London Borough of Enfield

General Purposes Committee

26 July 2022

Subject:	**Annual Internal Audit Report 2021-22**
Cabinet Member:	**Cllr Tim Leaver, Cabinet Member for Finance and Procurement**
Executive Director:	**Fay Hammond, Executive Director Resources**
Key Decision:	**N/A**

Purpose of Report

1. The Annual Internal Audit Report 2021-22 (**Annex A**) summarises:

   - the results of the work that the Internal Audit team has undertaken during 2021-22
   - the continued work of the Head of Internal Audit and Risk Management in collaboration with the internal Assurance Board to target limited resources at the highest priority services
   - the opinion of the Head of Internal Audit and Risk Management that there is **Reasonable** assurance over the arrangements for governance, risk management and internal control in the London Borough of Enfield
   - the actions the Internal Audit team will implement to ensure the continuous improvement of the service

Proposal

2. The General Purposes Committee is requested to note the contents and provide comment on the Annual Internal Audit Report 2021-22.

Reason for Proposal

3. In line with the Council's Internal Audit Charter, which is based on the requirements of the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit and Risk Management has a responsibility to regularly update the General Purposes Committee on the work of Internal Audit through periodic and annual reports.

Relevance to the Council's Plan

Good Homes in Well-Connected Neighbourhoods

4. An effective Audit and Risk Management Service helps to provide assurance over any risks that might adversely affect the delivery of good homes in well-connected neighbourhoods.

Safe, Healthy and Confident Communities

5. An effective Audit and Risk Management Service is an essential management tool which will help the Council achieve its objectives to sustain safe, healthy, and confident communities.

An Economy that Works for Everyone

6. An effective Audit and Risk Management Service will help the Council achieve its objectives in building an economy that works for everyone.

Background

7. In line with the Council's Internal Audit Charter, which is based on the requirements of the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit and Risk Management has a responsibility to regularly update the General Purposes Committee on the work of Internal Audit through periodic and annual reports.

8. These reports should include details of audit activities with significant findings along with any relevant recommendations. Periodic information on the status of the annual audit plan should also be included.

9. The PSIAS also require the Head of Internal Audit and Risk Management's annual report to include an opinion of the overall adequacy and effectiveness of the organisation's framework of governance, risk management and internal control. For 2021-22, the Head of Internal Audit and Risk Management's opinion is that there is **Reasonable** assurance on the overall adequacy and effectiveness of the Council's framework of governance, risk management and internal control.

10. Additionally, it is a requirement of the PSIAS that an external assessment of the Internal Audit function is conducted every five years by a qualified and independent assessor from outside the organisation. Such an assessment was carried out in 2019-20 and therefore was not required in 2021-22. However, an internal self-assessment has been carried out and details of actions to be taken to ensure continuous improvement of the service are outlined in the Internal Audit Quality Assurance Improvement Plan which forms part of the Annual Internal Audit Report 2021-22.

Main Considerations for the Council

11. Any large complex organisation needs to have a well-established and systematic risk management framework in place to identify and mitigate risks it may face. Through the Assurance Board, the Council has sought to target the available audit resources at services that require the greatest levels of assurance.

12. During 2021-22, the Council continued to improve its risk management procedures. It is recognised that the Council needs to continue to build on its successes in this area as outlined in the 2022-23 Risk Management Strategy and Risk Operating Plan presented to the General Purposes Committee on 3 March 2022.

13. The Internal Audit team works closely with senior managers in the identification and mitigation of risk. The Assurance Board, with membership consisting of the Council's Statutory Officers and Internal Audit, is seen as a best practice approach by the Head of Internal Audit and Risk Management.

14. As an impact of the Covid-19 pandemic, a hybrid working model was adopted for 2021-22.

15. The Internal Audit team was, in most cases, unable to visit schools during 2020-21, therefore testing requiring a physical attendance at schools was postponed into one single audit carried out in 2021-22.

16. While planning audits, Internal Audit identified any Covid-19 related changes that had been made to processes and ensured these were fully factored into the audit work carried out. Additionally Internal Audit took account of specific restrictions in place and ensured the timing of the audits did not place unnecessary pressure on individual services. **Annex A** shows that flexibility was applied to the 2021-22 audit plan to take account of circumstances such as these.

17. As well as hybrid working being a new challenge for Internal Audit, this was also a new challenge for audit clients. Internal Audit adopted a variety of methods to efficiently exchange information with clients based on individual circumstances.

18. In 2021-22, 59 audits (2020-21: 49) were commissioned through the Council and monitored by the Assurance Board, of which 38 (2020-21: 27) received an assurance rating.

19. 27 audits that received an assurance opinion were targeted at key corporate services and 11 were schools' audits. This compares to 19 corporate audits and 8 schools' audits in 2020-21.

20. The assurance opinion levels available are:

    - Substantial
    - Reasonable
    - Limited
    - No

The definitions underlying each of these levels are outlined in Appendix 3 of the Annual Internal Audit Report 2021-22 (**Annex A**).

By definition, the bar for attaining a Substantial rating is set high, so not many audits achieve this rating.

21. The assurance opinions in 2021-22 compared to 2020-21 are:

	2021-22		2020-21	
		%		%
Substantial	1	3%	4	15%
Reasonable	21	55%	12	44%
Limited	14	37%	10	37%
No	2	5%	1	4%

As can be seen from the above table, there has been little movement in the year on year assurance opinion profile.

22. In total, 278 actions for improvement have been discussed and agreed with management, including one action addressing a critical risk finding and 25 actions addressing high risk findings. The Council continues to make good progress in implementing actions.

Safeguarding Implications

23. There are no safeguarding implications related to this report.

Public Health Implications

24. There are no Public Health implications related to this report.

Equalities Impact of the Proposal

25. Following the Completion of the Corporate Equalities Impact Assessment initial screening, this report does not have an Equalities impact.

Environmental and Climate Change Considerations

26. There are no environmental and climate change implications related to this report.

Risks that may arise if the proposed decision and related work is not taken

27. The Internal Audit team supports management in the identification and mitigation of risks and therefore if this work is not carried out, reviewed, and followed up, the Council faces the risk of legal, financial, and reputational loss.

Risks that may arise if the proposed decision is taken and actions that will be taken to manage these risks

28. N/A

Financial Implications

29. Section 151 of the Local Government Act 1972 requires that every local authority in England and Wales should "make arrangements for the proper administration of their financial affairs." The Chief Finance Officer (Section 151 Officer) in a local authority must lead the promotion and delivery, by the whole authority, of good financial management so that public money is safeguarded at all times and used appropriately, economically, efficiently, and effectively. The role of the Section 151 Officer includes ensuring that the systems and processes for financial administration, financial control and protection of the authority's resources and assets are designed in conformity with appropriate ethical standards and monitor their continuing effectiveness in practice. The Accounts and Audit Regulations 2003 (England and Wales), requires that a "relevant body shall maintain an adequate and effective system of internal audit of its accounting records and its system of internal control."

30. The role of Internal Audit supports this by undertaking a review of the controls in place. The Internal Audit Plan set out in partnership to achieve this by:

    - ensuring that the authority puts in place effective internal financial controls covering codified guidance, budgetary systems, supervision, management review and monitoring, physical safeguards, segregation of duties, accounting procedures, information systems and authorisation and approval processes
    - ensuring that these controls are an integral part of the authority's underlying framework of corporate governance and that they are reflected in its local code

31. In this context, the Internal Audit Plan is developed in partnership with the wider organisation, seeking to focus on areas of the greatest risk in order to ensure that the appropriate controls are in place and, where controls are found to be inadequate, plans to address these are implemented.

32. As Section 151 Officer, I am confident in the management team and the organisation's commitment to continue to work on implementing the actions necessary and that overall the key financial safeguards are in place. The ongoing review of our key control systems will continue over the coming year to ensure that overall the finances continue to be well governed.

Legal Implications

33. The Council's Chief Finance Officer (the 'Section 151 Officer' – section 151 Local Government Act 1972) has statutory status and is responsible for financial administration. The Chief Finance Officer is also under a statutory duty to issue a formal report if s/he believes that the Council is unable to set or maintain a balanced budget (the 'section 114 report' (section 114 Local Government Finance Act 1988).

34. The Accounts and Audit Regulations 2015 (the '2015 Regulations') places an obligation on local authorities to maintain a system of internal audit whereby it:

    - facilitates the effective exercise of its functions and the achievement of its aims and objectives;
    - ensures that the financial and operational management of the authority is effective; and
    - includes effective arrangements for the management of risk.

35. The Internal Audit team must be effective in order to evaluate the effectiveness of its risk management, control, and governance processes, taking into account Public Sector Internal Auditing Standards or guidance.

36. Each financial year the council must conduct a review of the effectiveness of the system of internal control required by regulation and prepare an Annual Governance Statement.

37. This report addresses the statutory obligations for local audit processes. The Local Government Act 1972 and subsequent legislation sets out a duty for the Council and other Councils to make arrangements for the proper administration of their financial affairs. This report also complies with the requirement of the following:

    - Local Government Act 1972
    - Accounts and Audit Regulations 2015
    - CIPFA/IIA: Public Sector Internal Audit Standards (PSIAS)
    - CIPFA/IIA: Local Government Application Note for the UK PSIAS

38. The provision of an Internal Audit team is integral to the financial management at the Council and assists in the discharge of its duties.

39. There are various obligations upon the Council regarding ensuring that its business is conducted in accordance with the law and proper standards. This includes the duty (under the Local Government Act 1999) to make arrangements to secure continuous improvement, to have an Annual Governance Statement (Account and Audit Regulations 2015) and to undertake a review of the effectiveness of its risk management, control and governance processes taking into account public sector internal auditing standards and guidance.

Workforce Implications

40. There are no specific workforce implications related to this report.

Property Implications

41. There are no property implications intrinsic to the proposals in this report.

Other Implications

42. N/A

Options Considered

43. Given the requirements of the Public Sector Internal Audit Standards, no other options were considered.

Conclusions

44. The General Purposes Committee is requested to note:

- the work completed by the Internal Audit team during 2021-22 and the themes and outcomes arising from this work

- the opinion of the Head of Internal Audit and Risk Management that there is **Reasonable** assurance on the overall adequacy and effectiveness of the Council's framework of governance, risk management and internal controls

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Date of report: 14 July 2022

Appendices

Annex A: Annual Internal Audit Report 2021-22

Background Papers

None

Annex A

Internal Audit Annual Report 2021-22

July 2022

Contents

Summary of Internal Audit Work

Internal Audit

This report summarises the internal audit work undertaken during 2021-22 and provides an overview of the effectiveness of controls in place during the year.

In 2021-22, 59 assignments were undertaken, and audit opinions were given for 38 of these assignments. The remaining assignments included grant certifications, follow ups to previous audits and standalone advisory assignments for which no opinion was stated.

A summary of all audits completed during the year is included in **Appendix 1.**

Internal Audit Purpose and Mission

The purpose of London Borough of Enfield's Internal Audit team is to provide independent, objective assurance and consulting services designed to add value and improve the London Borough of Enfield's operations. The mission of Internal Audit is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight. The Internal Audit team helps the London Borough of Enfield accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes.

Governance

The Head of Internal Audit and Risk Management reports functionally to the General Purposes Committee and administratively to the Section 151 Officer. Additionally, the Assurance Board takes a key role in overseeing the work of the Internal Audit team. Briefly the functions carried out by the General Purposes Committee and the Assurance Board are:

General Purposes Committee

- reviews and approves the Internal Audit Charter annually
- reviews and approves the Internal Audit Plan annually
- receives regular progress reports on the Internal Audit Plan and implementation of agreed audit actions

Assurance Board

- reviews the Internal Audit Plan annually
- reviews progress against the Internal Audit Plan
- reviews the implementation of agreed audit actions
- receives verbal updates from owners of Limited or No assurance audits and from owners of overdue audit actions

Internal Audit Plan 2021-22

An Internal Audit Plan covering the financial year 2021-22 was agreed with the General Purposes Committee on 4 March 2021. As the year progressed, Internal Audit continued to liaise with Executive Directors, Directors and Heads of Service and changes to the plan were made as a result. These changes are outlined in **Appendix 2.**

Internal Audit Methodology

Our audits are conducted in accordance with the Council's internal audit methodology which is in compliance with the Public Sector Internal Audit Standards (PSIAS).

Terms of reference are agreed for each piece of work with the audit owner, identifying the scope and objectives of the audit as well as identifying key risks and controls. This approach is designed to enable us to give assurance on the risk management and internal control processes in place to mitigate the risks identified.

Our reporting methodology is based on four assurance levels in respect of our overall conclusions as to the design and operational effectiveness of controls within the system reviewed - Substantial, Reasonable, Limited or No assurance. An element of judgement will always be required when deciding upon the appropriate assurance level. Details of the assurance levels are given in **Appendix 3**.

Where it is not appropriate to provide an opinion, audit work is reported in the form of a management letter, which may include an action plan for improvement depending on the nature of the review. Results are reported in the form of a management letter for the following types of assignment:

- review of grant claims and the Mayor's charity financial statements
- follow-up of managers' progress with the implementation of recommendations from previous audit work
- where the system of control has changed recently, such that there was insufficient evidence of current controls in operation to facilitate testing of their effectiveness
- where management requests internal audit advice to assist in the design of a new or improved control framework
- where management requests an internal audit review to analyse or investigate areas of concern or known weakness and advise on the improvements needed.

The Head of Internal Audit and Risk Management has responsibility for services which, although related, are outside of the remit of the Internal Audit team. These services are Counter Fraud, Insurance Risk Management and Data Protection. To avoid potential impairment of objectivity, these services are risk assessed alongside other Council services in formulating the Internal Audit Plan. Where reviews are required, these are undertaken by the Councils co-source partner, PwC.

Draft reports are reviewed and agreed with audit stakeholders before final reports are issued.

Audit Actions Implementation

During the review of draft reports, audit actions and implementation target dates are agreed. The Internal Audit team follow up with action owners to ensure actions are implemented by the agreed target dates and report implementation progress to the General Purposes Committee and the Assurance Board.

Annual Schools Internal Audit Report

As part of the annual Internal Audit Plan, a number of schools' audits are carried out each year. Our aim is to audit all maintained schools every 4 to 5 years. The schools' audit programme covers:

- compliance with the Scheme for Financing Schools
- compliance with the Council's Finance Manual for Schools, including the Contract Procedure Rules
- ensuring good financial, data security, asset management and business continuity practices are in place

Each year we prepare a separate Schools Internal Audit Report that is shared with school stakeholders and the General Purposes Committee.

Annual Audit Opinion

Introduction

The Public Sector Internal Audit Standards (PSIAS) require the chief audit executive (who at the London Borough of Enfield is the Head of Internal Audit and Risk Management) to deliver an annual internal audit opinion and report that can be used by the organisation to inform its governance statement.

The annual internal audit opinion must conclude on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

The annual report must also include a statement on conformance with the PSIAS and the results of the quality assurance and improvement programme.

At the London Borough of Enfield, this is achieved through a risk-based plan of work agreed with management and approved by the General Purposes Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below and set out in **Appendix 4**. The opinion does not imply that Internal Audit has reviewed all risks relating to the organisation.

This report forms an important input to the Annual Governance Statement, which is a key requirement of the Council's annual accounts.

Head of Internal Audit and Risk Management's Annual Opinion

The General Purposes Committee agreed to an internal audit plan covering 59 subject areas. The work programme was targeted at the Council's highest risk areas of operation. I am satisfied that sufficient internal audit work has been undertaken to allow an opinion to be given as to the adequacy and effectiveness of governance, risk management and control. In giving this opinion, it should be noted that assurance can never be absolute that there are no major weaknesses in the system of internal control.

Reasonable Assurance

The opinion of the Head of Internal Audit and Risk Management is that the arrangements for governance, risk management and internal control provided **Reasonable** assurance that material risks, which could impact upon the achievement of the Council's services or objectives, were being identified and managed effectively. Improvements are required in the areas identified in our reports to enhance the adequacy and effectiveness of the framework of governance, risk management and internal control.

My opinion for 2021-22 is as follows:

Basis of the opinion

The basis for forming my opinion is as follows:

- an assessment of the design and operation of the underpinning assurance framework and supporting processes

- an assessment of the range of individual opinions arising from risk based audit assignments delivered during the year

- an assessment of management's progress in addressing control weaknesses both this year and carried forward from 2020-21

- any reliance that is being placed on third party assurances

- the effects of any significant changes in the Council's objectives or systems

- cumulative audit knowledge and intelligence gathered through attendance at key meetings and other working groups

- any limitations which may have been placed on the scope or resources of internal audit

In summary, the Head of Internal Audit and Risk Management's opinion is **Reasonable** which is consistent with 2020-21. The principal reasons for this opinion are:

- the profile of audit opinions given in individual audit reports during the year remains consistent with 2020-21

- there has been a continued focus on implementing audit actions

- the risk management culture in the Council continues to improve:

    - a full refresh of the Corporate Risk Register took place in 2021-22
    - the Risk Strategy, Risk Operational Plan and Risk Manual were all revised during 2021-22
    - utilisation of the Council's risk management software for recording and monitoring Departmental, Director level and service risk registers has increased.
    - communication and training around Everyone's a Risk Manager continued

A detailed analysis of the audit work performed is given below.

Analysis of Internal Audit Work

Overview of work done

The internal audit plan was designed to be flexible, and reviews have moved in and out of the work programme during the year to accommodate the Council's changing risk profile and ability to obtain assurances from other reliable sources. This resulted in a reduction of 26 reviews from the agreed audit plan of 76 audits. However, 9 new assignments were undertaken to substitute for some of the cancelled or deferred audits, resulting in a total of 59 assignments undertaken in 2021-22. The changes were notified to the General Purposes Committee during the year and have not impacted upon the assurance opinion. Full details of changes to the audit plan are given in **Appendix 3**.

Key points to note from the delivery of the 2021-22 audit plan are:

- internal auditors were independent of the areas audited
- no significant limitations or restrictions were placed on the scope or resources of Internal Audit
- the Head of Internal Audit and Risk Management attended departmental management team meetings, Assurance Board and Executive Management Team meetings during the year to present on ongoing and planned internal audit work, including the implementation of agreed audit actions. This enabled Internal Audit to provide early input on risk management and internal control matters for key activities and projects
- Internal Audit operated a co-sourced model in partnership with PwC. This continued to provide the Council with the ability to access specialist resources especially in the areas of Finance and Digital Services
- Internal Audit follows the Public Sector Internal Audit Standards (PSIAS). The PSIAS require an independent peer review to be carried out every 5 years. This was last carried out in January 2020. This year we performed a self- assessment and the findings from this have informed our Quality Assessment Improvement Plan (QAIP). Details of the QAIP are given in **Appendix 5**
- the work of the Council's Counter Fraud team was reported to the General Purposes Committee via a separate report on 29 June 2022.

Conscious of the significant pressure on resources that the Council faces, internal auditors continued to support management by identifying potential process efficiencies and streamlining controls wherever possible.

Impact of Covid-19 Pandemic

From March 2020, Internal Audit adapted its ways of working so that audits were delivered fully remotely until government restrictions were lifted. During 2021-22 a hybrid working model was adopted and this hybrid way of working is expected to continue.

The Internal Audit team was, in most cases, unable to visit schools during 2020-21. Therefore testing requiring a physical attendance at schools was postponed into one single audit in 2021-22.

While planning audits, Internal Audit identified any Covid-19 related changes that had been made to processes and ensured these were fully factored into the audit work carried out. Additionally Internal Audit took account of specific restrictions in place and ensured the timing

of the audits did not place unnecessary pressure on individual services. **Appendix 2** shows flexibility was applied to the audit plan to take account of circumstances such as these.

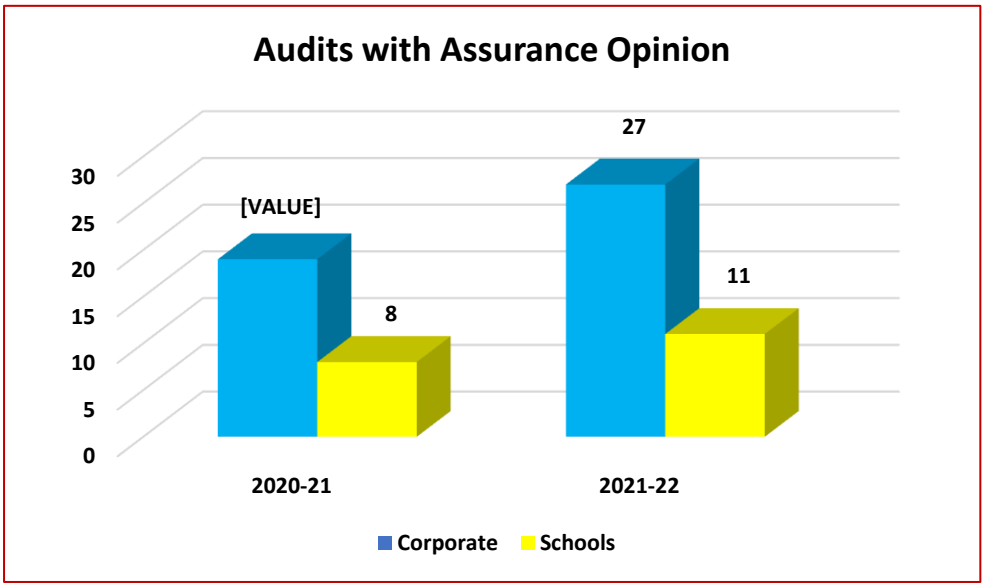
As well as remote and hybrid working being a challenge for Internal Audit, this was also a new challenge for audit clients and Internal Audit adopted a variety of methods to efficiently exchange information based on individual circumstances.

Specific Covid-19 related issues were acknowledged in audit reports.

Audit outcomes

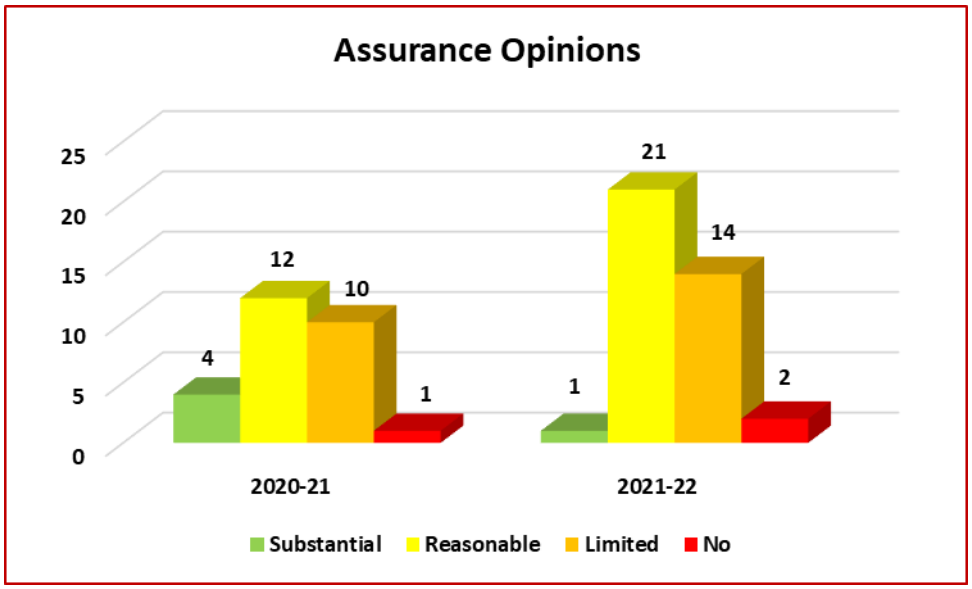
The Council's Internal Audit Plan covered the Council's key processes and systems and those operating in Enfield's schools.

In 2021-22, 59 audits (2020-21: 49) were commissioned through the Council and monitored by the Assurance Board, of which 38 (2020-21: 27) received an assurance rating.

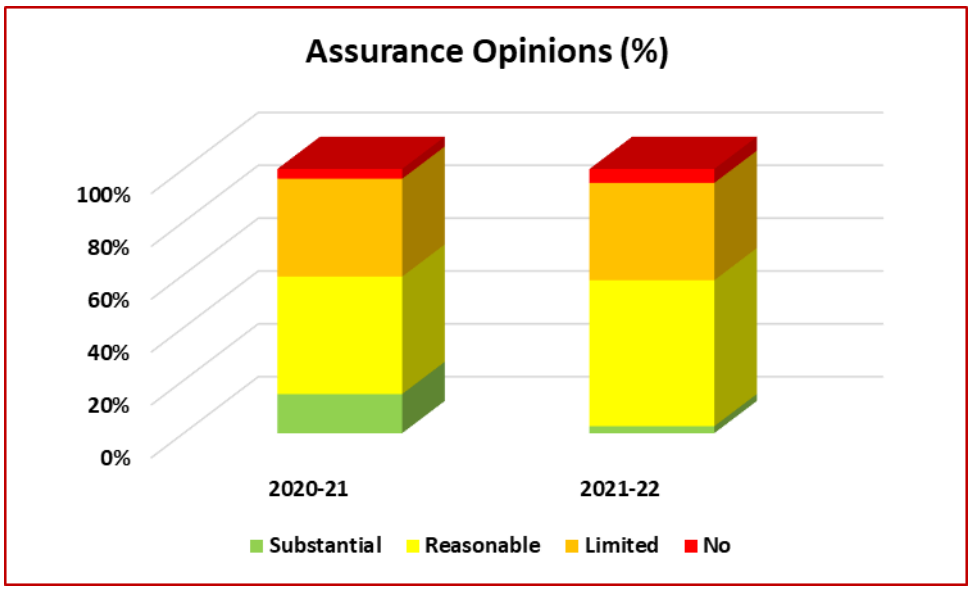


27 audits that received an assurance opinion were targeted at key corporate services and 11 were schools' audits. This compares to 19 corporate audits and 8 schools' audits in 2020-21.

The assurance opinions given for 2021-22 compared to 2020-21 can be summarised as follows:

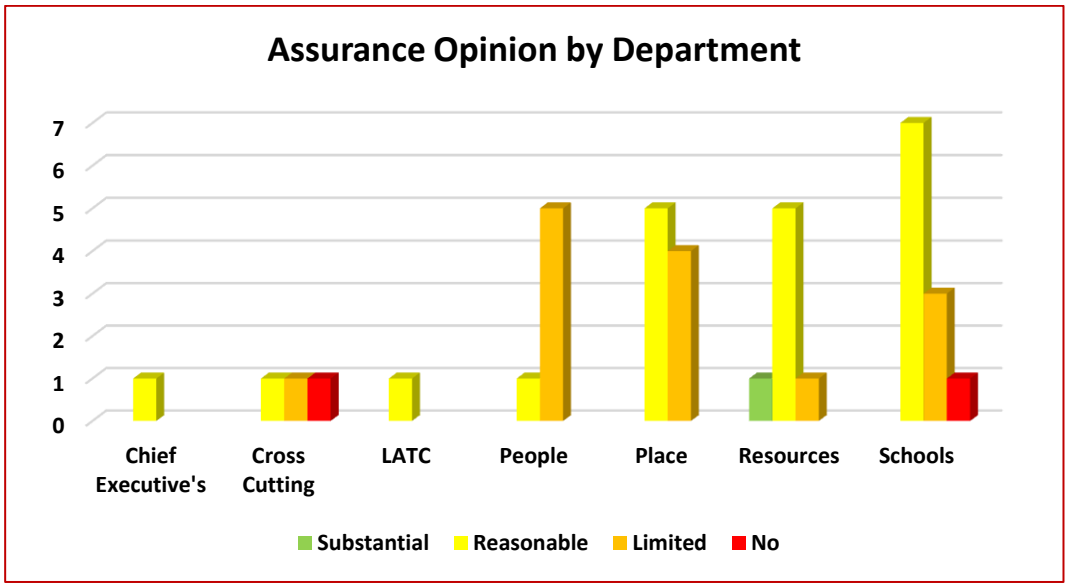


The following chart shows the assurance opinions given as a percentage of audits carried out:



As can be seen from the above charts, there has been little change in the direction of travel in terms of the assurance opinions issued in 2021-22 over 2020-21. This has contributed to the continued **Reasonable** annual opinion in 2021-22.

Analysis of audit assurance opinions for each of the Council's Departments is provided in the following chart:



Two **No** assurance opinion and 14 **Limited** assurance opinions were issued in 2021-22. These audits were:

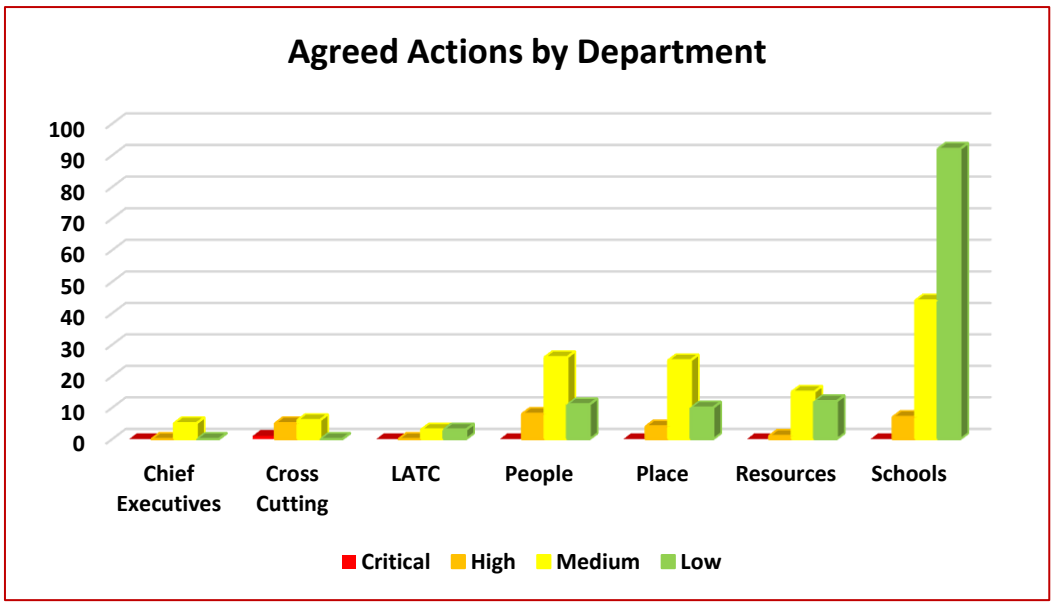
Dept.	Audit	Assurance Level	Actions			
			Critical	High	Medium	Low
Cross Cutting	DWP Revised Memorandum of Understanding 2020-21	**No**	1	3	-	-
Schools	St. Anne's Catholic High School for Girls	**No**	-	3	8	9
Cross Cutting	Leavers	**Limited**	-	2	3	-
People	Community Equipment Services	**Limited**	-	1	5	1
People	Deprivation of Liberty Safeguards	**Limited**	-	1	4	1
People	Financial Management of Bridgewood House	**Limited**	-	3	5	2
People	Primary Behaviour Support Service	**Limited**	-	-	7	2
People	Secondary Behaviour Support Service	**Limited**	-	3	4	3
Place	Community Infrastructure Levy	**Limited**	-	1	2	1
Place	Grounds Maintenance	**Limited**	-	-	7	1
Place	Meridian Water – Contract Management	**Limited**	-	1	2	1
Place	Oversight of Montagu LLP	**Limited**	-	2	3	2
Resources	Oversight of Energetik	**Limited**	-	1	1	1
Schools	Bush Hill Park Primary	**Limited**	-	2	3	8

Dept.	Audit	Assurance Level	Actions			
			Critical	High	Medium	Low
	School					
Schools	Eldon Primary School	**Limited**	-	1	7	-
Schools	Oakthorpe Primary School	**Limited**	-	1	5	8

Key findings from these audits are provided in **Appendix 6.**

Agreed actions

In total, 278 actions for improvement have been discussed and agreed with management, including one action addressing a critical risk finding and 25 actions addressing high risk findings. The actions are broken down by Department in the following chart:



The critical risk finding related to the DWP Revised Memorandum of Understanding 2020-21 audit as we could not evidence that mandatory security checks required by DWP had been fully completed. In view of this, the Council faced the risk of DWP revoking access to DWP/HMRC data which could have led to significant operational delays or the inability to deliver vital services to residents, particularly vulnerable residents. Following the audit, these checks have been fully carried out and evidenced to the satisfaction of DWP.

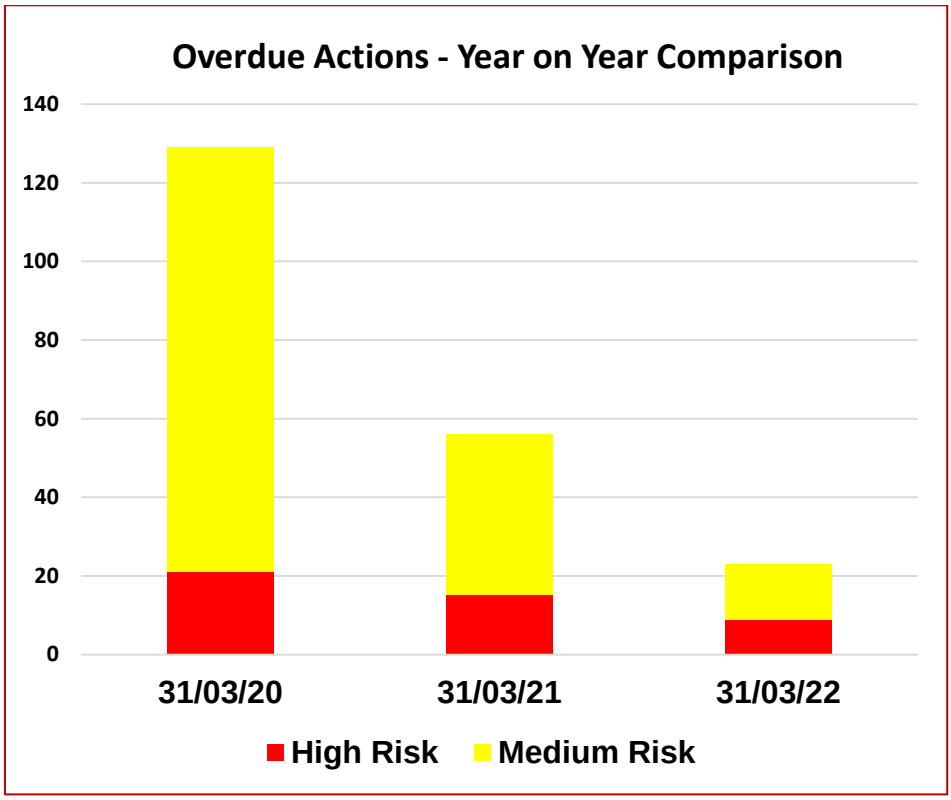
Due to the nature of the schools' audit programme it is not unexpected that a higher number of actions are allocated to schools.

Action implementation

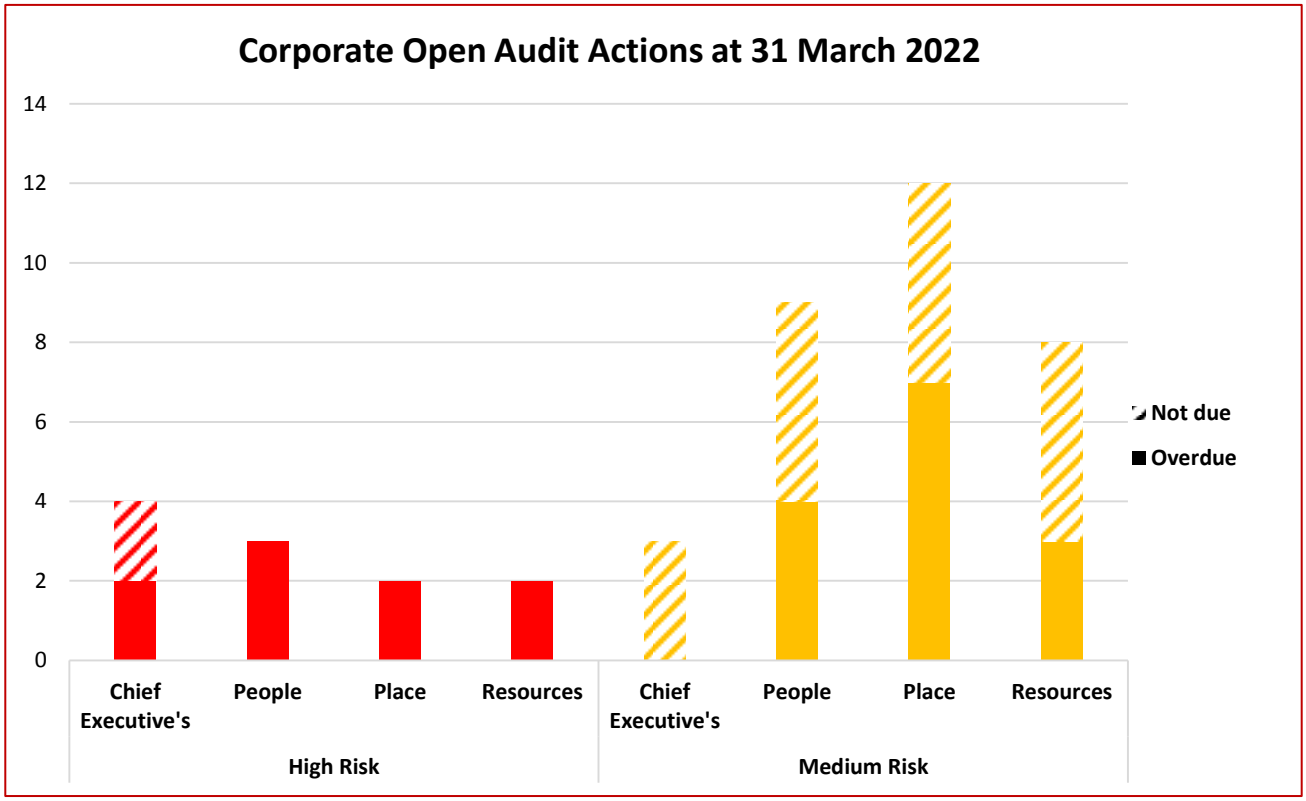
The implementation of agreed actions is tracked by the Internal Audit team and reported to the Assurance Board and the General Purposes Committee.

As can be seen from the following chart, significant progress has been made in implementing actions since 2019-20. The Assurance Board's focus on implementing actions has contributed

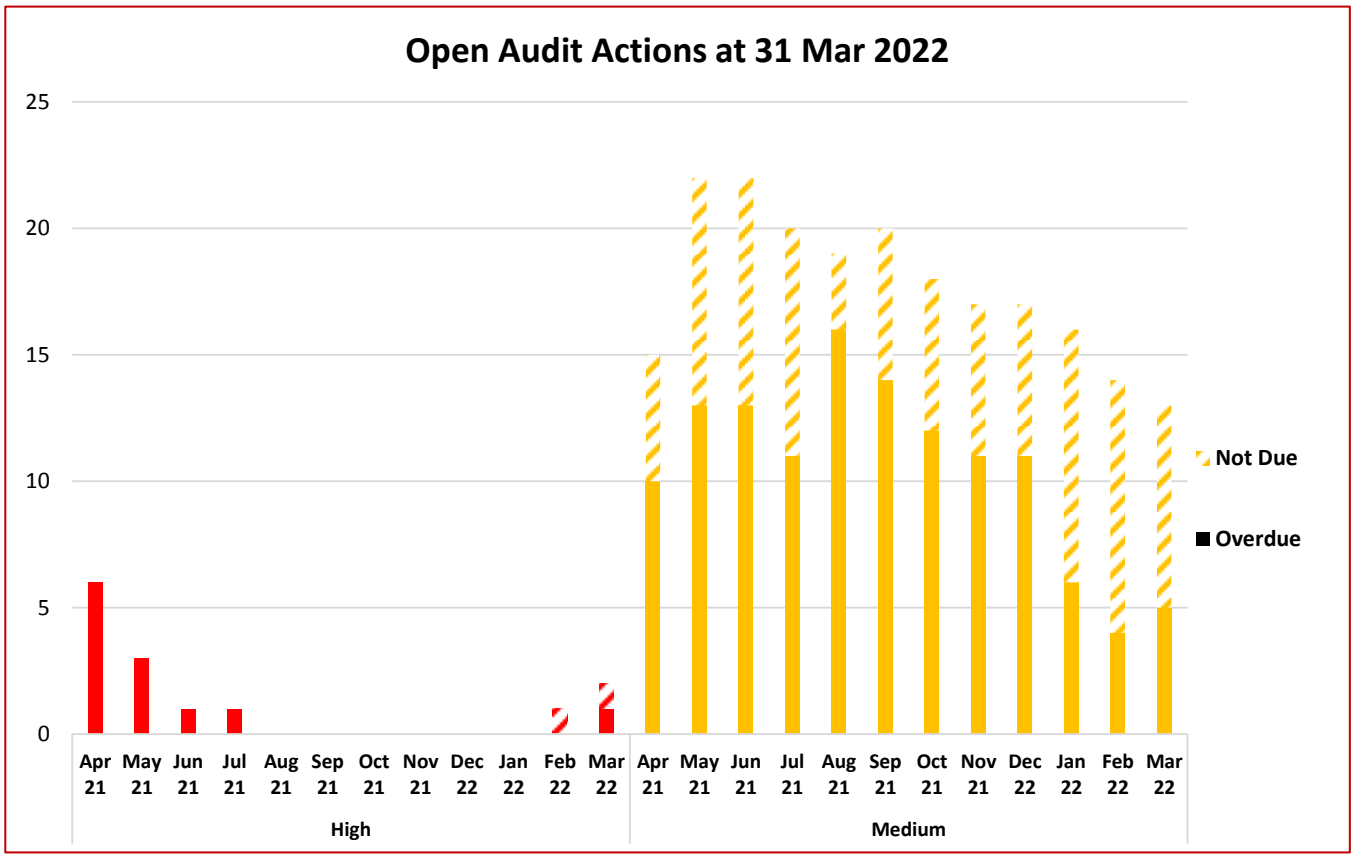
to this improvement. This progress is also a factor in the overall **Reasonable** opinion for the year.



Open audit actions at 31 March 2022 by Corporate Department is shown in the chart below:



The chart for schools also shows an improvement in action implementation:



Key Themes Identified

During 2021-22 a good level of engagement between Internal Audit and senior management has continued. This has enabled the Internal Audit team to focus on key areas of risk as well as work closely with management to formulate actions to address areas where improvement is required.

Although we have identified areas of good practice, some areas where we have identified areas for improvement are:

- ## Governance arrangements

Further improvements are required to strengthen the governance environment. In particular, we have continued to find that compliance with the Council's Contract Procedure Rules can be improved. Additionally, there is scope for better contract management practices to be put in place.

We also found there is scope for improving the wider understanding of related party transactions and conflicts of interest in relation to procuring services particularly in schools.

There is also a need for greater clarity in terms of governance arrangements particularly where several groups/boards have interest in particular areas or projects.

In some areas, policies and procedures, including authorisation and review procedures have not been kept up to date and in line with current operational practices.

The need to document and retain key checks carried out (e.g. Baseline Personal Security Standards) needs to be reinforced.

- ## Performance monitoring

In several audits we found that operational performance monitoring could be improved by the use of relevant metrics and ensuring performance is reported to and understood by relevant management levels.

- ## Mandatory training

Managers not ensuring their teams completed the Council's mandatory training was highlighted in a number of audits, We do appreciate that there are some difficulties in obtaining this information from the HR systems and acknowledge that the HR team are resolving these issues.

- ## Risk Management

The Audit and Risk Management Service continues to embed risk management into the organisation.

A revised Risk Strategy was implemented, together with a revised Risk Operational Plan during 2021-22. These were both presented to the General Purposes Committee in March 2022.

Key Risk Management improvements during 2021-22 were:

- A full refresh of Corporate Risk Register (CRR) was undertaken.

As well as consulting with internal stakeholders, we also reviewed a number of Local Authority Corporate and Strategic Risk Registers. This ensured that all emerging risks were covered. We didn't find any gaps when comparing our CRR to other authorities' risk registers.

To enable clear identification of root causes and potential impacts on risks, the format of the CRR was amended to show causes and impacts separately. Also this means the CRR is more sensitive to both external and internal events.

Two new medium risks were added during the refresh:

- CR18 Equality, Diversity and Inclusion
- CR19 Legislation, Regulations and Standards

One risk was closed during the refresh:

- CR09A Coronavirus

- The message that Everyone's a Risk Manager introduced during 2019-20 was reinforced during the year through extended risk management training that was made available to all Council staff. This enables strategic, pro-active, and holistic management of risks.

- A revised Risk Strategy and Risk Manual were published so that the most up to date information is available to all staff

- We increased utilisation of the Council's risk management software for recording and monitoring Departmental, Director level and Service risk registers.

Key planned Risk Management activities for 2022-23 are:

- Increased focus on risk management awareness and communications

- Forward looking horizon scanning and peer review of the CRR

- Building on the risk management training by offering further sessions and enhancing our e-learning training modules

- Improving reporting by utilising the growing data available on the Council's risk management software

Internal Audit Quality Assurance

External Assessment

It is a requirement of the Public Sector Internal Audit Standards (PSIAS) that an external assessment of the Internal Audit function is conducted every five years by a qualified and independent assessor from outside the organisation. Such an assessment was carried out in 2019-20 by the Chartered Institute of Public Finance and Accountancy (CIPFA)and the conclusion from this examination was that the function **partially conforms**.

Internal Assessment

Internal assessments comprise both ongoing reviews and periodic reviews. Reports of internal assessments are presented to the General Purposes Committee together with an action plan to address any areas for improvement, if necessary.

We have undertaken a self-assessment against the PSIAS, including an assessment of the progress made against the recommendations made during the 2019-20 external review conducted CIPFA.

A summary of the results of our self- assessment is:

Fully conforms	**92%**
Partially Conforms	**5%**
Non-compliant	**2%**

In order to ensure continuous improvement and to specifically address areas of non or partial compliance, we have developed a Quality Assurance Improvement Plan (QAIP) – see **Appendix 5**. Progress against the QAIP will be reported to future meetings.

Internal Audit Performance during 2021-22

The performance of the Internal Audit service has been measured during 2021-22 and is shown in the following table:

KPI/Quality Metric	Target	Actual
Audit plan to be delivered to draft report stage by 31 March	95%	78%*
Days from end of fieldwork to issue of draft report	15 days	15 days
Days from receipt of management comments to issue of final report	10 days	7 days
Survey responses	80%	77%
Terms of reference reviewed and approved by the Head or Deputy Head of Internal Audit and Risk Management	100%	100%

KPI/Quality Metric	Target	Actual
Supervision of engagements	100%	100%
Draft report reviewed and approved by the Head or Deputy Head of Internal Audit and Risk Management	100%	100%
Final report reviewed and approved by the Head or Deputy Head of Internal Audit and Risk Management	100%	100%

*****By 30th April 2022, 95% of audits had been issued in draft

Appendix 1: Detailed Analysis of 2021-22 Internal Audit Reviews

Chief Executive's

Title	Audit Team	Audit Status Description	Assurance Level Description	Critical Risks	High Risks	Medium Risks	Low Risks	Advisory Risks
Mayor of the Borough of Enfield Appeal Fund 2020-21	In House	Complete	N/A – Management Letter	-	-	-	-	-
Members' Ethics	In House	Deferred		-	-	-	-	-
Organisational Development	PwC	Complete	Reasonable	-	-	5	-	-
Staff Ethical Standards	In House	Deferred		-	-	-	-	-

Cross Cutting

Title	Audit Team	Audit Status Description	Assurance Level Description	Critical Risks	High Risks	Medium Risks	Low Risks	Advisory Risks
Board Reporting	In House	Deferred		-	-	-	-	-
CCTV Process	In House	Complete	N/A – Management Letter	-	-	-	-	-
Contain Outbreak Management Fund (COMF)	In House	Deferred		-	-	-	-	-
Culture	PwC	Deferred		-	-	-	-	-
DWP Revised Memorandum of Understanding 2020-21	In House	Complete	No	1	3	-	-	-
Equalities	PwC	Complete	Reasonable	-	-	3	-	-
Financial and Company Governance Review	PwC	Complete	N/A – Management Letter	-	-	-	-	-
Green Homes Grant	In House	Deferred		-	-	-	-	-
Handling of Members' Post	In House	Complete	N/A – Management Letter	-	-	-	-	-
Leavers	In House	Complete	Limited	-	2	3	-	-
Lessons Learned from the Pandemic	PwC	Cancelled		-	-	-	-	-
Local Government Transparency Code	In House	Complete	N/A – Management Letter	-	-	-	-	-
Low Traffic Neighbourhoods	In House	Complete	N/A – Management Letter	-	-	-	-	-
S31 Community Testing Grant	In House	Cancelled		-	-	-	-	-
Corporate Security Board	PwC	Deferred		-	-	-	-	-

Title	Audit Team	Audit Status Description	Assurance Level Description	Critical Risks	High Risks	Medium Risks	Low Risks	Advisory Risks
Test and Trace Grant 20-21	In House	Deferred		-	-	-	-	-

LATC

Title	Audit Team	Audit Status Description	Assurance Level Description	Critical Risks	High Risks	Medium Risks	Low Risks	Advisory Risks
Customer Services	In House	Cancelled		-	-	-	-	-
Enfield Let	PwC	Complete	Reasonable	-	-	3	3	-

People

Title	Audit Team	Audit Status Description	Assurance Level Description	Critical Risks	High Risks	Medium Risks	Low Risks	Advisory Risks
Adoption	In House	Cancelled		-	-	-	-	-
Bus Service Operators Grant (BSOG) Certification	In House	Complete	N/A – Grant Certification	-	-	-	-	-
Bush Hill Park Primary School	In House	Complete	Limited	-	2	3	8	2
Community Equipment Services	In House	Complete	Limited	-	1	5	1	-
Deprivation of Liberty Safeguards	In House	Complete	Limited	-	1	4	1	-
Financial Management of Bridgewood House	In House	Complete	Limited	-	3	5	2	-
Looked After Children - Financial Management	In House	Complete	Reasonable	-	-	1	2	-
Primary Behaviour Support Service	In House	Complete	Limited	-	-	7	2	1
Secondary Behaviour Support Service	In House	Complete	Limited	-	3	4	3	-
SEND Commissioning	PwC	Deferred		-	-	-	-	-
Supporting Families Grant Certification - Aug	In House	Complete	N/A – Grant Certification	-	-	-	-	-
Supporting Families Grant Certification - Dec	In House	Complete	N/A – Grant Certification	-	-	-	-	-
Supporting Families Grant Certification - Feb	In House	Complete	N/A – Grant Certification	-	-	-	-	-
Supporting Families Grant Certification - Jan	In House	Complete	N/A – Grant Certification	-	-	-	-	-
Supporting Families Grant Certification - July	In House	Cancelled		-	-	-	-	-
Supporting Families Grant Certification - June	In House	Complete	N/A – Grant Certification	-	-	-	-	-
Supporting Families Grant Certification - May	In House	Complete	N/A – Grant Certification	-	-	-	-	-

Title	Audit Team	Audit Status Description	Assurance Level Description	Critical Risks	High Risks	Medium Risks	Low Risks	Advisory Risks
Supporting Families Grant Certification - Nov	In House	Cancelled		-	-	-	-	-
Supporting Families Grant Certification - Oct	In House	Cancelled		-	-	-	-	-
Supporting Families Grant Certification - Sept	In House	Complete	N/A – Grant Certification	-	-	-	-	-

Place

Title	Audit Team	Audit Status Description	Assurance Level Description	Critical Risks	High Risks	Medium Risks	Low Risks	Advisory Risks
BEGIN Grant - 1	In House	Complete	N/A – Grant Certification	-	-	-	-	-
BEGIN Grant - 2	In House	Complete	N/A – Grant Certification	-	-	-	-	-
Capital Works	PwC	Complete	Reasonable	-	-	1	2	-
Community Infrastructure Levy	PwC	Complete	Limited	-	1	2	1	-
Culture Recovery Fund Grant Certification I and II	In House	Complete	N/A – Grant Certification	-	-	-	-	-
Culture Recovery Fund Grant Certification III	In House	Deferred		-	-	-	-	-
Garden Waste Collection Services	In House	Complete	Reasonable	-	-	3	2	-
Grounds Maintenance	In House	Complete	Limited	-	-	7	1	-
Homelessness	PwC	Complete	Reasonable	-	-	2	3	-
Housing Compliance - Safety Checks and Management of Lift Maintenance	PwC	Complete	Reasonable	-	-	5	-	-
Housing Repairs and Maintenance	In House	Deferred		-	-	-	-	-
Meridian Water - Financial Management	PwC	Deferred		-	-	-	-	-
Meridian Water - Supply Chain Risks	PwC	Deferred		-	-	-	-	-
Meridian Water – Contract Management	PwC	Complete	Limited	-	1	2	1	-
Oversight of Montagu LLP	PwC	Complete	Limited	-	2	3	2	-
Planning	In House	Deferred		-	-	-	-	-
Planning Consultation Notices	In House	Complete	N/A – Management Letter	-	-	-	-	-
Planning Service Data Quality	In House	Complete	N/A – Management Letter	-	-	-	-	-
Salix Programme	In House	Complete	Reasonable	-	-	1	-	-
Social Housing Assurance Framework	PwC	Complete	N/A – Advisory	-	-	-	-	-

Resources

Title	Audit Team	Audit Status Description	Assurance Level Description	Critical Risks	High Risks	Medium Risks	Low Risks	Advisory Risks
Counter Fraud	PwC	Complete	Reasonable	-	-	2	5	-
Digital Services: Contract Management	PwC	Complete	Reasonable	-	-	3	3	-
Digital Services: Cyber Security - Red Team Exercise	PwC	Cancelled		-	-	-	-	-
Key financial processes: Capital Budget Management	In House	Complete	Reasonable	-	-	3	2	-
Key financial processes: Financial Management of the Housing Revenue Account	PwC	Complete	Substantial	-	-	1	1	-
Key financial processes: Pensions - Fund/payroll contributions	PwC	Complete	Reasonable	-	-	2	-	-
Key financial processes: Revenue Budgeting and Forecasting	PwC	Complete	Reasonable	-	-	3	-	-
Oversight of Energetik	PwC	Complete	Limited	-	1	1	1	-
Procurement Social Value		Cancelled		-	-	-	-	-
Transformation Projects		Cancelled		-	-	-	-	-
Use of Spreadsheets	PwC	Deferred		-	-	-	-	-
Web Content Accessibility Guidelines 2.1 (WCAG 2.1)	PwC	Deferred		-	-	-	-	-

Schools

Title	Audit Team	Audit Status Description	Assurance Level Description	Critical Risks	High Risks	Medium Risks	Low Risks	Advisory Risks
Chase Side Primary School	In House	Complete	Reasonable	-	-	3	4	2
De Bohun Primary School	In House	Complete	Reasonable	-	-	4	11	2
Eldon Primary School	In House	Complete	Limited	-	1	-	7	1
Firs Farm Primary School	In House	Complete	Reasonable	-	-	4	10	-
Oakthorpe Primary School	In House	Complete	Limited	-	1	5	8	3
Prince of Wales Primary School	In House	Complete	Reasonable	-	-	6	13	3
St Andrew's Southgate CE Primary School	In House	Complete	Reasonable	-	-	2	5	3

Title	Audit Team	Audit Status Description	Assurance Level Description	Critical Risks	High Risks	Medium Risks	Low Risks	Advisory Risks
St Anne's Catholic High School for Girls	In House	Complete	No	-	3	8	9	1
St Michael at Bowes CE Primary School	In House	Complete	Reasonable	-	-	2	3	-
St. Paul's CE Primary School	In House	Complete	Reasonable	-	-	3	13	1
Schools Physical Asset Verification Testing from 2020-21	In House	Complete	N/A – Management Letter	-	-	4	1	-

Appendix 2: Changes to the 2021-22 Plan

The Council's Internal Audit Plan is flexible to ensure that the audit resource available is focused on the key risk areas. Therefore, reviews have been removed or added to the Plan during the year. The changes have not impacted on the level of assurance that has been obtained over key risks across the Council. The table below sets out the key changes to the 2021-22 Internal Audit Plan.

Area	Audit	Change	Explanation
Chief Executive's	Culture	-1	Agreed with the Head of Employee Experience to defer as the scope of the audit would be duplicative in view of the Investors in People work being undertaken. Although this audit was deferred to the 2022-23 audit plan, it was subsequently cancelled due to resource constraints.
Chief Executive's	Members' Ethics	-1	Due to the change of Monitoring Officer and local elections in May 2022, this audit has been deferred to 2022-23.
Chief Executive's	Staff Ethical Standards	-1	Agreed with the Director of HR & OD that due to unforeseen staffing issues in the Internal Audit team this has been deferred to 2022-23.
Cross Cutting	Board Reporting	-1	Due to unforeseen resourcing issues in the Internal Audit team, this has been deferred to 2022-23.
Cross Cutting	Test and Trace Grant	-1	Advised by Finance that submission of the grant certification is not required until June 2022, therefore this has been deferred to the 2022-23 plan.
Cross Cutting	Contain Outbreak Management Fund	-1	Advised by Finance that submission of the grant certification is not required until June 2022, therefore this has been deferred to the 2022-23 plan.
Cross Cutting	S31 Community Testing Grant	-1	Advised by Finance that no Internal Audit work is required.
Cross Cutting	Lessons Learned from the Pandemic	-1	As a priority 3 audit, agreed with the Head of Internal Audit & Risk Management that this audit is no longer required.
Cross Cutting	Green Homes Grant	-1	Advised by the Asset Manager that grant certification was not required until April 2022, therefore deferred to the 2022-23 plan.
Cross Cutting	Low Traffic Neighbourhoods	+1	Requested by Executive Director Resources
Cross Cutting	Handling of Members' Post	+1	Requested by Chief Executive

Area	Audit	Change	Explanation
Cross Cutting	CCTV Process	+1	Requested by Executive Director Resources
LATC	Customer Services	-1	Agreed with Energetik to reconsider in 2022-23 as new process improvements are being embedded.
People	Adoption	-1	Agreed with the Executive Director People that an internal audit of regionalised adoption was no longer required.
People	Supporting Families - July	-1	July testing cancelled at client request and was included in August testing.
People	Supporting Families - October	-1	October testing cancelled at client request and was included in December testing.
People	Supporting Families - November	-1	November testing cancelled at client request and was included in December testing.
People	Looked After Children – Financial Control	+1	Following the cessation of the ContrOcc project, to confirm that the introduction of a new control system is appropriate and working effectively.
People	SEND Commissioning	-1	Deferred to 2022-23.
Place	Planning	-1	Agreed with the Assurance Board to defer to 2022-23 as two other planning audits took place in 2021-22.
Place	Housing Repairs and Maintenance	-1	Agreed with the Director of Housing and Regeneration to defer to 2022-23 due to ongoing delays in the implementation of the new Civica system.
Place	Meridian Water – Supply Chain Risks	-1	Agreed with the Director of Development to defer to 2022-23.
Place	Meridian Water – Financial Management	+1	Added to the 2021-22 plan in place of Meridian Water – Supply Chain Risks and to confirm that appropriate financial management processes and controls are in place and working effectively.
Place	Meridian Water – Financial Management	-1	Agreed with the Director of Development to defer to 2022-23.
Place	Culture Recovery Fund Grant (phases I and II)	+1	Requested by Head of Service
Place	Culture Recovery Fund Grant (phase III)	+1	Requested by Head of Service
Place	Culture Recovery Fund Grant (phase III)	-1	Deferred to the 2022-23 plan as the submission deadline was 30 April 2022.
Place	Planning Service Data Quality	+1	Requested by Chief Executive

Area	Audit	Change	Explanation
Place	Planning Consultation Notices	+1	Requested by Executive Director Place
Resources	Transformation Projects	-1	Agreed with Executive Director Resources to include in 2022-23 plan.
Resources	Procurement Social Value	-1	Agreed with Executive Director Resources to defer to 2022-23 given ongoing work in this area. However as part of the 2022-23 audit planning process, this audit was not considered a priority.
Resources	Web Content Accessibility Guidelines 2.1 (WCAG 2.1)	-1	Agreed with the Head of Service to defer to Q1 2022-23.
Resources	Digital Services Cyber Security Red Team Exercise	-1	Agreed with Executive Director Resources that due other similar exercises being undertaken by Digital Services this review was no longer required.
Resources	Use of Spreadsheets	-1	Agreed with Executive Director Resources to defer to 2022-23 to allow new Finance Director involvement.
Resources	Security Panel	-1	Agreed with Executive Director Resources to defer to 2022-23.
	TOTAL	**-17**	

Appendix 3: Assurance Levels and Risk Ratings

Level of assurance	
Substantial	No significant improvements are required. There is a sound control environment with risks to key service objectives being well managed. Any deficiencies identified are not cause for major concern.
Reasonable	Scope for improvement in existing arrangements has been identified and action is required to enhance the likelihood that business objectives will be achieved.
Limited	The achievement of business objectives is threatened and action to improve the adequacy and effectiveness of the risk management, control, and governance arrangements is required. Failure to act may result in error, fraud, loss or reputational damage.
No	There is a fundamental risk that business objectives will not be achieved, and urgent action is required to improve the control environment. Failure to act is likely to result in error, fraud, loss or reputational damage.

Risk rating	
Critical	Life threatening or multiple serious injuries or prolonged work place stress. Severe impact on morale & service performance. Mass strike actions etc. Critical impact on the reputation or brand of the organisation which could threaten its future viability. Intense political and media scrutiny i.e. front-page headlines, TV. Possible criminal, or high profile, civil action against the Council, members or officers. Cessation of core activities, Strategies not consistent with government's agenda, trends show service is degraded. Failure of major Projects – elected Members & SMBs are required to intervene Major financial loss – Significant, material increase on project budget/cost. Statutory intervention triggered. Impact the whole Council; Critical breach in laws and regulations that could result in material fines or consequences
High	Serious injuries or stressful experience requiring medical many workdays lost. Major impact on morale & performance of staff. Significant impact on the reputation or brand of the organisation; Scrutiny required by external agencies, Audit Commission etc. Unfavourable external media coverage. Noticeable impact on public opinion Significant disruption of core activities. Key targets missed, some services compromised. Management action required to overcome med – term difficulties High financial loss Significant increase on project budget/cost. Service budgets exceeded. Significant breach in laws and regulations resulting in significant fines and consequences
Medium	Injuries or stress level requiring some medical treatment, potentially some workdays lost. Some impact on morale & performance of staff. Moderate impact on the reputation or brand of the organisation; Scrutiny required by internal committees or internal audit to prevent escalation. Probable limited unfavourable media coverage. Significant short-term disruption of non-core activities. Standing Orders occasionally not complied with, or services do not fully meet needs. Service action will be required. Medium financial loss - Small increase on project budget/cost. Handled within the team. Moderate breach in laws and regulations resulting in fines and consequences
Low	Minor injuries or stress with no workdays lost or minimal medical treatment. No impact on staff morale Internal Review, unlikely to have impact on the corporate image. Minor impact on the reputation of the organisation. Minor errors in systems/operations or processes requiring action or minor delay without impact on overall schedule. Handled within normal day to day routines. Minimal financial loss - minimal effect on project budget/cost. Minor breach in laws and regulations with limited consequence.

Appendix 4: Limitations and responsibilities

Limitations inherent to the internal auditor's work

Our work has been performed subject to the limitations outlined below.

- **Opinion**
  The opinion is based solely on the work undertaken as part of the agreed internal audit plan. There might be weaknesses in the system of internal control that we are not aware of because they did not form part of our programme of work, were excluded from the scope of individual internal audit assignments or were not brought to our attention. Therefore, management and the General Purposes Committee should be aware that our opinion may have differed if our programme of work or scope for individual reviews was extended or other relevant matters were brought to our attention.

- **Internal control**
  Internal control systems, no matter how well designed and operated, are affected by inherent limitations. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

- **Future periods**
  Our assessment of controls relating to Enfield Council is for the period 1 April 2020 to 31 March 2021. Historic evaluation of effectiveness may not be relevant to future periods due to the risk that:

  - The design of controls may become inadequate because of changes in operating environment, law, regulation or other; or
  - The degree of compliance with policies and procedures may deteriorate

- **Responsibilities of management and internal auditors**
  It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We endeavour to plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we shall carry out additional work directed towards identification of consequent fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, do not guarantee that fraud will be detected, and our examinations as internal auditors should not be relied upon to disclose all fraud, defalcations or other irregularities which may exist.

Appendix 5: Internal Audit Quality Assurance Improvement Plan

Standard	Compliance	Observations	Action	Target Date
Core Principles for the Professional Practice of Internal Auditing - **Communicates Effectively**	**Conforms**	There is effective communication through regular attendance at, Departmental Management Team (DMT), Executive Management Team (EMT) meetings as well as Assurance Board and General Purposes Committee. All attendance is supported with comprehensive written progress reports. Communication is accurate, objective, clear, concise, constructive, complete and timely. However, a greater awareness of good controls, and the audit process more generally across the Council, may aid understanding and improve the working relationships during the audit process.	Develop an Internal Audit Communications Plan to provide help and understanding around good controls and the audit process more generally.	30 September 2022
Core Principles for the Professional Practice of Internal Auditing - **Is insightful, proactive, and future-focused?**	**Partial**	Internal Audit works closely with audit clients to understand their service areas, the risks they face and any upcoming changes whether those be legislative or otherwise. As a result, we aim to make our findings insightful and forward thinking. Our scoping checklist includes questions and activities (such as carrying out independent research) to further	As part of continuous improvement of the service, we improved our terms of reference and reporting to demonstrate how our audits add value. We strive to ensure our reports are insightful and future focused. We continue to attend relevant training and webinars and discuss issues at team meetings.	On-going On-going

Standard	Compliance	Observations	Action	Target Date
		these aims also. Our formal PSIAS review highlighted that this is an area we need to improve on, and we are working on this.		
Code of Ethics	**Conforms**	This is now a regular agenda item for team meetings.	As part of continuous improvement of the service, we will continue to ensure team meeting discussions explore specific topics and debate potential examples to further improve knowledge and awareness	On-going
Standard 1200 – Proficiency	**Conforms**	Internal auditors have professional qualifications or are qualified by experience. Where appropriate, auditors undertake continuous professional development in accordance with the requirements of their professional body. All auditors are encouraged to undertake training, attend external courses/webinars – e.g. CIPFA or CIIA - and network and training opportunities within the Cross Council Assurance Service, part of the PWC framework contract. Although auditors have a record of their own training and development requirements and discussions with line managers, we do not currently hold a central record in order to identify individual and common	Develop a training matrix to capture record of training undertaken and identify future development and training requirements. This will include a requirement for IT audit skills training.	30 September 2022

Standard	Compliance	Observations	Action	Target Date
		training needs.		
Standard 1200 – **Proficiency**	**Partial**	The Chief Audit Executive has not completed the final steps to obtain her CIPFA qualification: it is a requirement that the CAE be professionally qualified.	Head of Internal Audit and Risk Management will complete the qualification as required.	31 October 2022
Standard 1300 – **Quality Assurance and Improvement Programme**	**Partial**	The external review by CIPFA in 2019-20, identified some required improvements. Our subsequent internal self-assessments confirmed that some of those improvements had been made, but this QAIP includes further actions required.	On-going monitoring to ensure continuous improvement within the service. Regular updates on progress of the improvement plan to be provided to General Purposes Committee. Annual self-assessment to be undertaken.	On going 31 May 2023
Standard 2000 – **Managing the Internal Audit Activity**	**Partial**	The Audit Handbook is the policy and procedures document for the delivery of audit activity. This is subject to review, but the 2022-23 review and update has not yet been undertaken.	The annual review and update of the Audit Handbook will be undertaken.	31 July 2022
Standard 2000 – **Managing the Internal Audit Activity**	**Non-compliant**	Currently there is no formal and central record of all forms of internal and external assurance provided across the Council. In 2021-22, a Value Chain Analysis was prepared to support the development of the 2022-23 Internal Audit Plan, but this was also the first	In order to ensure proper coverage, minimise duplication and prioritise resources, a pilot will be undertaken with Place Department to develop an Assurance Map. The process and outcomes will be reviewed, and lessons learnt	30 November 2022

Standard	Compliance	Observations	Action	Target Date
		stage in developing an Assurance Map that will current all forms of internal and external assurance.	used to further develop an Assurance Map for other departments across the Council.	
Standard 2200 – Engagement Planning	**Conforms**	A terms of reference is developed for all audit engagements, covering keys risks of the area under review and how the audit will add value to the Council. The reports are discussed and agreed with the audit client to ensure they are factually correct, and the actions relevant and achievable.	We will strive to include greater focus on the added value of audits and to provide creative and future focused solutions in our terms of reference, audit testing and reporting.	On going

Appendix 6: 2021-22 No and Limited Assurance Audits

Audit	Assurance	Detail
DWP Revised Memorandum of Understanding 2020-21	**No**	The Memorandum of Understanding (MoU) between the Council and the Department for Work and Pensions (DWP) is an annual agreement regarding the use of DWP and Her Majesty's Revenue and Customs (HMRC) data by the Council to provide services to residents. The information provided is sensitive and DWP takes a strict approach on how this information is handled and used. The Council must remain compliant to the terms of the MoU to be able to retain access to the data. Failure to comply with the terms and conditions of the MoU can result in DWP revoking access to its data for individual users or more seriously, all users across the Council. If DWP was to revoke access to the data referred to in the MoU, significant operational delays or the inability to deliver vital services to residents, particularly vulnerable residents, could result. During this audit, it was apparent that officers were unfamiliar with: • the detailed terms and conditions of the MoU • the Council's obligations • officers' individual roles and responsibilities. A portfolio of evidence had not been produced for those signing the MoU on behalf of the Council (S151 Officer and Operational Leads) or the Chief Executive, who has ultimate accountability. Also, limited collaborative working took place in relation to signing the MoU and therefore it is our view that: • the MoU was signed despite the conditions not being met • key stakeholders were not fully informed. The following **critical risk** finding was identified:

Audit	Assurance	Detail
		• It is mandatory that Baseline Personnel Security Standard (BPSS) checks are carried out prior to officers being given access to the DWP/HMRC data. We could not evidence that these checks had been fully completed for 14 officers from our sample of 20. We found instances where: ○ Checks were completed after the officer had commenced in their current role ○ Checks were not recorded on the officers' files ○ Officers' files could not be located. In addition, we were informed by Digital Services that they did not record the date when access was granted to individual users. This means that access to DWP/HMRC data was granted without the conditions outlined in the MoU having been met. Therefore, the Council faces the significant risk of DWP revoking access to the DWP/HMRC data. If DWP was to revoke access to the data, significant operational delays or the inability to deliver vital services to residents, particularly vulnerable residents, could result. In addition, a review of the Civica contract must be prioritised to understand what assurances are required for Civica staff who access DWP/HMRC data on our behalf and to ensure these assurances are in place. Section 1.1 of the MoU states: *Where the conditions defined within this MoU cannot be met, it is the responsibility of the LA to inform DWP of the non-compliance and underlying cause, without delay. In response, DWP will undertake security risk management activities to assure the confidentiality of data made available by DWP and the confidentiality, integrity and*

Audit	Assurance	Detail
		availability of departmental ICT and information systems. **Therefore, consideration must be given to sharing the findings of this audit with DWP**. **Three high risk** findings were identified: • There is no overall internal governance procedure around the signing of the MoU. This is important as several services need to provide information to support the Council's ability to sign the MoU. Not having a governance procedure in place has resulted in: o Officers' roles and responsibilities being unclear o Insufficient collaborative work between each service o No clear guidelines on expected timescales or deadlines being in place o Insufficient monitoring and reporting of activities relating to the MoU o Access being granted to DWP/HMRC data without appropriate checks having been made and recorded. • Annual GDPR training had not been completed by all staff with access to the DWP/HMRC data. This is a mandatory Council requirement and section 5.4 of the MoU states: *LAs must ensure that before prospective users are granted access to DWP information, they successfully complete appropriate data protection training* • We expected that a portfolio of evidence to support the signing of the MoU would have been immediately available to us. However, for us to confirm compliance with the IT aspects of the MoU, we had to request specific information from Digital Services and refer back to previous audits. As Digital Services took considerable time to provide this information, we can only conclude that a proper check against the MoU was not made prior to the document being signed. Additionally, Digital Services could not provide

Audit	Assurance	Detail
		evidence that the necessary End Point Access protocols were in place nor that the Public Services Network Code of Connection certificate had been in place during the entire audit period.
St. Anne's Catholic High School for Girls	**No**	Following Covid-19 restrictions from March 2020, St Anne's Catholic High School for Girls adapted its day to day processes for business continuity purposes by introducing remote working and rostered office attendance for those not shielding to ensure the safety of staff and pupils. The school continued to implement changes in line with Government restriction requirements when all schools reopened in September 2020 until December 2020, then again from March 2021. During this time, the school appointed a new Headteacher in 2020, the School Business Manager resigned, and a Director of Finance & Resources was appointed in 2021. The school is currently carrying a significant deficit. The school's 10 year deficit recovery plan is due to end in 2027. However, we were advised that the plan was reviewed in April 2022. At the end of November 2021. the school requested an increase to its rolling credit agreement with the Council, from £670k to approximately £770k to avoid going overdrawn at the end of 2021/22. During this audit we identified: **three high risk**, **eight medium risk** and **nine low risk** findings. We also identified one advisory item for management attention. This has resulted in an overall **No** assurance opinion. The following **high risk** findings were identified: 1. Improvements are required to the school's ordering and purchasing processes. These improvements include ensuring HMRC employment status checks are undertaken for self-employed individuals; ensuring order forms, which should be signed and dated prior to the purchase of goods and services, are completed; and maintaining one set of financial data to avoid duplication of work.

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		2. The Council's Contract Procedure Rules (CPRs) should be complied with at all times when the school enters into and/ or renews contracts and lease agreements. Where this is not possible, a Waiver of CPRs form should be completed. In addition, all contracts and agreements, signed by the school and service provider, should be retained at the school as part of its financial records. 3. Improvements to the reconciliation processes in place are required. Reconciliations should be completed monthly and subject to independent review. Dated signatures of both the preparer and independent reviewer should be included to confirm these checks are in place. A further **eight medium**, **nine low risk** findings and one advisory finding were also identified.
Leavers	**Limited**	The audit was designed to provide assurance that the Council has robust controls in place to ensure that the process around employees and agency workers leaving the Council is seamless. We specifically examined the overarching governance arrangements for the leavers process as well as the day to day administration of the leavers process in HR, Payroll, Facilities Management and Digital Services. During the audit we identified **two high risk** and **three medium risk** findings. The significant findings from the audit were: • There is no overarching governance of the leavers process. Therefore non- compliance with the process is not monitored, reported, or escalated with the result that non-compliance is not visible and the opportunity for making improvements is lost. • Sample testing of the Facilities Management processes found: ○ ID cards are not consistently recovered and destroyed when employees leave the Council. This is a security risk but may also be a risk to residents if ID cards are used

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		fraudulently. ○ In four out of 10 (40%) cases tested, cards were deactivated between eight and 204 days after the official leaving date. Also, we were advised that although there had been attempts to use two of the cards internally, Facilities Management were unable to confirm if these attempts had been successful. ○ In one of the 10 (10%) cases tested, there was no record of the agency staff leaver on the ID card system (Sataeon) even although the leaver had worked with the Council for nine months. • Only 19% of staff who left the Council between October 2021 and February 2022 completed an exit survey. Therefore, the Council is missing a valuable opportunity to improve retention and engagement through feedback on the workplace culture, day to day processes, management, and employee morale in the Council. • Staff not complying with the Leaving the Council Procedure document, especially around sending leavers' notifications on time, is leading to e.g. access to the Council's systems and ID passes not being deactivated on time. Therefore, we have recommended that a communications campaign is put in place to remind staff of the requirements of the leavers process and the importance (e.g. in terms of security, data protection, etc.) of complying with the documented procedures. • Although the Leaving the Council Procedure document is available on the intranet, underlying documents are not up to date and, in the case of the formal exit survey, the manual and electronic documents are inconsistent with each other. We also identified that Digital Services have an internal leavers process document that is inconsistent with the Leaving the Council Procedure document and that Facilities Management does not have an internal process document for the leavers' process. Therefore, we are recommending that Facilities Management put internal procedures in place and that as a collective, all leavers' process policies and procedure documents are updated, reviewed, and aligned.
Community Equipment Services	**Limited**	This review identified **one high**, **five medium** and **one low risk** findings, leading to a

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		Limited assurance opinion. The service was insourced from Independence and Wellbeing Ltd in June 2020. Since the on-set of Covid-19, the service has experienced a significant upturn in demand for equipment and adaptations to support hospital discharges. Average orders of 1,836 per month in 2019-20 rose to 2,044 per month in 2020-21 and 2,877 in 2021-22. Despite this, anecdotal evidence suggests a good service is being provided to clients. However, some processes such as routine maintenance, have had to be paused in order to meet the increase in demand. The following **high risk** finding was identified: • The Service is not following contract procedure rules when carrying out spot purchasing. The following **medium risk** findings were identified: • The Service needs to finalise a suite of KPIs that give an effective view of performance. Parameters for calculating the KPIs should be agreed and documented. • The stock control system is not being used effectively to track movements of stock into, around and out of the warehouse. • The maintenance programme has fallen behind as staff were reassigned to other duties due to Covid-19. Some maintenance has not been completed as clients did not want home visits during the pandemic; this needs to be fully documented in case injury claims against the Council arise. • Contracts with care homes have not been updated to reflect that it is the care homes' duty to advise the Council if the equipment for a specified client is no longer required. There are no regular audits of equipment in care homes. • The Service needs to document a Delegation of Authority whereby officers in the Service are authorised to destroy stock. The agreement with the waste collector should be formalised.

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		One low risk finding was also identified.
Deprivation of Liberty Safeguards	**Limited**	The audit was designed to provide assurance that there are appropriate controls in place to ensure that the Council is compliant with current Deprivation of Liberty Safeguards (DoLS) legislation and that the necessary steps are being taken to ensure a smooth transition to its replacement, Liberty Protection Safeguards (LPS) in 2022. It was expected that LPS would be introduced in April 2022, but the Department of Health and Social Care have confirmed this date will not be met and currently a new target date for implementation has not been set. Therefore, it is expected that DoLS will remain in place for some time. The DoLS Team has already commenced planning and preparing for the introduction of LPS. A Project Board overseeing the process meets regularly and is engaging with a number of stakeholders. Therefore, plans for LPS are in progress but are subject to the government issuing the Code of Practice which will provide further guidance on implementation. DoLS will remain in place in the interim and will function concurrently with LPS, once implemented, for an additional year to ensure a seamless transition. The audit testing focused primarily on the current DoLS process. This review identified **one high** risk, **four medium** risks and **one low** risk finding. The following **high risk** finding was identified: • When acting as the Supervising Authority, the Council engages the services of Mental Health Assessors (MHAs) and Best Interest Assessors (BIAs) to carry out the mandatory assessments required before deciding whether a service user's liberty has to be removed for their best interest. The MHAs and BIAs currently providing this service are not employed by the Council. We have identified that: ○ no contractual agreements are in place with any of these third party providers; ○ no data sharing agreements are in place with these third party providers who

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		handle sensitive information on behalf of the Council; ○ although the total expenditure for all providers during the current and previous financial year was £720k, no formal procurement exercise had been carried out. The following **medium risk** findings were identified: • Limited management reporting is made to the monthly Adult Social Care Performance Management Team meeting. A monthly update is provided on the number of DoLS referrals, but no further information is provided on: ○ the Council's compliance with the legislative requirement to complete assessments within 21 days; ○ progress against locally agreed performance indicators. The Service's records are maintained on Eclipse and on a spreadsheet, but these do not have the functionality to produce the relevant performance reports. Also, a sample of 25 cases was reviewed to confirm that as the Supervising Authority, DoLS applications were received, allocated promptly and assessments were carried out in a timely manner. We found that: ○ No data is held to confirm that applications are allocated promptly; ○ In all cases tested, MHA assessments were not completed with 72 hours of allocation; ○ In all cases tested, BIA assessments were not completed within 5 days of allocation; ○ In 52% of cases, the deadline for completing the assessment within 21 days was not met. • It is a requirement that each MHA and BIA has been appropriately trained, accredited, and completes annual refresher courses. We found that the training records for internal BIA assessors were not completed in full and so we were unable to confirm when refresher courses were last completed.

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		• Sample checks of BIAs' professional indemnity insurance found that, in one case, an external BIA's insurance was out of date. • A project board is in place to oversee the transitioning from DoLS to LPS. However, we were advised that the reconfiguring of Liquid Logic and RIO systems has not yet begun. However, the Project Executive Manager and Programme Change Manager are engaging with both work streams to commence the process. **One low risk** finding was also identified.
Financial Management of Bridgewood House	**Limited**	Bridgewood House is owned and managed by Enfield Council after being insourced from Independence and Well Being Enfield Ltd (IWE) in June 2020. The home is registered to provide care to 70 people and, at the time of the audit, the home was at full capacity. During the pandemic the staff at Bridgewood House adhered to Government requirements and guidance and adapted their day to day processes for business continuity purposes to ensure the safety of staff, residents, and visitors. Full Personal Protective Equipment (PPE) is worn around residents at all times. Our review focused on financial management aspects of Bridgewood House only. The Care Quality Commission (CQC) is responsible for assessing the care and safeguarding aspects of the home and therefore our review did not cover these areas at all. The latest CQC report for Bridgewood House was issued on 14 April 2021 and a **Good** rating was awarded. This was an improvement on the previous inspection in 2019 when the home was run by IWE and a Requires Improvement rating was given. Our review identified **three high** risk, **five medium** risk and **two low** risk findings. Our review highlighted control weaknesses in the home, particularly around the lack of reconciliation processes in place for residents' monies. Therefore, we have concluded that an overall **Limited** assurance opinion is appropriate in this case. The following **high risk** findings were identified:

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		1. Written processes and procedures detailing all financial roles and responsibilities in operation at the home are not in place. 2. Improvements to the reconciliation processes in place are required. For example, monthly reconciliations are not completed and appropriately approved supporting documentation is not retained for all resident expenditure. 3. We were unable to confirm that Bridgewood House has appropriate insurance cover in place in relation to valuables held in the safe on behalf of residents. In addition, regular checks to ensure the valuables held in the safe can be accounted for are not undertaken. A further **five medium** and **two low risk** findings were also identified.
Primary Behaviour Support Service	**Limited**	The Primary Behaviour Support Service (PBSS) was previously similar to a Pupil Referral Unit (PRU) and was given school status. However, a change in Government regulations led to the Service being deregistered as a school and it then became a demand led Council funded service, operating at a pre-statutory level. The Service is measured against reducing the number of permanent exclusions in Enfield primary schools. From March 2020, the PBSS followed Government guidelines in relation to the Covid-19 pandemic. Day to day processes were adapted for business continuity purposes by introducing remote intervention to help support students who were receiving behaviour support prior to the start of the pandemic and to those in need of support as a result of the Covid-19 restrictions. The Service continued to implement changes in line with Government guidelines to ensure staff and student safety. The number of permanent exclusions from Enfield primary schools has reduced over the years and has remained at zero since 2018/19.

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		This review identified **seven medium risk** and **two low risk** findings. One advisory item for management attention was also identified. This review highlighted a number of control weaknesses in the Service and highlighted that additional work is required to demonstrate the Service's value. Due to the nature of the Service and the seven medium risks highlighted; this has resulted in an overall **Limited** assurance opinion. The following **medium risk** findings were identified: 1. Exceptions were identified in relation to the policies and procedures in place, including discrepancies between individual documents and the Service's policy review cycle listing and the absence of an operational procedure document for school-based requests for involvement (RFI). 2. The PBSS has not undertaken the required annual 'Physical Intervention Training' since 2019. In addition, not all members of the Service had completed the Council's mandatory training via iLearn. 3. The Service does not have a Privacy Notice in place which is in contravention of GDPR 2016/679. Also, as the Service has a statutory obligation to share students' information for safeguarding purposes, it would be more appropriate to include a reference to the Privacy Notice rather than requesting consent from parents/carers. 4. Improvements are required to the Service's RFI processes. These improvements include ensuring intervention record sheets are completed in full and retained on file and that all RFIs received are taken to a scheduled RFI meeting for discussion within 14 days. 5. RFI case reviews are not formally documented and do not include confirmation that the

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		correct procedures were undertaken. 6. Follow-ups are not currently required for students that have re-integrated into school following an intervention programme or advice from the PBSS, therefore the Service is unable produce monitoring reports that demonstrate its effectiveness. In addition, the informal follow-ups that are undertaken are not documented or kept on file. 7. The most secure method of communication is not used by the PBSS when responding to RFIs received from schools. A further **two low risk** findings were also identified.
Secondary Behaviour Support Service	**Limited**	From March 2020, the Secondary Behaviour Support Service (SBSS) followed Government guidelines in relation to the Covid-19 pandemic. Day to day processes were adapted for business continuity purposes by introducing remote intervention to continue support to students. The Service continued to implement changes in line with Government guidelines to ensure staff and student safety. In addition, 'REACH Covid' was put into place, which saw the Respect, Effort, Achieve, Communication, Honesty (REACH) team adjust its intervention programmes to accommodate as many students as possible during this time. These interim arrangements will cease, and the usual REACH Service will resume in January 2022. The key performance measure for the SBSS is a reduction in the number of permanent exclusions in Enfield secondary schools. The number of permanent exclusions from Enfield secondary schools reduced from 57 in 2017-18 to 21 in 2018-19. This meant that in comparison to local surrounding boroughs and other London boroughs, Enfield's permanent exclusion rate improved from being the 11th highest to the 3rd lowest. In addition, of the 112 referrals made to the SBSS Outreach team during 2019-20, no students were permanently excluded. This review identified **three high risk**, **four medium risk** and **three low risk** findings.

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		This review highlighted a number of control weaknesses in the Service particularly around not completing and retaining supporting documentation. It is important to retain such documentation so that the Council can demonstrate it has fulfilled its duty to record and document decisions made if any challenges are made. Due to the nature of the high and medium risks identified, we feel an overall *Limited* assurance opinion is appropriate in this case. The following **high risk** findings were identified: 1. Controls in place around data security were found to be insufficient. We were unable to determine if appropriate arrangements were in place to ensure confidential information was being held securely by Council and non-Council staff. 2. Improvements are required to the Service's referral processes. These improvements include ensuring intervention record sheets and student progress notes are completed and retained on file in all cases. 3. There was no process, either formal or informal, in place for case reviews. We were unable to determine if the procedures were being applied correctly and consistently by all members of the SBSS or if inefficiencies or areas of improvement were being identified. A further **four medium** and **two low risk** findings were also identified.
Community Infrastructure Levy	**Limited**	This review identified **one high risk, two medium risk** and **one low risk** findings. The following **high risk** finding was identified: • **Lack of clarity of the CIL and Finance teams responsibilities and processes**– As part of our testing we were unable to determine the CIL team and the Finance team

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		responsibilities and processes, and how both functions work together to ensure that the council complies with statutory provisions regarding expenditure per CIL legislation. The following **two medium risk** findings were identified: • **Lack of clarity and transparency over the allocation of CIL costs** – We were unable to confirm whether the costs allocated to the admin pool complied with the Council's CIL budget. • **Lack of formalisation of CIL documentation** - We selected a sample of 20 planning applications and tested the documentation around the eligibility for CIL and any exemptions claimed. Through this testing, we identified that the process in place is not being consistently followed by the planning officers. **One low risk** finding was also identified.

Grounds Maintenance	**Limited**	This review identified **seven medium** and **one low risk** findings, leading to a **Limited** assurance opinion.
		
		The following **medium risk** findings were identified:
		
		• At 31 December 2021 a budget overspend of £212k was identified. This was in part due to additional Covid-19 related spending but also to:
		  ○ An unbudgeted recharge of £164k to support the Council's Blue and Green Strategy
		  ○ A grant claw back of £71k from Natural England as terms of the grant had not been complied with
		
		Although requested, later budget monitoring information was not shared with us.
		
		• Improvements are required around the authorisation of agency worker payments.
		• Key performance indicators for the service have not yet been finalised.
		• Worksheets detailing work completed are not always being signed by staff and their

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		manager. Uncompleted work is not being signed off at a later date, when it is completed. • Training records are incomplete, and a training needs matrix has not been finalised. • For services provided under the Service Level Agreement with Housing and Regeneration, costings evidencing that the service is being provided within budget were not provided. • We were unable to ascertain who is in charge of the strategy for Cooks Hole Road depot and we were unable to obtain evidence of how the rental of £12,000pa was determined. **One low risk** finding was also identified.
Meridian Water – Contract Management	**Limited**	This review identified **one high risk**, **two medium risk** and **one low risk** findings. The following **high risk** finding was identified: • **Adherence to Contract Procedure Rules (CPR):** We tested 5 Meridian Water (MW) procurements for adherence to the CPRs and noted that meeting minutes from all relevant Programme Boards during the procurement process had not been uploaded on to the E-Tendering system as per the CPRs. We also noted that in 3 out of the 5 (60%) procurements tested, we were unable to evidence that KPIs and risk registers capturing contractors' risks were maintained and monitored to ensure these were operating and delivering efficiently. Additionally, the overarching Programme Board Terms of Reference (ToR) notes that the Programme Board is responsible for "managing all of the individual projects" which form part of the Meridian Water programme. However, it was noted in our walkthroughs that the items in our contract testing sample were not discussed at the Programme Board. The following **medium risk** findings were identified: • **Purchase order process:** As part of our testing, we selected a sample of 25 purchase orders (POs) to determine whether each purchase had been approved in line with the Contract Procedure Rules (CPRs), and whether Meridian Water had identified sufficient

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		budget in each budget code to allow for the purchase to be made. We identified that for 2 out of the 25 POs tested (8%), we were unable to confirm the appropriate budget code as the budget code stated in the sample listing was different to the one stated on SAP. • **Meridian Water specific training:** As part of our testing, we selected a sample of 2 out of 7 new joiners to see whether they had received any specific contract management or Meridian Water specific training. Upon inspection of the training records and the induction checklist, we were unable to determine whether those joiners had been provided with such training. The following **low risk** finding was identified: • **Governance documentation:** We identified inconsistencies between the overarching Governance structure
Oversight of Montagu LLP	**Limited**	The objective of this audit was to assess the governance and financial controls in place regarding the Council's investment in the redevelopment of the Montagu Industrial Estate to ensure that Montagu LLP's operations are well controlled, operate effectively and are in line with the Council's expectations. This review identified **two high risk, three medium risk** and **two low risk** findings. The following **high risk** findings were identified: • We identified that: o There are no clear internal Council governance arrangements in place in relation to the oversight of Montagu's performance. o The Assurance Board and Executive Management Team (EMT) meeting minutes sampled did not evidence discussions held regarding Montagu's financial performance nor the progress made against the business plan. o Although Property Board meetings took place throughout the audit period in scope (1 September 2020 to 31 July 2021), these meetings were not minuted. • The organisational structure within the Council was, during the audit period in scope,

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		heavily reliant on one individual to oversee the Montagu project. The following **medium risk** findings were identified: • There was no tracking and monitoring of Key Performance Indicators (KPIs) for phase 1 of the project during the audit period in scope. In addition, no reporting mechanisms were in place with regards to Montagu's financial and operational performance during this time. • There was lack of clarity around escalation mechanisms in place with regards to the monitoring of the project's costs. • The Operational Risk Register was not regularly reviewed and updated throughout the audit period in scope. **Two low risk** findings were also identified.
Oversight of Energetik	**Limited**	The objective of this audit was to provide assurance that there are appropriate controls in place to ensure that the Council exercises good governance over Energetik, monitors performance and is able to react promptly to any issues. As a consequence, the repayment of loans by Energetik to the Council and the monitoring of Energetik's connections pipeline were not covered as part of this audit. Areas of good practice identified in the audit included: • Quarterly Strategic Client Group meetings are held between the Council's representatives and Energetik to discuss operational and financial performance updates against the business plan including any issues arising from prior meetings. • The respective roles and responsibilities for both Energetik and the Council are clearly outlined in the shareholder member agreement. • Quarterly Capital Programme updates are presented to the Capital Finance Board and Cabinet to report on the funding arrangements/expenditure against the Council's 10-year Capital Programme.

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		This review identified **one high risk, one medium risk** and **one low risk** findings.
		
		The following **high risk** finding was identified:
		
		• We identified that:
		  ○ there are no clear internal Council governance arrangements in place in relation to the performance of Energetik
		  ○ internal Council reporting on Energetik performance has not been consistent throughout the audit period in scope.
		  ○ the Commercial Board and Assurance Board meeting minutes sampled did not evidence discussions held regarding Energetik's financial performance nor on the progress made against the business plan
		  ○ the report presented to Cabinet in January 2022 did not provide up to date information on Energetik's performance and lacked clarity over the level of scrutiny it had undergone.
		
		The following **medium risk** finding was identified:
		
		• The Energetik quarterly monitoring reports did not consistently capture the targets set against KPIs as outlined in the overarching business plan and commentary against key variances was not consistently noted. In addition, no commentary on the financial figures was captured and no cashflow information was presented.
		
		The following **low risk** finding was identified:
		
		• The Capital Programme Monitoring quarterly reports should be enhanced to include a separate section for Energetik, with regards to the project current costs against the budget, forecast and business plan.

Bush Hill Park Primary School	**Limited**	This audit review identified **two high risks**, **three medium** risks and **eight low risk** findings. We also identified two advisory items for management attention. This has resulted in an overall **Limited** assurance opinion.

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		The following **high risk** findings were identified: • The controls around the school's Wrap Around Care processes were found to be weak with the following exceptions identified: - Invoices were not raised for wrap around care service between November 2021 to January 2022. As a result the school currently had non invoiced bookings of over £7,000 across 15 accounts. - We could not confirm that regular reconciliations between the income and attendance records had been completed and independently reviewed. • The controls around the schools' procurement processes were weak as we identified the following: - We could not confirm pre-authorisation for purchases made on the school's commercial card. Also, we noted that although reconciliations between the commercial card transactions and card statement took place, we could not confirm which officers performed this function as the documents were not signed and dated. - In all 15 cases tested, the terms and conditions for purchases made on behalf of the school were not provided to suppliers. - In three cases, purchase orders were not raised when engaging the services of agencies. - In five cases orders were raised either retrospectively or on the same day as the associated invoice. The following **medium risk** findings were identified: • There was insufficient information to confirm that: - Governors had approved how Pupil Premium would be spent - Sufficient financial records were maintained. • We were unable to confirm that an annual inventory check had been carried out. Also, the asset register needs to be updated to accurately reflect the location of assets as well

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		as to include the date assets were purchased and details of disposed assets. • Pre-employment checks were completed after employees had commenced employment and documentation was not submitted in a timely manner to the School's Personnel Service. A further **eight low risk** findings were also identified.
Eldon Primary School	**Limited**	This audit review identified **one high risk** and **seven low risk** findings. We also identified one advisory item for management attention. This has resulted in an overall **Limited** assurance opinion. The audit testing in this review covered the period April 2020 to October 2021. This included periods of Covid-19 restrictions and extra workload and pressures this imposed on the school. Office staff were following government guidelines, had a rota system for being on site and had adapted day to day processes to ensure the safety of staff and pupils. The school has continued to implement changes with Government requirements alongside preparing for this audit review. The following high risk finding was identified: • The controls surrounding the school's procurement processes were found to be weak with the following exceptions identified: - **Related Party Transactions:** The school purchases services for SEND and sports coaching from an agency and purchases school improvement plan services from another supplier. The value for the SEND and sports coaching services is £72,500 for the current financial year. The total spend for school improvement plan is £12,500 per annum.

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		Despite a staff member (SEND and sports coaching services) and a governor (school improvement plan services) having connections with the suppliers, no supporting information was provided to confirm that an independent review had been carried out by the Governing Body prior to the suppliers being engaged.
		- **Contracts:** Contract Procedure Rules (CPRs) were not consistently adhered to in several cases. We found:
		  ○ For the SEND and sports coaching contract mentioned above, a formal procurement process, as required by the CPRs, had not been carried out nor was the award of the contract formally approved;
		  ○ For the school improvement plan services contract mentioned above, a procurement exercise in line with the CPRs was not undertaken; neither was there a formal contract in place nor confirmation that the Governing Body approved the purchase of this service; In one case the contract was out of date; had not been signed by a delegated officer from the school; and, although a waiver was completed, there was no indication what period it was related to or when a best value exercise would be carried out;
		  ○ In one case the approval of the contract was not explicitly recorded in the Governing Body minutes; and
		  ○ In one case a waiver was approved after the contract had commenced.
		- **Purchase to Pay:** In several cases, purchase orders were raised retrospectively.
		
		A further **seven low risk** findings were also identified.

Oakthorpe Primary School	**Limited**	This full audit review identified **one high risk**, **five medium risk** and **eight low risk** findings. We also identified three advisory items for management attention. This has resulted in an overall **Limited** assurance opinion. This audit review was undertaken during Covid-19 restrictions. Following government

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		guidelines, Oakthorpe School has adapted its day to day processes to ensure the safety of staff and pupils since March 2020. The school has continued to implement changes with Government requirements alongside preparing for this audit review. Despite the restrictions and the **Limited** assurance opinion, we have noted significant improvement in the control environment at the school since the last audit undertaken in 2019/20, which resulted in a **No** assurance opinion, and which included four high risk findings and nine medium risk findings. The following high risk finding was identified: - In one out of five instances, pre-employment checks and Videpay forms were completed in advance but were not submitted to the Schools Personnel Service (SPS) before the official start date. In four of five instances, contracts of employment were issued after employment commenced. Although some staff were working from home due to Covid-19 restrictions, it is important that checks are carried out and the relevant documentation is in place prior to employment commencing. Doing so will avoid inappropriate appointments being made, which can become timely and costly to rectify. The following **medium risk** findings were identified: - The school's Organisational Arrangement and Scheme of Delegation had not been reviewed and updated to ensure they are complete, consistent and reflect the processes in operation at the school. - Purchase orders or pre-authorisations were consistently not in place for expenditure transactions. - We could not confirm that best value exercises had been carried out when required. Also, Governing Body minutes did not include explicit approval for the award of contracts.

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		- We were unable to confirm what action had been taken to locate items which were identified in the asset register as missing. Also, we could not confirm which assets had been checked during the annual inventory check. - The school maintains financial records for its wrap around care services. However a reconciliation between the income received and the attendance records was not presented for review. Also the monthly bank reconciliation was not completed in full. A further **eight low risk** findings and three advisory findings were also identified.