Audit Committee

Agenda Item:

A.7

Meeting Date:	24th January 2014
Portfolio:	Finance, Governance and Resources
Key Decision:	No
Within Policy and Budget Framework	Yes
Public	

Title:	Internal Audit Progress Report 2013-14 (No. 3)
Report of:	Director of Resources
Report Number:	RD79/13

Purpose / Summary:

This report summarises the work carried out by Internal Audit and details the progress made on delivery of the approved 2013-14 Audit Plan.

Recommendations:

Members are requested to:

- **Receive this report and note the progress made against the agreed 2013/14 Audit Plan referred to in section 2.**
- **Note the amendments to the 2013/14 Audit Plan as detailed in section 3.**
- **Note the position on the follow up of previous audit recommendations as outlined in section 4.**
- **Receive the completed audit reports referred to in section 5.**

Tracking

Audit Committee	24th January 2014
Overview and Scrutiny:	Not applicable
Council:	Not applicable

1 BACKGROUND

1.1 Management is responsible for the system of internal control and should put in place policies and procedures to ensure that systems are functioning correctly.

1.2 Internal Audit examine, appraise and report on the effectiveness of financial and other risk, governance and internal controls to enable it to provide an opinion on the adequacy of the control environment and report any significant control issues.

1.3 This report summarises the work carried out by Internal Audit and details the progress made on delivery of the approved Audit Plan during the third quarter period of 2013/14.

2 AUDIT PERFORMANCE AGAINST THE 2013/14 AUDIT PLAN

2.1 The 2013/14 Strategic and Annual Risk Based Audit Plans were presented to the Audit Committee on 15th April 2013 – report RD 06/13 refers.

2.2 To assist Members in monitoring the progress made against the agreed annual plan, **Appendix A** illustrates the current position of the plan up to the end of December 2013. The position can be summarised as follows:

	Allocated Days	**Actual Days**
High Risk	182	190
Value for Money & Efficiency	40	0
Main Financial System	148	61
ICT	25	1
Project Support	20	0
Fraud	25	12
Other	100	71
Total Audit Days 2013-14	**540**	**335**

2.3. The Plan calls for 540 direct audit days – 335 days (62%) have been delivered in the third quarter period. Time has been spent on the following areas:

- 5 audit reviews have been finalised. These final reports are considered in more detail within section 5 of this report.

- There are a 3 reports at draft stage; Procurement, Customer Services and Organisational Development (Devolved Development and Training). All audit

fieldwork and testing has been completed and the draft reports have been issued. Further discussions with management are now required to finalise these audit reports.

- The audits of Council Tax, Housing and Council Tax Benefit and National Non Domestic Rates, which are delivered by the Revenues and Benefits Shared Service, are being undertaken as joint reviews. This is a new audit approach which aims to achieve savings (time and cost) and provide a fuller assurance opinion for each of these core service areas.

- All the recommended data matches raised by the National Fraud Initiative (NFI) have now been examined. On conclusion of this work, a report on the findings will be prepared. .

- Planned audit reviews are ongoing in the areas of recycling, debtors, payroll and car parking income.

- An unplanned investigatory piece of work was concluded in the period.

2.4. Members are asked to note the progress made against the agreed Audit Plan.

3. AMENDMENT TO THE 2013/14 AUDIT PLAN

3.1. There are 20 days allocated in the plan to Project Support. This time has not been utilised to date so it is proposed that this time should be redirected to support the additional requirements which have been necessary to implement and monitor the revised arrangements for reporting of previous audit recommendations.

3.2. There are 40 days allocated in the Plan to undertake two Value for Money reviews but there is insufficient time to deliver both reviews in the remainder of the year due to necessary additional time being spent on certain high risk reviews (predominantly Procurement and Revenues Recovery). The Value for Money allocation will therefore be reduced to one review of 20 days to accommodate this additional time spent.

3.3. The above proposed amendments to the Plan have been discussed and agreed with the Director of Resources.

3.4. Members are asked to note the above changes to the Audit Plan.

4. FOLLOW-UP OF PREVIOUS AUDIT RECOMMENDATIONS

4.1. A report on the position of all follow ups of previous audit recommendations monitored via Covalent is attached as **Appendix B**. Attention is drawn to the colour coding used to highlight the progressive action taken against each audit recommendation.

4.2. In summary, a total of 69 recommendations have been monitored in this reporting period; 58 where sufficient action is reported and these recommendations are now closed. Of the remaining 11 'open' recommendations; 6 are in progress and 5 are where insufficient information has been provided to determine whether or not appropriate action has been taken to date. For those recommendations which have not had an adequate response, further enquiries with managers have been made.

4.3. Members are asked to note the position on the follow up of previous audit recommendations.

5. REVIEW OF COMPLETED AUDIT WORK

5.1. There are 5 audit reports to be considered by Members at this time. Guidance on the grading of audit recommendations, the audit follow up procedure and audit assurance ratings is attached as **Appendix C**.

5.2. The Management Summary and a copy of the Summary of Recommendations / Action Plan for each completed audit review listed below have been provided within **Appendices D-H.**

Audit of:	Assurance Evaluation	Appendix
External Funding	Substantial	D
Electoral Registration	Substantial	E
Performance Service Standards	Reasonable	F
Revenues Recovery	Reasonable	G
Records Management	Partial	H

6. CONSULTATION

Not applicable

7. CONCLUSION AND REASONS FOR RECOMMENDATIONS

7.1. Good progress has been made in delivering the Audit Plan in quarter 3. Priority work in quarter 4 will focus on the remaining material system reviews and the formal follow up audits of previous audits which were given lower level assurance.

7.2. The recommendations made in this report will enable Members to track the progress made on the delivery of the 2013/14 Audit Plan and gain assurance on the independent audit work undertaken in the period.

8. CONTRIBUTION TO THE CARLISLE PLAN PRIORITIES

8.1. To support the Council in maintaining an effective framework regarding governance, risk management and internal control which underpins the delivery the Council's corporate priorities and helps to ensure efficient use of Council resources.

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Appendices A-G attached to report:
Appendix A – 2013/14 Audit Plan Monitoring Update
Appendix B – Follow Up of Previous Recommendations
Appendix C – Grading of Audit Recommendations and Assurance Evaluations
Appendix D – Audit of External Funding
Appendix E – Audit of Electoral Registration
Appendix F – Audit of Performance Service Standards
Appendix G – Audit of Revenues Recovery
Appendix H – Audit of Records Management

Note: in compliance with section 100d of the Local Government (Access to Information) Act 1985 the report has been prepared in part from the following papers:

• None

CORPORATE IMPLICATIONS/RISKS:
Chief Executive's – not applicable
Community Engagement – not applicable
Economic Development – not applicable
Governance – not applicable
Local Environment – not applicable
Resources – not applicable

APPENDIX A

CARLISLE CITY COUNCIL
AUDIT PLAN 2013/14
(up to 31 December 2013)

Directorate	Audit Area	Audit Days Allocated	Status	Assurance Evaluation	Audit Committee Date
High Risk Reviews					
Community Engagement	Revenues Recovery (inc. Housing Benefit Overpayments)	15	Completed	Reasonable	24-Jan-14
Community Engagement	Customer Contact Centre	12	Draft Issued		
Community Engagement	Leisure Services Contract	10			
Community Engagement / Economic Development	Projects and Partnerships - Stewardship arrangements	20			
Governance	Electoral Payments	10	Completed	Substantial	24-Jan-14
Local Environment	Carlisle Cycle Way	10	Completed	Reasonable	26-Sep-13
Local Environment	Recycling Contracts	15	Ongoing		
Local Environment	'Clean up Carlisle' - Street Cleaning (education &enforcement)	15			
Resources	Procurement - Tendering and Contracting	20	Draft Issued		
Resources	External Funding - Compliance and Monitoring Arrangements	15	Completed	Substantial	24-Jan-14
Corporate	Records Management Arrangements	15	Completed	Partial	24-Jan-14
Corporate	Performance Management - Service Standards	10	Completed	Reasonable	24-Jan-14
Corporate	Organisational Development & Corporate Training	15	Draft Issued		
		182			
Value for Money and Efficiency Reviews					
Corporate	Improvement, Efficiency and VFM Programme	20			
Corporate	Charging and Trading - income generation	20			
		40			
Main Financial System Reviews					
Community Engagement	Council Tax	12	Ongoing		
Community Engagement	Housing and Council Tax Benefits	20	Ongoing		
Community Engagement	National Non Domestic Rates	12	Ongoing		
Resources	Main Accounting System	20			
Resources	Fixed Assets	15	Completed	Substantial	26-Sep-13
Resources	Creditors	10			
Resources	Debtors	10	Ongoing		
Resources	Payroll	12	Ongoing		
Resources	Treasury Management	10			
Resources	Income Management	12			

Local Environment	Car Parking Income	15	Ongoing
		148	
ICT Reviews			
Resources - ICT Connect	Project Management	10	
Resources - ICT Connect	IT Developments - use of electronic forms	15	Ongoing
		25	
Project Support			
Community Engagement	Welfare Reform Changes	5	
Resources	Procurement - e-Purchasing	15	
		20	
Fraud			
Corporate	National Fraud Initiative	15	Ongoing
Corporate	Counter Fraud Arrangements / Awareness	10	Ongoing
		25	
Other Audit Work			
Audit Management, Committee, Planning & Reporting		**50**	Ongoing
Follow Up of Previous Recommendations		**10**	Ongoing
Contingency		**40**	Ongoing
	Total Audit Days 2013-14	**540**	

APPENDIX B

Summary of Audit Recommendations - Monitoring Report (from April 2012 to-date)

	Current Position Jan-2014	*Previous Position Sept -2013*
Overall total number of recommendations	**69**	***42***
Total number of open actions - other	**5**	***13***
Total number of open actions - in progress	**6**	***6***
Total number of closed actions	**58**	***23***

RED - Overdue
Amber - In progress
Green - Actioned

OPEN ACTIONS

Date of Final Report	Audit of:	Directorate	Recommendation	Grade	Agreed action	Responsible Officer	Action completed by	Progress Update as at 10th January 2014	Revised Action complete by date
19/12/2012	Tullie House - Management of Assets	Community Engagement	R1 - Financial Services must liaise with Tullie House management to a) implement a valuation process that is robust & will maintain the requirements of the Collection Loan Agreement & this should be reflected in the Collections database b) Ensure that the insurance valuation of the Collection is brought up to date.	B	To be considered as part of the Insurance Tender renewal process that will hopefully see a new Fine Arts policy added to the insurance schedule. As part of this revised valuations will be undertaken, either formal valuations or desk top exercise.	Financial Services Manager, Chief Accountant	01/05/2013	Valuations have been delayed in order that they are taken out on the same valuation programme as the Council's other property assets. Work is ongoing to prepare lists of assets and associated documents, e.g. photos, in preparation of approaching a valuer to undertake the task. It is hoped	31/03/2014

								valuations will be undertaken by 31 March 2014.	
04/09/2012	Data Quality	Chief Executives Team	R6 All partners should be required to sign a 'data quality statement' to ensure that they comply with the same quality standards as the Authority. This requirement should be incorporated into both the revised Data Quality Policy and the Partnership Protocols in detail.	B	Partners will sign a data quality statement and this requirement will be incorporated into the Data Quality Policy and strengthened within the Partnership Protocols.	Policy & Communications Manager / Development & Support Manager	31/03/2013	On going as per progress report 17th September 2013	31/12/2013

04/09/2012	Data Quality	Chief Executives Team	R7 The risks associated with the availability of Authority data should be considered carefully and suitable mitigating actions applied to each. These should then be included within the relevant risk register(s) where appropriate.	B	Consider forming a data quality risk register or incorporating risks into existing registers.	Policy & Communications Manager	31/01/2013	Ongoing as per progress report 17th September 2013	31/12/2013
04/09/2012	Data Quality	Chief Executives Team	R10 The data quality checking measures should be centrally monitored via the completion of assurance statements from a senior officer, that declares that they are satisfied that the data quality is of the highest level achievable and also take ownership for data quality in accordance with the policy.	B	Assurance statements will be produced by a senior officer (TBC) stating their satisfaction with data quality.	Policy & Communications Manager	31/01/2013	Will be incorporated into 2013/14 end of year sign off service standards; including data quality, actual data and method statements.	31/05/2014
30/08/2012	Development Control/Management	Economic Development	R2 Applications from City Council employees should be formally recorded in Acolaid under a specific reference for statistical and transparency purposes.	C	New City Council Employee field to be set up in Acolaid and employees recorded	Planning Manager/LLPG-Acolaid Development Officer/Technical Officer(s)	01/10/2012	E mails sent 20/11/13 and 8/1/14. Awaiting progress report.	

25/03/2013	Systems Administration	ICT	R2 - A weeding process in line with the Authority data retention and data protection policies should be undertaken for aged records in Local Environment from 2003 onwards.	B	Systems & Development Officer to set in place data retention policy in line with legislation and to co-ordinate the weeding process.	Systems & Development Officer	30/09/2013	E mails sent 20/11/13 and 9/1/14. Awaiting progress report.	
25/03/2013	Systems Administration	ICT	R3 - MASS system administration support should be widened in line with the legislation of the new in-house database.	C	MASS is being phased out and replaced by new internal property database (PAD) which is being developed at the moment.	Property Manager	30/04/2013	E mails sent 20/11/13 and 8/1/14. Awaiting progress report.	
25/03/2013	Systems Administration	ICT	R5 Defined roles and responsibilities should be identified for staff with regards to the processing and parameter changes within the Flare system. Staff with data processing and system administration duties should be issued with separate passwords.	B	A defined structure of Users, Super Users and Administrators to be put in place by the Systems & Development Officer in consultation with Local Environment Service Managers. Separate password to be issued to the Technical Clerks.	Systems & Development Officer	30/09/2013	E mails sent 20/11/13 and 9/1/14. Awaiting progress report.	

25/03/2013	Systems Administration	ICT	R10 Staff should be requested to sign a declaration form before using each system regarding proper system use and control of data. This should be retained for reference and aid data protection purposes.	B	Agreed. Retention period should be established and the use of e-forms.	Corporate Information Officer	31/03/2013	Call logged with DIS helpdesk to add data protection/confidentiality text to login screen on all computers. Email to be sent to all staff alerting them to the fact that they will have to read and ok this screen every time they log in from next week.	17/01/2014
25/03/2013	Systems Administration	ICT	R12 The Zeus system should be updated to end all leavers from the authority upon receipt of the leavers form.	C	Currently Service Support (Personnel & Payroll) informs the flexi administrator of leavers on a monthly basis. Look at the possibility of including the flexi administrator in the Trent Leaver Workflow.	Service Support Team Leader	30/09/2013	Leavers are noted on Zeus but have to be left on the system in order to produce retrospective reports. The flexi administrator will be included in the workflow for starters and leavers once the Council moves onto its new payroll/HR system in April 2014.	01/04/2014

25/03/2013	Systems Administration	ICT	R14 Numerous issued were highlighted from the FLARE Extended Systems Development visit which need addressed.	C	Systems & Development Officer to investigate and co-ordinate actions.	Systems & Development Officer	30/09/2013	E mails sent 20/11/13 and 9.1.14. Awaiting progress report.	

CLOSED ACTIONS

Date of Final Report	Audit of:	Directorate	Recommendation	Grade	Agreed Action	Responsible Officer	Action completed by	Action taken	Action completed date
04/09/2012	Data Quality	Chief Executive's Team	R1 The outstanding Transparency Code and the Localism Act requirements be actioned as soon as possible. Specific attention be given to the adding the Authority's policy relating to the publication of and access to information relating to remuneration to chief officers within the actual Pay Policy Statement in accordance with section 38 of the Localism Act. This statement should then be published on the Transparency page of the Authority's website in accordance with this statement.	B	Information relating to the remuneration of chief officers will be included in the Pay Policy Statement and published on the Council's website on the Transparency pages.	Policy & Communications Manager	31/01/2013	Link to Pay Policy Statement added to Transparency web page 2/1/13	31/01/2013
04/09/2012	Data Quality	Chief Executive's Team	R2 The Transparency pages on the Authority Website should be updated on a timelier basis.	B	Review of the content of the Transparency pages will be conducted quarterly.	Policy & Communications Manager	30/11/2012	Link to Pay Policy Statement added to Transparency web page 2/1/13	31/01/2013

04/09/2012	Data Quality	Chief Executive's Team	R3 The Data Quality Policy for Carlisle City Council requires updating to reflect current requirements and revised working practices.	B	Data Quality Policy will be updated.	Policy & Communications Manager	31/01/2013	Complete - policy updated January 2013	31/01/2013
04/09/2012	Data Quality	Chief Executive's Team	R4 The Policy and Communications Manager should consider the merits (or otherwise) of internal audit verifying a number of performance indicators. If decided not necessary, the partnership should also be made aware of this decision. Any decision should be made in conjunction with the Audit Services Manager.	B	Benefits of internal audit verifying PIs to be considered and fed back to Audit Services Manager.	Policy & Communications Manager	31/12/2012	Audit Services has been requested to look at service standard:SS002 The percentage of missed waste or recycling collections	21/12/2012
04/09/2012	Data Quality	Chief Executive's Team	R5 The quality of data should be assessed at source document stage in addition to the data transfer to Covalent stage to assure accuracy of information. The requirement of this should be included in the revised Data Quality Policy.	B	Requirement of data quality to be assessed at source document stage to be incorporated into revised Data Quality Policy.	Policy & Communications Manager	31/01/2013	Completed- included in revised policy.	31/01/2013

04/09/2012	Data Quality	Chief Executives Team	R8 Consideration should be given to include responsibility for data quality within the senior officers and Performance staff job descriptions.	D	Consideration will be given to include responsibility for data quality within the senior officers and Performance staff job descriptions.	Policy & Communications Manager	31/03/2013	Completed - included in Chief Executive's job description.	31/03/2013
04/09/2012	Data Quality	Chief Executive's Team	R9 On updating the Policy, the opportunity should be taken to enhance the existing Policy by including more specific roles and responsibilities that are measurable so these too can be monitored to ensure compliance and assist in embedding data quality standards throughout the Authority.	B	The Data Quality Policy update will include specific roles and responsibilities that can be measured and monitored.	Policy & Communications Manager	31/01/2013	Complete - included in revised policy.	31/01/2013
04/09/2012	Data Quality	Chief Executive's Team	R11 It is important that after the revision of the Data Quality Policy, that staff are made aware of its existence and location, so that they are aware of their responsibilities regarding data quality from the outset and the importance of compliance. Staff training regarding data quality and the importance of such day to day working arrangements should	B	Revised Data Quality Policy will be highlighted to staff. Consideration will be given to producing a learning pool module.	Policy & Communications Manager	31/03/2013	Importance of ensuring data is accurate and up to date is covered in the Data Protection Act training. Data Quality Policy is available on the internet.	31/03/2013

			be made available.						
04/09/2012	Data Quality	Chief Executive's Team	R12 The homelessness statistics provided from the hostels and the final CLG P1E return should be reconciled prior to submission to ensure that all information input into the database is correct. Any deletions from the system that may affect any previously reported performance information should be logged separately and include a brief explanation for the deletion so that a report can be ran at any time and the information will be accurate.	B	Checks will be made to ensure the CLG P1E return matches the current homelessness stats and is correct. Deletions will be recorded with a reason for deletion.	Policy & Communications Manager	30/11/2012	The database is now checked on a monthly basis to ensure the accuracy of the information contained within the database. There are now no deletions made from the system that may affect any previously reported performance information. A log is kept of any amendments.	10/01/2014
04/09/2012	Data Quality	Chief Executive's Team	R13 Resources permitting the Authority should consider compliance to either of the best practice frameworks.	D	Consideration will be given to working towards best practice frameworks.	Policy & Communications Manager	31/03/2013	Existing policy will be revised based on the learning taken from practice.	17/09/2013
04/09/2012	Data Quality	Chief Executive's Team	R15 A designated trained officer should be given ultimate responsibility for managing records retention and providing guidance within the Authority.	B	A designated officer will be given responsibility for managing records and providing guidance.	Policy & Communications Manager	31/03/2013	Responsibility lies with Policy & Communications Manage. Changes are being made to this role within the team to help deliver on all these recommendations.	31/03/2013

08/11/2012	Housing Benefit Overpayments - Follow up	Community Engagement	R1 - Once an overpayment case has been heard at appeal stage, the Senior Appeals Officer should inform the Overpayments Team immediately so that recovery can restart or the system can be updated.	B	Complete	Housing Benefits Manager	30/09/2012	Completed	30/09/2012
08/11/2012	Housing Benefit Overpayments - Follow up	Community Engagement	R2 Due notice should be given to the Overpayments Team to be able to prepare the write-off information for the Director of Resources so that the due consideration can be given to each write-off and they are all viable and justified.	B	Complete	Housing Benefits Manager	01/10/2012	Completed	01/10/2012
08/11/2012	Housing Benefit Overpay-ments - Follow up	Community Engagement	R3 - It is recommended that a) ensuring all recovery and payments arrangements procedures so they can identify what is standard and not standard practice, and b) ensuring that notebooks are used in all cases so that if an overpayment appears unjustifiably low for the amount of debt, it can easily be identified why and/or questioned.	B	Complete	Housing Benefits Manager	10/10/2012	Completed	10/10/2012

30/08/2012	Develop-ment Control/ Manage-ment	Economic Development	R1 The Development Management Service Support staff should all be following the same procedures relating to the receipt, banking and reconciliation of Planning Fees.	A	Protocol guidance to be prepared and implemented by ED Admin team	Planning Manager / Senior Administrator Performance Management	01/10/2012	Implemented.	01/12/12
30/08/2012	Develop-ment Control/ Manage-ment	Economic Development	R3 Refunded Planning Application fees should have a letter accompanying the cheque to the applicant stating why the refund has been made and a copy put on file. The actual process of how the letter accompanies the cheque will need to be agreed between the Planning Office and Creditors Section.	B	Letter to be set up in Acolaid to be completed and issued with refund request to ED Admin and dispatched with refund cheque	Planning Manager / LLPG-Acolaid Development Officer	01/12/2012	Notifying applicants/agents when they require a refund	30/11/2012
30/08/2012	Develop-ment Control/ Manage-ment	Economic Development	R4 Creditor requests should be copied to file following authorisation.	C	Change in procedure to be implemented	Planning Manager / Senior Administrator Performance Management	01/10/2012	Procedure notes for dealing with creditor requests updated.	1/12/12
30/08/2012	Develop-ment Control/ Manage-ment	Economic Development	R5 Hard copy file information should be completed in full where appropriate.	C	Change in procedure to be implemented	Technical Officer(s)	01/12/2012	File notes completed	30/11/2012

17/09/2012	Gifts & Hospitality	Governance	R1 The Employee and Members Code of Conduct training should be mandatory for all. This may be achieved through the use of e-learning module supported by supplementary workshop sessions if appropriate.	B	As many courses as required will be provided; the issue is getting attendance. We do not have the power to compel Members to attend.	Director of Governance / Support Officer (SHE)	31/01/2013	The Ethical Governance Group has approved mandatory training for all. E-learning editing training is to be undertaken by a nominated member of staff. The package will then be rolled out to all staff and members.	09/01/2013
17/09/2012	Gifts & Hospitality	Governance	R2 Awareness surrounding the records of declined gifts and hospitality require to be addressed further.	C	E-learning may also assist this.	Director of Governance/Support Officer (SHE)	31/01/2013	Governance has written to all staff reminding them of the requirement	26/11/2012
17/09/2012	Gifts & Hospitality	Governance	R3 The Chief Executive's Gifts and Hospitality pro-forma should only be authorised by the Deputy Chief Executive.	C	Agreed and DoG will action. Not necessarily agreed that DoG is the responsible officer as to the level of delegation given to the CEO's PA	Director of Governance / Support Officer (SHE)	31/10/2012	Completed.	31/10/2012
17/09/2012	Gifts & Hospitality	Governance	R4 Staff should ensure that all appropriate boxes are completed when checking / scanning the Gifts & Hospitality forms.	C	Agreed.	Director of Governance / Support Officer (SHE)	31/10/2012	Instruction given.	31/10/2012
17/09/2012	Gifts & Hospitality	Governance	R5 Thought should be given to further developing the Mayors engagements schedule to accommodate space	C	Agreed.	Director of Governance / Support Officer (SHE)	31/10/2012	Registration system set up.	31/10/2012

			for registering gifts received or submitting an e-mail on a weekly basis to Committee Clerks a daily listing on any gifts or hospitality received when attending functions. This could be filed with the weekly engagements schedule forming a Mayors Gifts & Hospitality register.						
03/04/2013 -	Bereave-ment Services	Local Environment	R1 An actions plan should be prepared detailing specific objectives, responsible owners and target timescales.	D	Noted.	Neighbourhood & Green Spaces Manager	16/04/2013	Noted.	16/04/2013
03/04/2013	Bereave-ment Services	Local Environment	R2 The manual cash receipting system (the Kalamazoo book) should be replaced with an electronic system - ICON the Corporate Cash Receipting system should be directly utilised by Bereavement Services.	B	Service migration and transfer of office will be completed by June 2013.	Neighbourhood & Green Spaces Manager	30/06/2013	Completed	15/07/2013
03/04/2013	Bereave-ment Services	Local Environment	R3 Invoices should be raised through the Council's corporate debtor system and the centralised debt recovery procedures should be applied.	B	Service migration and transfer of offices will be completed by June 2013.	Neighbourhood & Green Spaces Manager	30/06/2013	Completed	15/07/2013

03/04/2013	Bereave-ment Services	Local Environment	R4 The identification of outstanding debts and appropriate follow up action to be taken (including write off where relevant) should be through the Council's main debtors system.	B	Service migration and transfer of offices will be completed by June 2013.	Neighbourhood & Green Spaces Manager	30/06/2013	Completed	15/07/2013
03/04/2013	Bereave-ment Services	Local Environment	R5 Staff should be reminded of the need to test check a sample of the service charges on debtors invoice in particular when commencing a new financial year to verify fee/charge rate applied are in accordance with the latest fees/charges booklet.	B	The Bereavement Services team leader will instigate 'test checks' on a sample of Debtors invoices to ensure they are being charged at the up-to-date rate.	Neighbourhood & Green Spaces Manager	30/04/2013	Staff have been reminded that charges have changed and to check a sample of debtors invoices to ensure the up-to-date charges are being implemented.	15/07/2013
03/04/2013	Bereave-ment Services	Local Environment	R6 BACS should be reconciled to the Kalamazoo (or electronic record when recommendation R1 is implemented) to ensure its completeness and accuracy.	B	Service migration and transfer of offices will be completed by June 2013.	Neighbourhood & Green Spaces Manager	30/06/2013	Completed	15/07/2013

03/04/2013	Bereave-ment Services	Local Environment	R7 As part of the 2013/14 Cemeteries and Crematoriums budget setting process, budgets should be removed when not utilised and reviewed when there is evidence of being under-utilised in previous years. In addition budget holders should be reminded of the need to ensure that expenditure should not be incurred when no budget is available.	B	A continuous review of budgets is on-going involving the service manager and senior accountancy assistant to identify under-utilised budgets and use them to offset spending pressures elsewhere in Bereavement Services. Recu rring virements will be prepared as necessary. Officers will be reminded of the Financial Procedures which prohibit the use of codes where no budget is allocated.	Neighbourhood & Green Spaces Manager	30/04/2013	A process of reviewing and reallocating budgets is underway. Officers have been reminded that no expenditure should be incurred against zero budgets.	30/04/13
06/09/2012	CCTV	Local Environment	R1 Policies and procedures should be reviewed and up dated where necessary to ensure there is full coverage over the activities of the CCTV service and appropriate guidance for relevant officers. Policies and Procedures should: * Be electronic to aid review and update; * Record details of	B	Agreed.	Environmental Health Manager	31/12/2012	15/11/12: Code of Practice updated and ready to go on the shared drive. Operating Procedures finished. Policies to be circulated to staff with signing sheet	11/01/2013

			review and update to include date undertaken and by whom; * Be brought to the attention of relevant staff, who should sign and date that they have been read and understood and; * Be accessible to all relevant staff - either hard copy (CCTV Operators etc) or electronic (e.g. management or those with access to a pc).						
06/09/2012	CCTV	Local Environment	R2 A review of all records and documents relating to the CCTV service should be undertaken so that only those are retained that are in current use and required by statute.	B	Agreed.	Environmental Health Manager	31/12/2012	Material removed via confidential waste – this exercise is ongoing. 3 x operatives completed DPA training in Oct. All recent documents are DPA compliant.	11/01/2013
06/09/2012	CCTV	Local Environment	R3 A complete and accurate register of all CCTV cameras and their location details should be maintained.	B	Agreed.	Environmental Health Manager	31/10/2012	4/11/12: Accurate list available. Information also on consultation document.	04/01/2012
06/09/2012	CCTV	Local Environment	R4 Consideration should be given to whether there are better ways or arrangements, to deliver the recording and monitoring of the Brampton & Longtown camera images.	C	This will be very dependent on the savings identified to be achieved in the latest savings round.	Environmental Health Manager	29/10/2012	19/11/12 Executive Report and recommendations on general CCTV provision and savings. Consultation process to start from 28/11/12.	11/01/2013

06/09/2012	CCTV	Local Environment	R5 A review of performance monitoring requirements should be undertaken to establish what measures are important to the service in order to evidence decision making, aid continuous CCTV service improvement and ensure the effective deployment of human resources.	B	Agreed.	Environmental Health Manager	03/12/2012	Stats now recorded on types of incidents; how reported and whether they are day or evening shifts of the days monitored. Monthly report data available from September 12.	21/11/2012
17/09/2012	Early & Flexible Retirements /Redundancy	Resources	R1 The Organisational Development Manager should be notified by the HR Manager and/or HR Advisor, at the beginning of any re-organisation likely to involve redundancy to enable the OD Section to formulate training plans and, if possible, tailored support packages.	B	The Organisational Development Manager will be notified by the HR Manager and/or HR Advisor, at the beginning of any re-organisation likely to involve redundancy to enable the OD Section to formulate training plans and, if possible, tailored support packages.	Personnel Manager	31/10/2012	Details passed to OD as/when available	31/10/2012

17/09/2012	Early & Flexible Retirements /Redundancy	Chief Executive's Team	R2 Managers should receive formal training to provide them with skills in managing early retirements and redundancies in addition to the day to day informal ad-hoc working support provided by HR Advisors.	B	Skills based training courses on managing early retirements and redundancies will be included in the corporate training programme, E-learning modules will also be developed.	Organisational Development Manager	31/03/2013	Training course on managing redundancies was organised for November '13 but has been postponed due to low numbers - will now take place in January '14.	31/03/2013
17/09/2012	Early & Flexible Retirements /Redundancy	Resources	R3 Leaver files should retain the sequentially dated documentation, divided into sub-sections they had when they were "current" files.	D	EDMS will hold the information electronically in sub-divided format. Hard-copy filing process to be reviewed.	Support Services Team Leader	31/03/2013	Work on EDMS on-going; manual files reviewed but time/resources insufficient to do this for benefit that would be achieved.	31/03/2013

17/09/2012	Early & Flexible Retirements /Redundancy	Resources	R4 Details used to calculate estimates/final calculations to support information in communications with staff and payroll should show the following information: * the actual salary used; * the grade and salary point: *whether the salary is affected by a protection period; *date of calculation. *ascertainment of weekly rate.	B	Details used to calculate estimates/final calculations to support information in communications with staff and payroll will show the following information: · The actual salary used. · The grade and salary point. · Whether the salary is affected by a protection period. · Ascertainment of weekly rate. Date of calculation.	Personnel Manager	03/10/2012	Format to meet this is now included in supporting documentation.	03/10/2012
25/03/2013	Systems Administration	ICT	R1 - Monitoring compliance with legislative requirements for the FLARE system must be formally assigned to and undertaken by responsible officers.	B	Systems & Development Officer designated as the responsible officer and to support Service Managers in identifying legislation regarding their area within the Local Environment and the FLARE system and monitor	Systems & Development Manager	30/04/2012	Currently meeting regularly to monitor compliance with legislation.	30/04/2013

					accordingly. Systems & Development Officer to implement a system of monitoring compliance.				
25/03/2013	Systems Administra-tion	ICT	R4 - Management should ensure that as far as possible, system administrators have limited/no processing responsibilities within Academy.	B	Administration privileges are contained within ICT Connect and the Members of the Performance Team. Members of the Performance Team may amend a Council Tax or NNDR account or a Benefit Claim but that would be by exception rather than anything routine. The types of accounts/claim s they would amend are those with exceptional integrity problems that cannot be resolved without specialist knowledge and administrator	Shared Service Performance Manager - Revenues & Benefits	16/04/2013	Complete before final audit report issued.	16/04/2013

					access. These are very much the exception rather than of any volume and it is safer that administrators deal with these problems as they can affect financial balancing, subsidy and batch processes if not corrected and corrected appropriately/holistically.				
	Systems Administration	ICT	R6 - The LLPG/Acolaid Technical Officer should (a) Contact system suppliers (Idox) to identify the possibility of implementing a program to prompt users to change their passwords regularly and; to ensure that passwords require the system administrator to reset password access after numerous failed password attempts.	C	This has been noted and will be discussed at the next maintenance visit from Idox. This recommendation is suspected to be treated as a development item which could take some time.	LLPG/Acolaid Technical Officer	01/04/2014	Recommendations can be implemented and will be done on next maintenance visit scheduled for 06/06/13.	07/06/2013
25/03/2013	Systems Administration	ICT	R9 A 'New Users' form should be developed for each corporate system and e-mails and all other appropriate documentation should be retained for	B	Once the 'New Users' form is developed by Service Support a retention period should be established	Service Support	31/03/2013	Personnel & Payroll inform ICT of all starters and leavers and managers inform them which corporate system employees require. Response ICT - The existing new users form has	10/01/2014

			future reference if required.		by the Corporate Information Officer. Also, the use of e-forms should be investigated to make the process more efficient.			been updated and now contains details of specific applications that users require access to and contact details of the line manager who is authorising access. Leaver's forms are also being updated accordingly and procedures put in place to ensure that employees that are changing role are also managed. All future requests for new users, leavers and movers will only be accepted in the future electronically from the authorising line manager. At the moment all requests are retained - this is being reviewed with the Corporate Information Officer.	
25/03/2013	Systems Administra-tion	ICT	R11 - An email to all staff should be issued with a reminder regarding data protection and ~Code of Conduct responsibilities. This also may be pursued through the e-learning system.	C	Data protection workshops are currently taking place which all staff are enrolled on which are facilitated by the Corporate Information Officer.	Learning & Development Co-ordinator	01/04/2014	Data Protection - there is a rolling programme of data protection workshops being facilitated in-house. These are currently taking place, which all staff including new starters are enrolled	31/01/2013

04/09/2013	Carlisle & Currock Cycleway	Local Environment	R1 The Director of Local Environment should ensure that the funding arrangements and restrictions on moving the Carlisle & Currock Cycleway Project 2012 Revised Plan forward is reported to the CPB that the cycleway will not be completed within a defined period as it is dependent on funding becoming available.	C	Agreed.	Director of Local Environment	06/11/2013	Minutes of the Corporate Programme Board meeting of 23/10/13 state the project is closed. An alternative project for the use of the s106 funding will be developed (cycling and pedestrian related scheme).	23/10/2013
04/09/2013	Carlisle & Currock Cycleway	Local Environment	R2 Once funding is received, the Carlisle & Currock Cycleway Project 2012 Revised Plan should be updated to record the date it is received and the project timescales reported to the Project Sponsor and where appropriate to the Corporate Programme Board.	C	Agreed. The Project Plan will be updated each time any funding for the Project is received and the date of receipt will be noted. The Director of Local Environment, the Project Sponsor, will be advised of any such funding being received.	Highways Manager	06/11/2013	The project plan was updated on 26/11/13 to show latest progress and funding.	26/11/2013
04/09/2013	Carlisle & Currock Cycleway	Local Environment	R3 Cycleway adoption reports to the joint Carlisle City and County Council Highways & Transport Working Group to recommend adoption for maintenance purposes should be	C	Agreed. Any reports sent to the HTWG regarding adoption of the cycleway are retained centrally by the Executive Assistant and	Highways Manager	06/11/2013	Project plan updated to show latest adoption details. Section between Holme Head and Viaduct Estate was adopted on 09/09/13.	26/11/2013

			retained centrally. The Carlisle & Currock Cycleway Project 2012 Revised Plan should be updated to show the date of the adoption request to the joint Carlisle City and County Council Highways & Transport Working Group and the date the Local Committee approved adoption.		also by the County Council. At the meeting of the HTWG on the 12th August 2013 it was recommended that the remaining completed sections of Cycleway which have been constructed between Holmehead and Viaduct estate Road should be adopted, excluding the Railway Bridge over the Caldew. When adoption is approved the Project Plan will be updated. It is then likely to be some considerable time before other sections are ready for adoption.				

04/09/2013	Carlisle & Currock Cycleway	Local Environment	R4 The project management arrangements for cycleway projects should be reviewed and approved by the Corporate Programme Board in accordance with corporate project management arrangements.	B	Key control documents have been reviewed and are now in accordance with Corporate Programme Board requirements.	Policy & Communications Manager	06/11/2013	Key control documents have been reviewed and are now in accordance with Corporate Programme Board requirements.	30/04/2013
04/09/2013	Carlisle & Currock Cycleway	Local Environment	R5 A project issues and exceptions log should be completed for each project and the Project Management check sheet and standard forms should be updated to include these.	B	Action doc0.28 on Project Management pro-forma, to include Exception and Issues Log considerations. Create Exception Reports and Issue log pro-forma. Transfer elements to main monthly report.	Resource Planning Manager	06/11/2013	Amended doc to include Exception and Issue Log considerations. Created Exception Report and Issue Log pro-forma. Transfer elements as necessary to main monthly report.	05/08/2013
04/09/2013	Carlisle & Currock Cycleway	Local Environment	R6 A risk owner should also be identified and recorded against each risk on the risk assessment and the risk register should be updated throughout the projects life. Wider consideration of the risk detailing the uncertainty over the future 'ownership' of the cycle way and ongoing maintenance	C	Agreed. Amend Doc.026 on Project Management W drive pro-forma, to include Ownership and status. Update current Risk log to include new criteria. Regular reviews as necessary.	Resource Planning Manager	06/11/2013	Amended doc to include ownership and status. Updated current risk log to include new criteria. Regular reviews as necessary.	05/08/2013

			costs should also be detailed in all cycleway project risk registers						
04/09/2013	Carlisle & Currock Cycleway	Local Environment	R7 When no project board is appointed the delegated authority to the Project Sponsor and Project Manager should be clearly defined i.e. approving project plans, changes to project requirements and project timescales, costs etc.	B	Agreed. Corporate programme Board (CPB) has agreed a new Project Lifecycle which deals with this issue. The Directorate and the regular DMT meetings link in with the CPB.	Policy & Communications Manager	06/11/2013	Corporate Programme Board (CPB) has agreed a new project lifecycle which deals with this issue. The Directorate and the regular DMT meetings link in with the CPB. The Lifecycle included the monitoring of projects through the Directorates DMT's and CPB. This is particularly important when no project board is appointed.	31/07/2013
04/09/2013	Carlisle & Currock Cycleway	Local Environment	R8 Guidance should be provided to project managers to define what is considered “a major project issue” to be reported to the Corporate Programme Board i.e. changes to project plan, timescale and cost.	C	Agreed. Clear matrix for projects now in place. This links to the lifecycle and the level of control required by the CPB.	Policy & Communications Manager	30/11/2013	Clear matrices for projects now in place, this links to the lifecycle and the level of control required by the CPB. The scoring matrix is completed with advice from Programme Office. The Project Managers are reminded that guidance on a major issue is available on the Prince2 manual. The Project Manager is expected to begin the evaluation of the impact of the issue using the key criteria.	31/05/2013
21/10/2013	Performanc e Service Standards	Chief Executive’s Team	R2 Where performance service standards are amended, any amendments should be approved by the SMT.	C	Ongoing activity. First amendments made at SMT on 6th August 2013.	Policy & Communications Manager.	06/11/2013	First amendments made at SMT on 6th August 2013.	06/08/2013

06/06/2013	IT Service Desk	ICT	R3 - The quality of call log data could be improved if a more consistent approach was adopted by service desk staff when recording information.	C	Best practise within the service desk to be adopted by the whole of D & IS to ensure consistency in approach.	Lead ICT Officer	01/09/2013	All staff, including service desk officers, have been instructed to ensure that all call logging, actions and subsequent resolution contain comprehensive details relating to the call. An emphasis has been placed on ensuring that call details are completed fully to enable any officer to have a complete understanding of the situation or technical issue without having to investigate further. Best practise has been identified with the approach taken by one officer and this is now being shared with colleagues.	10/01/2014
06/06/2013	IT Service Desk	ICT	R4 Incidents or requests should only be closed following user approval.	B	Procedures and practise to be introduced to ensure that incidents are only closed after authorisation from the user. Details of this authorisation to be included within the incident record.	Lead ICT Officer	01/09/2013	All staff have been advised to include details of correspondence between the service desk and the user as part of the call close procedure. For example an email from a user is now added into the call notes as part of call closure. Where a telephone conversation has taken place this is also included in the notes. When closed, the system automatically sends the user a call closure notification. Once completed the call instigator is sent a user satisfaction survey with the results discussed at team meetings. Areas of best practice or improvements required are identified and appropriate actions implemented. D & IS management are to ensure	10/01/2014

								adherence going forward.	
06/06/2013	IT Service Desk	ICT	R6 The service should consider increasing the level of monitoring against achieved service levels and comparison against the agreed service level targets.	C	Formal reporting and performance monitoring to be introduced against agreed service level targets.	Lead ICT Officer	01/11/2013	The service desk software is configured to meet the service level requirements of Carlisle City Council. To ensure that this SLA is reviewed and maintained weekly key performance indicators have been introduced: • calls open • calls on hold • calls resolved by 1st & 2nd line support • calls resolved by 3rd line support • emails received and logged • number of calls logged by the intranet self service portal • calls in breach of SLA • total number of telephone calls • telephone calls unanswered • calls specific to the Revenues and Benefits shared service Meeting the Carlisle City Council SLA is treated as a high operational priority within D & IS and as such has now been added as a standing agenda item for the KPI's to be reviewed as part of the D & IS operational management meetings.	10/01/2014

06/06/2013	IT Service Desk	ICT	R7 There should be documentary evidence that performance reports are monitored and reviewed on a regular basis by IT management and that key performance indicators are regularly reports to senior managements.	C	Monitoring and performance to be reviewed quarterly by the D & IS's management team. Reports to be produced for the shared service operations board.	Lead ICT Officer	01/11/2013	The service desk performance figures are now a standing agenda item for discussion at team meetings and the D & IS operational management meeting.	10/01/2014
06/06/2013	IT Service Desk	ICT	R8 The service should consider introducing a formal lessons learned approach following major problems or incidents.	C	Major incidents to be recorded in a forma l lesson log. This is to be incorporated and with reference to business continuity and disaster recovery planning.	Lead ICT Officer	01/11/2013	Formal lessons learnt log has been introduced. This enables a “full picture” to be available for all major problems or incidents. These are aligned to service desk incident reference numbers. This will be periodically reviewed by the D & IS management team to ensure all actions / recommendations are implemented which will ensure D & IS adopts a proactive approach to reducing impact upon service.	10/01/2014

APPENDIX C

Grading of Audit Recommendations and Assurance Evaluations

(1) Audit Recommendations

Each audit recommendation arising from an audit review is allocated a grade in line with the perceived level of risk. The grading system is outlined below:

GRADE	LEVEL OF RISK
A	Lack of or failure to comply with a key control leading to a fundamental weakness and /or non-compliance to statutory requirements and/or unnecessary exposure of risk to the Authority as a whole (e.g. reputation, financial etc).
B	Lack of or failure to comply with a system control leading to a significant system weakness.
C	Lack of or failure to comply with any other control leading to system weakness.

Where audit recommendations are arising from an audit review, a Summary of Audit Recommendations is attached to the audit report in the form of an Action Plan. This Action Plan is required to be completed by the lead client officer and provide details of proposed action to be taken to address the recommendation, the timescales for implementation and name of the responsible officer.

Internal Audit follow up all audit recommendations 6 months after the issue of the final report, with the exception of the material system reviews which are followed up as part of the next annual audit. When it is considered that insufficient or no action taken has been taken to address audit recommendations and there is no good reason to support the lack of action, the matter is reported to the Audit Committee.

(2) Audit Assurance Evaluations

Audit assurance evaluations are applied to each review to assist Members and officers in an assessment of the overall level of control and potential impact of any identified weaknesses. Internal Audit's assessment of internal control forms part of the annual assessment of the system of control, which is now a statutory requirement. The assurance evaluation given to an audit area can be influenced by a number of factors including stability of systems, number of significant recommendations made and impact of not applying audit recommendations, non adherence to procedures etc. The levels of assurance are:

Level	Evaluation
Substantial	Very high level of assurance can be given on the system/s of control in operation, based on the audit findings.
Reasonable	Whilst there is a reasonable system of control in operation, there are weaknesses that may put the system objectives at risk.
Partial	Significant weakness/es have been identified in parts of the system of internal control which put the system objectives at risk.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and expose the system objectives to a high degree of risk.

APPENDIX D

CARLISLE CITY COUNCIL

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SHARED INTERNAL AUDIT SERVICE

FINAL INTERNAL AUDIT REPORT

FOR:
RESOURCES DIRECTORATE

ON:
Audit Follow Up
GRANTS AND EXTERNAL FUNDING

Draft Report Issued: 8 November 2013

Final Report Issued: 12 December 2013

Section 1 – Management Summary

1. REASON FOR THE AUDIT

1.1. The 2013/14 Audit Plan includes the follow up of the Grants and External Funding review undertaken during 2012/13. The final report was dated 26 November 2012 and presented to the Audit Committee on 11 January 2013.

2. BACKGROUND INFORMATION

2.1. The previous audit review assigned a 'restricted' level of assurance over the administration of Grants and External Funding. The reasons for this opinion were because:

- There were concerns that the central grant monitoring arrangements and the records maintained by Financial Services for 2011-12 and prior years were not as accurate and up to date as they should be. This was largely due to directorates not keeping Financial Services informed of external funding they have obtained;
- Arrangements were found to be in place for quality checking of Disabled Facility Grants but a lack of communication led to the late submission of the 2011/12 claim;
- Improvements were identified for actions to be taken to make the Financial Services External Funding Monitoring Sheets more robust. These included the timeliness and completeness of the external funding information form received from directorates and the overall accuracy and reliability of the information collated and reported upon;
- Improvements were identified for actions to be taken on the Strategic & Private Sector Housing Section's electronic monitoring of Disabled Facilities Grant's, due to the current system not following sound accounting practices, i.e. financial years not updated or stated incorrectly, incorrect formulae and a lack of cross-checks and referencing on column and line totals; and
- The need for a more joined-up approach between directorates to the needs of individuals applying for Disabled Facilities Grants to reduce the likelihood of duplicated payments to grant applicants and time invested by council employees.

2.2. Grant Thornton 'Grant certification work plan for Carlisle City Council' year ended 31 March 2013, dated July 2013 stated the most significant claims and returns in 2011/12 were the Housing & Council Tax Benefit claim and the National Non-Domestic Rates return. N.B there have been no single programme claims required to be certified since 2010/11.

3. SCOPE AND OBJECTIVES

3.1. The scope and objectives of this review is to perform a detailed follow up of the recommendations contained within the previous audit report in order to evaluate and report upon whether appropriate and timely actions have been taken by management to strengthen corporate governance, system controls and risk management arrangements within the Council's administration of Grants and External Funding.

3.2. Follow up audit testing, verification and discussions with management have been carried out to form an opinion over the following areas examined:

- Policies and Procedures;
- Financial Administration;
- Submission of Grant Claims;
- Retention of Information; and
- Supervision and Review.

4. RECOMMENDATIONS AND STATEMENT OF ASSURANCE

4.1. Recommendations arising from this audit review have been allocated a grade in line with the perceived level of risk. The grading system is outlined below:

GRADE	LEVEL OF RISK
A	Lack of, or failure to comply with, a key control leading to a *fundamental weakness as a result of non-compliance to statutory requirements and/or unnecessary exposure of risk to the Authority as a whole (e.g. reputation, financial etc).
B	Lack of, or failure to comply with, a key control leading to a significant system weakness.
C	Lack of, or failure to comply with, any other control, leading to system weakness.

4.2. Audit assurance levels are applied to each review to assist Members and Officers in an assessment of the overall level of control and potential impact of any identified weaknesses. The assurance levels are:

Level	Evaluation
Substantial	Very high level of assurance can be given on the system/s of control in operation, based on the audit findings.
Reasonable	Whilst there is a reasonable system of control in operation, there are weaknesses that may put the system objectives at risk.
Partial	Significant weakness/es have been identified in parts of the system of internal control which put the system objectives at risk.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and expose the system objectives to a high degree of risk.

5. EVALUATION AND RECOMMENDATIONS ARISING

5.1. From the areas discussed with management, examined and tested as part of this follow up of Grants and External Funding, we consider the current controls operating within provide **Substantial** assurance. The overall evaluation of the 13 recommendations noted 12 have been implemented and one was considered to be no longer relevant

6. KEY FINDINGS ARISING FROM THE AUDIT REVIEW

6.1. The Substantial assurance level given to an audit area can be influenced by a number of factors including the stability of systems, number of significant recommendations made, impact of not applying audit recommendations, non adherence to procedures etc.

6.2. *Areas of good practice noted:*

Finance

- Policies and procedures covering the area of grants and external funding are regularly reviewed and updated;
- The processes and procedures are closely monitored and continuously being improved by Finance in what is currently an ever changing environment;
- Grants and External Funding training is provided annually facilitated by the Financial Services, to aid awareness and compliance with the guidance notes. This is over and above the e-mailing to relevant officers to aid the awareness, location and access to the guidance notes raised within the previous audit review;

- Officers in Financial Services who are involved with the grants and external funding process are highly experienced and have been involved within the process for many years; and
- Records maintained within Financial Services are clearly summarised and cross referenced. They also reflect the financial information recorded within the main ledger.

Housing

- The Housing Team members involved within the Disabled Facilities Grants administration are highly experienced and knowledgeable;
- The team has taken action to implement the previous audit recommendations and has done so successfully; and
- The contact with the County Council 's Occupational Therapists has been strengthened with the re-introduction of weekly progress meetings and good communication has been seen with Financial Services to ensure completion, certification and submission of the DFG to the stated deadline.

6.3. It is concluded that sufficient progress has been made to implement the 12 previous audit recommendations. One of the recommendations was considered to be no longer relevant. A number of opportunities to further enhance the guidance notes, system and controls have been identified and discussed with relevant officers. These matters are detailed within the relevant sections of this report for consideration.

REPORT DISTRIBUTION

The audit report has been distributed to the following officers.

Recipient	Action Required
Director of Resources	Report to be noted.
Director of Economic Development	Report to be noted.
Financial Services Manager	Report to be noted.
Chief Accountant	Report to be noted.
Communities, Housing & Health Manager	Report to be noted.

Other recipients of the final report:

Chief Executive	Report to be noted.
Deputy Chief Executive	Report to be noted.
Audit Committee	To consider the Report/Executive Summary at its next meeting on 24 January 2014.

APPENDIX E

CARLISLE CITY COUNCIL

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SHARED INTERNAL AUDIT SERVICE

INTERNAL AUDIT REPORT

FOR:
GOVERNANCE DIRECTORATE

ON:
ELECTORAL REGISTRATION

Draft Report Issued: 18 December 2013

Final Report Issued: 9 January 2014

Section 1 – Management Summary

1. REASON FOR THE AUDIT

1.1. The audit of Electoral Registration was identified for review as part of the agreed Audit Plan for 2013/14.

2. BACKGROUND INFORMATION

2.1. Electoral Registration is a statutory service situated within the Governance Directorate and is maintained by the Electoral Services Officer and 2 Deputy Electoral Services Officers. This audit review is to concentration upon the most recent Cumbria County Council Elections process and administration.

3. SCOPE & OBJECTIVES

3.1. Audit testing and verification have been carried out to form an opinion over the effectiveness of systems and controls in place relating to the risks identified. The key objectives for review were to ensure that for the Cumbria County Council Elections:

- Procedures are in place and comply with the most recent legislation and staff are aware of these;
- All income due is identified, claimed promptly, receipted, accurately recorded and banked; and
- All payments made are correct and accurate, appropriately authorised and in accordance with legislation and Council's approved guidance.

3.2. Detailed findings are shown in Section 2 of this report - Matters Arising.

3.3. The scope and testing undertaken as part of this review reflects inherent risks specific to Electoral Registration and those which have been raised through the Council's corporate risk management arrangements.

3.4. This audit reviewed the day to day operation of undertaking the work undertaken by the Electoral Registration Section at the request of the Returning/Deputy Returning Officer. In particular the process and operation implemented for the May 2013 Cumbria County Council election was reviewed to provide assurance that the systems and process remain effective.

4. RECOMMENDATIONS AND STATEMENT OF ASSURANCE

4.1. Recommendations arising from this audit review have been allocated a grade in line with the perceived level of risk. The grading system is outlined below:

GRADE	LEVEL OF RISK
A	Lack of, or failure to comply with, a key control leading to a *fundamental weakness as a result of non-compliance to statutory requirements and/or unnecessary exposure of risk to the Authority as a whole (e.g. reputation, financial etc).
B	Lack of, or failure to comply with, a key control leading to a significant system weakness.
C	Lack of, or failure to comply with, any other control, leading to system weakness.

4.2. Audit assurance levels are applied to each review to assist Members and Officers in an assessment of the overall level of control and potential impact of any identified weaknesses. The assurance levels are:

Level	Evaluation
Substantial	Very high level of assurance can be given on the system/s of control in operation, based on the audit findings.
Reasonable	Whilst there is a reasonable system of control in operation, there are weaknesses that may put the system objectives at risk.
Partial	Significant weakness/es have been identified in parts of the system of internal control which put the system objectives at risk.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and expose the system objectives to a high degree of risk.

5. EVALUATION AND RECOMMENDATIONS ARISING

5.1. From the areas examined and tested as part of this audit review, we consider the current controls operating within Electoral Registration provide **substantial assurance**. There were no recommendations arising from this review.

6. KEY FINDINGS ARISING FROM THE AUDIT REVIEW

6.1. The substantial assurance level given to an audit area can be influenced by a number of factors including the stability of systems, number of significant recommendations made, impact of not applying audit recommendations, non adherence to procedures etc.

6.2. *Areas of good practice noted:*

- It is a well established function within Carlisle City Council;
- Whilst the Deputy Electoral Officers are relatively new members to the team the lead officer has extensive knowledge and experience over the administration of Electoral Registration;
- There are detailed procedures in place and staff are aware and have ready access to these;
- Agreement and direction was sought and received from the relevant County Council Officer's before the administration of the Election was commenced; and
- There is a good working relationship with the Financial Services Manager, Service Support Team Leader and Finance Assistant who are integral to the delivery of the Electoral Registration service for the Cumbria County Council Elections.

6.3. No key issues are arising from this review. However, there are to be major changes in the foreseeable future to the administration of Electoral Registration through 'Individual Electoral Registration' this is being planned for implementation alongside the current day to day operations and it was requested that this be reviewed by Internal Audit once implemented.

Appendix A

REPORT DISTRIBUTION

The audit report has been distributed to the following officers.

Recipient	Action Required
Governance, Electoral Services Officer	Report to be noted along with consideration of suggested (management discretionary) improvements.
Resources, Financial Services Manager	Report to be noted.
Director of Governance	Report to be noted.
Director of Resources	Report to be noted.

Other recipients of the final report:

Chief Executive Deputy Chief Executive	Report to be noted.
Audit Committee	To consider the Executive Summary at its next meeting on 24 January 2014.

APPENDIX F

CARLISLE CITY COUNCIL

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SHARED INTERNAL AUDIT SERVICE

INTERNAL AUDIT REPORT

FOR: POLICY AND COMMUNICATIONS
CHIEF EXECUTIVE'S TEAM

ON:
AUDIT OF PERFORMANCE SERVICE STANDARDS

Draft Report Issued: 27th August 2013

Final Report Issued: 21st October 2013

Section 1 – Management Summary

1. REASON FOR THE AUDIT

1.1. The audit of Performance Service Standards was identified for review as part of the agreed Audit Plan for 2013/14.

2. BACKGROUND INFORMATION

2.1. The abolishment of the National Indicator Set created a gap in the Council's performance reporting. Alongside the Council's Corporate Plan performance reporting it agreed a set of service standards based on the services that mattered most to the Council's key stakeholders ie. customers, employees and members. These standards are long term measures of the standard of the service and will enable continuous improvement through comparison with trends and benchmarking with similar authorities, especially during the year on year budget cuts.

2.2. The 6 service standards set for 2012-13 are detailed as follows:

- Percentage of household planning applications processed within eight weeks
- Missed waste or recycling collections
- Percentage of waste sent for recycling
- Overall satisfaction with council services
- Days to process new benefit claims
- Staff Satisfaction with "working at Carlisle City Council".

2.3. On an annual basis Carlisle City Council will continue to review these service standards adding/amending or removing were appropriate.

2.4. The Policy and Communications Manager, supported by a team of Policy and Performance, is responsible for assisting Directorates in setting, reporting and publicising the Council's 6 key service standards. On a monthly basis the service standards are reported to each directorate and publicised at the Council's main foyer and on its website. In addition on a quarterly basis the service standards are reported to each Overview and Scrutiny Panel.

3. SCOPE & OBJECTIVES

3.1. Audit testing and verification have been carried out to form an opinion over the effectiveness of systems and controls in place relating to the risks identified. The key objectives for review were to ensure that:

- the service standards have been approved and are aligned to the Council's Corporate Plan priorities and/or Service Plans;
- the service standards are calculated and documented in accordance with the agreed methodology/definitions; and
- the monitoring and reporting arrangements in place both internal and external to Carlisle City are adequate.

3.2. Detailed findings are shown in Section 2 of this report - Matters Arising.

3.3. The scope and testing undertaken as part of this review reflects inherent risks specific to Performance Service Standards and those which have been raised through the Council's corporate risk management arrangements. Where applicable, other emerging risks have also been included in the scope and testing undertaken.

4. RECOMMENDATIONS AND STATEMENT OF ASSURANCE

4.1. Recommendations arising from this audit review have been allocated a grade in line with the perceived level of risk. The grading system is outlined below:

GRADE	LEVEL OF RISK
A	Lack of, or failure to comply with, a key control leading to a *fundamental weakness as a result of non-compliance to statutory requirements and/or unnecessary exposure of risk to the Authority as a whole (e.g. reputation, financial etc).
B	Lack of, or failure to comply with, a key control leading to a significant system weakness.
C	Lack of, or failure to comply with, any other control, leading to system weakness.

4.2. Audit assurance levels are applied to each review to assist Members and Officers in an assessment of the overall level of control and potential impact of any identified weaknesses. The assurance levels are:

Level	Evaluation
Substantial	Very high level of assurance can be given on the system/s of control in operation, based on the audit findings.
Reasonable	Whilst there is a reasonable system of control in operation, there are weaknesses that may put the system objectives at risk.
Partial	Significant weakness/es have been identified in parts of the system of internal control which put the system objectives at risk.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and expose the system objectives to a high degree of risk.

5. EVALUATION AND RECOMMENDATIONS ARISING

5.1. From the areas examined and tested as part of this audit review, we consider the current controls operating within Performance Service Standards provide **reasonable** assurance.

Report Ref	Control Area	Evaluation	Recommendations		
			A	B	C
7.1	The service standards have been approved and are aligned to the Corporate Plan priorities and/or Service plans	Reasonable	0	1	1
7.2	The service standards are calculated and documented in accordance with the agreed methodology/definitions	Reasonable	0	1	1
7.3	The monitoring and reporting arrangements in place both internal and external to Carlisle City are adequate	Reasonable	0	1	1
Overall Evaluation / No. of Recommendations		**Reasonable**	**0**	**3**	**3**

6. KEY FINDINGS ARISING FROM THE AUDIT REVIEW

6.1. The **reasonable** assurance level given to an audit area can be influenced by a number of factors including the stability of systems, number of significant recommendations made, impact of not applying audit recommendations, non adherence to procedures etc.

6.2. *Areas of good practice noted:*

- a performance standard methodology was in place to implement the first 6 service standards
- technical notes were available for each service standard; and
- in majority of cases there is transparency between results shown on Covalent and those recorded at a departmental level.

6.3. A number of opportunities to further enhance controls have been identified; these matters are detailed in Section 2 – Matters Arising and summarised in the Action Plan which is attached as Appendix B.

6.4. The key issues arising from this review are:

- audit testing noted for 3 of the 6 service standards there is no relationship to service plans. However it is noted that there is the intention that the service standard *days to process new benefit claims* would be changing to relate to the existing service plan in place. For the other two *missed waste or recycling collections and percentage of waste sent for recycling* it is noted although the service plan is a work in progress these have continued to be reported at a departmental level as one was previously reported a performance indicator and the other a local indicator;
- the technical notes lack formality to their content and use, leading to a lack of departmental ownership and accountability for these and for the service standards calculated and reported etc.
- prior to reporting and publicising service standard results there is no formal sign off by the owners of these service standards that these are accurate and complete.
- there is a need to ensure the service standards reported and publicised have been independently checked to the relevant systems and supporting documents, are accurately reported in compliance with the Data Quality Policy and not altered thereafter.

Appendix A

REPORT DISTRIBUTION

The audit report has been distributed to the following officers.

Recipient	Action Required
Director of Resources, Resources	Report to be noted.
Policy and Communications Manager, Chief Executive's Team	Action required. Please refer to Appendix B - Summary of Recommendations / Action Plan.

Other recipients of the final report:

Chief Executive Deputy Chief Executive	Report to be noted.
Audit Committee	To consider the Summary of Recommendations / Action Plan (Appendix B) at its next meeting on 24th January 2014.

CHIEF EXECUTIVE'S TEAM

Audit of Performance Service Standards (2013/14)

SUMMARY OF RECOMMENDATIONS & ACTION PLAN

REF	ISSUE RAISED	RECOMMENDATION	RISK IF NOT ACTIONED	GRADE	AGREED ACTION	RESPONSIBLE OFFICER	DATE TO BE FULLY ACTIONED BY
R1	The Performance Service Standard methodology states that the "*service standards for ...work areas ....must relate to service plans.*" Internal Audit testing of a sample of 3 service standards; *days to process new benefit claims, missed waste or recycling collections and percentage of waste sent for recycling*; noted that the "*days to process new benefit claims*" service standard does not relate to the existing Shared Service Plan for Revenue & Benefits which measures "*average time (days) for processing new claims*". For the other two service standards *"missed waste or recycling collections" and "percentage of waste sent for recycling"* service plans are not yet formulated,	In accordance with the Performance Service Standard methodology service standards should relate to existing or new service plans.	Lack of accountability and monitoring over the standard of the service provided. Non-compliance with service standard methodology.	B	A new template and approach to service planning will be rolled-out for 2014/15. This template will list the service standards for all customer-facing services.	Chief Executive / Deputy Chief Executive	April 2014
R2	Internal Audit noted that since, the 5th July when the SMT formally approved the 6 published service standards. amendments have been made	Where performance service standards are amended, any amendments should be approved by the SMT.	Lack of accountability when unauthorised amendments are made.	C	Ongoing activity. First amendment made at SMT on 6 August 2013	Policy and Performance Officer	6 August 2013

	to the service standards in particular to the *days to process new benefit claims* and there is insufficient evidence that these amendments have been approved.						
R3	Internal Audit's testing of the service standard's technical notes, noted that there is no **evidence:** • of a formal approval process in place where the managers' assigned responsibility to manage the service standards have approved the details of the technical notes; • that there is a standard format or defined criteria to the content of the technical notes; • that potential risks have been identified and documented should there be difficulties with the availability of systems and the dependency on others to obtain complete and timely information/data to calculate and report the service standards; • documented showing the period and frequency of reporting ie monthly, year-to-date; and • how often these service standards and notes will be reviewed.	The technical notes should be reviewed and updated:: • to include the service standard's purpose/ objective, method of collating data, formula guidance, how to measure, source of data etc • content should be in a standard format; • any potential risks should there be difficulties with the availability of systems and the dependency on others to obtain complete and timely information/data to calculate and report the service standards; • document the period and frequency of reporting ie monthly, year-to-date; • to define a unit of measurement more meaningful to the objective of the service standard; and • to detail how often the service standard and technical notes will be reviewed.	Non-compliance as a result of lack of understanding and awareness of expectations. Lack of consistency and accuracy Objective not achieved when there is a lack of clarity over risks that may occur. Lack of ownership accountability	B	New technical notes are being written **these will include:** • to include the service standard's purpose/ objective, method of collating data, formula guidance, how to measure, source of data etc • any potential risks should there be difficulties with the availability of systems and the dependency on others to obtain complete and timely information/ data to calculate and report the service standards; • document the period and frequency of reporting ie monthly, year-to-date; • to define a unit of measurement more	Policy and Performance Officer	30 November 2013

	Internal Audit noted that the methodology states that "*....percentages are the favoured"* unit measurement for all service standards. In Internal Audit's opinion in using percentages for all service standards may not be meaningful to the objective of certain service standard in particular missed waste or recycling collections reported as 0.02 or 0.03%. In addition when using percentages readers may make the assumption it is the intention to achieve a 100% which not always be achievable	The technical note should be approved by the department manager assigned responsible for it. The "assignee" responsible for collating the source data should input the service standard results on Covalent.			meaningful to the objective of the service standard; and • to detail how often the service standard and technical notes will be reviewed. These notes will be signed off by Service Manager and Director.		
R4	There is no evidence the individual named as responsible for managing each service standards independently checks the monthly results on Covalent prior to being reported to the Policy Team. Internal Audit noted the lack of independent checks prior to inputting data to Covalent had been previously highlighted in Internal Audit's Review of Data Quality. Internal Audit testing noted instances where the data on Covalent does not agree to department's supporting documentation.	The service standard data on Covalent should be independently validated prior to reporting to the Policy Team and evidence should be documented.	Inaccurate and/or inconsistent data reported. Non compliance with Data Quality Policy.	C	Guidance on Data Quality will be given to 'assignees' and officer providing validation. Validation will be recorded prior to submission.	Policy and Performance Officer	30 November 2013
R5	Internal Audit testing noted that although there is email evidence of Directors' commenting on the service standards to be reported and	Performance Service Standard results should be formally signed off by a responsible manager or Director prior to reporting and publicising.	Lack of responsibility and accountability	C	Process map will be updated to reflect the email 'signing off'.	Policy and Performance Officer	31 October 2013

	published there is no evidence of formal sign off of the monthly results prior to reporting and publicising.						
R6	Internal Audit testing of a sample of 3 service standards; processing new benefit claims, the percentage of waste sent for recycling, the missed waste or recycling collections; published on the poster at reception and the Council's website for November 2012 and February 2013 noted that: • for process new benefit claims the October 2012 results published in November 2012 did initially agreed to that months results shown on Covalent however since that date the results had been updated and now don't agree; • the percentage of waste sent for recycling the September 2012 results published in November 2012, 47.6% do not agreed to that months result of 48%, shown on Covalent however agree to the department's supporting documents for that month 47.63%. The November results published in February 2013, 42% do not agree to that month's results of 41.35% shown on Covalent and on the department's supporting documents. Internal Audit testing of a	There is a need to ensure that prior to and after reporting and publicising the service standard data and the supporting data shown on Covalent is not altered. In compliance with the Data Quality Policy there is a need to independently check the service standard results reported to Directorates, SMT, O&S and published on posters and the Council's website matches the data on Covalent and the department's supporting documentation attached to Covalent.	Inconsistency and lack of audit trail of results reported. Non-compliance with Data Quality Policy.	B	We will internally validate the data based on the information available. We will then request an annual audit of some or all of the data.	Policy and Comms Manager	April 2014

	sample of 3 service standards; processing new benefit claims, percentage of waste sent for recycling, the missed waste or recycling collections; on Directors' monthly reports for November 2012 and February 2013 noted: • for process new benefit claims the year to-date "YTD" results, 68.4%, for October 2013 reported in November 2012 and January 2013, 63.9% reported in February 2013 do not agree to the results of 59.27%, 53.82% calculated from the department's supporting documents; • for the percentage of waste sent for recycling the YTD results for September 2012, 49.4%, reported in November 2012 and November 2012, 49%, reported in February 2013 do not agree to the YTD results of 49.68% and 47.98% calculated from the department's supporting documents; and • for missed waste or recycling collections the YTD results for October 2012, 0.03%, reported in November 2012 do not agree to the YTD results, 0.02% calculated from the department's supporting documents. The YTD results for January 2013, 0.03%, reported in						

	February do not agree to the YTD results of 0.02% calculated from the department's supporting documents. Internal Audit testing of the 3rd Quarterly report of 2012/13 (December 2012/January results) for 3 service standards; processing new benefit claims, percentage of waste sent for recycling and missed waste or recycling collections noted that: • processing new benefit claims the YTD results of 63.9% did not agree to the results shown on Covalent; and • for missed waste or recycling collections the YTD results, 0.03%, did not agree to the YTD results of 0.02% reported on Covalent.						

APPENDIX G

CARLISLE CITY COUNCIL

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SHARED INTERNAL AUDIT SERVICE

INTERNAL AUDIT REPORT

For:
RESOURCES

On:
REVENUES RECOVERY

Draft Report Issued: 25th November 2013
Revised Draft Issued: 17th December 2013

Final Report Issued: 3rd January 2014

Section 1 – Management Summary

1. REASON FOR THE AUDIT

1.1. The audit of Revenues Recovery was identified for review as part of the agreed Audit Plan for 2013/14.

2. BACKGROUND INFORMATION

2.1. Carlisle City Council, Allerdale District Council and Copeland Borough Council have operated a Revenues and Benefits Shared Service since October 2010. Carlisle City Council is the 'host' authority of the shared service, the management of which now comes under the remit of the Resources Directorate.

2.2. Within Revenues and Benefits there are several types of debt for recovery; the main being Housing and Council Tax Benefit overpayments, Council Tax and NNDR. The recovery procedures for these three key service areas are not yet fully aligned across the shared service.

2.3. This audit concentrates in detail on the recovery of Housing and Council Tax Benefit overpayments and Council Tax and concerns the recovery arrangements in place at Carlisle City Council.

2.4. The Carlisle Recovery Team consists of the Senior Recovery Officer and 3 Recovery Officers and reports to the Revenues Manager. The Housing Benefit Overpayment Team consists of the Senior Overpayments Officer and 3 Overpayment Officers (2 temporary until 2014). This team reports to the Benefits Manager.

3. SCOPE & OBJECTIVES

3.1. Audit testing and verification have been carried out to form an opinion over the effectiveness of systems and controls in place relating to the risks identified. The key objectives for review were to ensure that:

- All established recovery procedures are documented, maintained and compliant with legislation.
- Arrangements are in place for determining the way in which debts are targeted and identified as requiring specific recovery action.
- Recovery action ensures that recovery is correctly calculated and enforced in line with agreed procedures.
- There is regular monitoring of debts undertaken by the Revenues and Benefits Shared Service which provides senior management with relevant and timely details of the scale of debts and recovery performance achieved.

3.2. Detailed findings are shown in Section 2 of this report - Matters Arising.

3.3. The scope and testing undertaken as part of this review reflects inherent risks specific to Revenues Recovery and those which have been raised through the Council's corporate risk management arrangements. Where applicable, other emerging risks have also been included in the scope and testing undertaken.

4. RECOMMENDATIONS AND STATEMENT OF ASSURANCE

4.1. Recommendations arising from this audit review have been allocated a grade in line with the perceived level of risk. The grading system is outlined below:

GRADE	LEVEL OF RISK
A	Lack of, or failure to comply with, a key control leading to a *fundamental weakness as a result of non-compliance to statutory requirements and/or unnecessary exposure of risk to the Authority as a whole (e.g. reputation, financial etc).
B	Lack of, or failure to comply with, a key control leading to a significant system weakness.
C	Lack of, or failure to comply with, any other control, leading to system weakness.

4.2. Audit assurance levels are applied to each review to assist Members and Officers in an assessment of the overall level of control and potential impact of any identified weaknesses. The assurance levels are:

Level	Evaluation
Substantial	Very high level of assurance can be given on the system/s of control in operation, based on the audit findings.
Reasonable	Whilst there is a reasonable system of control in operation, there are weaknesses that may put the system objectives at risk.
Partial	Significant weakness/es have been identified in parts of the system of internal control which put the system objectives at risk.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and expose the system objectives to a high degree of risk.

5. EVALUATION AND RECOMMENDATIONS ARISING

5.1. From the areas examined and tested as part of this audit review, we consider the current controls operating within Revenues and Housing Benefit Overpayment Recovery provide *REASONABLE* assurance.

Report Ref	Control Area	Evaluation	Recommendations		
			A	B	C
7.1	Established Procedures – Compliance to legislation	Reasonable	0	1	0
7.2	Operational Processes	Reasonable	0	1	1
7.3	Compliance to Procedures	Reasonable	0	1	2
7.4	Performance Monitoring	Substantial	0	0	0
Overall Evaluation / No. of Recommendations		**REASONABLE**	**0**	**3**	**3**

6. KEY FINDINGS ARISING FROM THE AUDIT REVIEW

6.1. The **Reasonable** assurance level given to an audit area can be influenced by a number of factors including the stability of systems, number of significant recommendations made, impact of not applying audit recommendations, non adherence to procedures etc.

6.2. *Areas of good practice noted:*

- Excellent in-team knowledge.
- Local awareness which assists in effective recovery.
- On-going efforts to align processes.
- Effective monitoring arrangements.

6.3. A number of opportunities to further enhance controls have been identified; these matters are detailed in Section 2 – Matters Arising and summarised in the Action Plan which is attached as Appendix B.

6.4. The key issues arising from this review are:

- Established Procedures.

  .

  Council Tax Revenue Recovery documented procedures are out of date. This is currently a work in progress with no specific deadline for completion. Management aim to ensure that once recovery procedures have been aligned throughout the shared service, then the updating of the documented procedures will then take priority.

- System Processes.

  Management regularly review to identify where and how procedures can be adjusted to improve efficiency. Where processes are amended, management must ensure that all system documentation is updated accordingly.

- Data Protection

  Staff in the Revenues and Benefits Shared Service should all undertake the updated Data Protection Training that is currently available either in course or e-learning format. The importance of keeping all Carlisle City Council staff updated on the developments with Data Protection legislation should be extended throughout the whole organisation.

- Compliance to Procedures.

  Alignment of the bailiff recovery processes between the 3 districts within the shared service should be addressed with a revised SLA incorporating the requirements of the forthcoming laws regarding bailiffs that are to be introduced in 2014.

- Performance Monitoring.

  There are adequate monitoring procedures in place for both Council Tax and Housing Benefit Overpayment Recovery.

Appendix A

REPORT DISTRIBUTION

The audit report has been distributed to the following officers.

Recipient	Action Required
Director of Resources.	Report to be noted.
Shared Services Partnership Manager (Revenues and Benefits) Resources Directorate.	Action required. Please refer to Appendix B - Summary of Recommendations / Action Plan
Benefits Manager Resources Directorate.	Action required. Please refer to Appendix B - Summary of Recommendations / Action Plan
Revenues Manager Resources Directorate.	Action required. Please refer to Appendix B - Summary of Recommendations / Action Plan
Performance Manager Resources Directorate.	Action required. Please refer to Appendix B - Summary of Recommendations / Action Plan

Other recipients of the final report:

Chief Executive Deputy Chief Executive	Report to be noted.
Audit Committee	To consider the Summary of Recommendations / Action Plan (Appendix B) at its next meeting on 24th January 2014.

RESOURCES DIRECTORATE

Audit of Revenues Recovery (2013/14)

SUMMARY OF RECOMMENDATIONS & ACTION PLAN

REF	ISSUE RAISED	RECOMMENDATION	RISK IF NOT ACTIONED	GRADE	AGREED ACTION	RESPONSIBLE OFFICER	DATE TO BE FULLY ACTIONED BY
R1	Revenues Recovery Processes within the Shared Service are not aligned.	Management should set a realistic timescale to complete and agree the Recovery alignment processes across the shared service so that the approach to recovery is consistent across the districts and maximise the potential for recovery. Once this process is complete, a unified procedure manual should be developed and circulated throughout the relevant staff in the shared service.	Recovery methods are not consistent throughout the shared service leading to confusion in effective recovery, staff training etc.	B	Agreed	Revenues Manager.	31st March 2014
R2	The HBOP Procedure manual does not accurately reflect the current recovery process.	The HBOP Procedure Manual requires updating to show that there is now only 14 days between invoice and first reminder stage. If it is also decided after the trial period that the additional letter also be adopted as common practice then this procedure must also be incorporated into the manual.	Outlined procedures are outdated.	C	Agreed	Benefits Manager.	31st March 2014
R3	Staff would benefit from updated in house Data Protection Training to	It would be beneficial for *all* Revenues and HBOP Recovery staff to undertake the most recent Data Protection Training	Data Protection knowledge is not current. Opportunities	B	Agreed	Shared Services Partnership	30th June 2014

	comply with best practice recommendations from the regulator, the Information Commissioners Office.	to ensure that they are fully conversant with Data Protection requirements. The importance of relevant current Data Protection knowledge should be emphasised authority-wide.	to access in house training are missed.			Manager.	
R4	Current procedure notes do not reflect the importance for new and inexperienced staff to have any payments arrangements authorised by a Team Leader during training.	The shared service composite procedural notes for revenues recovery should be updated to include the provision that all trainee / new recovery staff must consult a line manager prior to making any payment arrangement	Higher potential for ineffective / inappropriate payment arrangements.	C	Agreed	Revenues Manager.	30th June 2014
R5	The Service Level Agreement with Rossendale's Bailiff Services requires updating.	Alignment of the bailiff recovery processes between the 3 districts within the shared service should be made a priority. A revised SLA should be agreed on the back of this incorporating the requirements of the forthcoming laws regarding bailiffs that are to be introduced in 2014.	Recovery is not effective. Bailiff action does not operate in line with revised legislation.	B	Regulations are due to come into force on the 6th of April 2014 and the likely working practices which will be required are still under development.	Revenues Manager	31st May 2014
R6	The HBOP overpayment letters to the claimant on occasion do not sufficiently reflect the reason for the overpayment.	Management should remind Officers of the importance of ensuring that overpayment notifications with the classification 'other' should be manually adjusted to reflect the reason for the overpayment.	Claimants are issued with an overpayment notification letter that does not explain the reason for the overpayment which if uninformative and may hinder the right to appeal.	C	Agreed	Benefits Manager.	30th Jan 2014.

APPENDIX H

CARLISLE CITY COUNCIL

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SHARED INTERNAL AUDIT SERVICE

FINAL INTERNAL AUDIT REPORT

For:

Chief Executive's Team

On:

Follow Up of Records Management

Draft Report Issued: 15th October 2013

Final Report Issued: 9th January 2014

Section 1 – Management Summary

1. REASON FOR THE AUDIT

1.1. The Audit of Records Management was originally reported in September 2012. This review awarded a restricted assurance level and identified 3 high level recommendations. In line with the agreed arrangements for following up previous recommendations which relate to significant findings, this area was identified for a follow up review as part of the Audit Plan for 2013/14.

2. BACKGROUND INFORMATION

2.1. The previous restricted assurance level reflects the significance of the key findings arising from the initial review which highlighted concerns regarding the lack of systems, policies and procedures being in place over the administration of records management within the Council.

3. SCOPE AND OBJECTIVES

3.1. The objective of this review is to perform a detailed follow up of the 3 recommendations contained within the previous audit report in order to evaluate and report upon whether appropriate and timely actions have been taken by management to strengthen corporate governance, system controls and risk management arrangements within the Council's administration of Records Management.

3.2. Follow up audit testing, verification and discussions with management have been carried out to form an opinion over the following areas covered by the previous audit recommendations:

- Best practice framework;
- Records management policy; and
- Designated responsibility.

4. RECOMMENDATIONS AND STATEMENT OF ASSURANCE

4.1. Recommendations arising from this audit review have been allocated a grade in line with the perceived level of risk. The grading system is outlined below:

GRADE	LEVEL OF RISK
A	Lack of, or failure to comply with, a key control leading to a *fundamental weakness as a result of non-compliance to statutory requirements and/or unnecessary exposure of risk to the Authority as a whole (e.g. reputation, financial etc).
B	Lack of, or failure to comply with, a key control leading to a significant system weakness.
C	Lack of, or failure to comply with, any other control, leading to system weakness.

4.2. Audit assurance levels are applied to each review to assist Members and Officers in an assessment of the overall level of control and potential impact of any identified weaknesses. The assurance levels are:

Level	Evaluation
Substantial	Very high level of assurance can be given on the system/s of control in operation, based on the audit findings.
Reasonable	Whilst there is a reasonable system of control in operation, there are weaknesses that may put the system objectives at risk.
Partial	Significant weakness/es have been identified in parts of the system of internal control which put the system objectives at risk.

Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and expose the system objectives to a high degree of risk.

5. EVALUATION AND RECOMMENDATIONS ARISING

5.1. From the areas examined and tested as part of this follow up of Records Management, we consider the current controls operating within provide **Partial** assurance.

Control Area	Evaluation	Recommendations		
		A	B	C
Best practice framework	Partial	1	3	-
Records management policy	Partial	-	1	-
Designated responsibility	Reasonable	-	1	-
Overall Evaluation / No. of Recommendations	**Partial**	**1**	**5**	**-**

6. KEY FINDINGS ARISING FROM THE AUDIT REVIEW

6.1. The Partial assurance level given to an audit area can be influenced by a number of factors including the stability of systems, number of significant recommendations made, impact of not applying audit recommendations, non adherence to procedures etc.

6.2. *Areas of good practice noted:*

- Recognition, by those charged with corporate governance, of the need to address the lack of system and controls operating with regards to records management within the Council; and,
- There is a designated officer post - the Policy & Communications Manager - to progress the implementation of a formal system of records management throughout the Council with the necessary assistance (SMT, Directors and Service Managers).

6.3. Appendix B lists the 3 previous audit recommendations made and the actions that were agreed to be taken, in order to evaluate overall progress to date of the implementation of the recommendations.

6.4. It is concluded that there has been a lack of progress made to implement the 3 previous audit recommendations with a significant time delay in commencing the actions required. The recommendations arising from this review (either new or restated/modified) are contained within the Summary of Recommendations / Action Plan attached as Appendix B.

6.5. The key areas for further address can be summarised as follows:

6.5.1. The Council is to adopt a recognised corporate standard for its records management arrangements, but there is still much work to do to develop a suitable framework which reflects relevant legislation, recommended practice and which supports the management of potential risks in this area.

6.5.2. A Records Management Policy still needs to be prepared which sets the Authority's aim and standards to be achieved, along with supporting guidance notes for staff. With no formalised records management system documented and implemented, staff will not have a 'corporate' awareness of requirements, no reference point and no specific/tailored training. The intention is that there will be widespread awareness raising and targeted training but these arrangements are still to be implemented.

6.5.3. Some progress has been made to implement the use of retention schedules within some service areas and this does alleviate a degree of risk that the Council would otherwise face. However, it is difficult to evaluate the effectiveness of these retention schedules when there is no set direction in terms of a framework, procedures and guidance. The use and roll out of retention schedules will be a core element of the improvement work to be undertaken.

REPORT DISTRIBUTION

The audit report has been distributed to the following officers.

Recipient	Action Required
Policy and Communications Manager (Chief Executive's Team)	Action required. Please refer to Appendix B - Summary of Recommendations / Action Plan.
Policy and Performance Officer (Chief Executive's Team)	Report to be noted.

Other recipients of the final report:

Chief Executive Deputy Chief Executive	Report to be noted.
Director of Governance	Report to be noted.
Director of Resources	Report to be noted.
Audit Committee	To consider the Summary of Recommendations / Action Plan (Appendix C) at its next meeting on 24 January 2014.

CHIEF EXECUTIVE'S TEAM

Follow Up Audit of Records Management

SUMMARY OF RECOMMENDATIONS & ACTION PLAN

REF	ISSUE RAISED	RECOMMENDATION	GRADE	AGREED ACTION	RESPONSIBLE OFFICER	DATE ACTIONED BY
R1	Exposure to unnecessary risk of non compliance to statutory requirements. There is no established Records Management Policy.	The Code of Practice FOI Section 46 should be adopted by the Council in line with recommended practice. Resources should be concentrated on establishing an Authority-wide Records Management Policy. This policy should comply with the requirements of relevant legislation and also embrace recommended practice.	A	The following policy statement has been agreed by SMT: *The corporate standard for records management is Code of Practice FOI Section 46 or equivalent standard (ISO 15489-1:2001(E).* *It is the responsibility of every Service Manager to manage a Retention Schedule for their service area based on the corporate template.* *A well managed Retention Schedule is evidence for the Management Competency Framework, specifically 'Delivering the Service'.* A draft Records Management Policy will be ready for consultation in January. The implementation of this policy is dependent upon available resources within each Directorate. The draft Project Plan will help to identify when and where these resources will be needed. Monitoring of the implementation will	Policy & Communications Manager, Corporate Information Officer Policy & Communications Manager Policy & Communications Manager	Statement completed – Completion date November 2013 Draft policy January 2014 Final Policy target date - March 2014

				take place through the Directorate Management Teams.		
R2	There is no project group set up to implement the corporate records management system. It is difficult to evaluate the retention schedules when there is no set direction in terms of a framework, procedures and guidance. These are requirements that are set out within the code of practice FOI Section 46. Lack of sufficient trail of actions. There is no risk management of the project group to meet its aims and objectives.	A project group should be set up to ensure there is a defined and systematic approach to the implementation of a proper records management system within the Council. The project group should give consideration to the following improvements regarding the retention schedules to provide a full trail, including: - Details of preparer and date prepared; and, - Details of reviewer and date reviewed The project group should give appropriate regard to related risk exposure as part of its remit and within the set up arrangements and administration of the records data management system implementation of the records management process.	B	A Records Management Project has been scored and a business case will be brought to the Corporate Programme Board on 9th January 2014. Following on from the above a Project Board/Lead will be appointed. The project brief will include the recommendation requirement to include full audit trail relating to the retention schedules as recommended. The risks associated with the new Records Management Project will be captured and managed within the Project Risk Register.	Policy & Communications Manager Policy & Communications Manager	9th January 2014 February 2014
R3	Lack of structure to operational requirements for all officer's expected to be involved within the system and ensuring that the officer's hold	- Guidance notes and procedures detailing responsibilities, requirements and expectations should be prepared, accessible and communicated to	B	The Corporate Information Officer and Policy & Communications Manager have completed a 'Records Management' 1 day training course. This will be utilised in preparing the guidance notes and procedures and communicated through the Project Team. This will be included	Policy & Communications Manager, Corporate Information Officer	February 2014

	the relevant awareness to efficiently and effectively perform their responsibilities within the system as intended.	relevant officers; and - Provision of training, assistance and advice in records management should be available to officers who have responsibilities in operational administration within this area.		in the project plan deliverables. Training and ongoing professional development will be dealt with in the draft Project Plan. Advice is available on request, the first batch of retention schedules have been developed under the guidance of the Corporate Information Officer. This will be included in the project plan deliverables.	Policy & Communications Manager, Corporate Information Officer	February 2014
R4	Lack of overall guidance contained within the Council's Constitution.	The Constitution should provide clearer direction on the Council's arrangements in place for the retention of records.	B	Coverage on the retention of records within the Constitution (Appendix F - Financial Procedure Rules) will be revisited. General reference to the corporate arrangements for retention of records will remain within the Constitution. Specific guidance on record types and the statutory/recommended retention periods will now be maintained elsewhere, as it is at this level where the project team will establish the detailed guidance required in order to meet the requirements of the Records Management Policy.	Financial Services Manager Director of Governance	March 2014
R5	Knowledge of documents retained and when they have been disposed of assists with ensuring speedy access to meet Data Protection Act and Freedom of Information requirements when necessary.	A log should be kept to show when information has been destroyed.	B	A 'Disposal Log' will be developed as part of the suite of templates.	Corporate Information Officer	January 2014

R6	There should be overall ownership of the system to be implemented regarding the stewardship role of [corporate] records management.	Proper arrangements for the current or recent records of a local authority should involve the skilled supervision of their management by an appropriately trained member of staff who should be referred to (by post) within the Records Management Policy and within the associated job description.	B	The critical roles of: Senior Information Risk Owner (SIRO) and Information Asset Owners (IAO's) Corporate Information Officer will be clarified within the Records Management Policy. These roles will have overall ownership for managing information risk.	Policy & Communications Manager	January 2014