PART 1

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DATE: 20th October 2023

AUDIT SUB-COMMITTEE INFORMATION BRIEFING

Meeting to be held on Tuesday 7 November 2023

This briefing will only be debated if a member of the Committee requests a discussion be held, in which case please inform the Clerk 24 hours in advance indicating the aspects of the information item you wish to discuss.

1 INTERNAL AUDIT REPORTS (Pages 3 - 158)

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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.

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THE LONDON BOROUGH
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REDACTED INTERNAL AUDIT REPORT

PLACE DIRECTORATE

Temporary Accommodation and Housing Rents Arrangements

Issued to:
Group Manager Housing Registration & Allocations
Head of Housing Allocations and Accommodation
Group Manager Housing Management and Acquisitions
Assistant Director of Housing
Assistant Director Exchequer Services
Head of Finance, Adult Social Care, Health, and Housing
Senior Accountant, Housing
Director of Housing, Planning and Regeneration
Director of Finance

Prepared by: Internal Auditor (Mazars)
Reviewed by: Manager (Mazars)
Partner (Mazars)

Date of Issue: 13 October 2023

Report No.: PLA/09/2021

INTRODUCTION

1. This report sets out the results of our internal audit of the Temporary Accommodation Housing Rents Function managed by the London Borough of Bromley.
2. The internal audit looked to review whether effective management of the Council's Temporary Accommodation function was in place to ensure that:
   - Temporary accommodation was provided to eligible persons to prevent homelessness;
   - Reliability and integrity of the housing rents system and tenant records were maintained;
   - Rent and additional charges were completely and accurately identified and included in rent accounts promptly;
   - Rent income arrears were promptly and effectively pursued and recovery was maximised; and
   - Accurate information was provided to support effective decision-making.
3. In scoping the audit, it was recognised that there were initial problems with the housing management system following its implementation, which had since been resolved. The focus of this audit was to assess the effectiveness of the system in supporting the Temporary Accommodation Housing Rents arrangements.
4. We would like to thank all staff contacted during this review for their assistance and co-operation.

AUDIT SCOPE

5. The original scope of the audit was outlined in the terms of reference issued in January 2022.
6. We reviewed and tested controls over the following key risks:
   - Policies and procedures do not reflect the change in the housing management system. Staff do not have appropriate guidance to navigate the system.
   - Tenancy Agreements are not signed promptly to enable tenancies to be set up on the system within agreed deadlines.
   - Regular checks of properties undertaken by staff are not recorded within the system.

- Annual rent charges are not completely, accurately, and validly calculated, and these are accurately input on time and notified to tenants in line with legislative requirements.
- Rental income received in the authority's accounts is not completely and accurately recorded within the Housing system.
- The Housing system does not allow the production of reports on arrears and debts, which are reviewed every month.
- Audit trails of decisions undertaken to evict tenants are not recorded within the Housing system.
- Rent accounts are not regularly reconciled.
- Management does not oversee issues relating to the financial position and the effectiveness of the Housing system.

AUDIT OPINION

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

AUDIT OPINION	
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.

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
0	**2**	**4**

SUMMARY OF FINDINGS

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

- We noted that six monthly reports are provided by the Exchequer Services contractor to the Assistant Director of Exchequer Services, summarising the contractor's performance regarding the collection of rent arrears debts. We confirmed that these are reported to the Executive, Resources and Contracts Policy Development and Scrutiny Committee by the Assistant Director of Exchequer Services through a review of the June 2022 and January 2023 Public Agenda Packs.
- We reviewed a sample of ten tenants who commenced tenancy between April 2022 and February 2023 to confirm whether a sample of one rent payment per tenant can be verified to have been correctly applied to the tenant's rent account[1]. Via review of the Housing Management System and the batch payment files, we confirmed six were in receipt of, and related to housing benefit. Payments for these were imported for the correct amount and allocated to the correct tenant account, alongside the correct reference numbers.

  The remaining two payments were cash payments made via the Council's website and a direct transfer to the Council's bank account. We confirmed that the correct payment amount was imported to the correct tenant account, and the correct reference number was recorded within the Housing Management System.
- The Council has an Evictions Referral Process (December 2022), which outlines how eviction referrals received from the Housing Accommodation Charging team will be managed.
- The Council uses the TA Subsidy Spreadsheet to calculate the rent charges for its Nightly Paid accommodation properties, with this information then uploaded into the Housing system to update the rent charge amounts. We selected a sample of ten properties, six of which were nightly paid accommodation. In all six instances, the rent charge was correctly input to the Housing Management System.

However, we noted the following areas where improvements are required to the current control framework in place:

- Evidence of inspection visits could not be provided for our sample tested. Additionally, improvements are required to ensure the Council has adequate oversight of Managing Agents who are responsible for completing accommodation visits.

[1] We noted that rent recovery for two of the tenants within the sample was not the responsibility of the Council, thus, thus in total a sample of eight payments were reviewed.

- Appropriate and timely action had not been taken regarding arrears management and debt recovery for 6/10 cases in our sample.
- Documenting evictions decisions and accurately recording these including evidence of contacts with tenants in a timely manner.
- We could not evidence that all required documentation had been completed and that tenancies had been set up on the Housing Management System within the target time frame for 5/10 new tenancies sampled.
- Rent reconciliations are not formally and independently reviewed and approved.
- Multiple procedures did not have a review date and version control box recorded within the documents.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

9. 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.

1. Temporary Accommodation Property Checks

Finding

We were advised by the Housing Management Team Manager that tenancy visits for temporary accommodation should be recorded within the Housing Management Spreadsheet on the Temporary Accommodation Visits tab. Furthermore, we were advised that reactionary visits occur where issues are identified, after which scheduled visits are completed according to the location. We noted that the Council had not documented its approach towards completing temporary accommodation visits, details of the persons responsible for completing the visits, or how often visits are to be completed.

We reviewed a sample of ten tenants whose tenancy commenced between April 2022 and February 2023 and sought to confirm that a visit was recorded on the Housing Management Spreadsheet. We noted no record of a TA tenancy visit being completed in all ten instances. The Housing Management Team Manager advised that there are only two Officers who complete visits and over 1,500 temporary accommodation placements resulting in difficulties in visiting all placements.

Furthermore, we were advised by the Housing Management Team Manager that Managing Agents also have a responsibility to complete temporary accommodation checks. We reviewed the template SLA agreement, which is in place with the Managing Agents. We noted that this refers to the providers doing regular checks and that the Council may request evidence of these occurring. However, we noted that there is no documented framework outlining the information that should be documented by Managing Agents as part of TA checks. Furthermore, we were advised by the Housing Management Team Manager that there is no framework for regularly spot-checking Managing Agents to ensure that regular TA checks are completed, and evidence of these occurring being provided to the Council, other than in the case where issues are raised by tenants regarding the Agents.

Risk

The Council does not have sufficient monitoring or record-keeping arrangements regarding temporary accommodation visits and fails to identify and action overdue visits which may result in issues not being identified and remediated in a timely manner.

Due to the lack of a documented framework, temporary accommodation visits are inadequate, and visit records do not document sufficient details of the visits.

Recommendation	**Rating**
The Council should:	Priority 2

• Document its approach towards completing temporary accommodation visits to ensure that key details such as frequency of visits, staff responsibilities, and record-keeping arrangements are clearly outlined. • Document a framework to ensure that Managing Agents are doing Temporary Accommodation checks, including the expected content and frequency of these checks. • Select properties on a sample basis to ensure that temporary accommodation visits by Managing Agents are completed and to enable the Council to measure the Managing Agents' compliance with the SLA.	
Management Response and Accountable Manager There are currently over 1500 temporary accommodation placements and just 2 Visiting Officers. Without the provision of additional staffing resources, it would not be feasible to visit to all new TA placements. The team managed to undertake around 800 visits over the last year this will have included a mixture of single as well as return visits. There are also a range of variables which influence how many visits we can do in a year. Currently we are placing further afield; in areas such as West Bromwich, Leicester, Worthing, Essex and Kent. The geographic spread increases travelling time and therefore reduces the number of visits that can be done. However, taking on board the audit findings: • We will produce procedure for visiting, including how visits are selected, frequency, scope, outcomes, and record keeping. • We will document a framework to provide clearer guidance for providers regarding expectations around occupancy checks including frequency. • We will utilise provider liaison meeting schedule to sample check occupancy checks and compliance documents. Accountable Manager: Group Manager Housing Management & Acquisition	**Agreed timescale** End of October 2023

2. Arrears Oversight	
Finding We reviewed a sample of ten Temporary Accommodation tenants with arrears between £25,718 and £328 to assess whether rent recovery procedures had been followed. This sample was selected from the Aged Debt for Nightly Accommodation report (as of 28 February 2023), which totalled £1.5 million. We completed walkthrough testing with the Rent Recovery Team Leader and reviewed the correspondence with tenants and action taken to recover arrears for each case. For four out of ten cases, we confirmed that the Council made regular contact with timely responses from the tenant. We confirmed that the first and second reminder letters were issued within two weeks, and payment plans were arranged to reduce arrears as per the Rent Recovery Procedure. For the remaining six cases, we noted: • For five cases, the Council did not contact the tenant promptly despite arrears accumulating. These cases have accumulated arrears of between £614 - £25,718. We were advised by the Income and Recovery Operations Manager that arrears have accumulated due to system migration issues from the previous Housing Management System, the Coronavirus Act 2020 which resulted in being unable to take required eviction actions promptly and the current Housing Management System not recommending cases for action in the intended manner. We were advised by the Income and Recovery Operations Manager that this issue is currently being reviewed by the Council with the Exchequer Services contractor and the system provider. • For the remaining case, we were informed by the Income and Recovery Operations Manager that HB and rent charges were wiped from the rent account as it was incorrectly set up. Whilst the arrears value on the Housing Management system stands at £25,000, the Council cannot determine the correct amount of arrears and thus cannot chase the tenant. We were advised by the Income and Recovery Operations Manager that a solution to this issue is currently under investigation. **Risk** The Council fails to appropriately identify and respond to arrears, causing Temporary Accommodation arrears to increase and bad debts to transpire, which leads to the Council incurring a financial loss.	
Recommendation	**Rating**

The Council should: • Rectify the issues with the Housing Management System to ensure that the correct amount of arrears is known and can subsequently be recovered from tenants. • Ensure that the process is correctly followed and that key timeframes are followed within the collection process. • Consider whether staff require further training to ensure they are able to sufficiently action arrears cases.	**Priority 2**
Management Response and Accountable Manager All the cases affected by system issues will be identified and rectified, processes will be correctly followed with sampling undertaken to ensure key timeframes are being met. A training analysis will be undertaken on all staff involved in the recovery process so that any gaps can be identified, and the appropriate training can be provided if required. Accountable Manager: Revenues and Benefits Manager, Operations Manager - Income & Recovery	**Agreed timescale** 31 October 2023

3. Tenancy Evictions
Finding We reviewed a sample of five Temporary Accommodation evictions with Notice to Vacate letters served between June 2022 and February 2023, selected from the Housing Management Spreadsheet. Two were non-arrears cases, and three were nightly paid accommodation arrears. Our testing assessed whether Notice to Vacate letters had been communicated with the tenant, target time frames for responding and completing eviction referrals had been met where applicable, and that sufficient details of the eviction referral had been outlined within the Housing Management Spreadsheet. Our testing noted the following:

- In three instances, the Notice to Vacate end date was not recorded within the spreadsheet despite having a column input for this;
- In one instance, the decision to evict the tenant was made more than one day after the referral response target of three days. We were not advised as to the reason for this;
- In one instance, the Notice to Vacate letter was sent on 1 November 2022 despite the referral decision being made on 15 June 2022. We were advised that this was due to the tenant's imprisonment, recorded on the Housing Management System on 24 September 2022. However, no indication of this was recorded on the Housing Management Spreadsheet;
- In one instance, we were not provided a Notice to Vacate Letter for a non-arrears case;
- We requested screenshots of the contact made to the tenants, which should be recorded on the Housing Management System. In the two non-arrears cases, we were not provided with evidence of contact with the tenants; and
- In the instances of the two non-arrears cases, the reason for the cases was not recorded within the 'reason' column on the Housing Management Spreadsheet.

Additionally, we were advised by the Housing Management Team Manager that non-arrears eviction cases are managed on a case-by-case basis. There is no documented framework or procedure to follow regarding key elements of decision-making to be applied, target time frames for taking action and any approvals required.

Risk

The key stages of the eviction process are not adequately, sufficiently and consistently documented within the Housing Management Spreadsheet and the Housing Management System, leading to the Council being unable to assess the effectiveness of its eviction process and evictions being inappropriately managed.

Recommendation	**Rating**
The Council should ensure that: • Details regarding arrears-related evictions, such as reasons for delays with processing evictions and Notice to Vacate end dates, are recorded within the correct tab of the Housing Management Spreadsheet.	Priority 3

• Information on whether non-arrears evictions were processed within allocated time frames is recorded in the Housing Management Spreadsheet. • Recent contact with tenants outlined in the Notice to Vacate letters is recorded within the Housing Management System and can be evidenced. • Notice to Vacate letters can be evidenced in all instances, and these are indexed to the tenant's Housing Management System account. • Additionally, the Council should consider implementing a documented procedure or framework for managing non-arrears eviction cases to ensure these are managed consistently and effectively.	
Management Response and Accountable Manager • We will review and update existing procedure for arrears cases and incorporate non-arrears cases, including setting time frames for non arrears cases. • We will provide staff training on how to use Housing Management Spreadsheet to ensure staff understand what should be recorded where and why. Management to review monthly to ensure correct information being recorded. • We will Introduce a sign off procedure for non arrears cases before Notice to Vacate letter is issued. • We will add column on Housing Management spreadsheet to record any reasons for delays. • We will split Anti-Social Behaviour and non-occupancy eviction cases on the Housing Management Spreadsheet. Accountable Manager Group Manager Housing Management & Acquisition	**Agreed timescale** End of November 2023

4. New Tenancy Setups

Finding

We reviewed the Housing Allocation Coordinator Procedure effective from September 2021. The procedure outlines the roles and responsibilities of the Housing Allocations Coordinator to ensure that "Temporary Accommodation rent accounts are set up on the Housing Management System within the agreed KPI timeframes". The actual three day KPI timeframe is however not outlined within the procedure itself.

Using a report of active temporary accommodation tenancies from the Housing Management System, we selected a sample of ten tenants whose tenancy commenced between April 2022 and February 2023; to assess whether a signed licensing agreement and a New Tenancy Notification (NTN) or Start of Tenancy (SOT) is indexed to the tenant's Housing Management System account.

Testing identified five instances for which we were not provided with a Licensing Agreement, NTN or SOT notification. We were advised by the Group Manager that in three instances these have not been indexed to the tenants' Housing Management System accounts. In the remaining two cases, Management could not advise why these have not been provided.

Reviewing the Housing Management System account setup tracking spreadsheet, we assessed whether the tenancy rent accounts were set up in the Housing Management System within three days of receiving the NTN or SOT as per the related KPI. Our testing noted the following:

- In one instance, the rent account was set up within five days of the tenancy start date (two days over the target); and
- In four instances, we were advised by the Housing Management Team Manager that due to these being managed by Property Management Agents the account setup time is not monitored. However, the tenant's Housing Management System account is set up by LBB, the property is managed by a property management agent. Thus, the Council does not monitor the setup time of these accounts.

Risk

Details of new tenancies are not indexed to the Housing Management System, which results in tenancies not being processed and set up within a timely manner on the Housing Management System.

Recommendation	**Rating**
The Council should: • Ensure NTNs, SOTs and Licensing Agreements are indexed to tenant's accounts on the Housing Management System. • Ensure tenancies are set up within the target date on the Housing Management System. • Outline the three-day KPI for setting up tenant accounts on the Housing Management System within the Housing Allocation Coordinator Procedure. • Consider whether the time to set up tenant accounts on the Housing Management System for properties managed by managing agents should be monitored.	**Priority 3**
Management Response and Accountable Manager	**Agreed timescale**
• Procedure has been amended to include the target KPI's. Reports are in place to capture the set up time for tenancies and to effectively track this KPI. This includes those managed by third parties (the third parties provide us with the NTN's and SOT's) • Any outstanding NTN's, SOT's, or License agreements from the sample to be indexed. • Review of recent placements to ensure NTN's SOT's, or License agreements are indexed. To form part of officers monthly 1:1's and work reviews whereby random spot checks will be carried out by the Housing Allocations Team Manager. • In addition to the above, The Housing Allocations Team Manager should check the previous days placements to ensure all relevant sections of The Housing Management System are completed and associated documents indexed.	• ACTIONED • To be concluded before 8th September 2023 • In place by October 2023 • Has already started

5. Approval of Rent Reconciliations	
Finding Through discussion with the Income and Recovery Operations Manager, we noted that the Council's rent payment receipts recorded on the Finance System are reconciled to the Housing Management System every quarter. We reviewed the Q1, Q2 and Q3 2022/23 reconciliations and confirmed that the systems had been reconciled and any unreconciling balances cleared to zero. However, although these monthly reconciliations are provided to the Head of Finance and Senior Accountant, these are not formally and independently reviewed and approved. Based on our experience, best practice would be for a summary sheet to be included on the front tab/page of the reconciliation, and this sheet should be signed and dated by both the preparer and the reviewer. **Risk** Rent reconciliations are not scrutinised and approved by an appropriately senior staff member, which can lead to incorrect reconciliation methodology being applied or unreconciling balances not being investigated further.	
Recommendation The Council should ensure that details of the staff members responsible for completing and reviewing the reconciliations are documented within a reconciliation summary sheet.	**Rating** Priority 3
Management Response and Accountable Manager A summary sheet with details of the staff members responsible for completing and reviewing the reconciliations will be included with future rent reconciliations. Accountable Manager: Head of Finance Adult Social Care, Health, and Housing (LBB) / Operations Manager - Income & Recovery	**Agreed timescale** From September 2023

6. Approval of Policies and Procedures

Finding

We sought to confirm that the Council has Policies and Procedures in place regarding the management of Temporary Accommodation, including guidance for staff regarding the Housing Management system. We noted the following:

- A Housing Allocation Coordinator Procedure (September 2021) which outlines the roles and responsibilities of the Housing Allocations Coordinator to ensure that Temporary Accommodation rent accounts are set up on the Housing Management System within the agreed KPI timeframes.
- An Evictions Referral (December 2022) process document.
- A Temporary Accommodation Placement Policy (2015) which outlines how households will be prioritised for accommodation.
- An arrears recovery guide, 'HAC Process Manual', is in place and last reviewed in August 2021. We were advised by the Income and Recovery Operations Manager that this guide will be updated following developments to the Housing Management System being implemented and made live.

Additionally, we reviewed the following procedures. We noted none of these procedure have review dates and version control boxes recorded on the documents:

- 'New tenancy setups for Temporary Accommodation',
- 'Tenancy Start Date',
- 'Cancellation Requests',
- 'Vacation Notification',
- 'Adding Clients to the Housing Management System' and,
- Procedure outlining what to do when placements cannot be added to the Housing Management System.

Risk Procedures and Policies are not regularly reviewed and approved, which may result in outdated guidance being circulated to staff. Staff may deliver services inconsistently or inefficiently and/or may not follow the most up to date process.	
Recommendation The Council should: • Ensure Policies and Procedures are regularly reviewed and approved by appropriate Senior Officers, according to an agreed schedule or when significant changes occur. • Implement version control boxes on procedures shared with staff to ensure only the most up-to-date procedures are circulated to staff.	**Rating** Priority 3
Management Response and Accountable Manager Policies and procedures in relation to the HAC team and the recovery processes will be reviewed to ensure that they all up to date, are approved when significant changes take place and version control is applied. Accountable Manager: Revenues and Benefits Manager (LBB) / Operations Manager - Income & Recovery	**Agreed timescale** 31st October 2023

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

REVIEW OF SOUTHBOROUGH PRIMARY SCHOOL

AUDIT REFERENCE: PEO/07/2023

3 October 2023

Auditor	Auditor
Reviewer	Principal Auditor

Distribution list

Job title
Head Teacher
School Business Manager
Chair of Governors (Final only)
Director of Education (Final only)
Head of Finance, Children Education and Families (Final only)

Executive Summary

Audit Objective	The objective of this audit was to review the adequacy and effectiveness of the system of controls surrounding the financial administration of the school, as required by the 1998 School Standards and Framework Act Section 48, paragraph 2(d) and the Authority's Scheme for Financing Schools.

Assurance Level		**Findings by Priority Rating**		
		Priority 1	**Priority 2**	**Priority 3**
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.	0	5	1

Key Findings

We found that controls are in place and working well for financial management, governance arrangements including budget approval, submission of VAT returns, monitoring of IR35 before engagement, management of the school's purchasing cards and monthly reconciliation of the school bank account.

The school should consider the key findings summarised below:

1. **Lettings and Income** (Priority 2) – There was no formalised procedure to monitor and recover debt. Invoices were not raised in a timely manner to collect income, there were inaccuracies and missing information on the letting forms, lettings were not approved by the Head Teacher and an incorrect hirer's liability insurance policy had not been identified in pre-letting checks. The lettings policy still refers to the Council's insurers. ***See Recommendation 1.***

2. **Expenditure process** (Priority 2) – There were several issues arising from our testing of twenty expenditure transactions; purchase orders were not raised for four payments tested, an invoice date preceded the order date, a purchase order did not include the delivery costs and for one payment over £5k three quotes had not been sought and there was no evidence that a waiver had been secured. ***See Recommendation 2.***

3. **Asset Register and Equipment Loan Book** (Priority 2) – A stock take of non-electronic items has not been completed by the school. The IT (electronic) asset register does not include key information such as date of issue or disposal. The loans book and loan agreement forms are not updated timely. ***See Recommendation 3.***

4. **Contracts register and contract monitoring arrangements** (Priority 2) – The contracts register has not been updated since May 2022 and does not reflect the current status of all contracts. The register does not include the total value of the contract, or the contract start date. We could not evidence that the Contracts Register had been reported to the Governors for annual approval. ***See Recommendation 4.***

5. **Declaration of Interests** (Priority 2) There were no signed or dated pecuniary interest forms for the current Governors or staff with financial or procurement responsibilities. ***See Recommendation 5.***

Management Action Plan - **Please see Appendix A**.

Definitions of our assurance opinions and priority ratings are in ***Appendix B***.
The scope of our audit is set out in ***Appendix C***.

Appendix A - Management Action Plan

1. Lettings and Income
Finding We noted that the main source of invoiced income for the school is from lettings. We randomly selected a sample of 6 lettings to review and identified the following issues: • Four of the lettings had outstanding invoices for more than 91 days with a total value of £1197.15 owing to the school. • The Parents' Association are not charged for any letting but this was not specified in the Lettings Policy or Fees and charges schedule. • Four of the letting forms were not completed correctly and in full and had not been approved by the Head Teacher. • One of the hirer's liability insurance policy did not have his or the company's name on it and did not provide cover for children. • Two of the lettings had been invoiced after the letting had started, although the policy clearly states: "Full payment of the letting fee and refundable deposit must be made in full in advance of the letting date." • Two of the lettings had not been invoiced for the spring term let. • For one letting there was inconsistency in the name used on the lettings form, the liability insurance policy and the invoice. The Lettings policy is not dated and signed by the appropriate officers and includes the statement that the council is the school's insurer. This and any references to the Council will need to be removed and updated with the school's own insurers. The Aged Debtors report run on 6 May 2023 shows outstanding payments totalling £1569.15 for more than 30 days, four of which were over 91 days. We could not evidence that the school has a formalised debt monitoring process, including escalation and recovery. **Risk** Loss of income. Income may not be recovered in a timely manner which may impact the cash flow. Income collected may not agree to approved fees and charges. No clear responsibility where the lettings form is filled incorrectly or is not authorised. Reputational damage in the event of an incident where the hirer's insurance policy does not provide suitable cover.

The school may be inadequately insured and may not have adequate insurance cover for any claim that is received in respect of Public Liability. This may lead to legal challenge and significant unexpected expenditure in the event that a claim is made.	
Recommendation The Lettings policy should be updated to formalise the decision not to charge the Parents Association and remove any reference to the Councils insurers. The school should contact their insurers and clarify the insurance cover regarding lettings if a hirer does not have Public Liability cover and update the Lettings policy. The school should raise an invoice for income timely in agreement with the Lettings policy. Letting forms and supporting documentation should be checked for accuracy and completeness and authorised by the Head Teacher before the letting starts. The school should develop and formalise a procedure for the recovery of debt.	**Rating** Priority 2
Management Response and Accountable Manager SBM to update the current lettings policy to include the above recommendations. Lettings invoices will be raised the term prior to the requested dates, this should reduce the risk of any debt being incurred. Most debtors are from lettings, so the risk of losing the letting should discourage tardiness with payments. Lettings forms will be checked and approved in an accurate and timely manner. The SBM has will draft a debt recovery procedure and will work on the development of this. School Business Manager/Head Teacher	**Agreed timescale** 3 months Going forwards Going forwards 3 months

2. Expenditure process

Finding

We randomly selected a sample of 20 payments from School's bank history for the last 12 months and identified the following issues:

- A purchase order had not been raised for four of the payments.
- For one payment the invoice date preceded the purchase order date.
- For one purchase order the value did not include the delivery cost.
- For one of the five payments exceeding £5k, three quotes were not seen. We could not evidence that this had been reported to Finance Committee or that a waiver had been sought.

Risk

Unauthorised expenditure may be incurred by the school.
Value for money may not be achieved in the absence of quotes for payments exceeding £5k or where delivery costs are not considered before committing to the expense.

Recommendation	**Rating**
Purchase orders should be raised as the expenditure is committed. Purchase orders should include all expenses for the goods or services, including delivery costs. Three competitive quotes must be obtained for expenditure 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 as a waiver.	Priority 2
Management Response and Accountable Manager	**Agreed timescale**
We always try to raise a PO, however this is not always possible in instances such as emergency call outs. We will make sure that if we are aware of delivery costs, that these are included on the PO. We will always try to obtain 3 competitive quotes for any expenditure over £5,000. In instances where this isn't possible this will be formally recorded. School Business Manager/Head Teacher	Going forwards

3. Asset Register and Equipment Loan Book	
Finding The signed copy of the asset register, dated 15 May 2023, contains a stock take of electronic equipment owned by the school. However, the school does not hold a register for non- electronic equipment. The IT/electronic asset register does not consistently record 'date of issue of equipment' or 'date of disposal'. Our check identified that the record was not complete and an assigned officer's name was not updated for an iPad. Although, the school's IT manager maintains a loan book for all iPads and laptops purchased for staff and taken off site, this is not a documented procedure. We identified that the school had a 'Notice of Transfer' form indicating the collection of IT equipment on 8 June 2022, however, it did not hold the certificate of disposal for the equipment. We have requested that the IT Manager follow this up with the contractor. **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 complete an annual stock take of all electronic and non-electronic assets to comply with the Financial Regulations for Schools 2020, Section 13. The school should include 'date of issue', 'loan date' and 'return date' of equipment in the asset register and ensure that all fields are completed and updated timely. The school should monitor that the disposal certificate is received from the contractor and follow up if not returned.	**Rating** **Priority 2**

Management Response and Accountable Manager	**Agreed timescale**
At this point in time, we do not have any non-electronic items which would comply with the requirements to record these. We can work on this should we ever need to in future. The IT manager will add 'date of issue', 'loan date' and 'return date' of equipment in the asset register and ensure that all fields are completed and updated timely. The IT manager will monitor the disposal certificate and follow up if not returned. School Business Manager/Head Teacher	N.A 3 months Going forwards

4. Contracts register and contract monitoring arrangements	
Finding The Contracts register, dated May 2022, included contracts that had passed their end date. The Contracts register did not include the total value of the contract and contract start date. There was no evidence that the contract register had been approved by the Head teacher or reported to Governors annually. We checked two contracts, Admin IT Network and Grounds Maintenance from the contracts folder held at school, both were current and signed but the renewal details had not been updated on the Contracts register. The school does not have formalised contract monitoring arrangements in place. **Risk** The school may not be aware of its contractual agreements and payment liabilities.	
Recommendation The contracts register is a "live" document which should be kept up to date, record whole life contract values and be reported annually to Governors. The school should assign the responsibility of contract monitoring to appropriate officers to provide a documented opinion on contractor performance of the supplier to be used when the contracts are reviewed.	**Rating** Priority 2
Management Response and Accountable Manager The SBM will ensure the contracts register is a live document. The Head teacher will have the responsibility of monitoring/confirming each contractor is delivering an appropriate service. School Business Manager/Head Teacher	**Agreed timescale** 3 months Going forwards

5. Declaration of interest	
Finding We checked the declaration of interest forms held at the school site. The staff with procurement and financial responsibilities had signed their forms in February-March 2022, although the new school business manager had completed her form when she started the role in May 2023. The Governors forms were signed between October and December 2021. **Risk** Biased procurement or tendering	
Recommendation All governors and staff with procurement and financial responsibility should sign a declaration of interest form annually.	**Rating** Priority 2
Management Response and Accountable Manager The SBM has an updated form from each relevant staff member and will ensure that a new declaration of interest form is signed on an annual basis. The Governor clerk has requested that all current governors also sign an updated form. School Business Manager/Head Teacher	**Agreed timescale** Continuous Continuous

6. Documentation and Authorisation

Finding

During the course of the audit we identified documentation and information that had not been updated as summarised below:

- "The Scheme of Delegation and Statement of Responsibilities" was last updated in May 2022. We did not see evidence that these documents had been reviewed in the Resources meeting held in May 2023. The Scheme of Delegation had not been signed by the Head Teacher, the Chair of Governors and the Chair of Resource Committee. Appendix 4 of the document still referred to previous School Business Manager (SBM), who left in February 2023, as an authorised signatory.
- The officer's name on the school administrator's email had not been updated with new SBM's name and was still showing previous SBM's name. This was corrected during the audit.
- The actual cash flow statement should be completed and signed by the Head Teacher monthly, however, this had not been completed since February 2023 up to the point of the audit.
- The gifts and hospitality guidelines and reminder was last emailed to staff in January 2020.

Risk

Unauthorised expenditure may be processed through the school's accounts.
The school may not have the information to confirm that school funds can meet all liabilities.
Inaccurate information received by stakeholders and may result in incorrect decision making.

Recommendation	**Rating**
"The Scheme of Delegation and Statement of Responsibilities" should be reviewed and reported to Governors annually and signed by the Head Teacher and the Chair of Governor. All documentation should be updated, where required, when a key member of staff leaves. Actual cash flow statements should be completed timely and duly signed and dated by the Head teacher. Staff should be reminded of the gifts and hospitality guidelines and all other school policies regularly and be included in the induction pack for any new starters.	**Priority 3**

Management Response and Accountable Manager	**Agreed timescale**
The Scheme of Delegation and Statement of Responsibilities has been reviewed and signed.	Completed
Actual cash flows have since been completed and signed off by the Head Teacher.	Completed/continuous
The previous SBM's name has been amended to the new SBM's name on all websites.	Completed
A staff reminder about gifts and hospitality was sent out in July 2023. New employees are also reminded of this when starting. School Business Manager/Head Teacher	Completed/continuous

Appendix B - Assurance and Priority Ratings

Assurance Levels

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.

Action Priority 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.

Appendix C – Audit Scope

Audit Scope
We reviewed the adequacy and effectiveness of controls over the following risks: • Robust governance arrangements are not in place to oversee the financial management of the school or to ensure value for money • Decision making is not effective, as decisions are based on inaccurate financial information • The school pays for goods/services not received • Income due to the school is not collected • Loss or theft of assets The audit review considered the following areas of financial management: • **Financial Management Information** including budget monitoring, financial reports and returns to London Borough of Bromley • **Primary accounting documentation** including payments, income, contracts, voluntary funds and bank reconciliations • **Safeguarding Assets** • **Governance arrangements** including financial delegation, governor minutes, budget approval and business interests Whilst on site for two days, we examined the controls in place to mitigate the impact of the key risk areas. Our audit included a review of relevant documentation, interviews with key officers and sample testing of related procedures and processes.

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FINAL INTERNAL AUDIT REPORT

DOMICILIARY CARE

PEO/11/2022

22 September 2023

Auditor	Principal Auditor
Reviewer	Head of Audit and Assurance

Distribution list and Job title
Director of Adult Services
Assistant Director, Integrated Commissioning
Head of Service, Community Living Commissioning
Integrated Strategic Domiciliary Care Lead Commissioner
Contract Compliance Team Leader

Executive Summary

Audit Objective	The objective of this audit was a review of new contracts to ensure delivery of domiciliary care is in line with service objectives, outcomes are being met, and value for money is being achieved.

Assurance Level		**Findings by Priority Rating**		
		Priority 1	**Priority 2**	**Priority 3**
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.	1	1	0

Key Findings

We noted the following areas of good practice:

1. The contract specification for providers clearly aligns with the specific goals for re-modelling domiciliary care services.
2. A domiciliary care provider forum takes place regularly and providers are encouraged to attend, either in person or virtually. There is a focus on information exchange, with presentations on key topics. A newsletter is sent out to all providers regularly.
3. A Trusted Assessor initiative is being introduced to apply a reablement based approach and enable domiciliary care providers to make timely changes to their provider support plans without the need for prior sign off from care managers.

Our audit highlighted the following areas where controls need to be improved:

4. **Contract monitoring arrangements** (Priority 1). From our examination of the contract monitoring arrangements and completion of the strategic contract management dashboard, there is a lack of evidence to demonstrate that the needs of clients, desired outcomes and expected quality care standards are being met. ***See Recommendation 1.***
5. **Business Continuity Plans** (Priority 2). The Business Continuity Plan for one provider in our sample was dated February 2020 and therefore before the Coronavirus pandemic. For another of the Business Continuity Plans in our sample the Business Continuity Plan contained no specific details of actions to be taken in the event of cyberattacks, server issues and/or issues with the interface. ***See Recommendation 2***

Management has agreed actions for all findings raised in this report. **Please see Appendix A**.

*Definitions of our assurance opinions and priority ratings are in **Appendix B**.*

*The scope of our audit is set out in **Appendix C**.*

Appendix A - Management Action Plan

1. Monitoring arrangements to ensure that clients' needs, and desired outcomes are achieved, and standards of quality are met
Finding There are policies and procedures for establishing, meeting and reviewing on-going needs and support for care users, together with a Quality Assurance monitoring approach that care placements are only made with providers that have a CQC rating of "Good" or above. There is a variety of evidence which can be obtained on domiciliary care provision, both from providers themselves and from internal assurance work undertaken by the Adult Social Care Contract Compliance Team and others. Some of the evidence is compiled in a strategic contract management dashboard which has been created by the Integrated Strategic Domiciliary Care Lead Commissioner. The dashboard is in a spreadsheet format and is ambitious, consisting of 21 tabs to be completed with information. It covers areas including lessons learnt, social value, savings, benefits and action trackers, KPIs, outcomes based on provider evidence, safeguarding and customer satisfaction. We noted that there is no documented guidance or completed example which can be used to show providers what is expected and demonstrate how it will help them and the Council to identify strengths and assess areas for improvement in their performance. As part of our audit testing, we examined the latest dashboard for a random sample of four of the providers (two patch and two framework). We found that the dashboards were not fully populated and therefore not yet operating as intended. Findings from the internal assurance work undertaken by the Adult Social Care Contract Compliance Team for the providers in our sample had not been included on the dashboard, particularly where these related to issues identified and improvements required on matters such as safeguarding and lack of care plans. One Focussed Assessment Report carried out in March 2023 for one of the providers in our sample identified nine areas where further improvements were required. We suggested during our audit that evidence from these assessments should be included in the respective tabs of the dashboard for the providers and the Integrated Strategic Domiciliary Care Lead Commissioner agreed that this would be done in future. We noted that two of the providers in our sample failed to attend the quarterly strategic contract meetings arranged with them by the Integrated Strategic Domiciliary Care Lead Commissioner in April and May respectively. Subsequently, she told us that a further meeting has been arranged with one of those providers due to a potentially serious safeguarding issue, which may result in a material breach and possible termination of the contract. (Redacted). For the patch providers there is the option of extending the contracts for three successive one year extensions. For the framework providers however, there is no option to refresh the framework. (Redacted) We are concerned that at present there is a lack of evidence to assess existing provider performance and the success of the overall commissioning approach, to help inform the decision making process in future.

If the strategic contract management dashboard will continue to be used as the reporting tool for assessing providers' performance, then its use, format, and functionality needs to be reviewed as a priority. This is to ensure that all key information required is captured, analysed and reported comprehensively and timely.

Risk

Expected outcomes from the new framework of domiciliary care provision may not be achieved. Evidence obtained may not be timely, accurate or complete to inform decision making.

Recommendation	**Rating**
Management should review the sources and types of evidence that they will obtain to enable them to assess whether or not outcomes from domiciliary care provision are being met. This should include what key information is required, how it will be obtained, from whom and when, and how it will be analysed and reported to ensure that the needs of clients, desired outcomes and expected quality care standards are being met.	Priority 1

Management Response and Accountable Manager	**Agreed timescale**
The following improvement actions will be taken in accordance with the recommendation:	
1) The Domiciliary Care Dashboard will be reviewed. The aim of the review is to remove any duplication with: • The QAF • SW Practice (terms of the Initial Assessment and Review Process) • CQC Inspection Framework • Alongside removing any information that is now considered superfluous (reflecting the 2 years lessons learnt)	31 October 2023
2) Once completed, individual Quality Assessment Framework's (QAF) to be shared with the Commissioning Service so that Commissioners can reflect outcomes in a) the monitoring/dashboard b) the Provider meeting agenda c) a single contract performance and QA report.	Commenced/Completed
3) Commissioning Service to send quarterly return dates for monitoring to all providers for the next 2 years in order to promote the timely preparation and the submission of their monitoring data.	Completed

4) To support provider attendance at monitoring meetings, dates for the next 12 months to be sent to the £500+ and Patch and Safeguarding, Practice and Provider Relations team lead monitoring officer & domiciliary care manager.	Completed
5) Review Liquid logic functionality in relation to capturing and recording SMART outcomes via the Social Care Initial Assessment and Review process; in order to develop a report that arrives at a recommended solution for capturing the impact of domiciliary care providers (care and support) on service users outcomes in Care Plan. Accountable Manager: Head of Service, Community Living Commissioning	31 October 2023

2. Business Continuity Plans
Finding We selected a random sample of two patch providers and two framework providers and checked that they had completed the standard Business Continuity checklist and that measures for dealing with cybersecurity and other IT issues had been included in their Business Continuity Plan. We found that for one of the providers the standard Business Continuity checklist had been completed in April 2022, but the Business Continuity plan was dated February 2020 and therefore before the Coronavirus pandemic. We have discussed this with the Contract Compliance Team Leader who explained that a later version of a Business Continuity Plan was seen during a compliance visit to the provider. It has now been requested from the supplier by the Contract Compliance Team Leader. For another of the providers who we had selected as part of our sample, the Business Continuity Plan contained no specific details of actions to be taken in the event of cyberattacks, server issues and/or issues with the interface. The Domiciliary Care Forum minutes dated 22 March 2023 included the following: 'We have been made aware of at least 4 Providers who have been adversely affected by cyberattacks, server issues and/or issues with the interface. This has led to system failures. Providers are reminded that they must have specific details within their Business Continuity Plan to cover actions to be taken for these eventualities.'

Risk	
Loss of or compromise of clients' data by providers. Disruption of domiciliary care service occurs in the event of a cybersecurity attack.	
Recommendation Review Business Continuity Plans for all providers and ensure that: (i) They have been completed no later 1 April 2022 and (ii) They contain sufficient information about actions which will be taken in the event of cyberattacks, server issues and/or issues with the interface. When assessing the sufficiency of the cyber security arrangements, obtain advice from the Council's IT department if necessary.	**Rating** Priority 2
Management Response and Accountable Manager In response to the recommendation the following actions will be taken: 1. Safeguarding, Practice and Provider Relations to send the request for Business Continuity Plans to providers and collate the returns for all of the London Borough of Bromley utilised domiciliary care providers. Log to be created on SharePoint. 2. The Commissioning Service to refer to the shared Log (see point 1 above) to ensure that the service is fully informed on any potential Business Continuity Plan issues for Framework and Patch providers. When meeting with providers Business Continuity Plans will be included as a standard agenda item. 3. Business Continuity Plan expectations to be included for discussion at the Domiciliary Care Forum and in the Domiciliary Care Newsletter 4. Safeguarding, Practice and Provider Relations to ensure that the Business Continuity Plan includes reference to Cyber Attacks Accountable Manager: Head of Service, Community Living Commissioning	**Agreed timescale** By 31 October 2023 Ongoing from 1 September 2023 By 31 October 2023 By 30 September 2023

Appendix B - Assurance and Priority Ratings

Assurance Levels

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.

Action Priority 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.

Appendix C – Audit Scope

Audit Scope
We reviewed the adequacy and effectiveness of controls over the following risks: • Providers are not engaged or on board with the commissioning model, meaning that service delivery does not align to the specification objectives • The care provided does not meet clients' needs or facilitate the achievement of their desired outcomes • Service provision does not meet desired or expected quality standards Our scope included the following: • Realisation of expected benefits through the new framework • Governance, including contractual management, roles and responsibilities. • Review of the contract documents and contract monitoring procedures, including the design of these procedures, and quality assurance arrangements. • Analysis of management information about contractors' performance and the measures in place to ensure that value for money is being achieved from the current contract arrangements. • Review of the management relationship arrangements put in place by the Council for domiciliary care providers, to ensure that expected outcomes for the clients are being met. • All of our relevant contract audits in 2022/23 will also consider supplier business continuity arrangements. We will not include, as part of our scope, those quality assurance arrangements which have already been covered in our recent desktop review of the Adult Social Care Quality Assurance Framework. We will not include verification of payments made to contractors or budget monitoring.

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FINAL INTERNAL AUDIT REPORT

PLACE DIRECTORATE

Capital Schemes – Project Management (Housing) 2022/23

Issued to: Assistant Director (Housing, Planning and Regeneration)
Head of Regeneration (Housing, Planning and Regeneration)
Assistant Director (Culture and Regeneration)
Director (Housing, Planning, Property and Regeneration)
Head of Finance (Adult Social Care, Housing and Health)

Prepared by: Assistant Manager (Mazars LLP)

Reviewed by: Manager (Mazars LLP)
Manager (Mazars LLP)
Partner (Mazars LLP)

Date of Issue: 16 August 2023

Report No.: PLA/10/2022

INTRODUCTION

1. This report sets out the results of our internal audit of Capital Schemes – Project Management (Housing). The internal 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 London Borough of Bromley's (Council) Housing Strategy outlines that the Council is committed to providing 1,000 Council homes through development on Council owned sites or acquisition by 2030.
3. We would like to thank everyone contacted during this review for their help and cooperation.

AUDIT SCOPE

4. The original scope of the audit was outlined in the Terms of Reference issued on 5 September 2022. Our sample testing included the following projects: Bushell Way, Anerley Town Hall and York Rise.
5. We reviewed and tested controls over the following key risks:
   - There is little or no business requirement for the scheme to commence and a lack of background information to prove its purpose;
   - Inefficient use of public funds;
   - Insufficient planning is undertaken to ensure the objectives can be met, or the service is not being designed effectively to ensure an efficient operational service for customers;
   - Changes are made that can harm the overall project/scheme;
   - Failure of the project and, in the long term, additional costs for the Council to deliver its services;
   - The project will not deliver its expected outcomes or may not deliver within the required timescales/budget;
   - Concerns in the delivery of the project and failure to meet objectives sufficiently; and
   - Valuable lessons are not used for the remainder of the programme or future programmes.

AUDIT OPINION

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

AUDIT OPINION	
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.

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
-	-	8

SUMMARY OF FINDINGS

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

- Based on the review of the latest received budgets of Anerley Town Hall budget dated February 2023, Bushell Way budget dated January 2023 and York Rise budget dated September 2022, we have observed that all had budget surplus.
- Testing confirmed that there are Executive approvals dated 28 November 2018 on the commencement of the sample-tested projects.
- We have evidenced effective monthly reporting on the successful delivery of affordable housing. While testing a sample of four 'Programme Highlight Reports on Affordable Housing Delivery', we found that the report includes section updates on

the housing objective and top housing delivery risks and their mitigating actions in place, indicating effective risk management controls. We also noted that the reports provide updates on the key milestones achieved in the current and subsequent reporting periods, effectively updating the sample projects' progress. These reports provided a RAG rated assessment on quality issues and the mitigating actions taken.

- In addition to reporting in place concerning the sample selected projects and the housing delivery scheme, we confirmed there was transparency when reports were publicly shared. This was confirmed by reviewing public minutes of meetings from the Renewal, Recreation and Housing Policy Development and Scrutiny Committee.
- A handover checklist for the housing development projects provides the different steps of handover chronologically ordered. The checklist shows the roles and responsibilities of handover among the Regeneration, Property Services, Housing Team, Finance, Information and Communications Technology (ICT) and the Managing Agent.
- We also obtained and reviewed evidence of effective communication regarding the handover process for the Anerley Town Hall and Bushell Way through Handover Working Group meetings and Housing Handover meetings. These meetings reviewed the defects period quality issues with effective control on action management.
- Progress reports confirm evidence of effective progress reporting. These reports cover project controls around contractual reporting on project progress summary, factors likely to affect the progress of works, client instructions required, material approvals, critical actions, health and safety issues, risk register, and project progress photos. Use of standardised and agreed templates provides effective quality monitoring. Progress reporting provided good control on management of completion time of project activities in addition to monitoring the time to complete indicator within the report.
- For the York Rise project, dashboards provide details related to the project milestone tracker, risk trends and key risks, key actions tracker, client risk register, change control register, and client approval tracker. In addition, visit reports provide effective controls in reporting on-site issues and recommendations with project progress photos. Any contractual matters raised in the dashboards or visit reports and contractors' progress reports that must be reported to the Committee are summarised within Committee reports. This also applies to the Employer's Agent of the York Rise project. Use of dashboard and reporting with photos is an effective control that elevates project quality management.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

8. 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.

1. Standard Business Cases and Benefits Management Plan and Realisation	
Finding Although we have seen evidence of the Executive approvals for the three sample-tested projects dated 28 November 2018, we have not observed that a standard business case template was used. In addition to the approval, we reviewed the Executive reports received from May 2019 to January 2022 and a total sample of nine progress reports for the three sample-tested projects. We observed that benefits are contextually discussed. However, we could not find any evidence of any systematic benefits realisation plan or measurement (i.e. list of benefits, benefit owners, benefits measurement, and when the benefits shall be measured, which shall be part of a benefits management plan). It is noteworthy to mention that project benefits are referenced within the 'Post Completion Review Report' template. The Regeneration Manager (Culture and Regeneration) advised that this is a requirement included in the template, and such report should be completed for each sample project within one year from the completion of the construction phase, which was not due during the audit fieldwork. **Risk** Not having a standard and structured business case process could potentially impact the consistency of the information presented if relevant information to the project business case does not contain systematic representation on how the project meets strategic objectives, economic appraisal of options for delivery and commercial, financial, management arrangements for the project and information on how the project benefits will be measured and realised.	
Recommendation Management should establish standard business case templates to ensure that all relevant areas are completed. The following sections should be, at least, added to the business case standard template: • A benefits management plan that lists all expected benefits, frequency and means of measuring them, benefit owners, reporting on benefits realisation and considering the proper action plans and decisions based on the outcome of the benefit. These benefits shall be aligned with the Council's strategies and include both financial and non-financial benefits; • Financial analysis and forecasting inclusive of financial sensitivity analysis;	**Rating** Priority 3

• Alternatives and options and the recommended option. Reasons for disqualifying any alternative or option shall be highlighted as well; • Risks and mitigation strategies with the recommended strategy; • Timeline with milestone chart at each phase or on key review or approval points; • Governance and project team structure, and • Engagement and communication approach. Management should ensure that benefits are measured as planned, periodically reported to senior management and relevant committees, and seek support if any benefits are not achieved as planned.	
Management Response and Accountable Manager By the time a housing scheme is considered, there has been considerable discussion about site feasibility, and whether a site should be considered for disposal or for building housing. These meetings are conducted by the Strategic Asset Group, which are not public meetings in the interests of commercial sensitivities. The Housing reports then sets out a high-level options for consideration. Once agreed and a scheme is developed, all of the above are monitored by the project team, including project plan monitoring, risks and risk mitigation as well as governance.	**Agreed timescale** N/A
2. Project Initiation Document (PID) / Project Plans	
Finding Project Initiation Documents (PIDs) which are in place for the sample selected projects, provide information about the following: • Project background; • Site information; • Scope and objectives inclusive of design objectives; • Project team composition inclusive of their roles and responsibilities, and • Early risk considerations.	

The above elements within the PID are not comprehensive enough to cover all project management areas per best project management practices (i.e., Association for Project Management – Body of Knowledge 7).

We observed there are other project management areas required to be elaborated on, including:

- Project benefits in terms of the means to measure them and when;
- Procurement approach;
- Project milestones and initially approved schedule;
- Project cost management indicating how the budget will be approved and revised and how the project cost will be monitored;
- Change and variations management methodology;
- Lessons learned process;
- Risk management framework and methodology indicating how the project risks would be identified and monitored and the integration between projects risk registers and department risk register;
- Engagement and communication plans, and
- Project closure and handover approach.

We have also noted that the tested PIDs for the three sample-tested projects were not dated.

Risk

A lack of guidance on all project management areas may lead to delays and key activities not being completed per the expected quality level leading to an increase in the risk of the project not being delivered as agreed and benefits not being realised.

Recommendation	**Rating**
For each future project, establish and acquire dated approval for a standard project plan/PIDs that reflects the approach and sub-plans related to the following as a minimum: • Benefits management plan inclusive of how benefits are to be realised, when and how; • Project procurement approach and tools and techniques that will be used to monitor procurement and contracting activities; • Project time management indicating how the project schedule will be planned and monitored; • Initial project approved schedule/milestone chart;	Priority 3

• Project cost management indicating how to budget revisions that will take place and their relative authorisations in addition to explaining the tools and techniques to be used to measure cost variations; • Initial approved budget and cost breakdown; • Change control management indicating the approval process of changes inclusive of the governing entities who approve changes and the change process inclusive of variations and instructions; • Lessons learned process; • Engagement and communication plans with all projects stakeholders; • Project risk management methodology and framework and the tools and techniques to be used to manage risks, and • Project closure and handover approach; If an external project stakeholder manages any specific sub-plan, this must be referred to within the project plan.	
Management Response and Accountable Manager The only element of the above I can agree with is that project closure is not evidenced as it has not happened at the time of the audit Handover process has been streamlined There needs to be clearer benefit realisation plan There is clear evidence in our projects of change control, contract management, lesson learned, project management including close budget monitoring, as well as risk, and this has been evidenced and demonstrate thorough the successful delivery of the project, despite significant disruptions of Covid and significant inflationary cost pressures	**Agreed timescale** N/A
3. Lessons Learned	
Finding We have requested evidence for the three sample-tested projects related to lessons learned, focusing on lessons that resulted from completing the construction phase of the Anerley Town Hall and Bushell Way projects. We received evidence from the Housing Regeneration	

Project Manager Culture and Regeneration dated 27 May 2022, listing the lessons learned briefly. However, we have not observed any evidence of building appropriate action plans, assignment of action plans to action owners and logging lessons learned to a central lessons learned repository. We were informed by the Head of Regeneration that the lessons learned process and knowledge sharing process occurs through multiple team meetings, handover meetings and appointing a construction consultant to the York Rise project to provide more representation of project team members into the project boards. However, we observed that the process is not delivered in a standardised and systematic way.

Although the Head of Regeneration advised that the assignment of an employer's agent/consultant to the York Rise project was based on the health check report dated December 2021, the resulting opinions and recommendations within the health check report were not logged into a central lesson learned log/repository for continuous learning and knowledge sharing.

Moreover, no lessons-learned procedure or process map is in place that provides complete guidelines on the process.

Risk

If lessons learned resulting actions are not systematically implemented within new projects, this could lead to a risk of any lessons learned not being fully or inaccurately implemented, leading to increased project risks or issues. Not having a lessons-learned repository can be a missed opportunity for knowledge development in relevant housing development and project management areas.

Recommendation	**Rating**
Establish a lessons-learned procedure/process map that highlights the following areas at a minimum: • Identification of lessons learned inclusive of the source identified; • Classification of lessons learned inclusive of its importance, impact and governance level; • Identification of relevant action plans that include the action owners and due dates for implementation; • Organising lessons learned in physical or virtual workshops to enhance the learning process; • Monitoring and control of the lessons learned log, inclusive of the relevant action plans; and • Sharing lessons learned progress across all relevant stakeholders to improve the knowledge management process. Ensure the latest updated lessons learned log/repository is shared across all relevant staff and managers.	Priority 3
Management Response and Accountable Manager	**Agreed timescale**

As above	N/A
4. Stakeholder Engagement and Communication Plan	
Finding The Regeneration Manager (Culture and Regeneration) informed us that resident meetings were conducted during the planning phase of the sample-selected projects. We have also referenced evidence of acquiring residents' feedback within the reports HPR2020/051, HPR2020/038, and DRR20/0199, dated January 2021, November 2020 and February 2020, respectively. However, we have not observed evidence of project stakeholders being mapped into engagement and communication plans prepared for the three sample-tested projects, including analysis of external and internal stakeholders. Reasons communicated by the Regeneration team that the sample tested projects were delivered during the pandemic, so not all stakeholder engagement and communications plans were formulated. **Risk** Without stakeholder engagement, with prioritisation of stakeholders considered, and communications planning, there is a risk that those impacted by the project's changes are unaware of what is being delivered. This could lead to unrealised benefits, reduced returns on investment and negative perceptions of the Council.	
Recommendation For each project, Management should analyse internal and external stakeholders in terms of interest vs influence and reflect the analysis on a 'Stakeholders Analysis Map'. Based on the analysis result, identify the reporting, meetings, informal communication requirements, and frequency for each stakeholder. The plan can be a standalone engagement and communication plan or a sub-plan part of the overall project plan.	**Rating** Priority 3
Management Response and Accountable Manager Findings and recommendations are noted, and whilst the current budgets do not allow for such wider engagement this will be taken into consideration with the Director when planning resources in the future. This is not to say that engagement does not happen, but it is not planned engagement outside of Ward Cllr updates as it currently stands.	**Agreed timescale** Next Council funded project.

Recommendations on future projects to be discussed with the Assistant Director and Director for planning resources appropriately to allow for broader engagement. If not agreed, this will be captured in the PID or how engagement with stakeholder will work and why.	
5. RAID Logs	
Finding Although we have evidenced risk monitoring by reviewing a sample of three risk registers for each of the sample selected projects and a sample of four Highlight Reports for Affordable Housing Delivery, which identify top risks of the housing programme, we have observed a lack of implementation of the Risks-Actions-Issues-Decisions (RAID) logs for the three sample projects. **Risk** Not using RAID logs for projects can reduce the effectiveness of project monitoring and implementation, especially from the Council's project management side, where risks, actions, issues and decisions other than contractor-related ones can be added to track project performance and act accordingly.	
Recommendation Management should apply RAID logs to future projects consistently, periodically, and progressively report on its outcome to senior management and leadership. Escalate any outstanding issues, risks or decisions to the correct governing entity per the engagement and communication plan guidelines.	**Rating** Priority 3
Management Response and Accountable Manager Implementation of RAID Logs across the team for all projects. Head of Regeneration (Housing, Planning and Regeneration)	**Agreed timescale** Immediately
6. Projects Risk Monitoring and Integration	
Finding	

Monthly 'Programme Highlight Reports on Affordable Housing Delivery' are prepared by the Culture & Regeneration team and then reported to the Housing, Planning & Regeneration (HPR) and the Transformation Boards. They provide a Red-Amber-Green (RAG) rating on the housing delivery objectives and risks with mitigating actions and the Lead Responsible. We confirmed they include updates on the sample projects tested.

We reviewed Programme Highlight Reports: Affordable Housing Delivery for July, August, September-December 2022, and January 2023 and noted that the top risks and action against each risk are measured against the inherent risk only and not the residual risk so that the top risks ratings remain unchanged from July 2022 to January 2023.

Risk

Not measuring the residual risks after the actions and mitigations against each risk can provide an unclear representation of the remaining risk. This could provide an inaccurate outcome of the risk mitigations undertaken for top risks.

Recommendation	**Rating**
Management should update the slides within the Programme Highlight Reports: Affordable Housing Delivery to reflect both inherent and residual risks to allow for visibility on residual/remaining risk change as a result of progressing or completing risk-mitigating actions.	Priority 3
Management Response and Accountable Manager Implementation of management of residual risk and new risks register to go to the Transformation Board. Head of Regeneration (Housing, Planning and Regeneration)	**Agreed timescale** Immediately

7. Document Control

Finding

We have reviewed evidence that the contractors' and consultants' invoices for the three sample projects are being approved and reconciled, in addition to having approvals on contractors' variations and evidence on monthly financial statements.

However, we have identified multiple areas where document control is required, as follows:

- We reviewed a table on analysis of instructions between Anerley Town Hall and Bushell Way within the financial statements vs the actual approved ones. We have noted that the references used for the sample tested projects contract instructions within the contractor's financial statements differ from those used within the approved contract instructions. Management advised that the Anerley and Bushell projects started as one project and the financial systems have made it difficult to move to two separate project codes, and therefore there is some disparity between references for final accounts, so final accounts will be taken as the two cost centres put together again. Although project changes with financial impact are controlled within the Financial Monitoring sheets for each project, we have noted that there is no master log for project changes for both Anerley Town Hall and Bushell Way projects to monitor and control all project changes, including variations and instructions with and without financial impact. Notably, maintaining a change log was raised as a lesson learned by the Housing Regeneration Project Manager Culture and Regeneration on 27 May 2022.
- We have also noticed a discrepancy between the number of invoices within the Finance monitoring spreadsheets for Anerley Town Hall, dated February 2023 and Bushell Way, dated January 2023 and the actual invoices received. To illustrate further, the total number of invoices for the Anerley Town Hall project per the finance monitoring spreadsheet was 15, while the actual invoices received were 35. Similarly, the total number of invoices for the Bushell Way project per the finance monitoring spreadsheet was 13, while the invoices received were 51.

Risk

Lack of effective project document control can lead to decreased project monitoring and control efficiency and reduced time efficiency due to additional project figures reconciliation or sanitising project information if it was not timely updated.

Recommendation

Management should:

- Ensure that all project control and monitoring documents and logs match the actual approved project documents in place and that all project logs are up to date;
- Management should investigate the reasons behind the discrepancies between actual contractor invoices/variations issued against the internal log maintained by the Project Managers;
- Project referencing to the Council documents (e.g., variations and instructions) by any external stakeholders shall lead to internal references of the Council within the change control log;
- For each project, ensure that there is a monitoring and control log for all types of variations and instructions, and,

Rating

Priority 3

• We recommend using document revision control for original and revised versions of the main project baselines, mainly project schedule and project budget (i.e., revision 0 refers to the original project budget and original budget schedule)	
Management Response and Accountable Manager There have been challenges with new financial system that have made recording of financial logs challenging, and this is being worked through with Finance team. There are now clear logs in place for all variations on the financial spreadsheets	**Agreed timescale** Already implemented
8. Governance Structure for Housing Delivery Projects	
Finding Although we have been informed by the Head of Regeneration and observed evidence of the governing entities of the affordable housing delivery in terms of their authorities and their sample reports reviewed, we have noted that the governing entities are not mapped out into a governance structure. In addition, we noted a lack of mapping out of governance structures for the three sample projects tested. The current practice in place includes reporting to the following entities: • Weekly briefing to the Portfolio Holder but with no minutes; • Monthly reporting to the Transformation Board through the Programme Highlight Reports on Affordable Housing Delivery; • Ad-hoc updates to the Renewal, Recreation and Housing Policy, Development & Scrutiny Committee as required by Contract Procedure Rules (CPR) and Financial Regulations (FR) and requested by Members, but also included in the Quarterly Portfolio Plan Update, and • Ad-hoc updates to the Executive as required by Contract Procedure Rules (CPR) and Financial Regulations (FR). **Risk** There is a risk of lack of visibility on the governing entities for the housing delivery programme and the interrelationship across them, which can reduce programme and project governance if not well designed.	
Recommendation Management should:	**Rating** Priority 3

• Ensure that all governing entities are mapped into a governance structure inclusive of their updated and approved Terms of Reference; • Identify the governing entities of the project within each Project Plan, and • Identify any meetings or reporting requirements to the governing entities within each engagement and communication plan.	
Management Response and Accountable Manager All governing and reporting structures for all project to be fully mapped out, status checked quarterly and amended as necessary. Head of Regeneration (Housing, Planning and Regeneration)	**Agreed timescale** Immediately for all live and new projects

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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FINAL INTERNAL AUDIT REPORT

DOMESTIC ABUSE

AW/01/2022

OCTOBER 2023

Auditor	Principal Auditor
Reviewer	Head of Audit & Assurance

Distribution list

Assistant Director, Public Protection
Director of Environment & Public Protection
Director of Children, Education and Families
Director of Adult Social Care
Director of Housing, Planning and Regeneration
Director of Human Resources, Customer Services and Public Affairs

Executive Summary

Audit Objective	The overall objective of the audit was to review the adequacy and effectiveness of the Council's arrangements to discharge its duties under the Domestic Abuse Act, to ensure that tailored support is available to the victims and survivors.

Assurance Level		**Findings by Priority Rating**		
		Priority 1	**Priority 2**	**Priority 3**
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.	1	9	0

Key Findings

1. Since the responsibility of Domestic Abuse transferred in November 2022, the Head of Service has embraced the challenges facing the service and has made good progress such as getting a new contract in place from April 2023 with Contractor A.
2. The Domestic Abuse (DA) Strategic Lead has established strong working relationships with partners and agencies within the Operational Forum and the Assistant Director, Public Protection also has support from the Strategic Board members. Partner support for the Domestic Abuse service was evident from partner feedback regarding what the service is trying to achieve. Attendance at both these meetings is generally good.
3. The DA Strategic Lead and the Interim Community Safety Manager have both been proactive in addressing issues such as development of the action plans, evidencing achievements and the barriers to achievements.
4. The ownership and awareness of domestic abuse being a shared responsibility of everyone and every agency needs to continue to be embedded further. There was no comprehensive process to monitor the achievement of the 5 priorities within the Domestic Abuse Strategy. ***(See Recommendation 1).***
5. Feedback from officers was that there should be further clarity of the direction of the Strategic Board and that this needed more authority and the oversight of senior leadership. ***(See Recommendation 2).***
6. Domestic Abuse Training is required for the Public Protection team and members of the Operational Forum and Strategic Board. ***(See Recommendation 3)***

7. There is no comprehensive risk register in place for the domestic abuse service to enable risks to be identified and managed. ***(See Recommendation 4).***
8. For service planning, there needs to be a better way of recording achievements and where work has been progressed, but not necessarily with the desired outcome. ***(See Recommendation 5).***
9. Contract management and monitoring processes needed to be improved. ***(See Recommendation 6).***
10. DRIVE funding ceased at the end of June 2023 and will be replaced by a PAN London service for the perpetrator programme. The effectiveness of the latter is consequently not yet known ***(See Recommendation 7).***
11. There were no specific domestic abuse procedures and/or process maps written detailing the individual processes involved. ***(See Recommendation 8).***
12. We were not provided with evidence to confirm that annual reports required under the Domestic Abuse Act 2021 had been completed and submitted. ***(See Recommendation 9).***
13. It has not been possible for the service to identify and appoint the DA Ambassadors, which is one of the DA Strategy priorities, as it is dependent on the DA Employee Policy being approved. ***(See Recommendation 10.)***

Management has agreed actions for all findings raised in this report. **Please see Appendix A**.

Definitions of our assurance opinions and priority ratings are in ***Appendix B****.*

The scope of our audit is set out in ***Appendix C****.*

Appendix A - Management Action Plan

1. **Domestic Abuse Strategy & Ownership**
Finding The Domestic Abuse Act 2021 came into force on April 21st, 2021. Referring to the DA Act 2021 Guidance, Bromley document, one of the aims of the Act is to 'Promote awareness – put domestic abuse at the top of everybody's agenda'. (This relates to Priority 1 of the DA Strategy – 'We will promote the message that tackling Domestic Violence and Abuse (DVA) is everyone's and every agency's responsibility'. Intergenerational Domestic Abuse Strategy The document 'An Intergenerational Domestic Abuse Strategy for 2021-2024, Making Domestic Abuse Everyone's Business', highlights that 'The services we commission in Bromley support victims of all ages, genders, ethnicities, sexualities, and backgrounds. We are committed to ensuring that all services are accessible, and that they reflect and meet the needs of our diverse community. A multi-agency partnership approach is essential in the delivery of effective, robust support to victim survivors of DVA, and effective interventions for perpetrators. All partners have a responsibility to deliver on the actions and priorities outlined in this strategy'. One of the detailed areas of focus is 'Promoting the message that addressing DVA is everyone's and every agency's responsibility'. Feedback from officers and partners showed that a rethink is required with a new focus and determination to put this on the agenda for everyone and every agency. Staff within the Domestic Abuse service are committed to working to deliver on these collective priorities, but for there to be significant progress then there will need to be reconsideration of the ownership, raising the profile and communicating the Authority's commitment to tackling Domestic Abuse. It was highlighted by managers and partners that awareness of the strategy was 'variable' and limited to 'those who needed to know'. The strategy needs to be further embedded and communicated. We acknowledge that a Domestic Abuse Employee Policy and Resident Policy are in the pipeline. ***(See Recommendation 10).*** It should be noted that the service has worked hard in communicating the strategy and the service also produces a Domestic Abuse Newsletter. Contractor A also undertake their own promotional work. However, when reviewing the Bromley website, it was found that there was not a distinct page for public protection that is easily accessible detailing everything available pertaining to Domestic Abuse, the strategy, emergency contact details and help and support available.

There are 5 priorities detailed within the DA Strategy and findings within this report relate to all the 5 priorities. The five priorities are:-

- Priority 1 'We will promote the message that tackling DVA is everyone's and every agency's responsibility.
- Priority 2 We will commission effective services to support victims of DVA
- Priority 3 We will challenge perpetrators and explore interventions that measure the change in their behaviour
- Priority 4 We will increase and develop our existing training offer on DVA and Violence Against Women and Girls (VAWG) to improve local responses to victims and survivors, and their families
- Priority 5 We will introduce DVA Ambassadors to support staff in the workplace'.

Enquiries with staff showed that there was not a comprehensive process to monitor the achievement of the priorities detailed within the Domestic Abuse Strategy.

Risk

A lack of ownership and focus on the desired outcomes will lead to reputational risk to the Authority. It may also lead to worse outcomes for vulnerable residents.

Recommendation

The Intergenerational Domestic Abuse Strategy needs to be embedded, further publicised, and communicated to all staff and agencies. This could be in part through the Domestic Abuse Employee Policy, when approved and published. This process could be assisted by the appointment of the Domestic Abuse Ambassadors. The Residents Policy should then follow subsequently.

A comprehensive process to monitor and document achievement of the priorities within the DA Strategy, should be in place and overseen by the Strategic Board.

There needs to be better engagement and acknowledgement of the shared responsibility and ownership in addressing Domestic Abuse throughout the Council, as it is everyone's and every agency's responsibility. The Council needs to embed this ownership, responsibility and awareness of Domestic Abuse, to all staff and services. This could be done through staff training. The Domestic Abuse Ambassadors could attend team meetings within services for the relevant areas, to further increase awareness, supported by the Domestic Abuse Employee Policy.

Rating

Priority 1

The Bromley website should be updated with an easily accessible page detailing emergency contact details, the strategy and all help and support available.	
Management Response and Accountable Manager **In response to the recommendations the actions below will be undertaken. The Public Protection Team will coordinate these however many of these activities will be on-going and will require Council-wide support to enable effective implementation.** 1. A campaign of activity to further promote The Intergenerational Domestic Abuse Strategy will be developed to coincide with the Domestic Abuse Awareness Month (October) as well as other related nationwide campaigns which Bromley will seek to amplify locally within the Council and through encouraging Partner agencies to do the same. ***Domestic Abuse Strategic Lead***. 2. Internet and Intranet updates to be completed in preparation for promotion in October. ***Domestic Abuse Strategic Lead***. 3. A review of the proposed DA Champions will take place to determine if this should remain a stand-alone role or have a wider Safeguarding remit. The review to be completed by 30/10/23 and recommendations made to the Safeguarding Adults Board and Safer Bromley Partnership for agreement and implementation. ***Domestic Abuse Strategic Lead***. 4. In liaison with the Procurement Team seek to establish a process to encourage Contractors to provide a copy of their staff domestic abuse policy or encourage them to consider adopting a similar policy to the Council. ***Domestic Abuse Strategic Lead***. 5. Introduce an Action Plan and KanBan project management tool for activity to ensure clear accountability and timelines, track progress and record achievements. ***Domestic Abuse Strategic Lead***. 6. Develop a '7-Minute Learning' resource, including a recorded session, which can be accessed and utilised by Council officers. All staff to be encouraged to watch individually or as part of their team meetings by 31/3/24 and notify the DA Lead Officer when this has happened to capture the activity. ***Domestic Abuse Strategic Lead***. 7. Residents policy to be developed in consultation with key partners. ***Domestic Abuse Strategic Lead***.	**Agreed timescale** (1) 10/12/23 (2) 30/09/23 (3) 30/10/23 (4) 31/3/24 (5) 31/8/23 (6) 30/9/23 (7) 30/9/24

2. Operational Forum & Strategic Board

Finding

There are not two distinct terms of references for each Forum / Board, but a joint Terms of Reference. The copy of the terms of reference supplied was in 'draft' status. This was also the case for the Multi Agency Risk Assessment Conference (MARAC) meeting terms of reference.

The term of reference refers to the Head of Service for Early Intervention and Family Support reporting from the strategic board to various committees. 'The strategic board will feed up to the Executive Committee and the Head of Service for Early Intervention and Family Support will report formally to committees, as part of the annual cycle'. This does not reflect current roles and responsibilities.

Feedback from managers and partners was that the Strategic Board needed more authority with oversight from senior leadership and that there needed to be clearer aims and objectives.

Risk

Out of date and incorrect information will not provide a clear direction of the scope and remit of these meetings. Without the necessary authority and support at a senior level, the service may struggle to tackle domestic abuse priorities.

Recommendation	Rating
(i) The current structure and membership of the Strategic Board should be reviewed and finalised, as soon as possible along with the Board's aims and objectives. (ii) Terms of references for the Operational Forum, Strategic Board and MARAC meetings should be updated to reflect the current reporting lines, post holders since transfer in November 2022 and finalised.	Priority 2
Management Response and Accountable Manager	**Agreed timescale**
The Public Protection Team took over the management of the Domestic Abuse Strategic Board in November '22. As there is no requirement for the Board to be stand-alone and Membership to the Safer Bromley Partnership is very similar the option to merge the two will be reviewed and recommendations made to the groups for consideration. ***Head of Safer Communities and Assistant Director, Public Protection.***	31/01/24

As determined by the DA Strategic Board and SBP Group the Terms of Reference for the group(s) will be finalised and those of the associated operational/delivery groups. ***Head of Safer Communities and Assistant Director, Public Protection.***	31/03/24
The MARAC process will be reviewed to ensure it remains the most effective and efficient method for protecting high risk victims of domestic abuse. The review and recommendations will be presented to the Board for consideration and implementation. ***Head of Safer Communities and Assistant Director, Public Protection.***	31/03/24

3. Domestic Abuse Training

Finding

Since the Domestic Service (DA) service transferred to Public Protection in November 2022, the team have had to adapt quickly working with partners and delivering the service. The team will have had to acquire knowledge of the service quickly. Some members of the team are new to the Domestic Abuse service and would benefit from establishing their knowledge and awareness further. The work of the Domestic Homicide Reviews (DHRs) should be included. (This relates to Priority 4 of the DA Strategy - 'We will increase and develop our existing training offer on DVA and VAWG to improve local responses to victim survivors, and their families'.

Partners have also cited training as an area of weakness in various areas and lacking the ability in the absence of training, to complete required risk assessments to the desired standard. Feedback also included 'a lack of understanding of the dynamics of DA, the need for DA awareness training for every level of the Council, lack of understanding of the complexities involved in the referrals being made, lack of specialised support e.g. no recourse to public funds, barriers to victims/survivors accessing support and training does not always the objectives of the DA Strategy'.

Risk

Staff may not be sufficiently prepared to deal with the challenges in managing this service area, leading to incorrect decisions being made.

Recommendation	Rating
(i) A gap analysis of training needs to be undertaken across public protection and for the Operational Forum and Strategic Board members. Identified training needs for all the team including management and officers should then be taken forward in the development of a training plan for the service via learning & development. (ii) This should also include MARAC training including the completion of the risk assessments undertaken.	Priority 2

Management Response and Accountable Manager	Agreed timescale
Training is integrated into the DISCUSS process which has recently been completed in Public Protection and this information will be fed into the corporate Training and Development process. In addition to this, officers are encouraged to access events and opportunities which are provided through community safety and safeguarding networks. ***Head of Safer Communities.***	31/07/23
It is likely that DA training will already be available through statutory partner agencies, therefore, the Public Protection team will seek to identify gaps and opportunities which may be accessed across the partnership and promote these opportunities to staff. ***Head of Safer Communities.***	30/09/23
The 7-minute Learning package will seek to provide awareness and signpost officers to additional information and support if required. ***Domestic Abuse Strategic Lead***.	30/09/23
The need for training staff with a responsibility for undertaking Risk Identification Checklists (RIC) or Domestic Abuse, Stalking and Honour Based Violence (DASH) assessment will be undertaken, and opportunities established. ***Head of Safer Communities.***	30/11/23

4. Risk & Issues Log

Finding

A copy of the Domestic Regulation risk and issues log was provided; however, this is not specific to the DA Service. Furthermore, the risks have not been assessed, and the register does not specify how these risks are being managed or mitigated. It was not found to be comprehensive as risks that were raised at the start of the audit had not been included.

Risks that are not highlighted such as:-
1) Impact of DRIVE and funding ending in June 2023 and transferring to the PAN London service.
2) Lack of a MARAC Coordinator being in post, however a temporary appointment has since been made.
3) Funding limitations.
4) Training not in place for current members of the team and more widely for all staff, partners, and MARAC training.

Risk

Risks across the service are not captured and documented, which may lead to priority decisions not being made.

Recommendation	**Rating**
There should be a comprehensive risk register for Domestic Abuse. This should include risk ratings, mitigations, and responsible officers. It should also include horizon scanning and emerging risks. Consideration could also be made to issues arising from contract monitoring and DHR reports and outcomes and service data, to enhance and better inform this document. The risk register could be monitored via the action plans from the Operational Forum, Strategic Board, and/or other meetings.	Priority 2
Management Response and Accountable Manager	**Agreed timescale** 31/3/24

The responsibilities for reducing domestic abuse, managing risk, and behaviour change sit with a range of statutory partners as set out in the Domestic Abuse Act 2021. Whilst the Council is one of those agencies, it would not be appropriate for the Council to record these as corporate risks. Any specific risks for the Council identified as part of this exercise will also be considered as part of the Council's risk management processes. It is therefore proposed that a Risk Log is developed by the Domestic Abuse Board, once its structure is agreed, and the agreement and mitigation of the risks is held by the members of that board. ***Assistant Director, Public Protection***	

5. Service Planning	
Finding From discussions with the Interim Community Safety Manager and the DA Strategic Lead, it was confirmed, via interview, that there needs to be a better way of recording achievements and where work has been progressed, but not necessarily with the initially desired outcome. Officers explained there needs to be a recording mechanism detailing what has been achieved and what were/are the barriers to achieving the outcome. **Risk** With all the various work streams undertaken, work completed or in progress may be missed when mapping achievements over the year.	
Recommendation Work undertaken to achieve certain workstreams, projects and one-off pieces of work, should be documented within the service, to demonstrate outcomes and achievements. This will also help feed into the work undertaken in developing the new Domestic Abuse Strategy in 2024, future service planning and the MBEB priorities. (Making Bromley Even Better).	**Rating** **Priority 2**
Management Response and Accountable Manager It is intended to introduce an Action Plan and KanBan project management tool for activity to ensure clear accountability and timelines, track progress and record achievements. ***Domestic Abuse Strategic Lead***.	**Agreed timescale** 30/09/24

6. Contract Management & Contract Monitoring

Finding

(This relates to Priority Number 2 of the DA Strategy – We will commission effective services to support victims of DVA).

Contractor B (Chairing of Domestic Homicide Reviews)

The contract with Contractor B is for a five-year period with a total cost of £78,325. There are no formal contract management and monitoring meetings arrangements in place for Contractor B. The Head of Safer Communities confirmed that he does not undertake formal contract monitoring meetings. He advised that he has not had the need to query much with the contractor. The Head of Safer Communities advised that KPIs would be put in place for the new contract in 2024.

Contractor A

A new contract is in place with Contractor A from 1/4/23 to 31/3/25 with a total contract value of £467,686. The specification states that *'Precise key performance indicators and other performance impact measurements will be negotiated with the successful service provider during the post award mobilisation period.* This had not been put in place at the time of this report.

Quarterly monitoring reports had been provided by the contractor under the previous contract. We reviewed the January 2023 meeting notes and found that there was no standard agenda in place, no actions being identified and who would be responsible for taking this forward with agreed implementation dates.

Risk

If contract monitoring meetings are not undertaken and documented, there is no record of discussions and agreed decisions, in the event of a contractual dispute. Without the development and agreement of the KPIs with Contractor A, officers may not be sufficiently informed of the performance of the key areas of the contract since commencement.

Recommendation	Rating
Contractor B Contract management and monitoring should be undertaken regularly throughout the contract period, at an appropriate and proportionate frequency for the budget and ad hoc nature of the contract.	Priority 2

Contractor A The contract monitoring minutes should record meeting attendees, any issues that may need clarification regarding contractor service provision, KPI performance targets and actual data, actions arising and timescales for implementation by the action owner. Key Performance Indicators should be agreed as soon as possible with the provider and monitored through the quarterly performance data submitted by the provider, as well as through the contract monitoring meetings. There should be an agreed agenda, minuting format and frequency of meetings going forward for contract monitoring meetings.	
Management Response and Accountable Manager	**Agreed timescale**
Contractor B Contract management and monitoring will be undertaken regularly throughout the contract period, at an appropriate and proportionate frequency for the budget and ad hoc nature of the contract. ***Head of Safer Communities.***	30/09/23
Contractor A An agreed schedule of meetings with the contractor will be put in place with an agreed Agenda for standing items. There is limited capacity for administrative functions such as Minute Taking in the Public Protection Service, therefore for efficiency of officer time a Decisions, Action, Notes (DAN) Log on Teams will be maintained by all members to ensure that key aspects of the meetings are recorded, with clear timelines and ownership of actions and progress updates. This will commence in line with the schedule of meetings.	
A schedule of KPIs will be agreed at the next meeting with the provider. ***Head of Safer Communities.***	30/09/23

7. Perpetrator Programme	
Finding One of the priorities within the Domestic Abuse Strategy is "We will challenge perpetrators and explore interventions that measure the change in their behaviour" (Priority Number 3 of the DA Strategy). DRIVE, the perpetrator programme, ended in June 2023 dropping capacity in the borough from 70 to 8 places. A new PAN London service is due to replace this instead. This will impact on the perpetrator programme locally and will need to be reviewed, to ensure that the Council can deliver on the objective set out in the DA strategy. Further DRIVE only covers high risk high harm perpetrators. It remains the case that there is no support in the borough for other perpetrators of DA not deemed high risk or high harm. **Risk** Future perpetrators who would like to engage with the programme, may go unsupported. Victims of DA and their children and families will be exposed to increased risk as perpetrators cannot access support for behaviour change.	
Recommendation Management will need to assess and review the effectiveness of the new PAN London service to ensure that this supports the achievement of the objective detailed within the DA Strategy (Priority Number 3 of the DA Strategy).	**Rating** Priority 2
Management Response and Accountable Manager Reviews of the implementation and effectiveness of the pan-London service model will be forward planned to be undertaken and presented to the Domestic Abuse Board Quarterly, including updates from the Mayor's Office for Policing and Crime (MOPAC), Drive and Probation. ***Assistant Director, Public Protection.***	30/11/23

8. Procedures, Processes & Access to Information	
Finding Apart from guidance from the Domestic Abuse Act and the Bromley Guidance document, currently, knowledge is held by individual officers and there is not a shared understanding of processes or the location of documents or indeed access to them. Currently, the Domestic Abuse Strategic Lead has access to documents that other members of the team cannot locate or access. The Domestic Homicide Review (DHR) procedure was being reviewed at the time of testing, as confirmed by the Head of Service, Safer Communities. As the statutory guidance on DHRs is also in the process of being updated, which will feed into the Council's procedure, we have not made a further recommendation at this time. **Risk** Restricted access to key information and documents impact on service delivering and planning. If procedures are not reflecting current practice, different processes may be followed, which may not meet desired standards or outcomes.	
Recommendation Procedures and /or process maps should be written and be readily available to staff. There should be a central repository so all team members can access relevant documents.	**Rating** Priority 2
Management Response and Accountable Manager The Public Protection Service are actively moving towards a more collaborative working practice through Teams. All key information and documents will be stored in a Team, with access granted to external partners. This allows immediate access to information by staff. The function is currently being piloted with the Safer Bromley Partnership and, subject to agreement of the future delivery of the DA Strategic Board, this process will be extended to relevant members. ***Domestic Abuse Strategic Lead***.	**Agreed timescale** 31/01/24

9. Local Authority responsibilities under Domestic Abuse Act 2021	
Finding The DA Act 2021 – states that the local authority should 'Submit an annual report to the Secretary of State'. We made enquiries with various officers and we were not provided with evidence to confirm that the annual reports for 2021, 2022 and 2023 have been completed and submitted. **Risk** The Authority is not meeting its responsibilities under the Domestic Abuse Act.	
Recommendation The Assistant Director, Public Protection should confirm whether the annual report to the Secretary of State has been completed for 2021,2022 and 2023 and if these have not been submitted, implement the required process.	**Rating** Priority 2
Management Response and Accountable Manager The AD Public Protection will ensure the appropriate governance is in place to support the relevant services to submit the required returns under the DA Act 2021. ***Assistant Director, Public Protection.***	**Agreed timescale** 31/03/24.

10. Domestic Abuse Employee Policy	
Finding The DA Service have developed a DA Employee Policy that is planned to be issued. In order to support this, it is planned that DA Ambassadors will need be identified and appointed across the Council, which is one of the DA Strategy priorities, 'We will introduce DVA Ambassadors to support staff in the workplace'. (Priority 5 of the DA Strategy). The DA Employee Policy is awaiting approval prior to be being rolled out. It should be noted that within a previous published DHR report, one of the recommendations specific to Bromley was 'Implementing a champion system for domestic abuse throughout the partnership'. **Risk** Without an approved DA Employee Policy in place, training cannot get underway across the Council and the DA Ambassadors cannot be appointed to help create awareness of domestic abuse to support the embedding of the DA strategy. Without approval, this will further impact on the DAHA accreditation for housing and developing the DA Policy for Residents. (DAHA accreditation is the UK benchmark for how housing providers should respond to domestic abuse in the UK).	
Recommendation The DA Employee Policy should be progressed to approval as soon as possible to enable the service to progress with their service priorities, without further delay.	**Rating** Priority 2
Management Response and Accountable Manager The AD Public Protection will ensure appropriate governance is in place and expert advice is provided to support the relevant services to adopt and deliver this policy. ***Assistant Director, Public Protection.***	**Agreed timescale** 31/05/2024

Appendix B - Assurance and Priority Ratings

Assurance Levels

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.

Action Priority 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.

Appendix C – Audit Scope

Audit Scope
We reviewed the adequacy and effectiveness of controls over the following risks: ○ Governance arrangements may not be effective resulting in a lack of consistency of approach across the service and partners/ agencies, and lack of joined up working. ○ Strategy awareness and communication activities is not effective leading to awareness not being embedded. ○ Contractual spend is not within budget, impacting the financial resources within the wider service. ○ Poor service delivery and contractual performance that does not meet expectations or the needs of users. ○ Staff and partners are not suitably informed due to a lack of awareness of existing or new training available to them. ○ Lessons learnt and changes to approach and policy are not taken forward following Domestic Homicide and Violence Reviews. Our scope included the following: - • Governance arrangements specifically to the Domestic Abuse Strategy, Strategic Board, Operational Board, MARAC and Children & Families Hub with individual responsibilities - review of minutes and terms of reference for each meeting. • Budget for the Domestic Abuse Service and any associated grant funding and contractual spend. • Domestic Abuse contractual arrangements, management, and monitoring – review arrangements and contract monitoring minutes • Domestic Abuse perpetrator programme. – review programme. • Domestic Homicide Reviews and Domestic Violence Homicide Reviews – review processes. • Annual Return – review return depending on timescale for return date. • Domestic Abuse Partnership- review progress on establishment. We did not review instances of domestic abuse at case level. We interviewed relevant staff within Community Safety, the Head of Service for Safer Communities and key officers within the wider Council. We also interviewed representatives from some external partners.

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FINAL INTERNAL AUDIT REPORT

TRANSFORMATION

AW/02/22

August 2023

Auditor	Principal Auditor
Reviewer	Head of Audit and Assurance

Distribution List and Job title
Chief Executive
Assistant Director Strategy, Performance and Corporate Transformation
Director of Housing, Planning and Regeneration
Director of Environment and Public Protection
Director of Finance

Executive Summary

Audit Objective	The objective of this audit was to review the delivery of the Council's Transformation Programme for two specific workstreams, Housing and Environmental Services. For this review we looked at the mechanisms in place to measure the success and effectiveness of Transformation projects.

Assurance Level		**Findings by Priority Rating**		
		Priority 1	**Priority 2**	**Priority 3**
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.	0	2	1

Key Findings

We selected six projects from the 2022/23 Transformation Programme, three from the Housing workstream and three from Environmental Services (ECS). These selected projects were used to evaluate the delivery of successful outcomes, achievement of financial savings/income or improvement to service delivery, ongoing project monitoring and the regular update to all stakeholders. We did not review the specific services but the project management/mechanisms to deliver a Transformation scheme.

We identified good practice and sound controls specifically:

- Regular Transformation Board meetings, minutes and supporting papers available on the Transformation SharePoint site
- For Housing there is a designated officer responsible for Housing Transformation schemes to generate financial and project status information. The highlight reports we reviewed for Housing projects were detailed and contained explanations where projects were not assessed as on track
- Regular budget review and liaison with the service Heads of Finance
- Financial information was available and had been reported accurately to management.
- There is a Project Management Toolkit and supporting templates available on the Corporate Programmes and Projects Page.

We acknowledge the Assistant Director's report to COE on the 14 February that sets out the future requirements of the Transformation Programme whereby Directors will be *"required to monitor the delivery of agreed Transformation Programmes"* continuing the decentralised theme of the programme but going forward *"exceptions coming to the operational Transformation Board".* The findings identified below are therefore for the respective Departments to consider how to improve their project management of Transformation schemes and corporately for all projects across the Council.

We have identified the following areas for management attention:-

Business Plan and Project Management Toolkit (Priority 2) – There is a Project Management Toolkit and supporting documents including a Business Plan template available on the Council's Sharepoint site, however none of the six projects selected for audit review had a standardised business plan to establish the planned project outcome, financials and enable progress to be monitored, including non-financial benefits. ***See Recommendation 1.***

Availability and Identification of Documentation (Priority 2) – The Transformation SharePoint site contained a lot of information, reports and minutes but they were randomly stored and not readily identifiable. There was limited information related to ECS projects on the Corporate Transformation site or collated information on the ECS Transformation site. ***See Recommendation 2***

We have made one additional Priority 3 recommendation for good practice only.

Our findings and management comments are detailed in **Appendix A**.

Definitions of our assurance opinions and priority ratings are in **Appendix B**.

The scope of our audit is set out in **Appendix C**.

Appendix A - Management Action Plan

1. Business Plan and Project Management Toolkit
Finding We selected three Transformation projects from the Housing and three from the ECS workstreams; Community Infrastructure Levy (CIL), DFG provision administration further increasing the level of homelessness prevention, access to private rented accommodation to prevent/relieve housing pressures, Motor Traffic Contraventions (MTC), Automatic Number Plate Recognition (ANPR) and Street Lighting. Although there is a project management toolkit and a standard business plan template available on the Strategy, Performance and Corporate Transformation SharePoint site we could not evidence that this had been utilised for any of the six projects selected and the Council has not set out its expected approach to project management. We were able to identify the proposed financial savings and some proposed service improvements set out in committee reports, supporting documentation, and interviews with the relevant service leads. However, not having the project specifics set out in a business plan document has limited the effective monitoring of projects against goals and outcomes, financial and service improvements. Project monitoring has covered financial savings but has not incorporated realisation of non-financial benefits. Once accepted as a Transformation Scheme the income/expenditure becomes 'business as usual' and the project specifics can become lost. We have not, for example, been provided with evidence from the service to confirm that the Street Lighting project has achieved the proposed financial savings. For the projects sampled we did not evidence mid-term project or post project evaluations (where relevant) to formally review benefits realisation, delivery of outcomes and identify any lessons learned and unexpected benefits / disbenefits. We acknowledge that not all Transformation schemes are project based and that some have been adopted from existing service delivery. We also acknowledge that Transformation schemes vary considerably in terms of proposed financial impact and level of risk and, as such, a single approach to all schemes is unlikely to be appropriate. However, given the current financial pressures and the need to deliver more Transformation savings, the Council's schemes for the next iteration of Transformation are likely to become more complex and carry a greater degree of risk, including financial, reputational and operational. Therefore, we consider that a more structured approach via the use of a project framework will become increasingly important.

Risk

Without a comprehensive business case, decisions may be made on the basis of incomplete information and without a full understanding of the associated risks and opportunities. Benefits may not be defined, measured or realised, and lessons learned may not be applied to future projects.

Recommendation	**Rating**
Set out and clarify expectations for project management within the Council (utilising / reviewing the existing Toolkit as appropriate) and publicise these to officers. An overarching framework guidance document with links to the various templates would be beneficial. These expectations should include a prioritised / risk-based approach so that low value or less risky schemes do not have the same requirements as high value, complex or high-risk schemes. Expectations will need to be communicated effectively to departmental leads to ensure the toolkit is used where applicable. These expectations should also incorporate benefits management and realisation (both financial and non-financial), including how benefits are to be measured and reported.	**Priority 2**
Management Response and Accountable Manager Agreed. The Project Managers Toolkit and Change Management Guidance was developed and published in 2021 by the Assistant Director of Strategy, Performance and Corporate Transformation. Reminders of its use as a form of proportionate risk based best practice will be scheduled to CLT, Managers Briefing and circulated to all staff via the Transformation Newsletter during September and October, following the summer break. Responsible Officer: Assistant Director of Strategy, Performance and Corporate Transformation.	**Agreed timescale** October 2023

2. Availability and Identification of Documentation	
Finding The Transformation SharePoint site contained a lot of information, reports, minutes and Are We On Track (AWOT) reports but this was hard to follow. We counted over 170 documents randomly stored in the Housing, Planning & Regeneration Workstream folder. Standard title and date referencing would improve accessibility of information and version control in document folders. There was limited information related to ECS projects on the Corporate Transformation site and the Board minutes show that the Director of ECS will give a verbal update but there were no minuted details on the content of the update. ECS have created a departmental Transformation SharePoint site but this had limited information to support the Transformation process. We sourced the AWOT reports from the Director's PA as attachments to e-mails. Transformation is a standard item on the monthly ECS DMT but a review of 2022/23 minutes identified that this item related to proposed projects and not progress of current Transformation projects. The Director of ECS confirmed that once new projects are agreed for the Transformation Programme all monitoring and reporting is the responsibility of the service leads and will utilise business as usual processes. The Head of Corporate Programmes and Projects had previously supported the Housing workstream. Since December 2022 this role has been transferred to the Head of Housing Schemes. The role ensures that there is a focal point for all Housing Transformation projects, collation and dissemination of information. There is not a similar role in ECS, the Director of ECS is the lead for the Transformation Programme. **Risk** Key documents may not be easily identifiable or readily available to support decision making based on timely, complete and accurate information.	
Recommendation Review the Corporate Transformation SharePoint folders to introduce a digital file organisation system. ECS should update their Transformation Private SharePoint site to populate the folders with information relating to current projects, financial monitoring and highlight reports.	**Rating** Priority 2
Management Response and Accountable Manager Agreed. The corporate SharePoint site will be reviewed and restructured by October to allow for consistent file organisation. All workstream will be asked to review and update document management. Responsible Officer: Assistant Director of Strategy, Performance and Corporate Transformation.	**Agreed timescale** October 2023

3. Central Register for Council Projects	
Finding We used the Transformation master spreadsheet and MTFS report maintained by Finance to source our sample of Transformation projects to review. In the course of our audit testing we noted that Transformation projects are maintained on a master spreadsheet by the Transformation Team and circulated to COE/CLT. We identified however that there is no overall register of other projects at corporate or department level available to all officers and potential project owners to view. Access to a project register would allow liaison between colleagues for similar projects to share successes and lessons learnt. The register would also give an overview of Council activity and identify stand-alone departmental/Team projects early in the project process to ensure compliance to Council project management standards. We recognise that some projects may have sensitive information but the purpose, objectives or other key information relating to those projects could be restricted on a 'need to know' basis with the owner named as the only contact. **Risk** Potential interdependencies and efficiencies may not be identified, managed or used to best effect.	
Recommendation Set up and maintain an accessible central register of all projects taking place across the Council. As part of this initiative establish a criteria for which projects should be included, what information should be maintained and by whom. Projects recorded in the register, and the information about them, could be categorised for example by levels of financial expenditure or other pre-defined criteria.	**Rating** Priority 3
Management Response and Accountable Manager Not Agreed. The council does not currently resource a Corporate PMO office. Development and maintenance of a comprehensive whole council register of all projects and programmes would require additional human resources and would result in a growth pressure. The Transformation Master spreadsheet oversees key projects and programmes which are critical to the delivery of a balanced budget. The majority of risk is overseen through the Transformation Board and interdependences are identified. Other thematic areas of oversight exist within specialist areas to allow for best practice sharing, for example within the Capital Programme, Digital Programme and Housing Development programme. On a balance of cost, risk and value added and given the overall corporate budget position, such a growth pressure is not recommended.	**Agreed timescale** Not agreed.

Appendix B - Assurance and Priority Ratings

Assurance Levels

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.

Action Priority 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.

Appendix C – Audit Scope

Audit Scope
We reviewed the adequacy and effectiveness of controls over the following risks: • Misalignment between planned outcomes and strategic objectives • Failure to define and measure promised benefits • Failure to realise the financial savings and service improvements identified • Lack of involvement from the service with the project team Our scope included:- • Review of the business case submitted for each project selected for audit review within the Housing and ECS workstreams. • Review of the mechanisms in place to measure the success and effectiveness of the workstream projects. • Review of the processes in place to ensure the selected projects remain on target in terms of time, financials and service improvement. • Review of each selected project against the objective; to deliver savings and/ or outcomes intended. • Evaluate the controls within this ongoing monitoring process to ensure objectives are delivered. • Review of the supporting documentation for the selected projects to evidence progress, completion and delivered outcome, this will include reports to Members. • Review the achieved financial savings and how these are reflected in the Authority's accounts in line with the Medium Term Financial Strategy.

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REDACTED FINAL INTERNAL AUDIT REPORT

PERSONAL DATA BREACHES

CORP/01/2023

2 October 2023

Auditor	Trainee Auditor
Reviewer	Head of Audit and Assurance

Distribution list

Director of Corporate Services and Governance
Assistant Director & SIRO, IT
Head of Information Management

Executive Summary

Audit Objective	The objective of this audit was to assess the Council's response to personal data breaches in line with the Data Protection Act 2018 and to ensure that lessons are learnt from incidents to prevent reoccurrence.

Assurance Level		**Findings by Priority Rating**		
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.	**Priority 1**	**Priority 2**	**Priority 3**
		0	2	1

Key Findings

We found the following areas where controls are in place and working well:

1. Our analysis of the data breach incident log identified that a recurrent theme of personal data breaches is errors with emails, including emails sent to the wrong recipient. Although the risk of human error can never be eliminated, the Information Management Team evidenced that they have an action in progress to reduce the likelihood of email error by implementing an additional technical measure.
2. Appropriate information on reporting data breaches is readily available to staff via the intranet and the Council's policies align with legislation and Information Commissioner's Office (ICO) guidance.
3. For the cases that we sampled, we found through discussions with officers and review of documentation that there was an appropriate rationale for decisions not to report breaches to the data subject and / or the ICO.
4. 5/8 relevant cases had been reported to the ICO with the statutory 72 hour timeframe. There was a reasonable explanation for one exception and the other two are discussed in Recommendation 1 below.

We would like to draw managers' attention to the key findings below:

5. **Strategic oversight and lessons learned** (Priority 2) – There is currently limited corporate oversight and ownership of personal data breaches, to ensure that actions are implemented and lessons learned across the organisation. For 3/6 cases sampled, there was no evidence that actions to prevent reoccurrence had been taken within individual departments. ***See Recommendation 1.***
6. **Data breach records and investigations** (Priority 2) – Records of data breaches held by the Information Management Team were incomplete and, in some cases, inaccurate as, for example, five cases reported to the ICO or data subject had not been recorded as such on the central log. ***See Recommendation 2.***

We raised one further Priority 3 recommendation for good practice.

Management has agreed actions for all findings raised in this report. **Please see Appendix A**.

*Definitions of our assurance opinions and priority ratings are in **Appendix B**.*
*The scope of our audit is set out in **Appendix C**.*

Appendix A - Management Action Plan

1. Strategic Oversight and Lessons Learned	
Finding We understand that the Information Governance sub-group previously had oversight of personal data breaches, however this group no longer exists and there is no alternative body that receives regular assurance on the management of personal data breaches and lessons learned. Reporting to Corporate Leadership Team on Information Governance covers Freedom of Information and Subject Access Requests but does not cover data breaches. Whilst we acknowledge that there have been some organisation-wide communications on data breaches, there is no Council-wide group which oversees and scrutinises personal data breaches, disseminates lessons learned across the organisation and ensures that there is sufficient awareness of the Council's collective responsibilities within individual departments. For 3/6 cases that we sampled, there was no evidence to support that lessons learned had been identified and actioned within the relevant service (although we recognise that centrally, the Information Management Team are working on a solution to reduce the likelihood of human error with emails). We also found cases where officers within the relevant service had not notified the Information Management Team of the incident within 24 hours. One of these cases met the threshold for reporting to the ICO and consequently was not reported within the statutory 72 hour time period. A second case was reported late to the ICO because the relevant contractor did not immediately notify the Council that its data was affected as part of a wider incident. **Risk** Insufficient oversight may mean that effective management of data breaches is not embedded within individual services or the Council's culture, leading to avoidable errors or the Council not meeting its statutory obligations. The Council may incur significant financial penalties if relevant incidents are not reported to the ICO within statutory timeframes.	
Recommendation There should be appropriate corporate oversight and ownership of personal data breaches to: • ensure that appropriate actions are taken to prevent repeat occurrences • ensure that the Council meets its statutory obligations	**Rating** Priority 2

• cascade and disseminate lessons learned and issues arising within departments • raise awareness, and ensure compliance, within individual departments regarding the need to report breaches immediately to the Information Management Team, both to mitigate risk and to ensure the Council can meet statutory reporting timescales where relevant.	
Management Response and Accountable Manager (1) As part of the D&IT restructure and new IT managed service contract governance boards have been identified and will be implemented to include the discussion of data breaches and share lessons learned. (2) Breaches of significance are relayed to senior members of a directorate who may be involved in initial conversations or copied in to emails for information. This will be captured in breach logs and breaches of significance will be to the Senior Management Board. (3) Awareness will be raised at CLT and Managers briefing for officers to follow breach reporting guidance in an effort to ensure the Council meets the 72 hour reporting timescale where necessary, in line with recommendations. Accountable Manager: Head of Information Management	**Agreed timescale** (1) Jan-March 2024 in alignment with IT service provider contract implementation (2) 31st October 2023 (3) 30th November 2023

2. Data breach records and investigations
Finding The UK Data Protection Act 2018 states that organisations must keep records of personal data breaches including the facts relating to the breach, its effects and any remedial action taken. Our review of the Information Management Team's data breach Incident Log and sample testing of individual data breaches identified that the central records held were not fully complete, either because fields on the Incident Log had not been completed or because supporting documents were not readily available. This includes key errors in the information held such as: • one incident reported to the ICO which was recorded as 'not reported to the ICO' on the log • four incidents reported to the data subject which were recorded as 'not reported to the data subject' on the log

Further, the Council's Data Breach Investigation Guidance states that:

'Once an information security breach has been reported a member of the Information Management team will be identified to carry out the investigation and advise upon further action to, contain, remediate and recover if required. A manager or senior member of staff may be engaged within the service area to help during the investigation and offer further assistance if required to create a remediation action plan. The investigation should focus on what lessons can be learnt from the breach and what steps should be put in place to prevent a reoccurrence of the breach.'

There is template to complete for data breach investigations. This is dated 2018 although the Head of Information Management advised that it remains fit for purpose.

We found however that for 5/6 cases sampled for this purpose, the investigation template had not been completed. We also observed other cases during the course of our fieldwork where the template had not been completed or had not been fully completed.

Risk

Non compliance with the Data Protection Act 2018.
Ineffective oversight and management of personal data breaches, if information is not complete.
The investigation and outcomes do not cover all key aspects, actions are not identified and addressed, or decision-making cannot be subsequently justified.

Recommendation	**Rating**
Review end to end to process to ensure that information can be captured efficiently and effectively. Design and implement a proportionate quality assurance programme to ensure that records are accurate and up to date, and that necessary actions have been identified and completed.	Priority 2
Management Response and Accountable Manager	**Agreed timescale**
The process of logging the breaches with all necessary information to ensure all relevant information is recorded centrally will be reviewed and improved in line with recommendation. Accountable Manager: Head of Information Management	31st October 2023

3. Risk analysis and decision making	
Finding The Council's Information Security Policy and Data Breach Investigation Guidance do not specify that data breaches must be reported to the ICO within 72 hours, although we recognise that this requirement is clearly stated on the relevant intranet page. The policies also do not set out how a risk analysis should be undertaken in order to make a decision whether to report to the ICO or the data subject (including the risk factors to consider), and do not clarify who should make the decision to report or not. We were advised that the decision maker is the Head of Information Management or the Assistant Director – IT, but in practice, where the decision had been made not to report, this was made by a more junior officer within the Information Management Team. ICO guidance states that if a decision is made not to report a breach to the data subject, the organisation should ensure that the decision is documented. Whilst we were able to establish an appropriate rationale not to report for all cases sampled through discussions with staff and review of emails, our testing identified that the decision, and the risk-basis for the decision, was not always clearly or consistently documented. **Risk** Inappropriate decisions may be made, resulting in reputational damage or penalties from the ICO.	
Recommendation Review the suite of policies to enhance existing information concerning reporting to the ICO and the data subject, including timescales, risk analysis, documentation of risk analysis and decision making. The Data Breach Investigation Template could be amended to incorporate decision making for reporting purposes.	**Rating** Priority 3
Management Response and Accountable Manager There are clear breaches that do not meet the threshold to report based on information reported at the time and the initial risk assessment. The Principal Information Assurance Officer is deemed appropriate to determine where there is a clear need to not report to the ICO i.e. in such cases where there is clear containment of an incident, or the risk of identification is either mitigated or null. In all cases the Head of Information Management is sighted on the incident and will challenge if necessary.	**Agreed timescale** 30th November 2023

Where there is less clarity, or further considerations on reporting threshold and risk is necessary the Principal Information Assurance Officer will refer to the Head of Information Management for a decision. Where there is identification of potential significant risk to reputation and or financial penalty to the Council, the Head of Information Management will consult with the Data Protection Officer. The process and policies will be reviewed in line with recommendation and improved where necessary.	

Appendix B - Assurance and Priority Ratings

Assurance Levels

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.

Action Priority 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.

Appendix C – Audit Scope

Audit Scope
We reviewed the adequacy and effectiveness of controls over the following risks: • A significant personal data breach occurs as a result of error, omission, or negligence by the Council or Council's representatives. • The Information Management Team are not aware of personal data breaches that occur, meaning that timely and appropriate action cannot be taken. • Relevant personal data breaches are not reported to the ICO or to the data subject, leading to possible financial penalties and reputational damage. Our scope included the following: • Governance, including arrangements for monitoring and oversight of personal data breaches. • Policies and procedures, including alignment to the DPA 2018 and ICO guidance and arrangements to ensure staff are aware of these. • Incident response, including reporting to the ICO and to the data subject. • Investigation of personal data breaches, including identification and dissemination of lessons learnt, and implementation of actions to prevent reoccurrence. We focused our testing on data breaches from the 2022/23 and 2023/24 financial years.

REDACTED

REDACTED INTERNAL AUDIT REPORT
PRE-EMPLOYMENT CHECKS

CEX/02/2023

13 OCTOBER 2023

Auditor	Principal Auditor Auditor
Reviewer	Head of Audit and Assurance

Distribution list and Job title
Director of Human Resources and Customer Services
Head of HR Business, Systems and Reward
HR Business Services and Reward Manager

Executive Summary

Audit Objective	The objective of this audit was to review the adequacy of pre-employment checks in design to mitigate recruitment risks including fraud and safeguarding, and the application of these in practice.

Assurance Level		**Findings by Priority Rating**		
		Priority 1	**Priority 2**	**Priority 3**
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.	0	4	1

Key Findings

We identified areas of good practice and sound controls as set out below:

1. Training and guidance has been given to officers within HR to ensure that they are aware of how to carry out pre-employment checks effectively. This consists of written guidance and Powerpoint presentations on key aspects of pre-employment checks to ensure that any new legislation, regulations and specific checks required are communicated to HR officers.

2. The Council's Pre-employment Screening Policy and training Powerpoint presentations include reference to the relevant legislation such as 'Right to live and work in the UK' and BPSS checks. HR identify changes to legislation and give presentations to HR officers to make them aware of them.

3. The design of controls in place for pre-employment checks is appropriate, covering employment history, references, medical clearance, DBS, vetting and qualification checks. We noted that all of the employees in our sample had a medical questionnaire completed satisfactorily and the relevant level of DBS check where required and copies of their passport on file. Where any concerns had been identified through completing the medical questionnaire the relevant manager had been informed and the outcome was accepted by them.

4. Individual roles are risk assessed using the government's on-line assessment tool to determine the level of DBS check to be undertaken.

We have identified the following areas for management attention:

5. **Policies and procedures** (Priority 2) – Due to the introduction of a new HR system in April 2023, and from our sample testing of pre-employment checks carried out as part of this audit, the HR Business Service Manual and the Council's Pre-employment Screening Policy do not reflect current working practices in HR and there are gaps in information in the Pre-employment Screening Policy. ***See Recommendation 1.***
6. **Pre-employment checks carried out** (Priority 2) – We have provided separately to the Head of HR Business, Systems and Reward and the HR Business Services and Reward Manager details of those pre-employment checks which we could not see completed satisfactorily for each of our sample of employees tested. A summary of the issues identified is included in the finding at recommendation 2. ***See Recommendation 2.***

7. **Quality Assurance** (Priority 2). There is a monthly 'Audit spot checks' procedure, as described in paragraph 20 of the London Borough of Bromley Pre-employment Screening Policy, but we were unable to evidence when this was last carried out. ***See Recommendation 3.***

8. **Risk Assessment** (Priority 2) The Council's Pre-employment Screening Policy sets out screening levels under a definition of 'High risk (Qualified/safeguarding roles)' and 'Low risk' (Corporate roles)'. These definitions are not fully clear which roles are included in each level and also do not take into consideration risk factors other than safeguarding for specific employment roles and responsibilities, such as those with financial control and those with access to sensitive, financial or commercially sensitive information. ***See Recommendation 4.***

9. **Recruitment fraud and unsuitability mitigation checks** (Priority 3). Best practice pre-employment checks to mitigate recruitment fraud were recommended by CIFAS in their 2022 publication 'Slipping through the net'. The gov.uk website also has an 'Employers' right to work checklist' for organisations to check prospective employees. We compared the checks set out in these publications against the design of the Council's controls currently in place and have suggested where the Council's control framework could be strengthened. ***See Recommendation 5.***

Management has agreed actions for all findings raised in this report. **Please see Appendix A**.

Definitions of our assurance opinions and priority ratings are in ***Appendix B****. The scope of our audit is set out in* ***Appendix C****.*

Appendix A - Management Action Plan

1. Policies and Procedures
Finding The Council's Pre-employment Screening Policy and training presentations given to team members in HR include reference to the relevant legislation such as 'Right to live and work in the UK' and Baseline Personnel Security Standard (BPSS) checks. Our review of the Pre-employment Screening Policy identified that: • It does not have a nominated owner, date approved or future review date. • The training presentations for staff contain additional checks not included in the Pre-employment Screening Policy e.g on slide 11 'Obtain a name document where the passport is in a different name to other documents/references'. • It does not include the detail provided in the gov.uk website guidance 'Employers' right to work checklist' which states 'Reasons for difference in names across documents can be explained by providing evidence e.g. original marriage certificate or divorce decree nisi which should also be photocopied and a copy retained'. It also says 'any passport page containing information indicating that the holder has an entitlement to enter or remain in the UK should be copied and retained'. • It mentions that 'a DBS should not be initiated until a completed Rehab form has been completed' but does not specify how a Rehabilitation of Offenders check should be carried out. • It does not contain any guidance about driving documentation checks if the employee is designated as an essential car user and using their vehicle for work purposes. • Section 18 refers to BPSS checks for roles which require access to the government's 'Tell us once' system. There is no guidance however about what these roles are or how to how to identify them. • Sections 4 and 5 state that a comparison check should be done between the information declared on the CV and the information the applicant has declared on the application form. However the HR Business Services and Reward Manager told us that 'there is no requirement to send a cv if they have completed an application form.' We also noted that the HR Business Service Manual includes references to Directors and officers who no longer work at the Council and the previous HR system, which is no longer used. The manual also does not include the 'Disqualification in Childcare Act 2006' check requirement. It also says 'Please refer to the screening policy guide for reference requirements. ADD HYPER LINK ONCE SIGNED OFF', indicating that the document is still a draft version.

Risk	
Without regularly reviewed and updated policies, procedures and instructions, which are readily available to those who need them, officers may not fully understand their responsibilities. This may result in errors or gaps in control and a lack of consistency in pre-employment checks carried out.	
Recommendation Review, revise and update the various guidance and procedures including the Pre-employment screening policy, HR Services Manual and Powerpoint presentations to officers, ensuring that they are consistent in content and application of information, and that the policy and manual have a nominated owner, date approved and future review date.	**Rating** **Priority 2**
Management Response and Accountable Manager Agreed. HR Business Services and Reward Manager	**Agreed timescale** 31st December 2023

2. Pre-employment checks carried out.

Finding

We selected a random sample of 15 employees who started employment between the period 1 October 2022 – 31 May 2023 and reviewed documentation to confirm that required pre-employment checks had been carried out. Our audit testing identified the following issues:

1. For eight cases, although there was a copy of the passport on file, there was no written confirmation that the original had also been seen. HR have, however, advised us that the originals were seen, and the stamp used on these followed the wording expected by the Home Office.

2. For one case there was no record kept of who in HR carried out the face to face RTLW video call check.

3. For one case there were overlapping employment dates for a previous employment period but no explanation for this was recorded on file.

4. For two cases there was no evidence of the car insurance certificate for business purposes and DVLA driver's summary on IDOX.

5. For seven out of nine cases in our sample where the post required a professional qualification, a copy of the professional qualification certificate, instead of the original, had been provided by the prospective employee. The HR Business Services and Reward Manager told us that the HR officer relies on the documents provided by email and does not always see the original professional qualification certificate. The Pre-Employment Screening Policy states however that 'If a professional qualification is deemed essential for the role you should ask to see the original certificate.'

Risk

Risk of ID fraud and/or other criminal activity or serious incidents by staff engaged. Risk of engaging employees who do not have the required competencies, skills or qualifications.

Recommendation	**Rating**
Where there is a lack of clarity about what should be checked, or the wording of the declaration of identify checks, notify HR officers and include it in the Pre-employment Screening Policy and documented guidance and training. Please also refer to Recommendation 3 – Quality Assurance.	Priority 2
Management Response and Accountable Manager	**Agreed timescale**
Agreed. In relation to the right to work "Original seen" aspect of this recommendation, although this is not a Home Office requirement, we will implement this as it is an audit requirement for best practice. We will also be implementing the recording of the 'Right to work' impostor checks, as although there is no explicit requirement and guidance on this from the Home Office, we feel it would provide assurance.	1st February 2024

HR Business Services and Reward Manager	

3. Quality Assurance	
Finding There is a monthly 'Audit spot checks' procedure, as described in paragraph 20 of the London Borough of Bromley Pre-employment Screening Policy, but we were unable to evidence when this was last carried out. This is a useful management check to confirm that procedures and processes have been followed and identify any issues of non-compliance which may need further investigation. It also enables the reviewer to check that there is consistency across the team in documenting checks and obtaining evidence required, feeding as necessary into future training requirements and guidance for applying best practice. **Risk** The Council engages an employee who does not have the required skills or qualifications or may commit ID fraud or other criminal activity. Prosecution, fines and sanctions may be applied against the Council for failing to comply with employment legislation.	
Recommendation Re-introduce the monthly 'Audit spot checks' procedure, taking into account the areas of our pre-employment check audit testing where we identified issues of non-compliance or inconsistency in individual checks carried out.	**Rating** Priority 2
Management Response and Accountable Manager Agreed. HR Business Services and Reward Manager Head of HR Business, Systems and Reward	**Agreed timescale** 1st November 2023

4. Assessment of high and low risk roles.

Finding

The Council's Pre-employment Screening Policy sets out screening levels under a definition of 'High risk (Qualified/safeguarding roles)' and 'Low risk' (Corporate roles)'. This definition is not sufficiently specific regarding which roles should be included in each. Further, it seems to consider 'risk' through a safeguarding lens only and does not take into account wider risk factors for specific employment roles and responsibilities such as those which may be more vulnerable to fraud or those with access to sensitive, financial or commercially sensitive information.

As referred to in 'Finding 1', Section 18 of the Policy refers to the Baseline Personnel Security Standard (BPSS) checks for roles which require access to the government's 'Tell us once' system. BPSS is the recognised standard for the pre-employment screening of individuals with access to government assets. There is no guidance however about what these roles are within the Council or how to identify them.

Risk

The Council engages an employee who may commit ID fraud or other criminal activity. Prosecution, fines and sanctions may be applied against the Council for failing to comply with employment legislation.

Recommendation	**Rating**
Review the criteria for assessing pre-employment screening levels for high and low risk roles, including the definition of 'high risk' and 'low risk' roles. Take into consideration other risk factors such as fraud, access to sensitive, financial or commercially confidential information and set out what pre-employment screening checks should be carried out for roles with specific risk characteristics.	Priority 2
Management Response and Accountable Manager Agreed. HR Business Services and Reward Manager	**Agreed timescale** 31st December 2023

5. Recruitment fraud and unsuitability mitigation checks

Finding

We carried out a reasonableness review by comparing the adequacy of the Council's current range of pre-employment checks to mitigate recruitment fraud to the 'best practice' pre-employment checks recommended by Cifas in their 2022 publication 'Slipping through the net'. The gov.uk website also has an 'Employers' right to work checklist' for organisations to check prospective employees and we compared the Council's 'right to live and work' checks against that checklist.

Our review showed that overall, the Council's controls are adequate in design to mitigate the risk of recruitment fraud but there are several areas where the design of those checks could be enhanced to strengthen the control framework. These are set out below.

1. Qualifications. In the 2022 Cifas publication 'Slipping through the net' it says 'You should check qualifications specifically when it is essential to the role. When checking, you must obtain a copy of the original certificate(s) to check the validity (sometimes this can just be obvious on first glance). If it is not in English, then you should consider asking for it to be translated by an official translator. It is no longer considered best practice to simply see the certificate and establish that the awarding body is legitimate. It is recommended that you verify the individual's enrolment, attendance and attained grades directly with the awarding body, whether through an integration to their database or traditional correspondence. There are many organisations in the market who either do not check applicable qualifications at all, or simply accept a certificate provided by the candidate without any secondary verification. Diploma mills see a high proportion of their trade for qualifications which might be relevant to a role, but which are not classified as 'professional' as these typically go hand in hand with professional registration/memberships, which can be separately verified. In the screening process, such qualifications should be viewed as a greater potential fraud vector than Professional Qualifications, instead of the afterthought they commonly are today.' *Audit note: The following website explains more about this area and the risks involved.* https://www.eurocomci.co.uk/blog/how-to-avoid-diploma-mill-qualifications/

2. Identity fraud/residential history. The Council's Pre-employment Screening Policy does not specifically refer to identity checks. The 'Right to live and work in the UK' check would confirm the personal identity e.g. their name, age and date of birth. The gov.uk website has a 'Proof of identity' checklist for individuals (for companies and other legal structures) www.gov.uk/government/publications/proof-of-identity-checklist/proof-of-identity-checklist It consists of documents which can be used to prove identity and states 'You cannot use one form of identification for both name and address'. It then lists Proof of name' documents in one column and 'Proof of address' documents in the second column.

   The 'Slipping through the net' 2022 update provides guidance on residential history checks (which are not currently included in the Council's Pre-employment Screening Policy). It says in section 7, 'There are two elements to identity checks. The first is to confirm personal identity such as their name, age, and place of birth. The second is to evidence residential history in terms of their address and current country of residence.'

3. Right to live and work in the UK. The gov.uk website has an 'Employers' right to work checklist' for organisations to check prospective employees. The website has '3 basic steps to conducting a right to work check using an IDSP' and '3 basic steps to conducting an online right to work check'. The HR Pre-employment Screening Policy and the acceptable documents set out in the Council's 'Right to live and work guidance' mirror the gov.uk checklist. The gov.uk checklist however contains additional guidance such as 'Reasons for difference in names across documents can be explained by providing evidence e.g. original marriage certificate or divorce decree nisi which should also be photocopied and a copy retained' and 'any passport page

containing information indicating that the holder has an entitlement to enter or remain in the UK should be copied and retained'. https://www.gov.uk/government/publications/right-to-work-checklist/employers-right-to-work-checklist-accessible-version

4. Unsuitability for the role. There are questions in the reference template which is sent to referees asking about the applicant's honesty and integrity, any legal proceedings, police investigations or disciplinary action and anything else about the applicant that would help the Council make an employment decision in relation to the post applied for. No media specific checks are carried out by the Council, however and referees may choose not to answer these questions or, frequently, to submit their own standard reference. The Cifas guidance in 'Slipping through the net' 2022 suggests that media screening - adverse media and social media (a negative media profile identifying past conduct or social media screening to identify a reputational risk to the Council) could be considered for those roles in an organisation with access to sensitive areas or sensitive material, or roles with a specific type of responsibility or considered high profile.

Risk

The Council may not identify someone who is dishonest, leading to the risk of ID fraud and/or other criminal activity or serious incidents and significant reputational damage.

Recommendation	**Rating**
Enhance the Council's Pre-employment Screening Policy by including the above suggested best practice checks and procedures quoted from the Cifas 2022 publication 'Slipping through the net' and the 'Proof of identity' checklist and the 'Employers' right to work' checklist from the gov.uk website.	Priority 3
Management Response and Accountable Manager	**Agreed timescale**
Agreed. HR Business Services and Reward Manager	1st March 2024

Appendix B - Assurance and Priority Ratings

Assurance Levels

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.

Action Priority 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.

Appendix C – Audit Scope

Audit Scope
Our scope included the following: • Governance, including organisational management, and the clarity of roles and responsibilities, • Reviewing policies, procedures and arrangements for carrying our pre-employment checks, • Reviewing the design of controls in place for pre-employment checks, to ensure that these are robust, appropriate, and effective in practice. This will include a review of how individual roles are risk assessed to determine the level of checks undertaken, • Controls reviewed will encompass employment history, references, medical clearance, DBS, vetting and qualification checks, • Training and guidance which has been given to staff within HR and operational managers to ensure that they are aware of how to carry out pre-employment checks effectively, • Ensuring that any queries or concerns arising from pre-employment checks are identified, followed up and escalated to management promptly. Our audit included interviews with key officers, i.e. the Head of HR Business, Systems and Reward and the HR Business Services and Reward Manager. We reviewed relevant documentation, procedures and processes and carried out testing of a sample of staff recruited to confirm that the required pre-employment checks had been conducted. Our testing covered staff who had commenced employment with the Council between 1 December 2022 and 31 May 2023.

REDACTED

FINAL INTERNAL AUDIT REPORT

ST OLAVE'S GRAMMAR SCHOOL

AUDIT REFERENCE: PEO/09/2023

29 SEPTEMBER 2023

Auditor	Principal Auditor Principal Auditor
Reviewer	Head of Audit and Assurance

Distribution list

Headteacher
Director of Finance and IT
Chair of Governors (Final only)
Director of Education (Final only)
Head of Finance, Children Education and Families (Final only)

Executive Summary

Audit Objective	The objective of this audit was to review the adequacy and effectiveness of the system of controls surrounding the financial administration of the school, as required by the 1998 School Standards and Framework Act Section 48, paragraph 2(d) and the Authority's Scheme for Financing Schools.

Assurance Level		**Findings by Priority Rating**		
		Priority 1	**Priority 2**	**Priority 3**
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.	0	5	2

Key Findings

We completed a site visit to the school on the 5th and 6th July. We found that controls are in place and working well for financial reporting , committee reports and minutes, scheme of delegation, asset management, bank reconciliation, VAT returns and management of the purchasing cards.

The school should consider the key findings summarised below:

Income and Lettings (Priority 2) - Invoices had not been raised before the let which is contrary to the schools lettings policy. Lettings forms were incomplete and had not been approved by the Head teacher. ***See Recommendation 1.***

Expenditure process (Priority 2) – 2 out of 20 payments sampled had not been paid within 30 days and, in 5 instances out of those 20 payments, purchase orders had not been raised in advance of payments being made. ***See Recommendation 2.***

Compliance with IR35 (Priority 2) - In two instances sampled the status of an individual had not been established when they were engaged to provide a service. In one instance payment was made before all parts of a service had been received. ***See Recommendation 3.***

Contracts and leases (Priority 2) – The contracts register was not up to date with details of all current contracts and leases. We were unable to ascertain from our examination of the Resources Committee minutes for the last twelve months when the contracts register had been presented to and approved by Governors. ***See Recommendation 4.***

Governors Pecuniary Interest Forms (PI) (Priority 2) – PI forms for 3 governors had not been completed and for another three governors the PI forms were for the previous academic year. ***See Recommendation 5.***

Our findings and management comments are detailed in **Appendix A**.

Definitions of our assurance opinions and priority ratings are in **Appendix B**.

The scope of our audit is set out in **Appendix C**.

Appendix A - Management Action Plan

1. Income and Lettings
Finding The school are now hiring out their all weather pitch and will be expanding the letting activity to the school hall and sports hall. We reviewed the lettings policy and a sample of lettings. The main issues arising are:- • Invoices are raised after the hire, although the lettings policy clearly states that payment is 7 days in advance or a term in advance for ongoing books. • The Lettings Policy had not been reviewed in the last year • The hirers agreement sets out the cancellation terms which differ to the "Conditions of Hire" document We selected 4 clubs that are currently hiring the all weather pitch. The main issues arising were that:- • One invoice was for the wrong amount £42 and should have been £46 • The information included one of the invoices in our sample was incomplete. Clubs with multiple sessions and days had not been specified on the invoice. • The Premises Manager e-mails actual usage to allow Finance to raise an invoice – (see comment above regarding payment in advance). These emails did not state the reason for any cancelled sessions to apply the cancellation policy. • The hire forms for our selected sample were incomplete as details of booked sessions were not entered and referred to previous e-mails or schedules. • The Hire form is approved by the Premises Manager but given he is liaising with the clubs and initiating the let, it should be approved by another authorising officer. • Hire form relates to "using the schools insurance cover" but this needs to be confirmed with the school's insurers or removed. • The lettings folder included a hire form that subsequently did not take place and should have been marked as such. • There was no formal procedure to identify debt, escalate and recover. **Risk** Loss of income Income collected may not agree to approved fees and charges. The school may be inadequately insured and may not have adequate insurance cover for any claim that is received in respect of Public Liability. This may lead to legal challenge and significant unexpected expenditure in the event that a claim is made.

Recommendation	Rating
The cancellation terms and conditions are set out in the current policy and should be applied. The school is concerned that payment in advance would not be financially viable for small clubs. The school need to evidence a balanced risk assessment of debt, cash flow and utilisation of the facility. The lettings policy should be reviewed and updated, referencing the two recommendations above, but specifically the condition that all income is due before the letting takes place; any revision to the policy will need to be approved by Governors. The process to check and agree completed application forms needs to be improved; applications to be authorised by an officer outside of the Premises team. Information passed to the finance team and included on the invoice should be complete and accurate. The school should contact their insurers, RPA and clarify the insurance cover regarding lettings. The lettings diary will need to be developed to accommodate multiple lettings on the shared pitch area and increasing the facilities available. The school should utilise the financial system reports to develop and formalise a procedure for the recovery of debt.	Priority 2
Management Response and Accountable Manager • Lettings Policy has been revised to say that Payment Terms will be agreed at time of booking – this gives us flexibility to charge in advance or 1 month in arrears • The Lettings Policy was last reviewed at Resources Committee meeting on May 26th 2022 (prior to any bookings taking place. It was not reviewed at the Resources Committee June 7th 2023 as that agenda was dedicated to reviewing year end and the budget, as well as the extensive summer works schedule. The policy will next be reviewed at Resources Committee in November 2023 • Invoices will be amended to include all the dates and sessions (although number of fields in the financial system is limited in which case supporting schedule with the specific sessions will be sent with the invoices). Invoices will also include the reasons and details for a cancellation charge relative to the cancellation policy • Hire Forms will be completed for all new agreements with clubs detailing the agreed dates/times for hire and include an email back up agreement between both parties • Hire Forms will now be signed by Premises Manager and the Headteacher • Public Liability Insurance is required for all affiliated clubs letting the facilities. • Our RPA stipulates that it will cover for individuals or groups that would not be expected to have their indemnity insurance. it would not be the intention of the RPA to provide cover for liabilities of large groups or organisations who are hiring the premises such as a football/swimming club who should provide evidence of such insurances to the school. • As part of month end checklist, Aged Debtor report will be run monthly against the Trial Balance to ensure there is no risk of loss of income to the school. “Credit Control” to chase any bad debt will be added to Finance Assistant roles and responsibilities.	**Agreed timescale** Director of Finance Premises Manager 30 September 2023

2. Expenditure process	
Finding All invoices in our sample had been authorised correctly, had been paid for the correct amounts and the VAT had been calculated and paid correctly. The on-line payment system (Commercial Banking) had been set up with limited access, separation of duties, an appropriate approval and payment process, an audit trail of payments (authorisation has to be made in the system by two of the five members of the senior leadership team). 2 out of 20 payments sampled had not been paid within 30 days and 5 out of 20 payments had no accompanying purchase order. **Risk** Payments may not be made in compliance with Financial Regulations and the school's own procedures. Where purchase orders are not raised, commitment and authorisation requirements are bypassed. This may lead to the risk of purchases of inappropriate or unnecessary goods or services. Where invoices are not paid timely, there is a risk that the school may be subject to interest on those payments under the Late Payment of Commercial Debts (Interest) Act 1998.	
Recommendation The school should ensure that: (a) Payments to suppliers are made within 30 days, (b) Purchase orders are raised in advance of payments being made.	**Rating** Priority 2
Management Response and Accountable Manager **Payments > 30 days** • 'Company A' invoice for Science Flooring dated 25/04/22 which is after the works were completed in Easter hols (phase 1). Invoice date stamp says Finance received on 23/06/22 and was paid 08/07/22 • Invoice for printing of Olavian Magazine dated 30/04/22, received by Finance on 14/06/22 and paid 24/06/22 Both above can be explained by the school's legacy purchasing process which was heavily paper based. Suppliers were encouraged to post their invoices to school which meant they could sometimes go missing as they were not addressed specifically to Finance. Once invoices were received, they were stamped and put in pigeonholes for GRN and 2 approvers. Once	**Agreed timescale** Director of Finance 30 September 2023

approved, a cheque was printed and sent out for 2 further cheque signatories. The process from receiving invoice to paying supplier could take 2 weeks.

The school now asks all suppliers to email invoices. Invoices are emailed to PO originator for a GRN and Finance process a weekly BACS run meaning all invoices are now paid within 30 days

Non Order Invoices

- 'Company B' preparing energy input for Master Plan. Price quoted for engineers was a day rate and they did not scope and extent of works involved therefore no PO was raised
- 'Company C' – ongoing subscription to a very good resource used by staff and Governors
- 'Company D' – ongoing maintenance contract for alarms. Going forward if invoice is sent for year ahead, we will send a PO and ask they quote PO number
- 'Company E' – price is not determined until company come on site to assess
- 'Company F' – an oversight by Head PA

Director of Finance will continue to reinforce message to all staff about the requirement for a PO to be raised before we commit to expenditure on behalf of school in line with Financial Regulations

3. Compliance with IR35 requirements

Finding

From a sample of payments to individuals selected from the bank history, we confirmed that an IR35 check had been carried out for three out of five individuals sampled.

For the other two other payments, which had been made to 'Individual A' and 'Individual B', the individual had been set up on the system and paid, instead of the company name quoted on the invoice. In these two cases no IR35 check had been carried out and it was unclear if the company or the individual should have been paid.

We also noted that for the payment made to 'Individual C' for a series of career interviews undertaken in July 2022, it was made before the final two interviews had been carried out. An IR35 check had been completed, but it had been carried out in Oct 2022, after they had been engaged in July 2022 (they had also carried out interviews in Sept 2022). The email accompanying the invoice had the website address of their company, so it is unclear if they needed to be paid as an individual and the IR35 completed.

Risk

Non-compliance with HMRC regulations resulting in a financial penalty.

Recommendation

The school should ensure that:

(a) The status of an individual should be established when first engaging them to provide a service and, if required, an IR35 check should be carried out at that time, and

(b) payment is only made after the services have been received.

Rating

Priority 2

Management Response and Accountable Manager	**Agreed timescale**
'Individual A' is a lawyer who facilitates the Year 7 appeals process. We have subsequently carried out IR35 check to confirm she is self employed 'Individual B' is self employed and helped the school with Careers Interviews 'Individual C' we acknowledge should have had IR 35 check prior to being paid The former Finance Assistant who has now left did not check /question the invoices/bank payee names were different Going forward the new Finance Assistant will be trained to check/question all invoices that are paid direct to an individual rather than a company and to carry out an IR 35 check.	31 December 2023

4. Contracts register and leases	
Finding The contracts register is comprehensive in format with details of start and end dates, annual costs, payment schedules and relevant notes for contract and leases. It does however have an entry for six contracts or leases which have an end date between March 2022 and April 2023. It does not contain details of the lease for 'Company G' for the promethean IT panels. We were unable to ascertain from our examination of the Resources Committee minutes for the last twelve months when the contracts register had been presented to and approved by Governors. **Risk** The school may not be aware of its contractual agreements and payment liabilities.	
Recommendation The contracts register should be updated to include details of all current contracts and leases and then referred to Governors for approval.	**Rating** Priority 2
Management Response and Accountable Manager The Leases are managed as part of the ICT 5 year rolling expenditure analysis. ICT 5 year expenditure is reviewed and approved by Resources Committee annually. This, along with the contracts register, will be reviewed by Governors at the next Resources Committee meeting in November. ICT expenditure and leasing costs are managed directly by the Finance Director.	**Agreed timescale** 30 November 2023

5. Governors Pecuniary Interest Forms (PI)	
Finding The PIs for governors are managed by the Clerk of Governors and not held on site. The school requested a scanned copy of all current PIs for our inspection. As at 10th July 2023 3 PIs had not been completed by current governors and three were dated for the 2021/22 academic year (17/11/21 X 2 and 15/9/21). **Risk** Biased procurement or tendering.	
Recommendation The Clerk to Governors will need to ensure all PIs are completed by new governors and annually by all governors before attending and voting at a committee meeting. The school should verify that this has been completed. The school should consider an electronic version of the PI that would simplify the process and improve accessibility for the school.	**Rating** Priority 2
Management Response and Accountable Manager All Governors declare any conflict of interests at start of every committee meeting. This is minuted by the Clerk. Going forward an electronic PI form will be created that can be sent for e-signature to existing and new Governors once a year and filed electronically. Clerk will send to school and HR will follow up to ensure that all forms are completed (like she does for all staff). All PI forms are now signed and attached for your information.	**Agreed timescale** Clerk 30 September 2023

6. Control Accounts and Cash Flow Reports	
Finding The Aged Debtor and Creditor reports were run on the 5/7/23 whilst we were on site. Two debtors were identified, one of which had been outstanding for more than 60 days, the other a correction to a previous invoice. Eighteen payments were listed on the creditors report that could not initially be explained by the finance team as the report included several legacy entries that had been cleared at year end. The finance system provider was contacted but was unable to explain this "glitch". We acknowledge that this is a new finance system and the team are still developing reports to support the finance function. Since transferring to a new financial system the school have not utilised a cash flow report. The Finance Manager cited time pressures at year end and reduced finance resources that had limited the development of new reports The Director of Finance and IT was satisfied that completion of the monthly bank reconciliation, regular checking of the bank balance, Consistent Financial Reporting and the expenditure controls offered by the new finance system negates the need for a cash flow report. However, we have reported that 5/20 payments checked were not supported by a purchase order and would not then be shown in the financial system as committed expenditure and a cash flow report is a requirement under the Scheme for Financing Schools 2020. **Risk** Loss of income from bad debts. The Financial System does not accurately reflect the finance position of the school to support sound decision making. School fund balances may not be adequate to meet committed expenditure and the school account is overdrawn.	
Recommendation Regularly run the aged debtors and aged creditors reports to verify the information held in the system, investigate any anomalies, identify outstanding invoices and support income collection. Develop cash flow reporting for the school account.	**Rating** Priority 3
Management Response and Accountable Manager Monthly Aged Debtors & Aged Creditors to be run as part of month end process "Credit Control" added to Finance Assistant job description Cash Flow reporting to local authority (which is done retrospectively anyway so a little bit pointless) can't be done in this financial year as Finance manager did not calendarize the full year budget.	**Agreed timescale** 31 October 2023

Cash Flow is managed on a daily basis informally by Director of Finance – monitors bank account with upcoming pay lists and DD to ensure there is zero risk of going over drawn at bank.	

7. Loans Book	
Finding The only loans book on site is held by the Head of Art. As at the 6 July 10 items are out on loan, 6 of them relating to 2022. There was no evidence that this record is independently checked and verified as accurate. **Risk** Financial loss to the school	
Recommendation The loans book should be periodically checked by an independent officer to ensure that the assets are still on loan, that loans are recovered when a pupil leaves and that the loans book is accurate and current.	**Rating** Priority 3
Management Response and Accountable Manager Art department have clarified that the 10 items are still out on loan Going forward, Finance will perform periodic checks of the loan book to validate all items are indeed on loan and not lost	**Agreed timescale** Director of Finance 30 September 2023

Appendix B - Assurance and Priority Ratings

Assurance Levels

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.

Action Priority 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.

Appendix C – Audit Scope

Audit Scope
We reviewed the adequacy and effectiveness of controls over the following risks: • Robust governance arrangements are not in place to oversee the financial management of the school or to ensure value for money • Decision making is not effective, as decisions are based on inaccurate financial information • The school pays for goods/services not received • Income due to the school is not collected • Loss or theft of assets The audit review considered the following areas of financial management: • **Financial Management Information** including budget monitoring, financial reports and returns to London Borough of Bromley • **Primary accounting documentation** including payments, income, contracts, voluntary funds and bank reconciliations • **Safeguarding Assets** • **Governance arrangements** including financial delegation, governor minutes, budget approval and business interests Whilst on site for two days, we examined the controls in place to mitigate the impact of the key risk areas. Our audit included a review of relevant documentation, interviews with key officers and sample testing of related procedures and processes.

REDACTED INTERNAL AUDIT REPORT

GIFTS & HOSPITALITY AND DECLARATIONS OF INTEREST

AUDIT REFERENCE: AW/08/2022

11 September 2023

Auditor	Trainee Auditor
Reviewer	Head of Audit and Assurance

Distribution list

Director of HR & Customer Services
Director of Corporate Services
Head of HR Business, Systems & Reward
Senior HR Officer
Democratic Services Manager

Executive Summary

Audit Objective	The objective of this audit was to review the adequacy and effectiveness of the Council's arrangements for the declaration of interests and gifts and hospitality by Members, officers and agency workers.

Assurance Level		**Findings by Priority Rating**		
		Priority 1	**Priority 2**	**Priority 3**
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.	0	3	0

Key Findings

1. We found that the following controls are in place and working well:
   - A data matching exercise conducted as part of the mandatory National Fraud Initiative (NFI) between Payroll, Companies House and the Council's Creditors data did not highlight any significant issues or conflicts. Minor clarifications have now been resolved.
   - The Code of Conduct for Members, last reviewed in October 2020, is comprehensive and in line with the current procedures followed by the Council. We found that Members regularly declare their interest and update changes on the Bromley website.
   - A clause on Gifts or Gratuities is included in the contracts of employment for all staff and Register of Officers' Interests for staff whose post requires it. The Gifts or Gratuities clause briefly instructs staff of their responsibilities on accepting gifts and gratuities and also directs them to the documented Code of Conduct.

Management should consider the key findings summarised below:

1. **Employees' Declaration of Interest** (Priority 2) – There was no evidence for approximately 25% of relevant staff that they had completed a Declaration of Interest. ***See Recommendation 1.***
2. **Agency staff Declaration of Interest by** (Priority 2) – Sample testing highlighted that Agency staff declarations had not been fully completed or appropriately counter signed. ***See Recommendation 2.***

3. **Gifts and Hospitality (Officers)** (Priority 2) – The Council's Gifts and Hospitality Code of Conduct policy for officers was last updated in 2013. Review of arrangements across the Council highlighted inconsistencies in understanding and practice. ***See Recommendation 3.***

Management has agreed actions for all findings raised in this report. **Please see Appendix A**.

Definitions of our assurance opinions and priority ratings are in ***Appendix B****.*

The scope of our audit is set out in ***Appendix C****.*

Appendix A - Management Action Plan

1. Employees' Declarations of Interest
Finding We analysed a report of LBB employees whose post requires a declaration of interest and the date that they last completed this. The report was run on 5 April 2023 and provided information on declarations of interest completed on the HR system from 1 April 2019 to the date of the report. Out of 913 employees whose post requires a declaration of interest (DOI), we noted that: • 429 employees had not completed a declaration of interest in the 2022/23 financial year, i.e. in the last one year (the current policy does not define how frequently declarations of interest should be completed) • 205 of these 429 employees had completed a DOI between 1 April 2019 and 31 March 2021. • 224 staff had not completed a DOI. We have passed the list of exceptions to the Head of HR, Business Systems and Reward. Although these numbers are significant, on balance we consider this to be currently medium risk because the NFI data matching has not highlighted any significant impacts. However, this issue does have the potential to be high risk. The Council's Register of Officers Interest guidance was last reviewed in October 2014. We noted that: • The information in "Section F. Method of Disclosure" no longer reflects current practice • There is no reference to how frequently Employee Declarations of Interest should be completed. **Risk** Increased risk of fraud and corruption due to abuse of position in procurement of goods and services. Conflicts of interest which are not properly managed may lead to poor decision-making, failure to achieve value for money and non-compliance with legislation. Reputational damage to the Council.

Recommendation	Rating
Review and update the Register of Officers Interest guidance and ensure that this stipulates the frequency that declarations of interest should be completed (for best practice, we suggest annually). HR should regularly remind all employees whose post requires a DOI to complete it as soon as there is a change in their interest or at the required frequency even if there are no changes in personal interests, to ensure that the Council has the most up to date information. HR should run an exception report once a year to identify employees who have not completed a DOI within the desired time period and Directors should ensure that outstanding declarations are completed.	Priority 2
Management Response and Accountable Manager	**Agreed timescale**
Agreed. Accountable Manager – Head of HR Business, Systems and Reward	31 January 2024

2. Agency staff Declarations of Interest

Finding

From the list of 138 agency staff whose post requires a declaration of interest, we randomly selected a sample of 9 staff. We noted that:

- Four agency workers had not submitted a DOI in the last year. One worker had never submitted a DOI and the remaining three were dated in 2021
- Only one of eight DOIs had been countersigned by a line manager as required on the final page of the document
- No DOIs had been signed as received by a designated Council employee (as required on the first and final pages of the document)
- Three DOIs were only part-signed or signed incorrectly by the agency worker.

The Declaration of Interest form for agency workers was last reviewed in 2012.

We have provided these exceptions to the Head of HR Business, Systems and Reward.

Risk Inability to verify if the agency has done adequate due diligence in checking the DOI of agency staff. Conflicts of interest which are not properly managed may lead to poor decision-making, failure to achieve value for money and non-compliance with legislation. Increased risk of fraud and corruption due to abuse of position. Reputational damage to the Council.	
Recommendation Review the Declaration of Interests form and the authorisation process for agency workers to ensure that these remain fit for purpose. HR should regularly remind all agency staff and their line managers whose post requires a DOI to complete it as soon as there is a change in their interest or at the required frequency even if there are no changes in personal interests, to ensure that the Council has the most up to date information. Investigate if any quality assurance or exception reporting can be undertaken to ensure that the forms are completed as required.	**Rating** **Priority 2**
Management Response and Accountable Manager Agreed. Accountable Manager – Head of HR Business, Systems and Reward	**Agreed timescale**

3. Gifts and Hospitality Policy - Officers
Finding The Gifts and Hospitality Code of Conduct policy for officers was last reviewed in December 2013. We noted that: • It does not incorporate procedures currently adopted by the Council for declaring and documenting gifts and hospitality offered to staff • It is not clear if the current policy is applicable to agency workers • It does not refer to the Bribery Act 2010.

Overall, our review of arrangements within individual departments highlighted that there is inconsistency in understanding and application of the policy and procedures to declare gifts and hospitality. Specifically,

- There is no set process followed by the departments to remind staff of the code of conduct on accepting gifts and hospitality. Where some departments had sent out infrequent reminder emails, others had not sent out any reminders to their staff.
- We were not provided with gifts and hospitality registers for all departments and consequently these may not exist.
- There is no set process followed by departments for recording and maintaining the gifts and hospitality register. Some registers were incomplete or filled incorrectly.

We have discussed this issue with the Director of Human Resources, Customer Services and Public Affairs, who has consequently allocated resource to update the policy.

Risk

Outdated policies can leave the Council at risk of non-compliance with legislation and regulations.
Acceptance of personal inducements and bribery.
Breaches of the Code of Conduct, if not identified, could lead to adverse publicity and reputational risk.

Recommendation	**Rating**
The Gifts and Hospitality Code of Conduct policy for officers should be reviewed, updated and relaunched to all officers. The policy should include reference to the Bribery Act 2010 and state that it applies to all staff, including agency workers.	Priority 2
Management Response and Accountable Manager Agreed. Accountable Manager – Head of HR Business, Systems and Reward / Director of HR, Customer Services and Public Affairs	**Agreed timescale** 31 January 2024

Appendix B - Assurance and Priority Ratings

Assurance Levels

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.

Action Priority 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.

Appendix C – Audit Scope

Audit Scope
We reviewed the adequacy and effectiveness of controls over the following risks: • Conflicts of interest which are not properly managed may lead to poor decision-making, failure to achieve value for money and non-compliance with legislation • Gifts and hospitality which are inappropriately accepted may lead to perceived or actual conflicts of interest, both of which may damage the Council's reputation • Increased risk of fraud and corruption due to abuse of position The review focussed on the following elements: • policies in place for gifts and hospitality and declaration of interest. • adequacy of arrangements in place for gifts and hospitality and declaration of interest for staff, agency workers and members. Our audit testing was largely focused on the financial year 2022/23 but for Declarations of Interest, we also reviewed available information from previous financial years. Our audit included a review of relevant documentation and sample testing of members, staff and agency workers for declaration of interest, gifts and hospitality received. This included a review of declarations of interest against information publicly available at Companies House. We also interviewed key officers including the Democratic Services Manager, Head of HR Business, Systems & Reward and staff involved in maintaining the gifts and hospitality register.

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FINAL INTERNAL AUDIT REPORT

MEDIUM TERM FINANCIAL STRATEGY (MTFS) – PLANNING, FORECAST AND GOVERNANCE ARRANGEMENTS

CEX/03/2023

SEPTEMBER 2023

Auditor	Assistant Manager (Mazars LLP)
Reviewer	Manager (Mazars LLP)
	Partner (Mazars LLP)

Distribution list

Job Title
Director of Finance
Head of Finance, Children, Education, and Families
Head of Corporate Finance

Executive Summary

Audit Objective	The overall objective of the audit was to review the effectiveness of controls over the financial planning process and a review of assumptions made, including documenting, approving, and monitoring these. This internal audit does **not** provide assurance over the accuracy and robustness of financial plans and budgets.

Assurance Level		**Findings by Priority Rating**		
		Priority 1	**Priority 2**	**Priority 3**
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.	-	-	2

Key Findings

1. The Council Statement of Accounts for the year ending 31 March 2020 states that these were signed by the Director of Finance on 2 May 2023 and had been approved by the Chairman of the Audit and Risk Management Committee of the London Borough of Bromley on 2 May 2023.
2. Our review of the 2019/20 Statement of Accounts[1] found the following mentions related to the Council's Medium Term Financial Strategy (MTFS):
   - *"The Council's budget strategy has to be set within the context of a reducing resource base with Government funding reductions continuing beyond 2020. There remains an ongoing need to reduce the size and shape of the organisation to secure priority outcomes within the resources available"* (Pages 13,14);
   - *"Although it has been possible to achieve a broadly balanced budget for 2020/21 through identifying savings and continuing with prudent financial management, there remains a significant budget gap by 2023/24. The Council is a low-cost authority and the position will need to be regularly reviewed"* (Pages 14);
   - *"There remains a "budget gap" of £0.8m in 2021/22 rising to £16.9m per annum in 2023/24. The projections from 2021/22 have to be treated with some caution, particularly as the Government's next Spending Review, outcome of the Fair Funding Review and Business"* (Pages 149).
3. The latest Medium-Term Financial Strategy (MTFS) 2023/24 was presented to the Council's Executive on 8 February 2023 and Full Council on 27 February 2023[2]. The MTFS covers the 2023/24 to 2026/27 period. Through the review of the MTFS 2023/24, we noted:
   - The MTFS stated that *"the 2023/24 Budget enables the Council to continue to deliver on its key priorities, and the financial forecast enables medium-term financial planning";*

1 https://www.bromley.gov.uk/downloads/file/2084/lb-bromley-statement-of-accounts-2019-20
2 https://cds.bromley.gov.uk/ieListDocuments.aspx?CId=115&MId=7299&Ver=4

- The report mentions that *"the Council has been facing financial uncertainty and has a medium-term 'budget gap' to address. The Director of Finance recommends a minimum sum of £20m to be kept as general reserves to reflect this uncertainty"* (Page 27);
- The report suggests that *"the Council has limited scope to utilise general fund reserves for capital spending in excess of the current capital programme and will need to continue to progress a program of asset disposals"* (Page 27);
- The Council's financial forecast assumes that *"the level of core grant funding will remain unchanged, in real terms, from 2025/26. This suggests that the Council is not expecting significant increases in funding from the government*" (Page 2);
- The report provides a detailed breakdown of various funds and reserves, including their balances at the end of each fiscal year from 2022 to 2026. Some funds show a net decrease over the years, while others remain stable. For example, the 'Technology Fund' decreases from £1,198,000 in 2022 to £114,000 in 2026, while the 'Invest to Save' fund remains stable at £18,512,000 over the same period (Page 28-29)
- Upon review of the Council's Corporate Strategy 2021/2031[3] and the Council's MTFS 2023/24, we noted that the MTFS appears to align with the Corporate Strategy, for example, the Corporate Strategy states: *"During the life of this plan, our priorities and actions will be influenced by resident and service user engagement, demand pressures and performance management, staff engagement and workforce development, risk management, changes in statutory responsibilities, pressures arising from our Medium Term Financial Strategy and national, regional and local political priorities."* (Page 30)"; and
- The MTFS highlights the key areas which affect the Council's revenue and capital programs and plans for these over the medium term.

4. We noted through a review of Appendix 1 of the MTFS 2023/24 that assumptions are made. They considered factors relevant to the Council, such as the annual increase in Gross Domestic Product (GDP) and inflation. Assumptions used in forecasting were supported by documented evidence maintained by the Director of Finance.
5. Various services within the Council hold discussions with Directors who feed this into the MTFS process. We evidenced this thorough review of emails between different Directors (including the Director of Finance) regarding the assumptions used in forecasting.
6. We reviewed the Corporate Risk Register (May 2023) and Finance Risk Registers (dated April 2023) and confirmed that there is a risk management framework that includes financial risks within the MTFS. Also, Appendix 4 of the MTFS highlights key factors to determine the sustainable level of one-off reserves that should be retained and the significant value of retaining such reserves. The Council has estimated general reserves on hold of £18.5 million as of 31 March 2023 (as reported to the Executive members on 30 November 2022).
7. We reviewed the Council Tax Report presented to the Executive members of the Council on 08 February 2023 and noted that assumptions that were consistently being considered in the budgeting process of the Council covering areas such as treatment of interest rates and inflation, level and timing of capital receipts, revenue impact of the capital programme and so forth.
8. Budget reports are considered within the Council's management teams or relevant forums (such as Chief Officer Executive, Council Leadership Team and Finance Steering Group) before final reports are presented to Executive members. This was evidenced through a review of the Council's draft budget for

3 https://www.bromley.gov.uk/downloads/download/142/making-bromley-even-better-corporate-strategy-london-borough-of-bromley

2023/24 and a series of emails between the Director of Finance and other Officers involved in the budgeting process (for example, the Head of Finance, Children, Education, and Families) as evidence of deliberation of the budget monitoring reports.

9. We confirmed through review of the meeting minutes for Policy Development and Scrutiny (PDS) Committees (25 January, 15 March, and 28 March 2023) that the budget monitoring (and its related reports) were a standing agenda item and were deliberated in this structure.
10. From our review of the above-mentioned budget monitoring reports presented by the Head of Finance to the Executive for various decision makers such as (Portfolio Holder for Children, Education and families, Portfolio Holder for Adult Care and Health and Executive) on 14, 15 and 29 March, we confirmed that variances had been identified and analysed. Explanations were provided for both positive and adverse variances on each occasion.
11. We obtained the agenda for the Chief Officer Executive meeting (COE) in connection with the 'Budget Growth & Challenge Session' dated 24 August 2022 and noted that budget matters such as growth and assumptions for the current MTFS 2023/24 were deliberated. We noted that as part of ongoing budget monitoring when there is a change in the assumptions or circumstances, the budget is updated to account for those changes. In addition, we reviewed the budget challenge emails between Council Officers. We noted that the changes to the budget were scrutinised and discussed before the budget update.
12. As part of our work, we have raised two 'Priority 3' recommendations regarding the Risk Management Framework and the Financial Regulations.

Management has agreed to actions for all findings raised in this report. **Please see Appendix A**.

*Definitions of assurance opinions and priority ratings are in **Appendix B**.*

*The scope of the internal audit is set out in **Appendix C**.*

Appendix A - Management Action Plan

1. Risk Management Strategy and Risk Management Toolkit	
Finding Upon review of the Risk Management Strategy and Risk Management Toolkit, we noted that they were not regularly reviewed as they were last reviewed in April 2018, more than five years ago. Management indicated that they are aware that this guidance requires updating, and the Head of Audit and Assurance indicated that they are part of the work plan for the forthcoming financial year. **Risk** Over time, the business environment, industry, and internal factors may change, leading to new or different risks. If the risk management strategy is not reviewed periodically, it may fail to address emerging risks adequately and result in outdated risk assessments and the inability to mitigate or respond effectively to new threats.	
Recommendation The Council should consider defining the process for the periodic review of the Risk Management Strategy and Risk Management Toolkit. The Council may consider specifying the frequency of review of this guidance.	**Rating** Priority 3
Management Response and Accountable Manager As indicated by the Head of Audit and Assurance, the Risk Management Strategy and Risk Management Toolkit will be reviewed through the Corporate Risk Management Group and the outcome of the review with action plan for completion within 2024	**Agreed timescale** June 2024

2. **Financial Regulations**	
Finding Whilst we noted that the roles of various stakeholders involved in the budgeting process were clearly defined in the Financial Regulations and Procedures, we noted that the Financial Regulations and Procedures were dated 2020. The document did not contain a document version control and as a result, we were unable to determine the frequency of review and we could not determine when the next review date. **Risk** Where the document version control is not contained in the policy, there is a risk that it would be difficult for the new employees to understand the current practice of the policy review, this may result in the possibility of the policy review being missed.	
Recommendation The Council should consider showing evidence of a review of the Financial Regulations by way of the document version control and define the frequency of review such as two-yearly where applicable, the next review date should also be shown as part of the document version control. The Council may consider specifying the frequency of review of the Financial Regulations.	**Rating** Priority 3
Management Response and Accountable Manager Agreed. Version control and review frequency will be included in the next update of Financial Regulations, which had been discussed by the Financial Management Team prior to this audit commencing, although the start of the review has been delayed in order to prioritise publication of the Council's draft accounts for 2020/21 and external audit of those accounts.	**Agreed timescale** April 2024

Appendix B - Assurance and Priority Ratings

Assurance Levels

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.

Action Priority 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.

Appendix C – Audit Scope

Audit Scope

We reviewed the adequacy and effectiveness of controls over the following risks:
• Long and medium-term financial plans and/or business plans may not be in place, be up to date, or may not adequately reflect:
  o The organisation's strategic objectives and long-term aspirations.
  o Key strategic considerations (including corporate objectives, risk analysis, budget setting and investment plans).
• Assumptions used in forecasting are not supported by reliable evidence leading to inaccurate financial projections.
• Inadequate financial planning may lead to the Council not having access to the appropriate level of cash when financial plans and/or business plans require it.
• Suitable buy-in to the financial and business planning process from stakeholders may not be achieved, leading to unsupported plans being progressed.
• Failure to identify and manage financial risk. Inadequate risk mitigation strategies. Inadequate monitoring and reporting of financial risks.
• Monitoring progress against financial plans and/or business plan targets may not occur regularly, be effective or lead to corrective action being taken where key variances occur.
 	
The internal audit scope included the following:
 	
• **Financial Planning and Forecasting**
 	
The Council has an approved medium-term financial strategy aligned with the strategic objectives of the Borough.
 	
Assumptions used in forecasting are supported by reliable evidence and subject to independent scrutiny or review before the MTFP is presented to Members.
 	
Allowances are made to ensure the MTFP adequately covers risks (i.e., contingency planning and reserves).
 	
The sensitivity of forecasts to changes in key assumptions is analysed and considered regularly.
 	
• **Governance and Control**
 	
There is an established governance framework for financial planning and budgeting. The MTFP is subject to different levels of scrutiny and challenge before it is presented to Council Members.
 	
The role of the key stakeholders and decision-makers is clearly outlined.
 	
There is wider consideration within the Council's management teams or relevant forums before final reports are presented to Members. (i.e., assumptions in forecasting, approvals, and independent reviews).
 	
• **Risk Management**
 	
A risk management framework includes the identification and measurement of financial risks faced by the Borough.

Risk mitigation strategies are in place that are adequate and based on best practice frameworks.

Management and Senior Management maintain regular meetings to review operational and strategic risks, including financial risks linked to the MTFP.

- **Monitoring and Reporting**

The financial forecasts are reported regularly, accurately, and completely to Senior Management.

Monitoring and reporting arrangements are effective and include material variances and exceptions.

The MTFP is updated if needed based on the changes in the assumptions or circumstances the Council faces. There is a feedback mechanism for improvement suggestions.

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FINAL INTERNAL AUDIT REPORT

HIGHWAYS MANAGEMENT OF MAJOR WORKS

PLA/05/2022

August 2023

Auditor	Principal Auditor
Reviewer	Head of Audit and Assurance

Distribution list

Job title
Director of Environment and Public Protection
Assistant Director Highways
Highway & Street Lighting Manager
Head of Performance Management & Business Support

Executive Summary

Audit Objective	The overall objective of the audit was to review the management of a sample of capital works to include controls in place to deliver to time, cost and quality. We also considered supplier Business Continuity arrangements.

Assurance Level		**Findings by Priority Rating**		
		Priority 1	**Priority 2**	**Priority 3**
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.	1	2	0

Key Findings

1. We noted that the condition surveys of the Highways are automated through the analysis of video surveys using artificial intelligence (AI). A boroughwide AI survey using vehicle mounted cameras along with GPS location technology was completed and the data collected was processed using the AI web-based software to identify the priorities for carriageway planned works for 2022-23. The automation of the survey process has made the results repeatable and consistent.
2. We verified from the meeting minutes that monthly contract meetings are held, where Highway major works are discussed. Progress reports are provided by the contractor prior to the meeting for discussion.
3. The Highways manager advised that since 2020 instead of filling manual remeasurement sheets, they have approved works completed for payment based on emails from the Highways Inspector confirming the final remeasurement completed at site. We checked this process for the 3 sampled schemes which have been invoiced and paid. For 3/3 schemes, Highways Inspector's email to confirm the remeasuring on site was not available. Therefore, we could not confirm if the work completed was measured and that details of what was checked were sufficient to allow the Certifying Officers to satisfy themselves that the payment was accurate and due to be paid.
4. We also noted that the agreement of work to be undertaken, interim and final inspection of work completed and remeasurements to support payment is undertaken by the same Highways Inspector. Therefore, we could not confirm if at least three designated officers were involved in the whole process (ordering / receipt of goods or services / payments approval).

5. The Highways manager advised that he quality checks the remeasurements completed by the Highways inspector by reperforming 10% of the completed measures. We asked but no evidence of the quality checks by the Highways manager was provided hence we cannot confirm if measurements to support payments are independently checked.
6. We could not test if managements own procedures are being complied with as processes for selection of schemes, agreement of work to be undertaken, raising and varying orders (price and quantity), inspections, rectification of defects, supervising arrangements, measuring works completed and payments are not documented and ratified.
7. We noted that at the ECS PDS committee meeting in March 2022, the committee members were informed that due to limited revenue budgets it is not possible to resurface all roads needing maintenance and consequently, those roads with the highest overall priority are being put forward for planned works programmes in accordance with annual budget provision for approval. We requested but management has not provided the information to verify the prioritisation process for schemes in the 2022-23 work programme and therefore the reasonableness of the process could not be fully verified.
8. We asked how the supplier risk of failure of Business Continuity is being managed and if LBB's Business continuity checklist has been completed. The Assistant Director Highways advised that they have not yet completed the Business Continuity checklist however this will be arranged.

Management has agreed actions for all findings raised in this report. **Please see Appendix A**.

*Definitions of our assurance opinions and priority ratings are in **Appendix B**.*

*The scope of our audit is set out in **Appendix C**.*

Appendix A - Management Action Plan

1. Compliance
Finding: The Highways manager advised that since 2020 instead of completing manual remeasurement sheets to confirm works completed, they have approved payments based on emails from the Highways Inspector confirming that he has remeasured the site to check that the work completed. We checked this process for the 3 sampled schemes which have been invoiced and paid. The Financial regulation states that: *"8.2.1 The overriding principle to be adhered to is that authorisation and certification checks should be meaningful. To this end, they should be carried out and evidenced by those officers who are in a position to judge, for instance, whether goods / services have actually been received or whether invoice prices are correct. The evidence should also be unambiguous e.g. an isolated signature on an invoice does not make it clear what has been checked or what is being authorised or certified and is therefore not acceptable.* *8.2.5 Certifying Officers are responsible for ensuring that adequate checks are performed and evidenced prior to the payment of an invoice to satisfy themselves that the payment is accurate and due to be paid."* For 3/3 schemes, the Highways Inspector's email to confirm the remeasuring on site was not available. Therefore, we could not confirm if the work completed was measured and that details of what was checked were sufficient to allow the Certifying Officers to satisfy themselves that the payment was accurate and due to be paid. The Financial regulation also states that: *"8.1.17 Chief Officers should ensure that all invoices input onto Accounts Payable for payment have been properly authorised and certified, with evidence of at least three designated officers having been involved in the whole process (ordering / receipt of goods or services / payment). The Director of Finance must specifically approve exceptions to this requirement e.g. where authorisation / certification is performed electronically or where less than three officers are involved in the process."* We also noted that the agreement of work to be undertaken, interim and final inspection of work completed and remeasurements to support payment is undertaken by the same Highways Inspector. Therefore, we could not confirm if at least three designated officers were involved in the whole process (ordering / receipt of goods or services / payments approval).

The Highways manager advised that he quality checks the remeasurements completed by the Highways inspector by reperforming 10% of the completed measures. We asked but no evidence of the quality checks by the Highways manager was provided hence we cannot confirm if measurements to support payments are independently checked.

Risk:

- Payment for works that have not been completed.
- Lack of segregation of duties may lead to fraud or error being undetected.

Recommendation	**Rating**
Management should ensure that i) the work completed are measured and details of what is being checked is sufficient to allow the Certifying Officers to satisfy themselves that the payment is accurate and due to be paid. ii) Supporting evidence for payment i.e. the Highways Inspector's emails to confirm the final site remeasurement are retained. iii) at least three designated officers were involved in the whole process (ordering / receipt of goods or services / payments approval). iv) All site visits by Highways officers, and their observations are recorded and retained.	**Priority 1**
Management Response and Accountable Manager	**Agreed timescale**
i) All works are currently measured and details recorded to allow the Certifying Officers to satisfy themselves that the payment is accurate and due to be paid, a process which will continue – **no further action required** ii) Supporting evidence of site measurements for payment are currently recorded. Moving forward these documents will be retained on SharePoint to confirm the final site remeasurements – **Highway & Street Lighting Manager** iii) Three designated officers are currently involved in authorising all contractual payments – **no further action required** iv) Details of site visits by Highways officers, and their observations are currently recorded. Moving forward these documents will be retained on SharePoint – **Highway & Street Lighting Manager**	N/A September 2023 N/A September 2023

2. Procedure notes	
Finding: We could not test if managements own procedures are being complied with as processes for the selection of schemes, agreement of work to be undertaken, raising and varying orders (price and quantity), inspections, rectification of defects, supervising arrangements, measuring works completed and payments are not documented and ratified. **Risk** Poor management leading to delays and overspend.	
Recommendation Management should ensure that written procedure notes are produced and agreed for the selection of schemes, agreement of work to be undertaken, raising and varying orders (price and quantity), inspections, rectification of defects, supervising arrangements, measuring works completed and payments.	**Rating** Priority 2
Management Response and Accountable Manager A written procedure will be prepared for the selection of schemes, agreement of work to be undertaken, raising works orders, inspections, rectification of defects, supervising arrangements, measuring works completed and payments – **Highway & Street Lighting Manager**	**Agreed timescale** December 2023

3. Selection process	
Finding: We noted that at the ECS PDS committee meeting in March 2022, the committee members were informed that due to limited revenue budgets it is not possible to resurface all roads needing maintenance. They were advised that those roads with the highest overall priority are being put forward for planned works programmes in accordance with annual budget provision for approval. We requested but management has not provided the information to evidence the prioritisation process applied for selecting the schemes included in the 2022-23 work programme and therefore the reasonableness of the process could not be fully verified. **Risk** Failure to manage highways leading to unsafe conditions for highway users and unnecessary expenditure on schemes that do not require it.	
Recommendation Management should ensure that the rationale for prioritising the Highways major work schemes is fully documented and the reasonableness of their selection should be evident.	**Rating** Priority 2
Management Response and Accountable Manager Prioritisation of major work schemes is based on condition survey results, network hierarchy and engineering judgement. A procedure will be prepared to clarity the processes and decisions taken in selecting schemes before submission to members for approval – **Highway & Street Lighting Manager**	**Agreed timescale** April 2024

Appendix B - Assurance and Priority Ratings

Assurance Levels

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.

Action Priority 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.

Appendix C – Audit Scope

Audit Scope
We reviewed the adequacy and effectiveness of controls over the following risks: • Failure to manage highways leading to unsafe conditions for highway users • Poor quality repairs leading to insurance claims (trips, falls and Road Traffic Accidents) and reputational damage • Poor contract management leading to delays and overspent on capital works Our audit included a review of the relevant documentation and testing of related procedures, processes, and systems. Our testing focused on the list of schemes approved by committee for completion in 2022-23. A random sample was selected and then tested against available information. We included the following as part of our scope: • Financial management including payments and arrangements for monitoring and measuring works completed • Change control and order variations • Project monitoring and contract management • Supplier Business Continuity arrangements

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