Internal Audit Annual Report

Brent Council

2022-23

1. Introduction

1.1 This report outlines the work undertaken by Internal Audit in respect of delivery of the 2022-23 Internal Audit Plan.

1.2 The report is intended to support the Council's Management Team and the Audit and Standards Advisory Committee in obtaining assurance that the Council has a sound framework of governance, risk management and internal control. It does this by summarising delivery of the Internal Audit plan, updating on the performance of the function, highlighting areas where high priority recommendations have been made and commenting on the level of implementation of audit recommendations by management.

2. Internal Audit Independence and Objectivity

2.1 The Public Sector Internal Audit Standards (PSIAS) requires that the internal audit function must be independent and internal auditors must be objective in performing their work. To this end, the Chief Audit Executive (Head of Internal Audit) must confirm, at least annually, that the organisational independence of the internal audit function has been preserved.

2.2 The Head of Internal Audit is therefore pleased to report that there have been no actual or perceived threats to the independence and objectivity of the Internal Audit function in relation to the work carried out to deliver the 2022-23 internal audit plan. The Head of Internal Audit and all internal auditors have continued to receive unfettered access to senior management, officers and all information/records necessary to undertake our work. The internal audit function also received an External Quality Assessment (EQA) during 2022-23, which identified no concerns regarding the independence or objectivity of the function.

2.3 The PSIAS also requires that the Head of Internal Audit must report to a level within the organisation that allows the internal audit function to fulfil its responsibilities. The Head of Internal Audit now reports directly into the Corporate Director Finance and Resources (S151), following a Council-wide senior management reorganisation in Summer 2022. In line with usual practice, the Head of Internal Audit also continued to have direct access to the Chief Executive and the Chair and Vice-Chair of Audit and Standards Advisory Committee.

3. Delivery of the 2022-23 Plan

3.1 A risk-based Annual Internal Audit Plan for 2022-23 was approved by the Council's Management Team and Audit and Standards Advisory Committee in March 2022. The plan originally included a total of 35 audits, excluding follow-up reviews, school audits and advisory work. In addition, 14 audits were carried forward from 2021-22.

3.2 As in previous years, the plan remained fluid and was adjusted in-year, in consultation with senior management and auditees, to ensure that the plan continued to provide assurance against high risk areas and to respond to any

new or emerging risks/issues. To this end, nine audits were cancelled/deferred and an additional three audits were added to the plan.

3.3 A summary of the performance against the 2022-23 Internal Audit Plan is shown in the below table. A more detailed summary of the status and outcome of each audit review can be seen at ***appendix A.***

Summary of Internal Audit Activity *(as at 30 April 2023)*	**Number**	**%**
❖ Audits included in the 2022-23 plan	35	
❖ Audits carried forward from 2021-22	14	
❖ (Audits cancelled/deferred)	(9)	
❖ Additional audits added to the plan	3	
❖ Total planned engagements for 2022-23	**43**	
- Completed	33	77%
- Draft report stage	3	7%
- Fieldwork completed	1	2%
- In progress	6	14%

3.4 **The following six audits remain in progress**, and it is anticipated that these will be completed by end Q1 2023-24:

- Information Governance – Data Breaches
- Key Financial Controls – Northgate
- Licensing
- Tenancy Management Organisation
- Better Care Fund
- Private Sector Property Licensing

3.5 **The following four audits have been carried forward** and will now be completed as part of the 2023-24 plan:

- Redefining Local Services Project (Integrated Street Cleansing, Waste Collections & Winter Maintenance Contract)
- Recruitment and Retention
- No Recourse to Public Funds (NRPF) and Intentionally Homeless
- Climate Change and Sustainability

3.6 **The following five audits were cancelled/deferred** (in agreement with senior management and auditees).

- Brent Commissioned Arrangements
- Oracle Programme - Phase 2
- Mental Health and Learning Disabilities
- Fire Safety
- Extended Follow-up Review - Use of Agency Workers

School Reviews

3.7 A programme of school audits is undertaken to provide assurance over the key governance arrangements and financial management controls in place within individual schools. Seven school audit reviews were scheduled to be carried-out as part of the 2022-23 plan, in addition to a follow-up review relating to an audit completed in 2021-22.

3.8 As at 30 April 2023:

- Five reviews have been completed;
- The follow-up review is in progress;
- Two reviews have been carried forward to 2023-24.

Advisory Work

3.9 Internal Audit continue to carryout consultancy and advisory work where required or requested. During the year, various pieces of advisory work have been undertaken, including:

- Annual Certificate of Expenditure - Brent River College
- Funeral Service - Advice Request
- Participatory Budgeting (Consultancy)
- Grant certifications

4. Summary of Risks/Issues Identified

4.1 For each review undertaken, where gaps or weaknesses in the design and operation of controls are highlighted, or where opportunities for the further improvement/optimisation of controls are identified, recommendations are raised and agreed with management.

4.2 Findings and issues raised by Internal Audit (and therefore the resulting recommendations) are graded in terms of the associated level of risk. An indication of the level of assurance and confidence provided from an audit review is therefore gained by examining the number and level of issues identified.

4.3 The following definitions are used to inform these ratings:

Critical	A finding that could have a: critical impact on operational performance; critical monetary or financial statement impact; critical breach in laws and regulations that could result in material fines or consequences; and/or a critical impact on the reputation or brand of the organisation which could threaten its future viability.
High	A finding that could have a: significant impact on operational performance; significant monetary or financial statement impact; significant breach in laws and regulations resulting in significant fines and consequences; and/or a significant impact on the reputation or brand of the organisation.

Medium	A finding that could have a: moderate impact on operational performance*; m*oderate monetary or financial statement impact; moderate breach in laws and regulations resulting in fines and consequences*;* and/or a moderate impact on the reputation or brand of the organisation*.*
Low	A finding that could have a: minor impact on the organisation's operational performance*;* Minor monetary or financial statement impact; minor breach in laws and regulations with limited consequences; and/or a minor impact on the reputation of the organisation*.*

4.4 For work undertaken as part of the 2022-23 plan, Internal Audit raised a total of 108 issues. The below table summarises these against the four risk categories:

Summary of risk issues raised:	2022-23	%	2021-22 Comparator	%
Total issues raised:	**108**		**72**	
Critical risk	0	*0%*	0	*0%*
High risk	**17**	*16%*	10	*14%*
Medium risk	**70**	*65%*	49	*68%*
Low risk	**21**	*19%*	13	*18%*

4.5 2021-22 figures have also been provided above for comparison purposes. However, whilst an increase or decrease in the number of risk issues raised per category may indicate an improvement or deterioration in the Council's internal control environment; there may also be a number of other factors behind this, including variations between the number and/or type of audit reviews that were completed in each year. In future iterations of this report, and as this table expands to incorporate additional years, it is anticipated that senior management and the Audit and Standards Advisory Committee will be able to track and monitor trends across a wider period.

4.6 In August and December 2022 the Audit and Standards Advisory Committee received internal audit progress reports summarising completion of work against the agreed plan. As part of these updates, details of any critical, high or medium risk issues raised was provided, alongside the responses and actions agreed by management/auditees. For audits completed since December 2022, a summary of issues identified and agreed with management can be seen at ***appendix B.***

5. Follow-up Activity

5.1 Agreed recommendations and actions emanating from all planned audit work is subject to follow-up to ensure that agreed actions have been implemented.

5.2 During 2022-23, 20 follow-up reviews were completed, which sought to evidence that 177 actions had been implemented as agreed. Outcomes are summarised in the table below:

Implementation Status	High Risk	Medium Risk	Low Risk
Total Actions:	**41**	**104**	**32**
Implemented:	**32**	**69**	**17**
Partially Implemented:	**7**	**27**	**14**
Not Implemented:	**2**	**4**	**1**
No longer relevant/superseded:	0	4	0

5.3 Further details relating to the follow-up activity undertaken in 2022-23 can be seen at ***appendix C***. It should be noted that follow-up outcomes included in this appendix are reported as at the time of concluding the follow-up review. As a result, owing to the time that may have elapsed since, the rate of implementation may have since changed. Internal Audit continue to review implementation of recommendations with Management, and in line with usual practice, will report any instances of persistent non-implementation of recommendations to the Committee.

Overdue actions

5.4 Where actions are found to remain partially or not implemented at follow-up, revised target dates are agreed with management. Outstanding actions are then monitored and reported via departmental 'action trackers', which are reported to Departmental Management Teams on a quarterly basis. These trackers contain all actions that relating to audits or follow-up work completed since 2021-22, including those that may not yet be due for implementation, or where a follow-up is in progress.

5.5. In order to identify actions as 'overdue', the following criteria is applied:

a) Internal Audit has undertaken/completed a follow-up review;
b) The actions were assessed as being partially or not implemented; and
c) The revised target implementation date has elapsed.

5.6 Using the above criteria, we can report the following position of overdue actions as at 25th May 2023:

Number of actions outstanding (past revised target dates) *as at 25 May 2023:*	50	
Critical risk	**0**	0%
High risk	**7**	14%
Medium risk	**41**	82%
Low risk	**2**	4%

5.7 It should be noted that this is a live and ongoing process, and therefore the position of overdue actions changes on a daily/weekly basis. Internal Audit continues to liaise with management to close all outstanding actions. Engagement with management continues to be positive, and any issues regarding the persistent non-implementation of actions will be raised with the Audit and Standards Advisory Committee as appropriate.

6 Head of Internal Audit Opinion

6.1 The PSIAS require that the Head of Internal Audit (HIA) provides an annual opinion and report that can be used by the Council to inform its governance statement. The standards require that the annual opinion must conclude on the overall adequacy and effectiveness of the Council's framework of governance, risk management and control. In addition, CIPFA's guidance on the *'Role of the Head of Internal Audit in Public Service Organisations' requires that the* Head of Internal Audit's overall opinion is objective and supported by sufficient, reliable, relevant, and useful information and evidence.

6.3 The HIA opinion in relation to the financial year 2022-23 is '*Reasonable Assurance'*. The information and evidence supporting this opinion is set out in the paragraphs below.

Reasonable Assurance	The adequacy and effectiveness of the overall arrangements for the Council's systems of internal control, risk management and governance are adequate, with some improvement required.

Scope

6.4 The HIA opinion is primarily supported by the delivery of the 2022-23 Internal Audit plan (the plan), which was agreed by the Council Management Team and the Audit and Standards Advisory Committee in March 2022. It is provided for consideration in the Council preparing its Annual Governance Statement for 2022-23, which is published alongside its financial statements for the year ended 31 March 2023.

6.5 In considering the HIA opinion, the following limitations should be recognised:

- the plan does not purport to address all risks facing the Council, and instead represents a deployment of limited audit resource. The Council Management Team and the Audit and Standards Advisory Committee acknowledged these limits in approving the plan;
- Assurance can never be absolute and neither can internal audit work be designed to identify or address all weaknesses that might exist;
- The responsibility for maintaining adequate and appropriate systems of internal control resides with management, and not Internal Audit.

Reliance on work undertaken

6.6 The 2022-23 plan was aligned to the Council's Strategic Risk Register and corporate priorities. In addition, Internal Audit undertook an independent risk assessment and consulted with senior management to identify significant risks and to gain an understanding of the Council's assurance needs. As a result, the audits included on the plan focussed on areas with a high assurance requirement.

6.7 In-year, the plan has been delivered by a skilled and experienced in-house team, supported and complemented through the use of a co-sourced provider, PwC, who provide access to skills and specialisms, including IT audit. As detailed in section 7 of this report, the Internal Audit was subject to an External Quality Assessment in-year, which evidenced and confirmed conformance with the PSIAS.

6.8 No specific reliance has been placed on external sources of assurance in forming the HIA opinion.

Basis of opinion

6.9 The HIA opinion is supported by the wider contents of this report. A total of 37 reviews have been delivered in-year, including eight reviews that sought to provide assurance on the effectiveness of the controls and mitigating actions in place pertaining to the Council's strategic risks. A further four audits focussed on the effectiveness and robustness of the Council's key financial systems. In addition, a number of audits also focussed on providing assurance over key departmental and service level risks (as indicated within departmental risk registers).

6.11 No critical risk issues/concerns were identified in delivery of the plan. 17 high-risk issues have been raised within individual audit reviews; however, in the main, where weaknesses were identified during individual audits, these were not considered to be significant, in aggregate, to the Council's overall governance arrangements and system of internal control.

6.12 A number of pieces of unplanned/additional work was also undertaken at the request of management. This demonstrates a willingness on the part of management to proactively seek Internal Audit advice in relation to the

improvement of controls and risk management, outside the delivery of the audit plan.

6.13 Internal Audit has also continued to closely monitor management's implementation of recommendations and actions arising from audit reviews. Of the 41 high risk actions subject to a formal follow-up review in 2022-23, 31 (78%) were found to have been implemented within agreed target dates, with a further 7 (17%) actions partially implemented and only 2 (5%) actions not implemented.

Other considerations

6.14 In addition to the outcomes of the 2022-23 plan, in reaching the HIA opinion, the following was also considered:

- The HIA is satisfied that the Council's framework of governance for the year ended 31 March 2023 complies in all material respects with guidance on proper practices as set out the CIPFA/SOLACE publication "Delivering Good Governance in Local Government (2016)".
- The Council's risk awareness and risk culture has continued to improve in 2022-23. Overall, there is a good awareness of the Council's risk management framework and strategic risks, although further work is necessary to enhance the quality and completeness of risk registers at a departmental and service level.

Areas for improvement

6.15 In determining the annual opinion, the HIA has also considered any key themes or issues emanating from audit work undertaken in 2022-23, and/or any areas where enhancements can be made to the Council's governance, risk management and internal control frameworks. The following observations were noted:

'Second line' gaps in control

6.16 Where *gaps* in control were identified by Internal Audit, these were generally found to be in relation to the Council's 'second line' (of defence). In brief, the 'first line' is the provision of services and the application of an internal control framework to manage associated risks; and 'second line' responsibilities include the monitoring, reporting and challenge of the effectiveness of 'first line' functions. The 'third line' is the independent and objective assurance provided by Internal Audit.

6.17 For example, during the audit review of contract management it was identified that there was a lack of oversight, at a strategic/corporate level, to obtain regular assurance regarding the (devolved) contract management of strategically important contracts. In addition, Internal Audit have continued to report 'second line' gaps in relation to the monitoring and reporting of the Housing Compliance. As reported to the Audit and Standards Advisory Committee in December 2022, six high risk issues were raised in relation to the monitoring, reporting and oversight of health and safety compliance.

6.19 It should be acknowledged that positive steps and actions have been taken in both instances to address the risks/issues identified. However, the issue regarding the 'second line' gaps in control was raised within the HIA opinion for 2021-22, and audit work undertaken in 2022-23 indicate that further work is required to improve the effectiveness of the Council's second line of defence.

Implementation of audit recommendations/actions

6.20 As identified above, we noted a positive rate of implementation of high risk actions. Whilst this is pleasing, it was found that only 69 of the 104 (66%) medium risk actions had been implemented. This suggests that further effort is required to implement all actions within agreed timescales to ensure that the risks identified during the original audit are appropriately mitigated.

Policies and procedures

6.21 Whilst relatively insignificant in terms of risk, we again noted that policies and procedures were often absent or outdated, and as such, roles and responsibilities were not always clearly defined/outlined.

Conclusion

6.22 In summary, the Head of Internal Audit is satisfied that the work undertaken by Internal Audit during 2022-23, as well as wider governance arrangements, has enabled an opinion to be formed on the Council's control framework, risk management and governance arrangements.

6.23 Internal Audit will continue to monitor the issues identified above and, where relevant, will provide support and guidance to help aid improvements.

7 Quality Assurance and Improvement Programme

7.1 The PSIAS require the HIA to develop and maintain a quality assurance and improvement programme (QAIP) that covers all aspects of internal audit activity. Internal Audit has therefore developed a QAIP that is designed to provide reasonable assurance to the various stakeholders of the service that Internal Audit:

- performs its work in accordance with the PSIAS (including the Definition of Internal Auditing and Code of Ethics) and the CIPFA Statement on the role of the Head of Internal Audit;
- operates in an effective and efficient manner;
- is perceived by stakeholders as adding value and continually improving its operations; and
- undertakes both periodic and on-going internal assessments, and commissions an external assessment at least once every five years.

External Assessments

7.3 The PSIAS require an external quality assessment (EQA) be undertaken at least every five years. As reported to the Audit and Standards Advisory Committee in February 2023, a review of Internal Audit's performance at the London Borough of Brent was undertaken in Q3-4 2022-23. The assessment was led the Head of Internal Audit for the London Borough of Barnet.

7.4 The assessment found that the Internal Audit Service ***Generally Conforms*** with the PSIAS, which is the highest available level of assessment for local authorities. Furthermore, the assessment of the compliance against the PSIAS found that Internal Audit conformed with each individual standard. A total of 10 good practice recommendations, which did not impact on conformance with the PSIAS, were raised by the assessors. An updated action plan will be reported to the Audit and Standards Advisory Committee in 2023-24, as appropriate.

7.5 Five areas of notable practice were also highlighted, where the activity of the Internal Audit Service reflected current best practice. Overall, the assessors commented that Internal Audit is a well led, professional and respected service that adds value and provides evidence based, reliable assurance over the Council's governance, risk management and internal controls. The full report can be seen here.

Internal Assessments

7.6 In accordance with the PSIAS, internal quality and performance assessments are undertaken through both on-going and periodic reviews. On-going assessments are conducted as a matter of course, in-line with the service's protocols and audit methodology. These assessments include: management supervision of audit activity, the application of a consistent audit methodology across audits, regular 1:2:1s between audit management and auditors to review and monitor performance, and the review and approval of all outputs by the Audit Manager and HIA.

7.7 Regular periodic assessments are also undertaken during the year to monitor and measure the impact of, and value added by the delivery of the annual audit plan. A key aspect of these assessments comprises of the quarterly progress reports presented to the Audit and Standards Advisory Committee, which summarise progress against the annual plan and key outcomes of audit activity. Furthermore, an annual assessment is undertaken in drafting the annual audit plan, which is aligned to the Council's Strategic Risk Register to ensure that the work of internal audit centres around the key risks that threaten the achievement of corporate objectives.

7.8 Other periodic assessments include (but are not limited to):

- annual self-assessments to ensure conformance with the PSIAS;
- regular feedback from senior management and Council Management Team
- benchmarking with other London Borough internal audit services, via the Cross Council Assurance Service and London Audit Group.

7.9 In summary, the Head of Internal Audit is confident that the Internal Audit function has continued to comply and conform with the PSIAS during 2022-23.

Key Performance Indicators

7.10 To complement and inform the ongoing and periodic assessments detailed above, Key Performance Indicators (KPIs) have been defined to measure the performance of the internal audit service. Achievement scores against each of these KPIs for 2022-3 are set out in the table below:

KPI	Details	Achievement (RAG)	Comments
KPI1	**90%** of the Annual Internal Audit Plan completed by 31 March (conclusion of fieldwork)	Partially Met	**74%** of Plan completed by 31 March.
KPI2	**100%** of the Annual Internal Audit Plan completed by 30 April (conclusion of fieldwork)	Partially Met	**86%** of Plan completed by 30 April.
KPI3	**100%** acceptance of all Critical and High risk recommendations	Met	**100%** acceptance of all High risk recommendations (no Critical recommendations).
KPI4	Follow-up of all Critical and High risk recommendations within (at least) 12 months of the final report being issued.	Met	20 follow ups completed and seven in progress. **100%** of recommendations followed up within 12 months of final report.
KPI5	**90%** of client satisfaction surveys rated the service as good or better.	Met	8 forms returned. **23%** very satisfied and **69%** satisfied.

Appendix A – Status and delivery of 2022-23 Plan

Audit / Indicative Scope (as per 2022-23 Plan)	Status	Summary of issues			Comments
		High Risk	Medium Risk	Low Risk	
ASC Budget Monitoring *A risk based review to provide assurance over the effectiveness of the controls in place in Adult Social Care to ensure the effective monitoring and managing of budgetary spend including the governance and monitoring controls in place regarding the Savings Programme.*	***Completed***		2	1	*Outcomes reported to the Committee in August.*
Flexible Working *A risk based review to provide assurance provide assurance over the design of the controls and the processes in place to manage and monitor the objectives of the flexible working strategy. The review focused on assessing the effectiveness of controls across a number of key areas, including Flexible working strategy and the remote working.*	***Completed***		1	3	*Outcomes reported to the Committee in August.*
Council Companies and Governance Review *A risk based review to provide assurance on the governance and monitoring arrangements the Council has in place, including review of the companies' financial information, performance reports and KPI reporting. The review focused on assessing the effectiveness of controls across a number of key areas, including governance arrangements, financial management, performance Management and reporting.*	***Completed***		5		*Outcomes reported to the Committee in August*
Equality Strategy *A risk based review to provide assurance on the robustness and adequacy of the controls and governance arrangements in place surrounding the delivery and development of the Equalities Strategy and Action Plan. The review focused on assessing the effectiveness of controls across a number of key areas, including Equality Strategy Governance, Equality Strategy Action Plan Development, and Equality Strategy Progress Monitoring.*	***Completed***		3		*Outcomes reported to the Committee in August.*
Key Financial Controls *The audit was designed to identify, review, and assess the control design and test the operating effectiveness of key financial controls operating within the Council for five sub-processes: General Ledger (GL); Purchase-to-Payment (P2P); Accounts Receivable (AR); Payroll; and Fixed Assets.*	***Completed***		2	8	*Outcomes reported to the Committee in August.*

Audit / Indicative Scope (as per 2022-23 Plan)	Status	Summary of issues			Comments
		High Risk	Medium Risk	Low Risk	
I4b Health and Safety Compliance *The objective of this audit was to review the effectiveness of the controls in place in relation to health and safety and compliance.*	***Completed***				*Outcomes reported to the Committee in September (as part of the i4b and FWH performance report).*
FWH Health and Safety Compliance *The objective of this audit was to review the effectiveness of the controls in place in relation to health and safety and compliance.*	***Completed***				
Brent Housing Management Housing Compliance *The objective of this audit was to review the effectiveness of the controls in place in relation to health and safety and compliance.*	***Completed***	6	1		*Outcomes reported to the Committee in December.*
Debt Management *A risk based review to provide assurance on the effectiveness and robustness of the control environment relating to the Council's arrangements for Debt Management. The review focused on assessing the effectiveness of controls across a number of key areas, including Policies and Procedures; Write Offs; Approvals and Management Information and Reporting.*	***Completed***	1	2		*Outcomes reported to the Committee in December.*
Fostering *A risk based review to provide assurance on the effectiveness and robustness of the control environment relating to the arrangements in place around the strategic administration of providing a local authority fostering service. The audit focused on the following sub-processes: Payments; Training, Support and monitoring; Vetting; and Reporting.*	***Completed***		4		*Outcomes reported to the Committee in December.*
Annual Certificate of Expenditure - Brent River College *(Additional Request)* *Internal Audit acted as an independent examiner and reviewed Annual Certification of Expenditure for Brent River College for 2021-22.*	***Completed***	n/a	n/a	n/a	n/a
Barham Park Accounts *To provide an independent examination and review of the Barham Park Trust ("the Trust") 2021-22 accounts.*	***Completed***	n/a	n/a	n/a	n/a
Funeral Service *(Additional Request)* *Risk/control advice and support provided.*	***Completed***	n/a	n/a	n/a	n/a

Audit / Indicative Scope (as per 2022-23 Plan)	Status	Summary of issues			Comments
		High Risk	Medium Risk	Low Risk	
Purchasing Cards *Advisory review in relation to the use of purchasing cards. The objective of the review is to provide assurance that purchasing cards are used only in accordance with Council policy and that the control framework is efficient and effective in ensuring the risk of inappropriate spend, fraud or loss is mitigated.*	***Completed***	2	7		Outcomes reported in Appendix B
Housing Voids *Advisory review. The objective of the review was to provide assurance that the voids management process and control framework is operating efficiently and effectively in ensuring the risk of inappropriate spend, fraud or loss is mitigated.*	***Completed***	1	6	1	Outcomes reported in Appendix B
Building Control Finance *A risk based review to provide assurance on the design and operating effectiveness of key controls in place around building controls income management arrangements.*	***Completed***	1	4		Outcomes reported in Appendix B
Contract Management *A risk based review to provide assurance that the Council's contract management arrangements are operating robustly and effectively to ensure that major and operational contracts are delivered in accordance with agreed definitions.*	***Completed***	2	3		Outcomes reported in Appendix B
Demand For Services *A risk based review to provide assurance over strategies in place to mitigate the departmental risk of the level of demand for services growing beyond the services' ability to manage effectively. This is specifically in respect of the effectiveness of the control framework and arrangements in place around the delivery of Brent Family Front Door CYP services.*	***Completed***		3		Outcomes reported in Appendix B
Grant Management *A risk based review is to provide assurance on the effectiveness and robustness of the control framework around the Council's arrangements for grant management.*	***Completed***		2	1	Outcomes reported in Appendix B
Large Event Day Management *A risk based review of Large Event Day Management to provide assurance on the effectiveness and robustness of the control framework around governance arrangements, planning, communications and licensing/enforcement.*	***Completed***		9	1	Outcomes reported in Appendix B

Audit / Indicative Scope (as per 2022-23 Plan)	Status	Summary of issues			Comments
		High Risk	Medium Risk	Low Risk	
Cyber Security – Website Review *A risk based review to evaluate the capability that exists to recover the Council's website in the event of an outage.*	***Completed***	3	1	1	Outcomes reported in Appendix B
Financial Management Code *A risk-based review to assess compliance with CIPFA's Financial Management Code including progress against implementation of the code, strategy, communication, benefits realisation, monitoring and reporting.*	***Completed***		1		Outcomes reported in Appendix B
You Decide / Participatory Budgeting *(Additional Request)* *Advisory review to provide consultancy and advice support to management to assist with the identification and management of risks associated with the You Decide Participatory Budgeting programme.*	***Completed***	1	5		Outcomes reported in Appendix B
IT Service Management Maturity Workshop *To assess the current capacity and maturity of the Council's IT Service Management components within the Target Operating Model, focusing on Governance and Assurance, and Support and End User Devices (EUDs) capabilities.*	***Completed***	n/a	n/a	n/a	Outcomes reported in Appendix B
Property Valuations *A risk based review review of the key controls in place to provide assurance over processes and risks associated with property valuations.*	***Completed***		3	2	Outcomes reported in Appendix B
Digital Strategy *Programme assurance regarding the design and delivery of the Council's Digital Strategy within the Digital Place theme to ensure it supports and enables the achievement of the Council's strategic goals.*	***Completed***		2	3	Outcomes reported in Appendix B
Housing Compliance – Extended Follow-up *Extended follow-up review of the recommendations raised in the Internal Audit review of Housing Compliance undertaken in January 2022.*	***Completed***		4		Outcomes reported in Appendix B
Grant Certifications *To undertake grant certification where required.*		n/a	n/a	n/a	Three grant certifications completed.
Income Management Strategy *(Additional Request)*	***Completed***	n/a	n/a	n/a	Resource diverted to providing advice and guidance on revised

Audit / Indicative Scope (as per 2022-23 Plan)	Status	Summary of issues			Comments
		High Risk	Medium Risk	Low Risk	
Advisory review to provide consultancy and advice support to management to assist with the identification and management of risks associated with the Income Management Strategy.					billing and payments process and guidance.
Procurement *A risk based review of Procurement to focus on areas of key risk.*	***Completed***	n/a	n/a	n/a	Resource diverted to providing advice and support on design of controls around contract management.
Public Health *A risk based review of Public Health to focus on areas of key risk.*	***Completed***	n/a	n/a	n/a	Resource diverted to conducting Public Health risk workshop and risk management support.
Income and Debt Management *A risk based review to consider key areas of risk including, refunds, suspense accounts, reconciliations, management information, reporting and adequacy of debt management.*	***Completed***	n/a	n/a	n/a	Resources diverted to advice and consultancy on specific areas of debt management risk following issues raised in other reviews.
FWH/i4B *Audit plan to be agreed separately with FWH/i4B. Audits to focus on areas on high risk and to include follow-up of recommendations raised in 2021-22 reviews.*	***Completed***	n/a	n/a	n/a	Resources diverted to follow up of actions raised in Housing Compliance Review and providing support and guidance on issues raised in Voids audit.
Capital Programme *A risk based review of the Council's Capital Programme. The scope to consider governance arrangements, strategy, planned savings, budgeting, approvals, risk management, monitoring and reporting.*	***Draft Report Issued***				Outcomes to be reported to Committee in next update 2023-24

Audit / Indicative Scope (as per 2022-23 Plan)	Status	Summary of issues			Comments
		High Risk	Medium Risk	Low Risk	
Financial Strategy/Savings Programme *A risk based review of Financial Strategy/Savings Programme. The scope to consider governance arrangements, planning, targets, monitoring and reporting.*	***Draft Report Issued***				Outcomes to be reported to Committee in next update 2023-24
Key Financial Controls – Payroll *A risk based review of key financial controls.*	***Draft Report Issued***				Outcomes to be reported to Committee in next update 2023-24
Family Wellbeing Centres *A risk based review of Family Wellbeing Centres. Scope to include governance arrangements, performance management and reporting.*	***Fieldwork Completed***				Outcomes to be reported to Committee in next update 2023-24
Information Governance – Data Breaches *A risk based review of the arrangements in place to prevent, identify and report data breaches. Scope includes: policies and procedures, ICO reporting arrangements, training and awareness, and lessons learned.*	***In progress***				Outcomes to be reported to Committee in next update 2023-24
Private Sector Property Licensing *A risk based review of Private Sector Property Licensing. Scope to include applications, processing, approvals, income management and performance monitoring arrangements.*	***In progress***				Outcomes to be reported to Committee in next update 2023-24
Key Financial Controls – Northgate *A risk based review of key financial controls.*	***In progress***				Outcomes to be reported to Committee in next update 2023-24
Better Care Fund *A risk based review of the governance arrangements in place for the Better Care Fund. Scope to include financial reporting and performance management.*	***In progress***				Outcomes to be reported to Committee in next update 2023-24
Tenancy Management Organisation (Establishment Review) *A risk based and deep-dive review into a tenancy management organisation (TMO).*	***In progress***				Outcomes to be reported to Committee in next update 2023-24

Audit / Indicative Scope (as per 2022-23 Plan)	Status	Summary of issues			Comments
		High Risk	Medium Risk	Low Risk	
Licensing *A risk based review of Licensing. The scope to consider governance arrangements, licence applications and decisions, fees, inspections, breach of licence conditions, and management/performance information.*	***In progress***				Outcomes to be reported to Committee in next update 2023-24
Recruitment and Retention *A risk based review of the Council's recruitment and retention strategy and policies/procedures. Scope to provide assurance over the mitigating actions in place surrounding this area of strategic risk.*	***Deferred to 2023/24***				Review deferred to 2023-24 at management request.
Climate Change and Sustainability *Programme assurance regarding the delivery of the Council's climate change strategies and action plan.*	***Deferred to 2023/24***				Review deferred to 2023-24 at management request.
Redefining Local Services Project (Integrated Street Cleansing, Waste Collections & Winter Maintenance Contract) *To provide internal audit risk/control support, where required.*	***Deferred to 2023/24***				Review deferred to 2023-24 at management request.
No Recourse to Public Funds (NRPF) and Intentionally Homeless *A risk based review of the NRPF process. Scope to include governance arrangements, acceptance process, screening, financial support and property procurement.*	***Deferred to 2023/24***				Resources diverted to other work.
Oracle Programme - Phase 2 *Ongoing risk-control support.*	***Cancelled***				Review no longer required.
Extended Follow-up Review - Use of Agency Workers *Extended follow-up review of recommendations previously raised in this area.*	***Cancelled***				Review deferred to 2023-24
Mental Health Disabilities *A risk-based review of governance arrangements in place for mental health disabilities care.*	***Cancelled***				Review deferred to 2023-24

Audit / Indicative Scope (as per 2022-23 Plan)	Status	Summary of issues			Comments
		High Risk	Medium Risk	Low Risk	
Brent Commissioned Arrangements *A risk based review of the commissioning arrangements and dynamic purchasing vehicles (in accordance with Brent's commission placements and in collaboration with West London Alliance).*	***Cancelled***				Resources diverted to other work.
Fire Safety *A risk based review of fire safety arrangements to include I4B and FWH at each stage.*	***Cancelled***				Fire Safety included as part of Housing Compliance work.

Appendix B – Summary of audits completed in Q4 2022-23

Audit Title	Summary of Key Findings
Purchasing Cards *Indicative Scope:* a risk based review to provide assurance that purchasing cards are used only in accordance with Council policy and that the control framework is efficient and effective in ensuring the risk of inappropriate spend, fraud or loss is mitigated. The review focused on assessing the effectiveness of controls across a number of key areas, including: • Procedural guidance and training; • Administration of new cards; • Expenditure; • Monitoring and • Management of existing cards.	There were **two** **high** and **seven** **medium** risk issues raised: **High-risk issues:** **1)** A backlog of uncoded and/or unapproved purchases. For transactions made between October 2019 and November 2021, 1,134 purchases amounting to £189k were uncoded. A further 674 purchases, amounting to £196k were pending approval from a Line Manager (as of December 2022). *Management Response: : Internal Audit were informed of this by Finance in 2021-22 and their advice sought on how best to address this issue. It was addressed in 2021-22 as had been planned before the advice of Internal Audit was sought on how to address this issue. .Any uncoded transactions at the end of the month are coded by the Chief Accountant's team to ensure that they are recorded in the ledger. First draft of a policy to be drafted and shared with the Deputy Director of Finance which will include a note on how approving/coding is expected to be conducted.* **2)** Due to the backlog of uncoded and/or unapproved purchases, as well as issues surrounding recording of transactions within the General Ledger (due to a change in subjective code as a result of implementation to Oracle Cloud), departmental budgets/ cost centres are currently inaccurate. *Management Response: Internal Audit were informed of this by Finance in 2021-22 and their advice sought on how best to address this issue. This was addressed in 2021-22 as had been planned before the advice of Internal Audit was sought on how to address this issue. The backlog of PFS transactions due to a change in subjective code have been cleared and all payments made using the GPC and PFS card are now charged to the respective departmental budgets. All respective cost centre managers are regularly reminded of any payments incurred with prepaid cards to facilitate adequate oversight over budgets.* **Medium-risk issues:** **3)** A number of transactions sampled did not have sufficient supporting documentation to evidence legitimacy of spend and to ensure that all purchases are in line with Council policies and represent value for money. *Management Response: First draft of a policy to be drafted and shared with the Deputy Director of Finance– which will include notes to address the recommendations. The purpose of cards will be reviewed and will be defined by this policy.* **4)** There is a lack of monitoring around the allocated credit limit and monthly spend for cardholders.

Audit Title	Summary of Key Findings
	Management Response: Annual Review to be completed in March whereby cardholder spend is reviewed and will be reduced if agreed criteria are met. **5)** Only 14% of PFS card transactions relate to direct payments, cash withdrawal and BACS payments. All other transactions were purchases made via telephone, online or at a shop. Purchases via telephone, online or at a shop can be made using GPC cards. Considering the ease of use and effective monitoring controls available for GPC, the Council should aim to minimise the number of PFS cards in circulation. *Management Response: GP Card is promoted with new card requests. PFS cards are given only to staff in exceptional circumstances, as defined in the new policy, where a GPC card is not appropriate; funds returned from existing PFS cards issued to staff.* **6)** There is a lack of effective recording of VAT incurred with purchases using the prepaid cards. Therefore, the Council may be forfeiting the re-claiming of VAT. *Management Response: Guidance document to be updated which will include points to address the recommendations.* **7)** Monthly expenditure forms for PFS are not promptly submitted to Finance for monitoring. In addition, a monitoring tracker is not in place to ensure the submission of expenditure forms. *Management Response: A note on expenditure logs to be included in the previously mentioned guidance documents and will include what will happen in the event of non-compliance. A monitoring document to be created which will keep record of who isn't submitting their expenditure logs.* **8)** Up-to-date guidance and application forms are not in place for both PFS and GPC cards. *Management Response: Guidance to be updated and circulated.* **9)** There is currently no regular reporting to Senior Management regarding the use of PFS or GPC cards. *Management Response: Monthly update pack to be completed and presented as part of the reconciliation meetings which are held monthly.*
Housing Voids *Indicative Scope:* a risk based review to provide assurance that the voids management process and control framework is operating efficiently and	We raised **one high, five medium** and **one low** risk issue. **High- risk issue:**

Audit Title	Summary of Key Findings
effectively in ensuring the risk of inappropriate spend, fraud or loss is mitigated. This review sought to provide assurance over the following sub-processes and control objectives: • Policies and procedures • Notice period and pre-inspection • Repairs • Post repair inspection and re-let • Monitoring and reporting.	**1)** Inconsistencies and a lack of clarity in the calculation of voids KPIs. There were significant variances in the voids and contractor turnaround days calculated by CRM, in comparison with our calculations. *Management Response: The Council will ensure that:* • *KPIs are SMART (Specific, Measurable, Attainable, Relevant and Time-Bound) against which to monitor performance;* • *KPIs and their metrics are clearly defined and accurately calculated within CRM;* • *Where KPIs are not consistently met, an appropriate action plan should be put in place to address any under-performance.* **Medium-risk issues**: **2)** Inconsistencies were identified in the recording and retention of supporting documentation within the CRM shared drive, resulting in the absence of an effective audit trail. *Management Response: The Council will ensure that:* • *All staff members are provided training to promptly update CRM for each void property.* • *All relevant documents are uploaded into CRM and/or SD to aid an adequate audit trail.* • *All work orders, along with approvals and variances are promptly uploaded into the CRM.* • *Spot checks are conducted on a periodic basis to ensure CRM is updated for all void properties.* **3)** There is an absence of formally defined minimum lettable standards for all Council properties: *Management Response: Management will ensure that:* • *Minimum lettable standards are created and approved by relevant Senior Management.* • *Once approved, standards will be uploaded to the Council's website to be accessed by residents.* • *The minimum lettable standards will be provided to all contractors to ensure that all properties are repaired to an acceptable standard.* **4)** Where repairs are caused due to misuse, abuse or accidental damage, the cost of repairs and maintenance are not always re-charged to the previous tenant(s), leading to financial loss for the Council. *Management Response: Management will consider implementing the re-charge policy for repairs due to damage or misuse.*

Audit Title	Summary of Key Findings
	5) Variances or discrepancies within the work order specifications are not always promptly clarified. *Management Response: Management will ensure that:* • *Initial and final work orders are examined and approved by management.* • *All variances are thoroughly examined and approved prior to the completion of repairs* • *Final work specification should be approved prior to the payment of the invoice.* **6)**. Absence of adequate contracts or agreements in place with contractors *Management Response: The Council will ensure that formal extensions of the contractual agreements are in place with all void repair contractors. The contracts should include the following:* • *Formally agreed KPIs* • *Regular contractual meetings* • *Penalties for failing to meet the agreed KPIs* • *Responsibilities of the Council and the contractors*
Building Control Finance *Indicative Scope:* to provide assurance on the design and operating effectiveness of key controls in place around Building Control income management arrangements. This audit provides assurance over the following sub-processes and control objectives and focused on controls in place to mitigate potential key risks: • Governance arrangements	We raised **one high** and **four medium** risk issues. **High- risk issue** **1)** Inconsistencies and delays were noted in the management of Building Control fees. Invoices are not sent to the applicant alongside invalidation letters, which leads to payments that are not matched with invoices. *Management Response: Building Control will ensure that:* *a) Where required, invalidation letters requesting payment of fees will be sent to the payee along with a copy of the invoice.* *b) Where invoices are raised for outstanding fees, the wording within the invalidation letters will be amended to ensure that it does not prompt payees to pay using the Building Control reference number.* *c) Staff will ensure that the applicant has not paid via the portal, citing the Building Control reference number, prior to raising an invoice, thereby eliminating any duplication.*

Audit Title	Summary of Key Findings
• Income Management • Reporting.	*d) A monthly reconciliation of income due and income received to Building Control will be undertaken to identify any instances of unallocated income, where payments have not been matched to the invoice raised. Where payments have been made, a credit note should be raised to offset the invoice.* **Medium-risk issues** **2)** There are a lack of effective controls within Acolaid to avoid duplicate invoices for the same payments/applications, leading to inflated budgets and credit notes. *Management Response:* *a) Acolaid is now already being updated with payments received via Customer Service or the online portal. The monitoring of invoices raised will continue. As part of our continued efforts to improve this area, when invoices are raised, a screenshot is recorded on Acolaid in the fee notes, thus eliminating the risk of duplication and the requirement for Credit Notes to be issued.* b) *A report of raised invoices will be run to check if Accounts Receivable have executed invoice instructions without duplication.* **3)** Invoices and credit notes are raised with significant delays (i.e. in excess of two years in one instance), which leads to distorted budgets and lack of effective monitoring. *Management Response: Building Control accepts that there are no fixed targets in getting invoices raised / sent out and will look to develop the targets and include in its performance returns. Since January 2022, invoices are only being raised for Major Project type applications. These will be raised within seven days of management instructions as and when the projects come to key invoicing milestones.* **4)** There are a number of outstanding payments from historic applications, which have not been invoiced or chased. *Management Response:* The Council will ensure that: *a) All outstanding payments as per Acolaid system will be invoiced and sent to the payee promptly.* *b) All outstanding debts should be notified to the Debt Recovery team to be monitored and chased.* *c) A report of all outstanding (non-invoiced) payments from Acolaid system will be examined on a regular basis to promptly highlight any debts.* **5)** There is an absence of procedural documents or guidance in place setting out the approach to managing and monitoring the income for Building Control.

Audit Title	Summary of Key Findings
	Management Response: Procedural guidance was in place back in 2010, however, this needs to be updated to reflect current practices and systems. We are looking for specialist assistance from within the Council to help with this and provided this is forthcoming, our aim is for this to be completed by January 2023.
Contract Management A risk based review to provide assurance over the effectiveness of how well the Council's contract management arrangements are working in practice and to provide assurance over the controls in place to mitigate this area of strategic risk The audit focused on the following sub-processes and key risks: ▪ Governance Arrangements; ▪ Contract management Framework – Strategic and Operational Contract Management; ▪ Performance/Financial Management and Reporting.	**Two high** and **three medium** risk issues were identified: **High risk issues:** **1)** There is currently a lack of strategic/central oversight of contract management from a cross-council *perspective.* *Management Response: The Corporate Procurement team will provide corporate oversight of key contracts. The team will review the top contracts once criteria has been agreed. The selection will then be discussed at the Commissioning and Procurement Board. The process will be further supported by the production of an annual report that will be presented to CMT for consideration. The report will highlight the performance of the key contracts to include identified risks and mitigation plans.* **2)** A number of gaps in control within the departmental contract management arrangements were noted during a sample review of contracts. *Management Response: The Corporate Procurement team will ensure that each contract has an assigned Contract Manager and that a contract management plan is completed; copies of the contract register are sent out to Contract Managers for checking; Contract Manager Training is made available for all that require it and regular performance reports for key contracts from the relevant Contract Managers will be obtained.* **Medium risk issues:** **3)** The Contract Management Policy requires enhancement to enable more effective strategic and operational management of key contracts, including the requirements relating to performance and financial reporting. Additionally, an assigned Contract Manager is imperative for all contracts, however this is not stipulated. *Management Response: The Corporate Procurement team will update and publish a revised Contract Management Policy that includes refined definitions for responsibilities for both Contract Managers and the Corporate Procurement team. This will also be updated to include any future changes required by the Procurement Bill.* **4)** The Central Contract Register requires updating to ensure that data is accurate and is up to date;

Audit Title	Summary of Key Findings
	Management Response: The Corporate Procurement team will ensure that the details of the contract register are correct and all errors/duplicate entries will be removed. The Corporate Procurement team will produce a standard operating procedure that will cover all the steps that a Contract Manager is required to take. This procedure will link to the Contract Manager training and reference details in the Contract Management Policy. **5)** The Contract Segmentation Tool has not been applied to Council contracts to assist Contract Managers in carrying out their roles. *Management Response: The Corporate Procurement Team as a first step will implement the assessment of contracts using the contract segmentation tool to identify the Top 30 key contracts. This will enable us to provide a more focused oversight over the contracts that pose the most risk to the council. Then as a separate piece of work, we will facilitate the assessments for all new contracts going forward using the tool. We will include in the responsibilities section of the Contract Management policy the requirement for all new contracts to be assessed using the segmentation tool.*
Demand for Services A risk based review to provide assurance over strategies in place to mitigate the departmental risk of the level of demand for services growing beyond the services' ability to manage effectively. This review provided assurance over the following sub-processes and control objectives. • Governance; • Demand Management; • Roles and Responsibilities; • Training and Support; • Management Monitoring and Reporting	We raised **three medium risk** issues: **1)** The BFFD Multi-Agency Safeguarding Hub (MASH) Procedures Protocol document has not been updated since January 2021. Also, the section on operational procedures does not include expected timelines for contact handling of received concerns. *Management Response: The MASH Procedures/Protocol was updated in January 2023 and a further review is planned for in January 2024. The procedures set out a rag rating for each contact based on the threshold document and respective timescales. Contacts are recorded onto Mosaic in priority order based on the rating. In addition, we will conduct a review to check compliance and consistency against the rag rating and timescales as described in the procedures/protocol of a sample of contacts.* **2)** A significant number of anomalies were identified, including cases of duplicate contact files in both 2022 and 2021. Also, examples of significant delays between receiving a contact through the BFFD and when the contact was recorded in Mosaic. *Management Response: All new staff will receive induction training that includes the use of Mosaic, compliance with the MASH Procedures/Protocol and safeguarding. In addition, we will check random samples of contacts to ensure compliance and consistency against the rag rating and timescales. Those staff identified as requiring improvement in their skills in entering contact information into Mosaic will receive refresher training. All staff will receive refresher safeguarding training and a record will be kept of the training. Additional reassurance was provided by an Ofsted Inspection of Local Authority Children's Services (ILACS) in February 2023 that considered the effectiveness of operational practice within the BFFD. Significant case sampling and scrutiny was undertaken with work considered to be of good quality. The sub-judgement for the Council's Early Help and Protection areas of work were judged to be 'Good' with the overall Council judgement also being 'Good'.*

Audit Title	Summary of Key Findings
	3) Management is not keeping local records of staff training so are not able to confirm whether training has been completed or when it requires refreshing. *Management Response: A database will be developed of all training provided and completed by staff of MASH expectations as well as ensuring that all staff have received up to date training, including regular refresher training.*
Grant Management A risk based review to provide assurance on the effectiveness and robustness of the control framework around the Council's arrangements for grant management. The audit focused on key controls in place to mitigate the potential risks in the following areas: • Governance • Accounting • Monitoring • Reporting	**Two medium risk issues** and **one low risk** issue were identified: **Medium risk issues:** **1)** There is a general issue regarding money coming into the Brent bank account and Finance Business Partners have to work out what the money is for and where to allocate the funds. *Management Response: Management recognises the ongoing issue with obtaining remittances and as a result the delays in allocating income in the finance system. To monitor this Finance DMT will receive regular updates on the reconciliation of the grant register with the finance system and unallocated income on an ongoing basis.* **2)** Not all the required documentation is being stored in the grants evidence folder held on SharePoint. *Management Response: Management recognises the ongoing issue with obtaining remittances from grant awarding bodies and is working with FBPs to target grant awarding bodies to use the grant inbox. To monitor this Finance DMT will receive regular updates on completeness of the grant evidence folders on an ongoing basis.*
Large Event Day Management A risk based review to provide assurance that management has assessed all relevant risks and implemented adequate and effective controls within Large Day Event Management.	We identified **nine medium** and **one low risk** issue. **Medium risk issues:** **1)** Stakeholder cooperation exists in delivering large event days; however, details of these arrangements have not been formally documented and agreed upon. *Management Response: A draft protocol document will be created to share with partners and officers, the document will include pre-planning, event day and post event processes and procedures. It will also be shared with partners as part of a wider development of Zone Ex roles and roles and responsibilities. The number of staff required for each event type and their required training will also be included.* **2)** Defined lines of responsibility exist between stakeholders; however, they have not been formally documented or agreed upon.

Audit Title	Summary of Key Findings
This audit provided assurance over the following sub-processes and control objectives: • Governance • Training and Staffing • Risks and Safety • Enforcement and Licensing • Post Euro 2020 Report Action Plan	*Management Response: There is a need for a wider agreement on roles and responsibilities of partners working in Zone Ex. This work will require working with wider stakeholders to agree a Zone Ex protocol.* **3)** Documented procedures to support staff and stakeholders in the management of large events are not in place. *Management Response: A draft protocol document will be created to share with partners and officers, the document will include pre-planning, event day and post event processes and procedures. It will also be shared with partners as part of a wider development of Zone Ex roles and roles and responsibilities. The number of staff required for each event type and their required training will also be included.* **4)** Alternative methods of communication should be evaluated as a replacement for WhatsApp, which can fail when there are high capacity audience attendances. *Management Response: As part of the Casey review there is currently a project in place to improve communications including a partnership control room within the stadium. As part of this process the F.A have agreed to explore improving communications. The control room is expected to be in place for March 2022.* **5)** Large event day actions are captured but do not include target dates for completion and the relevant responsible officer. *Management Response: There is a general acceptance that following the Casey review we have made a number of changes at pace to both address the recommendations of the Casey report with a primary focus on managing large event days to prevent future issues. Whilst processes have not all been recorded, there has been a consistent approach to event day management with debriefs taking place after each event. A robust log is now standard practice to record activity throughout the day.* **6)** Event staff training cannot be monitored effectively as a local training database including refresher requirements does not exist. *Management Response: A log will be created which will include all operational staff that have the required training to be selected to work on event days, this will enable a fair distribution of event attendance for all capable staff.* **7)** Staff ratios required for different types of events are based on previous similar events, these ratios have not been documented. In addition, the Council does not have contingency plans in place to maintain staff ratios during peak event months. *Management Response: A review of current staffing and planning for 2023 with the Football Association (FA) is taking place to look at staffing requirements.*

Audit Title	Summary of Key Findings
	8) All large events are risk assessed by both the Police and the Council; however, the methodology by which these assessments are achieved have not been documented. *Management Response: The planned protocol document will include the risk assessment process for large events and will state that these assessments are agreed upon with key event partners prior to publishing.* **9)** There is no structured process to enable issues or lessons learnt to be brought to subsequent event planning meetings. *Management Response: We will share relevant information with partners/stakeholders at SAG meetings that were captured at previous event debrief meetings to ensure that all issues/concerns/lessons learnt are seen by our event partners.*
Cyber Security – Website Review The objective of this audit was to understand and evaluate the capability that exists to recover the Council's website in the event of an outage. This audit provided assurance over the controls within the following sub-processes: • Business continuity and disaster recovery; • Redundancy, replication, and resilience; • Roles and responsibilities; and • Reputational risk and personal identifiable data.	We identified **three high risk, one medium risk** and **one low risk** issues. **High Risk Issues:** **1)** Evidence of testing the Council's website business continuity plan was not available, nor was a physical copy of the plan retained. *Management Response: Agree to implement an annual testing regime for the full BCP including involvement from senior stakeholders where necessary.* **2)** No evidence was available to demonstrate the testing regime for Disaster Recovery plan *Management Response: Agree to implement an annual testing regime on full and partial system recovery using the DR Plan and back-ups. Agree to outline the expected frequency and nature of the testing regime in the DR Plan or policy.* **3)** There was no regular testing regime in place to establish if the redundancy, resilience, and replication would function as intended should an outage or disaster occur. *Management Response:* Agree to implement an annual testing regime of the website where all elements of the redundancy, replication and resilience are tested. Lessons learned from each annual testing procedure will be incorporated. **Medium Risk Issue:** **4)** Segregation of duties is inferred in several key documents but not clearly defined nor documented. There is a lack of representation of the Web team on the Change Advisory Board (CAB). *Management Response: Agree to create a policy and procedural document defining expectations regarding segregation of duties and define such duties in the procedural document. As part of this, a register of all staff with elevated permissions should also be maintained and periodically reviewed (i.e., once every six months) for appropriateness.*

Audit Title	Summary of Key Findings
Financial Management Code The objective of this audit was to review and assess the high-risk actions for the Medium-Term Financial Strategy and financial resilience elements of the Council's self-assessment conducted against the CIPFA Financial Management Code. This audit provided assurance over the following sub-processes: • Oversight and governance • Development of the MTFS high-risk action plans • Development of the financial resilience action plans	**One Medium Risk** issue: **1)** The key governance and oversight mechanism (weekly programme team meetings) does not explicitly provide a view on the progress of the implementation of actions across all workstreams. *Management Response: We have put a standing item on the weekly meeting for programme progress, which is an opportunity to flag anything that is not on target. Once a month we review the latest statistics for actions completed and address any remedial action needed for anything falling behind. We currently report key work arising from CIPFA's FM Code in major financial reports to CMT and Cabinet. We also reported the initial project plan and progress to date to the Audit Standards Advisory Committee. At a suitable juncture we will report progress against the plan again.*
You Decide / Participatory Budgeting (PB) *(Additional Request)*	This review was undertaken at management's request. The objective of this review was to assist with the identification and management of risks associated with the PB programme delivered in summer 2022, to ensure that any issues and/or gaps/weaknesses in control could be addressed ahead of any future/similar exercises. This review sought to provide assurance over the following sub-processes and control objectives: · Eligibility and assessment · Consultation and engagement with stakeholders · Decision-making · Funding · Monitoring In summary, **one high** and **five medium** **risk** issues were raised regarding areas for improving and enhancing overarching governance arrangements and framework, covering the following areas:

Audit Title	Summary of Key Findings
	1. Documented policies/procedures 2. Declaration of interests 3. Collaboration and joint working 4. Due diligence and vetting 5. Verification of voters 6. Payments Consideration will be given to how the recommendations will be implemented in similar funding exercises in the future.
Property Valuations The objective of this audit was to review the key controls in place to provide assurance over processes and risks associated with property valuations. This audit provides assurance over the following sub-processes: • Governance • Fixed asset register (FAR) • Reconciliations • Revaluations, depreciation, and impairment	**Three medium** and **two low risk** issues: **Medium Risk Issues:** **1)** Insufficient procedure documentation was in place or available to staff in relation to the property valuations process, detailing the day-to-day operational activities and the associated roles and responsibilities. *Management Response: Officers accept the recommendations above to establish a high level handbook and checklists (checklists are already in place) to ensure that there is continuity should a member of staff leave. CIPFA publishes a manual for Asset Manager (the FAR system Brent uses) detailing process for the FAR functions, our high level handbook will make reference to this to prevent duplication of work. This will need to be done during the next valuation process to ensure that all steps are captured and lessons learnt implemented. It should be noted that Officers currently use the RICS handbook and guidance on asset valuations which is a comprehensive handbook for carrying out asset valuations. In terms of governance the internal handbook will provide ready reference for the necessary steps that are required and map out the overall process and complement the handbooks being used.* **2)** We were not able to evidence certain documentation during the review as it had not been centrally saved/ retained and staff who had left their positions had not uploaded it to central repositories. As a result, staff did not have access to (and could not provide as evidence) several documents requested for the audit. *Management Response: We already have in place a share folder containing the information set out in the recommendation. The missing documents found in the internal audit are anomalies. Officers responsible for the 2017/18 external revaluations report have all left the Council and therefore we weren't able to find these but every revaluation*

Audit Title	Summary of Key Findings
	since then has been saved in a central location and will continue to be saved. The only document not saved locally because of the previous FA leaving is the evidence of spot check. We will ensure this is saved going forward. As per previous recommendation we will implement a formalised year end sign off going forward. **3)** The due date for the next valuation was not populated for all assets in the fixed asset register (FAR). Management was therefore not able to directly track assets requiring revaluation. *Management Response: Management recommendations are noted and will be implemented for the financial year 2023/24 asset valuation process. The valuation exercise for 2022/23 has already commenced and needs to be carried out within a very tight deadline. We will agree with the external surveyor by August 2023 what needs to be done to implement these changes and they will take effect for the next valuation exercise which will commence in November 2023.*
Digital Strategy The objective of this audit was to ascertain whether management has assessed all relevant risks and implemented adequate and effective controls over the roll out of full fibre broadband within the Digital Place theme of the Digital Strategy and ensured it supports and enables the achievement of the Council's strategic goals. This scope of the audit covered the following core areas as determined by the Council. • Council requirements and benefits management. • Digital Place infrastructure. • Stakeholder management.	**Two medium** and **three low risk** issues were raised: **Medium Risk Issues:** **1)** The Council meets with its delivery partners regularly to discuss progress with the roll out, but it has not set KPIs for monitoring the performance of delivery partners, such as minimum internet speeds, service delivery standards, etc. *Management Response: Providers have confirmed that they are unable to provide information regarding minimum internet speeds and service delivery standards as it is commercially sensitive information. However, the council will collect information from providers every six months regarding the percentage area of completed implementation of infrastructure. Information will also be collated on any complaints regarding the build in properties on a quarterly basis as part of existing connectivity deep dives.* **2)** We were unable to confirm that all relevant stakeholders across the Council were engaged with during the formulation of the Digital Place element of the strategy. *Management Response: On review of the Digital Place strand of the strategy, a wider group of stakeholders, including community and voluntary partners, housing officers and senior management will be consulted on its development and priority areas.*

Appendix C - Summary of Follow-up Activity

***** *Follow-up outcomes reported in the table below are as at the time of concluding our follow-up review. As a result, owing to the time that may have elapsed since, the status of implementation may have since changed. Internal Audit continue to review implementation of recommendations with Management, and in line with usual practice, will report any instances of persistent non-implementation of recommendations to the Committee.*

****** *The numbers in brackets are high risk actions that are partially or not implemented. All outstanding recommendations will continue to be monitored and reported via Departmental Management Teams.*

Follow-up	Status	Follow-up Outcomes (as at first follow-up)				Comments
		Implemented	Partially Implemented	Not Implemented	No longer relevant	
IT Asset Management in Shared Service	***Completed***	**1**	11 (4)	0	0	Management continues to provide updates regarding the outstanding actions.
ITDR	***Completed***	**14**	0	0	0	
Council Tax	***Completed***	**6**	0	0	0	
i4B SLA	***Completed***	**4**	7	0	2	Management continues to provide updates regarding the outstanding actions.
FWH SLA	***Completed***	**4**	4	0	2	Management continues to provide updates regarding the outstanding actions.
Temporary Workers	***Completed***	**3**	1	1	0	Management continues to provide updates regarding the outstanding actions.
Planning	***Completed***	**4**	0	0	0	

Follow-up	Status	Follow-up Outcomes (as at first follow-up)				Comments
		Implemented	Partially Implemented	Not Implemented	No longer relevant	
Homecare	***Completed***	**5**	**0**	**0**	0	
Oracle Cloud PIR	***Completed***	**9**	**0**	**0**	0	
Residential and Nursing Care	***Completed***	**7**	**0**	**0**	0	
GLA Affordable Housing Programme	***Completed***	**2**	**0**	**1**	0	Management continues to provide updates regarding the outstanding actions.
Accounts Payable	***Completed***	**16**	**2**	**0**	0	Management continues to provide updates regarding the outstanding actions.
Gifts and Hospitality	***Completed***	**2**	**0**	**3**	0	Management continues to provide updates regarding the outstanding actions.
Early Years	***Completed***	**3**	**0**	**0**	0	
Cyber Remote Working	***Completed***	**12**	**6**	**0**	0	Management continues to provide updates regarding the outstanding actions.
Flexible Working	***Completed***	**3**	**5**	**0**	0	Management continues to provide updates regarding the outstanding actions.

Follow-up	Status	Follow-up Outcomes (as at first follow-up)				Comments
		Implemented	Partially Implemented	Not Implemented	No longer relevant	
Leaseholder Repairs	***Completed***	**6**	**6**	**0**	0	Management continues to provide updates regarding the outstanding actions.
ASC Budget Monitoring	***Completed***	**4**	**1**	**0**	0	Management continues to provide updates regarding the outstanding actions.
I4b/FWH Health and Safety Compliance	***Completed***	**12**	**5 (3)**	**2 (2)**	0	Management continues to provide updates regarding the outstanding actions.
Financial Management Code	***Completed***	**1**	**0**	**0**	0	

The following follow-ups are in progress and will be reported in 2023-24:

- **Workforce and Succession Planning**
- **Key Financial Controls**
- **Council Companies and Governance**
- **Debt Management**
- **Fostering**
- **Contract Management**
- **Purchasing Cards**