PAPER B

Audit Committee Internal Audit Progress Report

Isle of Wight Council

FINAL

May 2019

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Introduction and Internal Audit Overview

Introduction

This report presents a summary of the activities of Internal Audit for the period February to May 2019. It provides the executive summary for the ten reports, rated as medium risk or below, finalised since February.

Two further reports, General Data Protection Regulation (GDPR) and Regulatory Compliance have been rated as no assurance, with a third report, on Nicholson Road, rated as high risk. As such, in line with usual practice, these are presented separately to this meeting of the Audit Committee, under the same agenda item.

2018/19 Update

All fieldwork is now complete for the 2018/19 programme of Internal Audit reviews. Reports not presented today, either summarised within this report or presented separately, in full, will be presented to July’s meeting of the Audit Committee.

Full details of performance against key performance indicators for 2018/18 can be found in Appendix C and Appendix D within this report.

2019/20 Update

Scoping has now been completed for the quarter one, 2019/20 programme of Internal Audit reviews. Fieldwork is either underway, or scheduled to commence shortly.

Executive Summaries from Internal Audit Reports

In this section we provide the executive summary for the ten reports rated as medium risk or lower, finalised since the last meeting of the Audit Committee in February 2019.

Executive summary – Project Management

Classification	Trend
Low Risk	We have not previously carried out a review with an equivalent scope.

By type

	Control design	Operating effectiveness	Total
Critical	0	0	**0**
High	0	0	**0**
Medium	1	0	**1**
Low	3	0	**3**
Advisory	0	0	**0**

By scope area

	Critical	High	Medium	Low	Advisory
Strategic Programme Board	0	0	0	1	0
Project Management Framework: Implementation	0	0	1	2	0
Project Management: Effectiveness	0	0	0	0	0

Summary of findings

The review focussed on the Council's approach to Project Management, covering at a high level:

- *Strategic Programme Board*: confirming that this forum is correctly constituted, has appropriate membership and meeting frequency and is receiving sufficient reporting over the full breadth of strategic initiatives / projects.
- *Project Management Framework*: *Implementation*: confirming that appropriate steps are taken to support adoption of revised corporate expectations regarding project management, for example promotion and training/support provision.
- *Project Management: Effectiveness*: on a sample basis confirming that projects are managed in line with corporate expectations and more widely good project management practice.

The recently revised governance for strategic projects represents a step change to historic practice at the Council. Senior officer and member strategic boards are in place, with clear terms of reference, appropriate membership, meeting frequency and comprehensive reporting – collectively this provides a robust framework to support timely and effective decision making. Below this there has been considerable effort to fully identify all projects, including those requiring senior oversight, across the Council, with a central team, Organisational Intelligence, available to provide focussed support. A range of training has been provided with a project management framework, sufficiently flexible to accommodate the scale and needs of individual projects, with further guidance planned.

The main enhancement required is to change management, with the rationale for and approval of changes not always being sufficiently clear. However Internal Audit does note that the size of the current strategic project portfolio at 24 projects is extremely ambitious for an organisation of the Council's size. While the resourcing requirements do vary there are only approximately five FTEs in the Organisational Intelligence Team to support this Portfolio and the Team has significant business as usual responsibilities, on top of supporting projects, for example Performance and Risk Management. Other findings relate to further promoting consistency. While the framework is deliberately flexible mandating a corporate approach to areas such as highlight reporting and project planning will support good practice.

Fieldwork is documented as three detailed findings, summarised below:

Change Management: (**medium risk**) while issues materialising from changes were not identified on the projects reviewed (Island Plan, Integrated Children's System Move

and Replacement Cash Receipting projects) how change has been managed on these projects varies and is not always sufficiently clear. Although the existing Project Management Framework is deliberately flexible regarding change management this could lead to the impact of changes not being sufficiently considered and changes being progressed which either negate projects or should have been responded to by re-scoping. The Council's Project Management guidance needs to be updated, to make it explicit that tolerances always need to be identified for time, cost and quality, that the impact of changes need to be sufficiently considered, documented clearly and approved at an appropriate level.

Documentation Consistency: (**low risk**) a range of documentation/templates were observed in use across the three projects reviewed (Island Plan, Integrated Children's System Move and Replacement Cash Receipting projects), with further variations observed across the wider programme of Internal Audit reviews. Many of these contain good practice, which could be replicated across the Council's project portfolio. Specific to this review the planning seen for the Island Plan Project was particularly strong, covering key tasks, detailed status, risks, issues, budget and lessons learned, with only minor potential enhancements, for example better capturing changes, as identified above – for context this is the only project reviewed directly supported by the Organisational Intelligence Team. This has already been recognised as a desirable enhancement by the Organisational Intelligence Team. As planned the range of templates currently in use needs to be collated, with a set of mandated templates defined, maintaining flexibility to accommodate a range of project types and contexts, while enforcing greater consistency and helping to further promote good project management.

Strategic Project Reporting: (**low risk**) a clearly defined governance framework is in place over the Council's strategic initiatives, with regular and comprehensive reporting considered by both senior officer and member forums. This is supported by a comprehensive register of projects across the Council with projects deemed strategic clearly identified. The framework is relatively new (there have been two meetings to date) and reporting could be further enhanced, by providing separate RAG scores for time, cost and quality, supported by a quantified set of criteria to arrive at RAG scores. This would help to ensure that senior officers and members are presented with a consistent picture of the status of each initiative, to ensure they both have an accurate view and intervene when necessary. This has already been recognised as a desirable enhancement by the Organisational Intelligence Team, with a draft 'scoring' template provided for Internal Audit review; as planned this should be further developed and its use implemented. Internal Audit also notes that the number of strategic projects at 24 is high, given the small size of the Organisational Intelligence (OI) Team. The Council should either review and rationalise this Portfolio or make additional resources available to the OI Team.

Job Descriptions: (**low risk**) job descriptions for project related roles were last updated in 2015 and are no longer reflective of current arrangements. This has already been recognised by the Team, with review and updating planned; this should continue.

Internal Audit also reviewed the steps taken to implement the Council's Project Management Framework and reviewed three projects (Island Plan, Integrated Children's System Move and Replacement Cash Receipting projects), to confirm they are being correctly managed. While detailed findings have not been raised regarding these areas a summary of the current position is provided below for completeness.

- *Project Management Framework*: *Implementation*: documentation is available on the Council's intranet, staff engaged in project management activity across the Council have been identified and training has been provided centrally, through the Learning and Development Team, for example the 'Accidental Project Manager' training. A central register is in place, capturing change initiatives across the Council and their current position, while focussed support is available from the Organisational Intelligence Team, as requested. With the current level of resourcing in the Organisational Intelligence Team, beyond further mandating consistent templates/documentation as covered above, further enhancements are not realistic without making extra resourcing available.

- *Project Management: Effectiveness*:
  - The Island Plan has been subject to increased costs and delays but these are captured in documentation, with appropriate contextual information. Internal Audit notes that this initiative is focussed on the revision of a statutory document (the island Plan), so not continuing with the Project is not an option.

- The Integrated Children’s System Move Project has now been completed and should realise significant cost savings for the Council, when compared to predecessor arrangements. Documentation is limited but is appropriate to the scale/nature of the project and was approved by the Council’s Chief Executive.
- The Replacement Cash Receipting Project is approximately 50% complete, although the next phase is potentially the highest risk, encompassing development of a replacement system; Internal Audit also notes that much of the ‘cost’ of this Project is in terms of existing officer time, who also have business as usual responsibilities. Progressing the enhancements above, a more formal approach to change management and mandated documentation, will help to ensure that the Project stays on track.

Executive summary – Accounts Payable

Classification	Trend
Low Risk	***Accounts Payable was also rated low risk in 17/18.***

By type

	Control design	Operating effectiveness	Total
Critical	0	0	**0**
High	0	0	**0**
Medium	0	1	**1**
Low	0	1	**1**
Advisory	0	0	**0**

By scope area

	Critical	High	Medium	Low	Advisory
Large payments (>£100k)	0	0	1	1	0

Summary of findings

Accounts Payable staff within the Business Centre are responsible for paying debts owed by the Council, such as invoices relating to goods and services received. The payments are processed through the SAP financial system. Service Departments have nominated officers with access to the SAP system that allows them to raise an order, authorise orders over £200 and acknowledge when goods/services have been delivered/received within appropriate segregation of duties controls. Payments are then generated by SAP once a corresponding invoice is received.

Good Practice:

- The three-way match process is deemed to be operating effectively, with no issues noted for any of the sampled orders subject to review. Internal Audit did note two of our sample had not yet been invoiced but the orders were dated September and December 2018 respectively. The Council are confident these will be invoiced in March 2019.
- The orders reviewed were deemed to be appropriately coded and in all cases correctly matched the nature of the expense to which the order relates.
- The process in relation to one-off payments (10 CHAPS and 15 WightNet Payments) was evidenced by clear and consistent documentation and appropriate approval.

Key Findings:

Documentation of the checks performed for payments over £100k is inconsistent with the Council's procedure document **(Low Risk).** The procedure document stipulates that the report should be manually signed-off by the individual performing the checks. Although the majority of reports reviewed were reviewed in line with this procedure not all were. In one instance, the report documented excluded the amount of the individual orders, therefore deviating from the report parameters as stipulated in the procedure document.

Not all payments over £100k have been subject to checks prior to the payment run **(Medium Risk)** In one instance, the report parameters of the over £100k report resulted in a payment being excluded and as such, no checks were performed prior to payment. For context this was corrected during fieldwork, with processes amended

to ensure that the issue does not reoccur.

Observations:

Two of our sample related to self-billing vendors. This is used by suppliers who provide hourly support to Council clients assisted by the Supporting People team. These suppliers use the SPOCC system to record the number of hours their employee’s work, which are then manually approved/rejected by the 'Supporting People' team. This data is then manually input from SPOCC into SAP. After which, a GRN is generated automatically and payment made. Therefore, no actual invoice is raised. The 'Supporting People' team subsequently use 'audit visits' to corroborate the hours that have been input. It is noted that this occurs after the payment has made, but any discrepancies identified would result in a deduction from future payments to the supplier. It is recommended that future internal audit work could verify the adequacy of the “audit visit” control in checking the hours supplied to the Council from self-billing vendors.

For the vast majority of our sample the goods/services quantity in SAP is recorded as one regardless of the actual quantity ordered. As such, it is not usually possible to match the GRN & PO quantity. The Council are confident that the correct quantity of goods/services is provided because the GRN is system generated only when someone goes into SAP and manually confirms that the goods/services have been provided as per the PO. However, using the SAP quantity field would increase the robustness of the control.

Executive summary – Contract Management

Classification	Trend
Medium Risk	***We have not previously carried out a review with an equivalent scope.***

By type

	Control design	Operating effectiveness	Total
Critical	0	0	**0**
High	0	0	**0**
Medium	2	1	**3**
Low	1	0	**1**
Advisory	0	0	**0**

By scope area

	Critical	High	Medium	Low	Advisory
Contract Management Framework	0	0	0	1	0
Existing Contracts	0	0	2	0	0
Implementation Action Plan	0	0	1	0	0

Summary of findings

For all goods and services procured the expectation is for Council's standard contract terms to be used – these include the expectation that there will be quantified performance metrics, regular reporting and regular oversight meetings between Council and contractor representatives. Following the successful implementation of e-tendering the Council implemented an additional system module in 2018, to support a more consistent approach to contract management across the Council. The ProContract system manages the whole procurement lifecycle; from the planning stages, the live procurement and contract award right through to managing the contract and exiting at the end of the term. The Procurement and Contract Monitoring team (PCMT) own ProContract and the database contains in excess of 180 contracts with a combined whole life value of over £1bn**.** The contract management framework is in draft pending finalisation and once this is complete the Council plans to promote this to service areas, supported by training as necessary and enhance the information in the contract management module with further detail regarding individual contracts. Following on from this use of the contract management module will become 'business as usual', with the expectation that meeting minutes and performance reporting will be uploaded regularly for all contracts. This will enable the Council to have full visibility of its entire contract portfolio for contracts over £25,000 in value, drive maximum value from contracts, to produce regular reports for management and enable any issues to be identified and addressed at the earliest opportunity.

The Council spends in the region of £202.5m with third parties on a wide range of goods, services and works. It is important that these contractual arrangements are adequately managed to ensure that they deliver in line with contract commitments and that value for money is achieved for the tax payer. On average, the Council runs 120 procurement processes per annum where the contract value is over £25,000. Contracts below this threshold do not require a formal advertised procurement process and are dealt with and managed within the service area.

At a high level this review will covered:

- *Framework*: reviewed the proposed contract management framework against good practice, to confirm that it clearly identifies expectations as to how service areas will manage contracts, how the contract management module should be used and how the Council will monitor its contract portfolio, escalating any issues to senior management.
- *Existing contracts*: reviewed a sample of existing contracts, to confirm that there are appropriate, measurable performance expectations specified and that

reporting and oversight
expectations set out in contracts is being complied with.

- *Implementation Plan*: reviewed arrangements associated with fully implementing the planned enhancements to contract management, confirming that actions are sufficiently granular,
assigned to specific individuals, appropriately monitored and reported and that progress is on track.

This review raised four findings summarised below:

Contract Population: (**medium risk**): Review of the entire live listing of contracts held by the Council identified missing / incorrect contract owners, duplicate / expired contracts and one incorrect end date.

Contract Management Framework: (**low risk**): The draft contract management framework needs finalisation and version control adding. Minor enhancements could be made to the expectations detailed concerning supplier performance review meetings and KPI monitoring / recording and how this should be recorded on ProContract.

Implementation Action Plan: (**medium risk**): There is an action plan place to monitor the implementation of more robust and effective contract management procedures across the Council. Some actions could be more granular and some have "ongoing" as a due date, which risks slippage not being identified. The action owner for all bar one action is the Contracts Officer and given the scale and deadlines of the actions in the plan this could prove challenging. The plan does not explicitly state when contract owners are expected to have uploaded all of their KPI information and data and does not state when the contract management framework is expected to be implemented in full. Reviews and updates of the plan could be enhanced.

Existing Contracts: (**medium risk**): Detailed testing of ten contracts with an annual spend of at least £25k identified one draft contract and two contracts / works orders that could not be found. One annual performance review meeting had not been held with a supplier with whom there are known performance issues. In one further instance, supplier meetings are not documented although there were no performance concerns with this supplier reported. Three contracts were for IT systems / applications and contract issues is ad-hoc. An assessment should be done of the criticality of third party IT applications supplied to the Council and whether contract management and performance reviews should be more robust. Four contracts were due to expire in the next 12 months (three in the next three months) but limited formal procurement activity has commenced. This risks single tender waivers or rushed extensions with limited opportunity to market test the supply or resolve any supplier performance issues.

Executive summary – Journals & Reconciliations

Classification	Trend	By type			
			Control design	Operating effectiveness	**Total**
Low Risk	***The 2017/18 General Ledger review was also rated low risk.***	**Critical**	0	0	**0**
		High	0	0	**0**
		Medium	0	0	**0**
		Low	0	3	**3**
		Advisory	0	0	**0**

By scope area	Critical	High	Medium	Low	Advisory
Journals	0	0	0	1	0
Control and Suspense Accounts	0	0	0	2	0

Summary of findings

The general ledger module within the SAP main accounting system provides key financial information to managers regarding financial performance, as well as forming the main source of data for the production of the Council's statement of accounts. Therefore, robust journal controls and reconciliation procedures are key to ensure the integrity, accuracy and completeness of the Council's financial information and reporting.

Suspense accounts are used to temporarily carry funds until they can be allocated and accounted for correctly. The Council has a number of suspense accounts, for example related to payment processing such as the GRNI (Goods Received Not Invoiced) account. The majority of these accounts should clear to zero on a monthly basis, however individual items should not remain in this account beyond an identified maximum period. Particularly where individual item values are high this could lead to a significant impact on the Council's creditors' position.

Control accounts are used to record summary totals of subledgers or systems, such as accounts payable, within the general ledger. The purpose of this is to ensure the general ledger is correct, without including all of the detail on the ledger. To ensure that the control accounts are correct, reconciliations should be performed between the sub ledger and the control account, with any differences investigated and explained or corrected.

Good Practice:

- Testing of 20 bank account reconciliations for accuracy, completeness and review controls noted no exceptions.
- All journals tested had the required approvals for the value of the journal and these were obtained prior to processing with the reasonable exception of backdated pension valuation corrections.
- All journals tested were prepared and reviewed prior to posting to the general ledger.

Key Findings:

- Not all suspense are reconciled monthly (**low risk**).
- Thirteen of our sample of 35 control and suspense accounts had been prepared/reviewed by one person and the GRNI account had long standing entries **(low risk).**

For five journals tested, the email approval was not a screenshot of the original email but copy and pasted into the journal workbook enabling the approval and date to be edited. **(low risk).**

Executive summary – Looked after Children

Classification	Trend
Medium Risk	***We have not previously carried out a review with an equivalent scope.***

By type

	Control design	Operating effectiveness	**Total**
Critical	0	0	**0**
High	0	0	**0**
Medium	4	0	**4**
Low	2	0	**2**
Advisory	0	0	**0**

By scope area

	Critical	**High**	**Medium**	**Low**	**Advisory**
Policy	0	0	1	0	0
Strategy	0	0	2	1	0
Delivery	0	0	1	1	0

Summary of findings

This review focussed on the Council's strategic management of Looked After Children, in overview covering:

- *Policy*: confirming that the Council has a current, approved Policy in place to ensure it meets its responsibilities as a 'corporate parent', that children are involved in decisions regarding their care and that links with parents are maintained wherever possible.
- *Strategy*: confirming that an appropriate strategy is in place to 'realise' the Council's policy objectives, informed by analysis of need and prioritising Island placements, to minimise disruption to children's lives and help ensure that family links are maintained.
- *Delivery*: confirming that the strategy is supported by delivery plans and that these are on track with projections.

Children's Services has recently been subject to an Ofsted review. This rated the Service as good overall, with leadership, child protection work and innovative social work practice being singled out for particular praise. This is supported by the operational reports seen during the fieldwork for this review, for example the high level of quality assurance work carried out by managers in Children's Services and the positive effect this is having on social work practice. For clarity this review was focussed on one strand of work within the Service, the strategic initiatives associated with Looked After Children, how clearly these support policy and confirming that the various strategic initiatives are on track with schedule.

Policy documents, which, while largely still reflective of practice, need to be reviewed and updated. In addition, strategic documentation needs to be clearer and improvements made to how the various initiatives collectively managed under the overarching strategy are monitored and reported at the portfolio level. However, this review has not identified any serious gaps in the work the Service is doing nor in the progress, which the various initiatives are making.

Fieldwork is documented in six detailed findings, summarised below:

Corporate Parenting Strategy: (**medium risk**) while termed a 'strategy' the 2011 Corporate Parenting Strategy, published on the Council's website, sets out the Council's overarching 'policy' regarding corporate parenting. While the high level pledges set out in this document have not changed and the key structures, most importantly the Corporate Parenting Board, are still in place clearly there have been changes at the Council since 2011. Most importantly, the strategic partnership with Hampshire County

Council is in place and the directorate structure at the Council has changed, with Children's and Adult social care no longer combined. The Corporate Parenting Strategy needs to be reviewed and updated, to ensure that it is reflective of current practice on the Island.

Strategic Documentation: Review/Timeline: (**medium risk**) the core document setting out the strategic initiatives related to Looked After Children (LACs) is the 'Children in Care Strategy', although there is also 'strategic' level content in the Isle of Wight Sufficiency Duty 2017-2020. The Sufficiency Duty document is overdue review from September 2018. While it is not possibly to combine the documents (a separate sufficiency document is a legal requirement) ensuing there is no duplication between the documents, cross referencing where necessary, will reduce the overhead of maintaining the documentation and remove the potential for inconsistencies. Strategic documentation also does not currently reference the overarching Corporate Parenting Strategy; this should be addressed as part of review. How strategic level initiatives are documented could also be made clearer, for example by highlighting key milestones in the core strategic documentation, with a separate single, detailed action plan, to support reporting and monitoring progress at the portfolio level.

Strategic Documentation: Corporate Plan and Policy Linkage: (**medium risk**) the metrics for LACs in the Corporate Plan are incorrect, quoting percentages rather than actual numbers. While this is reported and monitored correctly by management within Children's Services, reported upward to Cabinet, it should be corrected in the Corporate Plan to remove any ambiguity. The strategic level documentation (the Children in Care Strategy and Sufficiency Duty document) also do not reference the target in the Corporate Plan; this should be addressed when the documents are reviewed in 2019. When the Corporate Plan is next refreshed the appropriateness of the current objective to reduce the number of LACs should also be revisited, as this is unlikely to be realistic, with numbers on the Island currently growing at 4% a year (improved from 6%, identified in Sufficiency document), in line with national trends; a better measure would be one which focusses on outcomes achieved for LACs.

Strategic Documentation: Evidence Base: (**medium risk**) while the strategic documentation (Children in Care Strategy and Sufficiency Duty document) clearly reference the legislative requirements they support, for example the Children Acts, 1989 and 2004, they do not explicitly reference the Joint Strategic Needs Assessment (JSNA), nor how they have been informed by feedback from LACs, for example the annual CORAM Voice Survey. For the Council to be able to demonstrate that its strategic level documentation is appropriately informed the linkage to the evidence base should be made explicit when the strategic level documentation is reviewed in 2019.

Monitoring: (**low ris**k) comprehensive, quantified reporting was provided for Internal Audit's review regarding Children's Service's performance. This details 40 individual measures, including seven which explicitly link to LACs, which are considered at regular senior management meetings. However, while these cover 'operational' performance, they do not give a sufficient view as to how well the various strategic initiatives are progressing. Specific metrics, clearly linking to strategic initiatives, need to be identified, reported and monitored to enable senior management to be able to fully understand the impact strategic initiatives are having.

Reporting: (**low risk**) We reviewed the 19 actions set out in the strategic documentation on a sample basis and did not identify any issues with work not progressing. However oversight needs to be improved at the portfolio level, to enable senior management to clearly see the current progress of each initiative, to identify and address any issues at the earliest opportunity. This would best be supported by an action plan, with clear officer ownership and scheduled completion dates, regularly updated and considered at senior management meetings.

Management Response

Subsequent to the completion of fieldwork, for the internal audit into Looked After Children (LAC), Children's Services are pleased to report that following progress has been made in relation to addressing the actions identified;

1. Review and update the Corporate Parenting Strategy

The Corporate Parenting Strategy is currently being reviewed and consultation with our children in care council (HYPE) is underway. The strategy will be taken to the Corporate Parenting Board for sign off and then published on iwight.com in line with the target timescale of August 2019. Monitoring and reporting of the associated action plan will be through the Children and Families Management Team and Corporate Parenting Board.

2. Review the Children in Care strategy and Sufficiency Duty-with clear cross referencing and high-level milestones clearly documented.

Both the Children in Care Strategy and Sufficiency Duty are in the process of being reviewed and updated. These will be completed within the target timescale of August 2019 and the associated actions plans will be monitored through Children and Families Management Team.

3. Ensure the Corporate Plan refresh includes correct metrics regarding rate of Looked After Children, and revisit service targets as planned.

The correct metrics have been supplied to the relevant officer responsible for drafting the revised corporate plan. In relation to service targets - these are being revised as planned as part of Children's Services transformation programme. Necessarily Children's Services will maintain a focus on reducing the rate of looked after children which remains higher than statistical neighbours. The revised Corporate Parenting Strategy will provide an emphasis on the quality of provision for looked after children, as does the quality assurance framework now embedded within Children's Services. This includes an annual child in care and care leavers survey conducted by an independent organisation.

4. Ensure that strategic level documentation explicitly references the underlying evidence base (feedback from LAC and JSNA/research and good practice).

This will be incorporated into the review of the strategies highlighted above. The Ofsted report following the most recent inspection did highlight the good provision in place for children in care, including the high level of participation from looked after children in their own care planning and in developing and improving service provision. Social care interventions and support delivered are all evidence based and the transformation programme, including the strengths-based methodology, being delivered across Children's Services over the next two years is informed by a strong research programme undertaken by the University of Winchester, and Stirling.

5. Ensure that appropriate metrics are identified within strategy action plans to ensure senior managers have sufficient oversight of various strategic initiatives.

Comprehensive performance and quality assurance data is provided to senior managers through the internal quality and performance management framework. However in relation to specific strategies it is recognised that more formal reporting is required and this will be implemented as highlighted above (1 & 2).

6. Implement an action plan with officer ownership and scheduled completion dates.

Please see response to number 5.

Executive summary – Payroll

Classification	Trend
Low Risk	***We have not previously carried out a review with an equivalent scope.***

By type

	Control design	Operating effectiveness	Total
Critical	0	0	**0**
High	0	0	**0**
Medium	1	0	**1**
Low	1	0	**1**
Advisory	0	0	**0**

By scope area

	Critical	High	Medium	Low	Advisory
Starters, leavers and amendments	0	0	1	1	0
Timesheets	0	0	0	0	0
Payroll advances	0	0	0	0	0

Summary of findings

The Payroll Team is located at the Business Centre, with the HR Transactional Team being located at County Hall. The Payroll Team is responsible for processing the payroll for directly employed Council staff but not Island schools staff. The HR Transactional Team is responsible for processing starters, transfers and leavers. Both payroll and HR systems are managed through the integrated SAP system.

Good Practice:

- Testing of 25 payroll amendments concluded that all were completed on the appropriate Wightnet form, supported by evidence and approved prior to implementation (where required).
- Testing of ten payroll advance payments verified that all were appropriately authorised prior to payment.
- Testing of five timesheet payments from timesheet, to timesheet spreadsheet (a summary of all timesheet payment each month sent to payroll by the function) to payslip noted no issues.

Key Findings:

- Testing of 25 leavers noted some are processed without the appropriate Wightnet form and / or a resignation letter / email and 13 were removed from SAP more than 10 days after the last date of service increasing the risk of erroneous payment **(medium risk)**
- Testing of 25 starters noted two had start dates that pre-dated the completion of the new joiners form **(low risk)**

Executive summary – Schools

School	Rating
Arreton	**Low Risk**
Barton	**Medium Risk**
Binstead	**Medium Risk**
Cowes	**Low Risk**
Hunnyhill	**Medium Risk**
St Mary's	**Low Risk**
Medina House	**Low Risk**
Medina College	**Low Risk**
Newport	**Low Risk**
St Helens	**Low Risk**

Summary of findings

The Council is responsible for 42 schools on the Island, 36 primary schools, three secondary schools, two special schools and one pupil referral unit. All of these schools, as required, returned completed copies of the Schools Financial Value Standard (SFVS) self-assessment questionnaire by the end of March 2018, covering the 2017/18 financial year. The purpose of the SFVS is to 'help schools to manage their finances and to provide assurance to the local authority that they have secure financial management in place'. The self-assessment questionnaire contains 25 questions, grouped under the following headings:

A: The governing body and school staff,

B: Setting the budget,

C: Value for money,

D: Protecting public money.

Internal Audit undertook a thematic approach to the review of school financial management in 2018/19. A sample of ten schools was contacted, requesting evidence to support the assertions made in a subset of their SFVS self-assessment questionnaire responses. Internal Audit then reviewed the evidence provided, to assess the degree

to which it supports the assertions made. Following consultation with senior management within Children's Services and the Finance Team the following questions have been selected:

1. In the view of the governing body itself and of senior staff, does the governing body have adequate financial skills among its members to fulfil its role of challenge and support in the field of budget management and value for money?

2. Does the governing body have a finance committee (or equivalent) with clear terms of reference and a knowledgeable and experienced chair?

5. Are business interests of governing body members and staff properly registered and taken into account so as to avoid conflicts of interest?

6. Does the school have access to an adequate level of financial expertise, including when specialist finance staff are absent, e.g. on sick leave?

13. Is end year outturn in line with budget projections, or if not, is the governing body alerted to significant variations in a timely manner, and do they result from explicitly planned changes or from genuinely unforeseeable circumstances?

14. Does the school benchmark its income and expenditure annually against that of similar schools and investigate further where any category appears to be out of line?

22. Are all staff aware of the school's whistleblowing arrangements and to whom they should report concerns?

The assertions made on the School Financial Value Standard (SFVS) returns by each of the schools selected for audit have been assessed against the evidence provided for each of the assertions and compared to the government guidelines for good practice.

The conclusion of this report is mostly positive, though there are a number of recurring discrepancies that Internal Audit have identified across all schools. The most common was that the school's whistleblowing policy is not published to the school's website, which would help improve transparency and access for both staff and parents. It was also noted that income and expenditure benchmarking exercises had either not been undertaken or that there was little evidence of any follow up action from the findings within the exercise where outlier categories were noted.

There were however a number of positive themes throughout the review, most notably that the governors' business interests were kept up to date on the register, published to school's websites and governors' were also given the opportunity to declare any new business interests at each meeting. Furthermore, the financial skills and competency of the finance staff at the schools was evidenced at a satisfactory level.

Executive summary – Domiciliary Care

Classification	Trend	By type			
			Control design	Operating effectiveness	Total
Medium Risk	***We have not previously carried out a review with an equivalent scope.***	Critical	0	0	**0**
		High	0	0	**0**
		Medium	3	0	**3**
		Low	3	0	**3**
		Advisory	0	0	**0**

By scope area

	Critical	High	Medium	Low	Advisory
Strategy	0	0	1	1	0
Operation	0	0	2	1	0
Oversight	0	0	0	1	0

Summary of findings

This audit focussed on domiciliary care, both in terms of future plans to support the relevant overarching objectives in the Corporate Plan and business as usual activity, sourcing and overseeing domiciliary care services. In overview this review covered:

- *Strategy*: confirming that the Council has an approved Strategy, appropriately informed by evidence and setting out the Council's plans over a defined timeframe, monitored by a set of baselined, quantified performance indicators.
- *Operation*: confirming that there are appropriate arrangements in place to source care packages and quality assure provision.
- *Oversight*: confirming that there are appropriate oversight arrangements, both regarding business as usual and progressing planned changes/enhancements.

On the strategic 'change' side the headline is that performance reporting shows that the indicators in the Corporate Plan are on schedule to be met or exceeded:

Measure	**Baseline (2017)**	**Target (2020)**	**Actual (Dec 2018)**
Permanent admissions to residential and nursing care homes, per 100,000 population <	952.4	596	454.2
Proportion of all people in receipt of ASC supported to live at home >	27.3%	35%	34%
Number of admissions to permanent residential/nursing care as a % of all initial contact referrals <	6.5%	2%	0.9%

However Internal Audit's review has identified enhancements, regarding how the Strategy is documented, reported and monitored at the programme/portfolio level. The Service is planning on reviewing the Strategy at an upcoming away day, which should be informed by the findings of this review.

Regarding business as usual activity significant progress has been made since this area was last reviewed, as part of the 2016/17 review of Adult Social Care Contracts. All contracts reviewed are current, signed and set out at a high level what is expected of providers. Adult Social Care has developed a comprehensive contract management framework, quality assessment matrix (informed by provider self-assessments, quality assurance visits to providers and Care Quality Commission (CQC) reports), considered at regular team meetings, with key information escalated to senior management; only minor enhancements are identified below. The most significant gap is the limited activity to validate that providers are delivering the contracted level of care, both in terms of hours and meeting the objectives of care plans; this is largely limited to self-reporting by providers and reviews by social workers, which are usually carried out at 12 month intervals. Internal Audit notes that these issues have been recognised by the Council, with plans in place to enhance arrangements, for example a new, more comprehensive and integrated software system, which will more clearly capture and evidence the work providers deliver. The results of fieldwork are documented as six detailed findings, summarised below:

Care Packages: (**medium risk**) Internal Audit reviewed 25 of the 374 care packages implemented since 1st April 2018, to confirm payments were correctly made and there is sufficient validation that the care provided matches the contracted level. Testing identified that information is fragmented between a number of systems and paper care plans and validation activity is largely limited to annual review by social workers. These issues are known to the Council and a new, replacement system is planned to be in place by December 2019 which will partially address this by better documentation of care needs in the new replacement system, than is currently the case with Adam (the system currently used to manage the interface with providers). However further controls are necessary, to ensure that providers are held to the contracted level of care: ensuring information in the new replacement system is used to inform social worker review, validating assertions made by providers with care clients and using the information in the new replacement system to inform the work of the Quality Assurance (QA) Team. Linked to this the decision to remove a specific post which during 2017 was responsible for recovering £47,131.52 from incorrect (over) charging by providers should be revisited.

Provider Oversight: *Quality Assurance Team*: (**medium risk**) at the provider level oversight is largely provided by the Integrated Quality Assurance Team (QA), which sits within the Clinical Commissioning Group (CCG). This does limit the 'control' the Council is able to exercise over the Team and, to better ensure that the Team is meeting the Council's needs, options to bring the Team under the Council, collocated with the core Commissioning Team should be investigated. Regarding the work of the Team Internal Audit has identified three issues: there are a number of gaps identified on provider self-assessments which do not appear to have been followed up on at QA Team visits, for example ensuring that providers have appropriate arrangements to confirm safe water temperatures; follow-up of action plans stemming from QA Team recommendations appears informal, for example emails from providers asserting that actions have been addressed being accepted as evidence of completion; the QA Team may not be sufficiently sharing exemplar documents and processes with providers, for example copies of the SHIP (Southampton, Hampshire, Isle of Wight and Portsmouth) Safeguarding Policy. These issues will be easier to address if the Team was directly under the control of the Council. Either way the Council needs to confirm that the self-assessments are being used to inform inspection visits, that the Team has a robust and formal process for following up on and evidencing completion of actions and that an agreed set of exemplar documents/processes is being shared with providers.

Provider Oversight: Contract Team: (**low risk**) while the contract management framework is in place and accepted by all providers its expectations are not explicitly identified in current contracts; in parallel with the new replacement system new agreements will be rolled out, ensuring the expectations of the contract management framework are sufficiently referenced. One of the key expectations of the contract management framework is that providers will submit a self-assessment, however six providers have yet to submit their self-assessments for 2018. While effort should continue to chase these more importantly the breach process needs to be consistently enforced.

There is also currently limited validation of the assertions made by providers in their self-assessment forms. This should be addressed by either revisiting how this links to the work of the QA Team, or by implementing a standalone process to validate a sample of assertions on an annual basis.

Care Close to Home: Delivery: (**medium risk**) the RAG rating of initiatives under Care Close to Home does not currently present an accurate view of the progress which is being made. Specifically the December 2018 highlight report flags 13 of the 30 initiatives as red for 'status' (indicating a failing programme), while the overarching performance reporting (above top) shows that the programme has either already met or is on track to meet its 2020 targets. Internal Audit's review of three constituent initiatives (Planned new domiciliary care system, the Domiciliary Support Service and ICT Mobile Working Project) supports this conclusion, with detailed reporting not supporting the overarching RAG ratings in the highlight reporting. How RAG ratings are arrived at and presented needs to be revisited, to ensure it presents an accurate

view of the status of each initiative. Specific to the planned new domiciliary care system timescale cannot slip, as the contract for the Adam system expires and notice has been given to the existing system provider that the contract will not be extended. All stakeholders must be held to completing their allocated tasks as schedule and, if there is any slippage, a 'plan b' needs to be identified by September 2019 at the latest.

Care Close to Home Strategy: (**low risk**) while the work comprising the Strategy, the timeframe over which it will run, the benefits it will realise and the evidence base on which it is based is documented this is fragmented across a range of documents, rather than being set out in the 'core' Strategy. For example the Corporate Plan identifies overarching performance measures (reducing residential care and maximising use of domiciliary care), the evidence base is largely set out in the Market Position Statement and timescales are identified in individual project plans. The Service plans to review the Strategy at an upcoming away day; the revised Strategy needs to more fully document the key initiatives, high level milestones, benefits which will be achieved, the evidence base and how the Strategy supports the Corporate Plan.

Care Close to Home: Monitoring & Oversight: (**low risk**) the current reporting has grown organically, with the aim of presenting a picture of progress across all 'change' in Adult Social Care. This has led to an excessively long highlight report format (in excess of 16 pages) and information being split across a number of separate documents – it is not currently possible to easily see high level progress across the three dimensions of time, cost and quality. This has been recognised by the Council, with both a summary cover sheet (covering time, cost and quality) and efforts to reduce the length of the highlight report; this is sensible and should continue as planned.

Executive summary – Local Care Plan (Support for Providers)

Classification	Trend	By type			
			Control design	Operating effectiveness	**Total**
Low Risk	***We have not previously carried out a review with an equivalent scope.***	**Critical**	0	0	**0**
		High	0	0	**0**
		Medium	2	0	**2**
		Low	0	0	**0**
		Advisory	1	0	**1**

By scope area	**Critical**	**High**	**Medium**	**Low**	**Advisory**
Plan	0	0	0	0	0
Delivery	0	0	2	0	0
Oversight	0	0	0	0	1

Summary of findings

This review focussed on the 'Support for Providers' strand of the Improved Better Care Fund (iBCF). The overarching aim of the iBCF being to fund changes to the health and social care system, leading to services which are more effective, efficient and sustainable in the long term. The iBCF forms part of the Better Care Fund Section 75 Agreement, £621,000 being spent on the Support for Providers strand between 2017 and 2019 in overview this review covered:

- *Plan*: confirming that the high level plan for the Support for Providers strand of the iBCF was developed into detailed delivery plans for 2018/19, informed both by the initial scope and experiences from 2017/18 and included an appropriate range of activities to achieve the benefits projected to be achieved by the initiative, with appropriate metrics defined to 'capture' the success of the initiative.
- *Delivery*: confirming that the initiative has progressed as envisaged or, where not, change has been correctly managed/approved, including assessment of impact on the originally envisaged benefits.
- *Oversight*: confirming that appropriate governance is in place, to guide delivery, keep the initiative is on track and ensure that senior management understand the progress which is being made and are suitably informed, to enable them to intervene if issues are encountered.

The Council has led a range of activities during 2017/18 to deliver the "support for providers" strand of the iBCF initiative and drive improvements in the adult social care sector in line with the stated objectives. Historically there has been a poor relationship between the sector (both private and voluntary providers) and the Council, as noted in the background papers provided for this audit, while the fact that the sector is independent of the Council means the Council can offer and signpost support but it cannot compel participation. What is clear from the evidence reviewed to inform this review is that while progress has been made there is more work to do. Three key findings are summarised below:

Training: (**medium risk**) a key element of the "Support for Providers" strand was to provide a range of training to providers from 2017, the content informed by an independent meta-analysis of provider 'quality', based on Care Quality Commission (CQC) data and a range of other information sources. This included interviews with management at the Council and NHS regarding the state of the care sector on the Island. A workshop was also held during early 2017 with sector representatives, to help them shape and have ownership of the training programme. The most important element of the training was a five day classroom course led by Mountbatten Hospice

(rated as outstanding by the CQC), delivered over four cohorts, during 2017/18. While the majority of providers engaged well there are a g number of 'no shows' when attendance had been confirmed in advance (19 no shows on day one across the four cohorts, increasing to 34 by day five, against 100 confirmed attendees), although 'no shows' were chased, to ensure that training was completed at subsequent sessions. There is further work to do and lessons which can be learned from the experiences of 2017/18. For example while charging for training may further discourage attendance charging for no shows should be investigated. The Mountbatten 2018 evaluation report also identifies that taking an integrated approach across those supporting providers (both training and wider support/oversight roles) would avoid duplication and ensure there are no gaps in provision. These areas should be considered when planning the training offer for 2019/20.

Change management: (**medium risk**) three changes were made between 2017 and 2019 to the originally proposed work under the Support for Providers strand of the iBCF: the ceasing of the independent chair post for provider organisations and not all provider secondments were progressed. Lastly, the 2018/19 ASC Market Day was amalgamated with the Adult Social Care Conference, rather than happening as a standalone event. This led to an underspend during 2017/18 of £102,040, which was used to fund wider initiatives under the iBCF during 2018/19. While these changes were within the delegated authority of the scheme lead they were not formally documented and are not included in reporting to relevant oversight forums. To ensure that change is correctly managed, including consideration of its impact on projected benefits and what the best use of the resources would be to provide the same or similar benefits, a hierarchy of tolerances/change authorities should be defined, change approvals evidenced in future and changes and their impact reported to relevant forums for future initiatives of this type. Linked to this original proposals and the analysis carried out to inform training need included initiatives to support providers beyond the core training offer, which have not been progressed, for example a virtual centre of excellence. These proposals and recommendations should be revisited when scoping further work to support providers.

In addition to the two findings summarised above this review also identified weaknesses in associated reporting. While there is a comprehensive governance framework in place, with the Operational Delivery Group (ODG) and Local Care Board (LCB) reporting upwards to the Health and Wellbeing Board (HWB), the reporting going to these forums is limited. Specifically the Local Care Board (LCB), at their request, only receive information on an exception basis, which means they have limited information to inform their oversight role, while the quarterly 'quad' report provides placeholders for activity in period, upcoming activity and risks/issues, along with an overall RAG rating but does not cover performance against targets.

While these gaps in reporting would ordinarily result in a risk rated finding, being applicable across the BCF and in a mandated format, they are both outside of the authority of the Council to directly change and would impact across the Programme, rather than being applicable solely to the Support for Providers strand. As such current issues should be highlighting to relevant stakeholders, to identify if it is possible to progress enhancements.

Executive summary – Fire Service Governance

Classification	Trend	By type			
Low Risk	*We have not previously carried out a review with an equivalent scope.*		Control design	Operating effectiveness	**Total**
		Critical	0	0	**0**
		High	0	0	**0**
		Medium	0	0	**0**
		Low	1	0	**1**
		Advisory	0	0	**0**

By scope area	Critical	High	Medium	Low	Advisory
Framework	0	0	0	1	0
Reporting	0	0	0	0	0
Oversight	0	0	0	0	0

Summary of findings

In January 2019 the Council took the decision to apply to the Secretary of State to approve a new combined fire authority covering both Hampshire and the Isle of Wight (Combined Fire Authority, CFA). This follows on from the partnership with the Hampshire Fire and Rescue Service (HFRS, Delivering Differently in Partnership (DDIP)), which has been running since early 2015. This review covers the DDiP, the existing agreement with HFRS, which is likely to remain in effect up to April 2020, as below:

- *Framework*: a current, approved agreement or equivalent is in place, which clearly identifies what is being provided, the responsibilities of the respective parties and expectations regarding reporting and monitoring.
- *Reporting*: reporting is being produced as specified in the contract/agreement, appropriate to the forums at which it is considered, with summary/exception reporting escalated as necessary.
- *Oversight*: a regime of oversight meetings is in place, with correctly constituted forums, with appropriate membership and meeting frequency, receiving the reporting specified in the contract/agreement, sufficient to enable them to assess the level of performance and identify/escalate any issues as necessary.

The conclusion of this review is overwhelmingly positive. DDiP is projected to achieve approximately £1,194,895 of financial savings to the Council, while ensuring an effective service continues to be provided and giving the Island access to the greater resources of HFRS, supporting the service being more resilient. The main focus of effort is now on progressing the CFA. However, the Partnership Commitment Agreement entered into in 2015 continues to specify how the relationship with HFRS operates until the CFA comes into effect, which itself is dependent on approval by the Secretary of State. Internal Audit's review has identified that, while still substantively correct, the relationship has changed since the partners decided to pursue the CFA in 2017. There are minor differences in governance arrangements, some elements delivered by DDiP have now transitioned to 'business as usual', with outstanding change moving under the CFA project and the Annual Report to Full Council has not been produced since 2016 – this report informed members as to the progress being made with DDiP and the ongoing effectiveness of the Partnership. One low risk finding has been raised covering these changes and how the Council and HFRS need to respond, summarised below:

Contractual Accuracy: (**low risk**) the Partnership Commitment identifies in clause 21.6 that 'any changes to this Agreement must be agreed between the parties and recorded in a Deed of Variation'. At a high level the focus has shifted to preparing for a new CFA, to include the Isle of Wight, although this does require approval from the Secretary of State and is not anticipated to come into effect, if approved, before April 2020; until this date the relationship between the Council and HFRA continues to be governed by the terms of the Partnership Commitment. There have been a number of changes from the terms of the 2015 Agreement, for example changes in governance arrangements and ceasing to produce an Annual Report for Full Council (last presented in 2016). To normalise the relationship between the Council and HRFS until the CFA comes into effect, or until the scheduled end of the partnership in 2020 if the CFA is not approved by the Secretary of State, how the relationship is currently working should be documented in an appropriate Deed of Variation, to be approved by both organisations.

Appendix A: Basis of our classifications

	Effect on Service	*Embarrassment/ reputation*	*Personal Safety*	*Personal privacy infringement*	*Failure to provide statutory duties/meet legal obligations*	*Financial*	*Effect on Project Objectives/ Schedule Deadlines*
Critical	A finding that could result in a: • Major loss of service, including several important areas of service and /or protracted period. Service Disruption 5+ Days	A finding that could result in: • Adverse and persistent national media coverage • Adverse central government response, involving (threat of) removal of delegated powers • Officer(s) and/or Members forced to resign	A finding that could results in: • Death of an individual or several people	A finding that could result in: All personal details compromised/ revealed	A finding that could result in: • Litigation/claims/ fines from Department £250k + • Corporate £500k +	A finding that could result in: • Costs over £500,000	A finding that could result in: • Complete failure of project/ extreme delay – 3 months or more
High	A finding that could result in a: • Complete loss of an important service area for a short period • Major effect to services in one or more areas for a period of weeks Service Disruption 3-5 Days	A finding that could result in: • Adverse publicity in professional/municipal press, affecting perception/standing in professional/local government community • Adverse local publicity of a major and persistent nature	A finding that could result in: • Major injury to an individual or several people	A finding that could result in: Many individual personal details compromised/ revealed	A finding that could result in: • Litigation/claims/fines from • Department£50k to £125k • Corporate £100k to £250k	A finding that could result in: • Costs between £50,000 and £500,000	A finding that could result in: • Significant impact on project or most of expected benefits fail/ major delay – 2-3 months

	Effect on Service	Embarrassment/ reputation	Personal Safety	Personal privacy infringement	Failure to provide statutory duties/meet legal obligations	Financial	Effect on Project Objectives/ Schedule Deadlines
Medium	A finding that could result in a: • Major effect to an important service area for a short period • Adverse effect to services in one or more areas for a period of weeks Service Disruption 2-3 Days	A finding that could result in: • Adverse local publicity /local public opinion aware • Statutory prosecution of a non-serious nature	A finding that could result in: • Severe injury to an individual or several people	A finding that could result in: • Some individual personal details compromised/ revealed	A finding that could result in: • Litigation/claims/fines from Department £25k to £50k • Corporate £50k to £100k	A finding that could result in: • Costs between £5,000 and £50,000	A finding that could result in: • Adverse effect on project/ significant slippage – 3 weeks–2 months
Low	A finding that could result in a: • Brief disruption of important service area • Significant effect to non-crucial service area Service Disruption 1 Day	A finding that could result in: • Contained within section/Unit or Directorate • Complaint from individual/small group, of arguable merit	A finding that could result in: • Minor injury or discomfort to an individual or several people	A finding that could result in: • Isolated individual personal detail compromised/ revealed	A finding that could result in: • Litigation/claims/fines from Department £12k to £25k • Corporate £25k to £50k	A finding that could result in: • Costs less than £5,000	A finding that could result in: • Minimal impact to project/ slight delay less than 2 weeks
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.						

Report classifications

The report classification is determined by allocating points to each of the findings included in the report.

Findings rating	*Points*
Critical	40 points per finding
High	10 points per finding
Medium	3 points per finding
Low	1 point per finding

Report classification	*Points*
Low	6 points or less
Medium	7– 15 points
High	16– 39 points
Critical	40 points and over

Appendix B: Progress on the 2018/19 internal audit plan

Audit name	Fee	Current Status	Report classification for those audits completed
Asset Management	£7,800	Draft Report	-
Commercial Strategy/Income Generation *	£7,800	Suspended	n/a
Contract Monitoring	£7,800	Final Report	Medium Risk
Cross Services Outcomes *	£7,800	Suspended	n/a
Domiciliary Care	£7,800	Final Report	Medium Risk
GDPR/Data Sharing	£7,800	Final Report	No Assurance
Home to School Transport	£7,800	Final Report	High Risk
Houses with Multiple Occupation	£7,800	Final Report	Medium Risk
Income Collection (Cowes Bridge, Shanklin Lift, Crematorium)	£7,800	Draft Report	-
IT General Controls (ITGC)	£7,800	Final Report	High Risk
Key Financial Systems (KFS):	£11,600	-	-
• Accounts Payable	-	Final Report	Low Risk
• Journals & Reconciliations	-	Final Report	Low Risk

Audit name	Fee	Current Status	Report classification for those audits completed
• Payroll	-	Final Report	Low Risk
Local Care Plan (Support for Providers) **	£7,800	Final Report	Low Risk
Looked After Children	£7,800	Final Report	Medium Risk
Nicholson Road *	£7,800	Final Report	High Risk
Parking	£7,800	Final Report	High Risk
Project Management	£7,800	Final Report	Low Risk
Regulatory Compliance	£7,800	Final Report	No Assurance
Schools	£7,800	Final Report	n/a
Social Media/CCTV	£7,800	Final Report	High Risk
Special Educational Needs and Disability (SEND)	£7,800	Final Report	High Risk
Third Party Relationship Governance (Fire Service)	£7,800	Final Report	Low Risk

Audit name	Fee	Current Status	Report classification for those audits completed

* Two substitutions have taken place regarding our quarter four programme of work, as below:

- *Commercial Strategy/Income Generation*: development of the Council's revised Commercial Strategy is not as advanced as anticipated when the Internal Audit Plan was scoped. This review will now take place in 2019/20, being substituted in 2018/19 with a review of Nicholson Road, one of the initiatives of the Council's Regeneration Programme.

- *Cross Services Outcomes*: this review was to focus the Council's work to prevent domestic violence, supporting the 'Vulnerable people are supported and protected' outcome in the Corporate Plan. The Council is in the process of revising its arrangements in this area and this review will now take place in 2019/20; time released has been used to support Internal Audit planning for 2019/20.

** The Local Care Plan review focussed on the Support for Providers strand of the overall Programme.

Appendix C: Internal audit performance against key performance indicators 2018/19

	Asset Management	Nicholson Road	Contract Monitoring	Domiciliary Care	GDPR/Data Sharing	Home to School Transport	Houses with Multiple Occupation	Income Collection	IT General Controls (ITGC)	Key Financial Systems (KFS)	Local Care Plan (Support for Providers)	Looked After Children	Nicholson Road	Parking	Project Management	Regulatory Compliance	Schools	Social Media/CCTV	Special Educational Needs and Disability (SEND)	Third Party Relationship Governance (Fire Service)
Scope agreed prior to fieldwork commencing?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Exit meeting held?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Draft report issued within 10 working days of completion of exit meeting?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Draft report issued within 10 working days of receiving documentation from auditee?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	y	Y	Y
Management response received?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Final report issued within five working days of agreement of management response?	-	Y	Y	Y	Y	Y	Y	-	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Client satisfaction survey score (if received)?	-	-	-	-	-	-	-	-	10	-	-	-		8.4	-	-	-	-	-	-