable Manager SBM will complete online questionnaire (HMRC) to assess external providers before the individual is engaged.	**Agreed timescale** As required

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4. Declarations of interest	
Finding We reviewed the declaration of interest signed by the Head Teacher on 11 March 2021 at the time of joining the school, however there were no other declaration of interests on site for the governors and staff with financial/ procurement responsibility. The SBM informed us that the clerk has now circulated the declaration of interest forms after the finance committee meeting on 6th July 2022 for completion by the governors and staff with financial/ procurement responsibility. **Risk** Biased procurement or tendering.	
Recommendation All governors and staff with procurement and financial responsibility should sign a declaration of interest annually. The school should retain these declarations on site.	**Rating** Priority 2
Management Response and Accountable Manager **Declaration of Interest Forms** where needed are signed at time of employment start and have been issued where needed to existing staff. All governors and staff with procurement and financial responsibility will sign a declaration annually. The declarations will be stored on school site.	**Agreed timescale** Now operational

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5. Contract Register	
Finding The contract register was a comprehensive document and included the annual cost, contract term, expiry/ review date and PO date. We selected a sample of four contracts from the contract register and examined if they are current, signed and were held by the school. We identified the following issues: • The school did not hold a signed copy of the contract and service level agreement with the IT contractor. • The contract register only contains the annual value of the contract and not does not show the whole life value of the contract which would support financial management and decision making. **Risk** The school may not be aware of its contractual agreements and payment liabilities.	
Recommendation The school should hold a copy of signed contracts or service level agreements onsite. The contract register should include all contractual and service level agreements with whole life contract values.	**Rating** **Priority 3**
Management Response and Accountable Manager The school will retain signed copies of contracts/service level agreements and include whole life values for purpose of financial planning.	**Agreed timescale** Now operational

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6. Petty cash	
Finding The SBM confirmed that petty cash is no longer in operation and our testing did not identify any movement of funds. The balance of £27.66 in petty cash is held in the school office. **Risk** Loss or theft of cash. Inefficient use of resources to manage a fund that is no longer required.	
Recommendation As the school no longer operates a petty cash system, the cash balance should be paid back to the school fund and the petty cash should be closed down.	**Rating** Priority 3
Management Response and Accountable Manager The Head Teacher & Governors are considering the petty cash recommendations.	**Agreed timescale** Ongoing

OPINION DEFINITIONS **APPENDIX B**

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

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