Public
Key Decision - No

HUNTINGDONSHIRE DISTRICT COUNCIL

Title/Subject Matter:	Internal Audit Service: Annual Report 2019/20
Meeting/Date:	Corporate Governance Committee – 23 July 2020
Executive Portfolio:	Strategic Resources: Councillor J A Gray
Report by:	Internal Audit Manager (Acting only)
Ward(s) affected:	All Wards

Executive Summary:

The Public Sector Internal Audit Standards (PSIAS) require the Committee to receive an annual report on the work of the Internal Audit Service. The report is required to include:

- The opinion
- A summary of the work that supports the opinion; and
- A statement on conformance with the PSIAS and the results of the quality assurance and improvement programme.

This report details the work undertaken by Internal Audit during the year ending 31 March 2020 to support the following opinion statement.

Audit Opinion on the Council's internal control environment and systems of internal control in providing adequate assurance over key business processes and financial systems:

Due to the decreased resources available in 2019/20, a limited number of audits were conducted and full audit coverage across the Council was not achieved; therefore an 'adequate assurance' opinion can only be given in respect of the assurance gained from those audits conducted and does not represent the wider Council.
Confidence in assurance can be taken from the fact that coverage included all the Council's key financial systems and IT Service; however it did not include a full wider coverage of general services.

Deborah Moss
Acting Internal Audit Manager July 2020

Last year 2018/19 the assurance opinion was stated as adequate assurance. This year 2019/20, there is no evidence to suggest that this assurance level has dropped and only two red audit actions were reported. However, limited coverage means that this level may not be truly representative.

The opinion is based on the outcome of 11* audit reviews and the review of key controls within all seven key financial systems.
(* two reports issued from 18.19 Plan)

The 11 audits have identified 53 actions for improvement. Three of these actions have been classified as ‘red’ or ’high risk’ actions (i.e. meaning the uncontrolled risk has the potential to seriously affect service delivery).

The following areas are brought to Committees attention.

1) Absence of definitive lone working procedure for safety of staff.
2) The lack of oversight of the minor works contract due to a lack of specialist and expert knowledge.
3) Little attention/progress on risk management.
4) Managers continued poor performance in introducing on time, actions that they have already agreed to.

The Internal Audit Manager continues to report functionally to the Corporate Governance Committee and maintains organisational independence. There were no constraints placed upon him in respect of determining overall audit coverage, audit methodology, the delivery of the audit plan or proposing actions for improvement or forming opinions on individual audit reports issued.

Quality Assurance and Improvement Programme

One of the major elements of the PSIAS is the requirement to maintain a quality assessment and improvement programme This has been in place throughout the year. A self-assessment review was undertaken in May 2018 to evaluate Internal Audit’s conformance with the PSIAS ahead of a planned independent external assessment. Neither the action plan from the self-assessment nor the external assessment have been delivered, due to the Internal Audi Manager deciding that delivery of the internal audit plan was more important than allocating resources to the QAIP.

The Resources restructure removed non-audit functions of Insurance and Risk Management from the team, allowing more time to be spent on delivering the action plan. Unfortunately, the lengthy absences of the Audit Manager resulted in a very significant loss in audit days and consequently a number of audits could not be carried out.

Recommendation(s):

It is recommended that the Committee:

1. Consider and comment upon the report; and

2. Take into account the audit assurance opinion when considering the Annual Governance Statement for 2019/20.

1. PURPOSE OF THE REPORT

1.1 This is the annual report of the Internal Audit Manager (IAM). It covers the period 1 April 2019 to 31 March 2020.

1.2 The report includes the IAM's annual opinion on the overall adequacy and effectiveness of the Council's internal control and governance processes.

2. WHY IS THIS REPORT NECESSARY

2.1 The Accounts and Audit (England) Regulations 2015 require the Council to 'undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance'.

2.2 The Public Sector Internal Audit Standards (PSIAS) require an annual report to be considered by the Committee as they fulfil the role of the Board (as defined by PSIAS). The PSIAS details the matters that are required to be included in the annual report. These are:

a) The opinion
b) A summary of the work that supports the opinion; and
c) A statement on conformance with the PSIAS and the results of the quality assurance and improvement programme.

3. OPTIONS CONSIDERED/ANALYSIS

3.1 Last year 2018/19 an overall opinion of adequate assurance was given and the internal control environment stated as generally effective. This year, 2019/20, it has not been possible to provide full coverage across the Council services and therefore only an audit opinion of adequate assurance can only be given with the caveat that it represents only those audit areas undertaken and not that of the Council-wide systems.

The Audit Service can state that all the key financial systems were reviewed quarterly for quarters 1-3 and no significant weaknesses / red issues were identified (quarter 4 reviews succumbed to Covid priorities which meant no year-end annual assurance was given for each system); It is anticipated that adequate ratings would have been given to all key systems except Accounts Receivable where a limited assurance would most likely have applied.

3.2 There have been two substantial assurance, five adequate assurance and three limited assurance reports (general and IT) issued in 2019/20. There are a number of matters within these reviews and from other work undertaken that need to be brought to the Committee's attention:

Minor Works Contract
This concern was reported to Committee last year, and still remains. HDC is now 'out of contract' and the contract needs reletting. Following cessation of the Projects & Assets team, this contract was transferred

to Operations who have never had the priority/capacity to renew it. Without a decision and action to re-let the contract, we may risk falling foul of procurement regulations.

Lone Working
The Council does not have a written corporate protocol for lone working. Whilst there are procedures that were previously in place, these are deemed no longer current; staff are not aware of them and do not follow them. Some employees follow their department's own local procedures, the design and approval of which is unknown. Whilst most local procedures 'work', they are not complete and carry a higher risk of not being sufficiently robust if something did go wrong.

Implementation of agreed audit actions on time
The performance indicator (% of agreed internal audit actions introduced on time) provides an assessment of the commitment and effectiveness of management in implementing actions. Managers who do not implement agreed actions arising from internal audit findings expose the Council to continued risk. Over the course of the year performance has fallen for the second year. Only **42%** of agreed actions were introduced on time at February 2020 compared to a reported 63% in March 2019 and 79% at March 2018.

Risk Management
The Council has not embedded risk management. Little or no attention or impetus has been given to this for a considerable time and it is my opinion that not enough importance is placed upon it.

There are also a significant number of draft reports that, despite auditor efforts, have not been replied to or signed off. This prevents the audit actions being added to the formal record and are not monitored for implementation. The risk or efficiency that each action stands to address, remains present.

4. KEY IMPACTS / RISKS

4.1 Failure to provide an annual report would lead to non-compliance with the PSIAS and require the matter to be reported in the Annual Governance Statement.

5. WHAT ACTIONS WILL BE TAKEN/TIMETABLE FOR IMPLEMENTATION

5.1 The annual report will be considered by the Committee during the preparation of the Annual Governance Statement.

6. LINK TO THE CORPORATE PLAN, STRATEGIC PRIORITIES AND/OR CORPORATE OBJECTIVES

6.1 The Internal Audit Service provides assurance to management and the Committee that risks to the delivery of the Corporate Plan across all of its areas are understood and managed appropriately.

7. REASONS FOR THE RECOMMENDED DECISIONS

7.1 In fulfilling its obligations under the PSAIS, the Committee is required to receive an annual report on the work of the Internal Audit Service. The outcomes of the report, particularly the annual opinion statement, will be included within the Council's annual governance statement.

8. LIST OF APPENDICES INCLUDED

Appendix 1 – Internal Audit Service Annual Report 2019/20

9. BACKGROUND PAPERS

Internal Audit Reports
Internal Audit performance management information

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Internal Audit Service
Annual Report 2019/20

1. INTRODUCTION

1.1 This is the annual report of the Internal Audit Manager (IAM) as required by the Public Sector Internal Audit Standards (PSIAS). It covers the period 1 April 2019 to 31 March 2020.

1.2 The report includes the IAM's annual opinion on the overall adequacy and effectiveness of the Council's internal control and governance processes. The opinion is based upon the work carried out by Internal Audit during the year.

1.3 The report provides information on:
- the delivery of the annual audit plan;
- audit reports issued and issues of concern;
- implementation of agreed actions;
- Internal Audit's performance; and
- the quality assessment and improvement programme.

2. OVERALL OPINION

Audit Opinion on the Council's internal control environment and systems of internal control in providing adequate assurance over key business processes and financial systems:

Due to the decreased resources available in 2019/20, a limited number of audits were conducted and full audit coverage across the Council was not achieved; therefore an adequate assurance opinion can only be given in respect of the assurance gained from those audits alone and does not represent the wider Council.
Confidence in the assurance can be taken from the fact that coverage included all the Council's key financial systems and IT Service; however it did not include a full wider coverage of general services.

Deborah Moss
Acting Internal Audit Manager July 2020

2.1 Assurance can never be absolute. The audit opinion reflects the IAM view on the current state of the internal control environment and the effectiveness of the systems of internal control across the Council and provides the Committee with an opinion for inclusion in the Annual Governance Statement (AGS).

If significant changes occur to the internal control environment prior to the Committee approving the AGS the Committee will be informed.

2.2 In preparing the internal audit plan for 2019/20, Managers were asked if they were aware of any planned reviews by external organisations from which assurance could be obtained on the operation of the internal control environment and systems of internal control. With the exception of the statutory external audit of accounts no other external assurances were identified for 2019/20.

2.3 The IAM continues to report functionally to the Corporate Governance Committee and maintains organisational independence. In 2019/20 the Audit Manager had no constraints placed upon him in respect of determining overall audit coverage, audit methodology, the delivery of the audit plan or proposing actions for improvement or forming opinions on individual audit reports issued.

3. DELIVERY OF THE 2019/20 AUDIT PLAN

3.1 The Audit Plan was approved in two half-yearly Plans for 2019/20. Committee was advised in March of the intention of the restructure to remove Insurance and Risk Management out of the Audit team; Committee sought explanation as to the rationale behind the move and confirmed that they would continue to receive Risk Management reports direct to them; and sought confirmation that the [Internal Audit]Service would not be outsourced.

3.2 Committee expressed disquiet at having to approve an Audit Plan that would be likely to change following a restructure, but agreed on the proviso that an update was received from the Executive Councillor for Resources on the restructure and its impact upon the Committee's role.

Internal Audit Reports Issued

3.3 Audit reports issued are listed in the table below - grouped by assurance opinion (see Annex B for further explanation) and showing action type and number of actions.

Audit area		Action type & No.	
		Red	Amber
Substantial			
	Disabled Facilities Grants	0	0
	Protocol Policy Mgt System	0	2
Adequate			
	Staff Recruitment *	0	12
	Housing Benefit 18.19	0	6

Audit area		Action type & No.	
		Red	Amber
	S/w and H/w Asset Management	0	8
	Network Access Control	1	4
	Network System Resilience & Availability	0	3
Limited			
	Purchase Order Compliance *	0	9
	Lone Working *	1	5
	Delivery of Capital Schemes	0	0
No opinion given			
	GDPR (update only)	---	---
	Land Charges 18.19	0	4
	* Draft reports (status as at 31/03/2020).		

3.4 A number of internal audit reviews from the 2019/20 plan are still underway (but work was paused due to the COVID situation). Reports are anticipated on the following audit reviews:

- Enforcement Policy
- Dashboard/Sickness
- achievement of KPIs
- Maintenance Schedule Planning

3.5 In addition to the reports listed above, reviews or audit involvement have also been undertaken on the following areas.

- Investigating a data breach and supporting the disciplinary process that arose from the investigation.
- Supporting investigations surrounding staff
- Whistleblowing
- DFG Certification required by County Council
- 4Action system upgrade
- Resources restructure
- Follow-ups
- Ad hoc advice
- Information Governance Group attendance/work
- Audit Manager duties
- Elections
- Staff Council involvement

Guidance has also been provided to managers and staff on an ad-hoc basis on a wide variety of risk and control issues.

As in previous year's, the audit plan included time to review key controls within a number of key financial systems. These were completed for quarters 1-3 for all key systems but quarter 4 /end of year reviews were not completed due to COVID and the redeployment of the Service. These remain not completed and as such no assurance opinion was given for each of these key systems. However, the quarters 1-3 reviews provide assurance that the controls were operating adequately. Detailed below …

3.6 The assurance opinions given on the remaining key financial systems are set out in the table below.

Audit area	Level of assurance				Action type & No.	
	Substantial	Adequate	Limited	Little	Red	Amber
*Council Tax		✓			-	-
*Non-Domestic Rates		✓				
*Housing Benefits – payments		✓			-	-
– recovery		✓			-	-
*Main accounting system		✓			-	-
*Accounts payable (Creditors)		✓			-	-
*Accounts receivable (Debtors)			✓		-	-

* These audit reviews were undertaken for quarters 1-3 but quarter 4 was not undertaken due to COVID/redeployment of resources. Consequently no end of year opinion and audit actions were provided for each of the areas and the above level of assurance is taken from Q1-3 work only.

3.7 Appendix A provides a summary of the main findings from each audit report issued.

4. IMPLEMENTATION OF AGREED ACTIONS

4.1 The Corporate Leadership Team has set a target of 100% of agreed actions to be implemented on time, based on a rolling 12 month timeframe. As at the 29 February 2020 the figure achieved was 42% (18 actions due from a total of 43 were on time). This increases to 86% (37 actions from a total of 43) when actions implemented on time and late are combined. 6 actions were not introduced (due but not acted upon) – none of these are red actions. Statistics were not issued for March and chasing was halted because of lockdown.

4.2 Not all the introduced actions are routinely followed up. The IARM decides if a follow-up review is required after considering the action's classification, the action itself, the evidence provided by a manager to support the closure of the action and his own knowledge of the action taken.

4.3 Follow-ups were not managed during 2019/20 due to limited resources and priority given to audit reviews. With continuing limited resources, it is the intention that priority will continue to be given to audit reviews and not to follow-up work, which can be monitored by Management.

4.4 A new version of 4Action (the database used to manage the audit actions) was introduced in Nov 2019 and at the time of lockdown, the team were preparing a to introduce a new process for follow ups which would allow this information to be captured and reported from the system.

6. INTERNAL AUDIT PERFORMANCE

6.1 Internal Audit maintains a series of internal performance targets. The performance as at 31 March 2020 is detailed below.

6.2 Customer satisfaction

Target: 85% or more of customers rating service quality as good or better via customer survey forms.
Outcome: 2019/20 – 100%

Four* customers surveys have been issued and responded to during the year. All three rated the overall quality of the review to be 'very good'.
* Practice is for surveys to be issued to customers alongside the final audit report, and since some of the audits have stagnated at draft stage the surveys have not been issued.

6.3 Service delivery targets

Data on performance indicators is usually presented in the annual report. However, it is not included for 2019/20 as it is deemed not representative; where few audits are carried out, each carries a disproportionate weighting. As previously reported, a number of audits are issued out as memorandums rather than final reports and are not therefore included in the metrics.
Additionally, issues with customers not replying to audit reports means there is less data to measure and the data can become unrepresentative.

7. QUALITY ASSESSMENT & IMPROVEMENT PROGRAMME (QAIP)

7.1 In May 2018 an auditor undertook a self-assessment to evaluate Internal Audit's conformance with the PSIAS in preparation for the independent external review that (as per PSIAS) was required to be completed by March 2019. It was reported in last year's annual report that the IARM decided not

to commission an external review, primarily due to the need to spend time delivering the audit plan rather than dealing with an external assessment and, for similar reasons, the action plan prepared from the 2018 self-assessment was also not delivered. This remains unchanged for last year 2019/20 as there were no plans to carry out an external review.

As reported in the last two years, the main issues identified from the self-assessment (and which remain) are:

- Auditor training on PSIAS changes introduced from April 2017
- On-going assessment and identification of auditor training and development needs
- Full review of the audit manual to reflect a number of initiatives introduced over the last two years (output from LEAN review of Jan 2017, changes to the QAIP, revised follow-up process).

7.2 The Resources restructure (effective from July 2019) removed responsibility for both insurance and risk management services from internal audit to allow for operational independence. The IARM spent a significant amount of time on insurance matters during 2018/19 and anticipated that by removing both of the service areas, time would become available to deliver the self-assessment and prepare for the external PSIAS review in 2019/20. This was not delivered due to absence of the IARM for most of the year. However, the IARM stated in the last report that he did not consider that there are any issues identified in the self-assessment or since, that would result in non-conformance with PSIAS.

Appendices

A. Summary of key findings and good practice identified from 2019/20 internal audit reviews.
B. Definitions used in the report

Deborah Moss: Acting Internal Audit Manager
Huntingdonshire District Council
July 2020

Annex A

Summary of key findings and good practice identified from 2018/19 Internal Audit reviews

Appendix A: A summary of the main findings from each audit report issued

<u>Substantial assurance</u>

Disabled Facilities Grants

Key findings	The review established that there is a robust control framework in place, with a high level of compliance.

Protocol Policy Mgt system

Key findings

- There is no appropriate process to monitor staff awareness of the ICT policies.
- A benefit realisation review of the solution has not been performed.

<u>Adequate assurance</u>

Staff Recruitment

Key findings	• There were only 3 cases of withdrawal after acceptance; and a bigger risk was found to be the number of unsuitable applicants or no applicants applying for positions • a significant number of new recruits left within months of starting • notice periods before start dates are not used effectively • talent pools are not used to retain details of applicants we could employ in the near future • recruitment statistics to highlight recruitment patterns/risks are not maintained
Good practice	• Staff's enthusiasm is in place to improve the recruitment at HDC • Recruitment advice is tailored towards the individual Service • Policy updates are already in the HR program • Recruitment metrics are now being maintained, since the audit.

Housing Benefit 18.19

Key findings	• Sample levels of new claims checking are suspected to be too low to be meaningful • The Policy and Procedure do not reflect what supporting documentation is accepted in practice • The evidence List is not always referred to by front line staff which may cause further unavoidable contact • Protocol for handling prime and valuable documents needs amending.

Summary of key findings and good practice identified from 2018/19 Internal Audit reviews

Good practice

- Moves towards acceptance of electronic and copy documents to align with how customers receive documents (although the risk category still needs to drive what is accepted)
- Introduction of e-forms for new claims
- Development of uploading supporting documentation (soon to be introduced)
- Regular monitoring

Network Access Management Control

Key findings

- Formal policies are not in place for setting up new users to the network
- Password policy settings do not enforce nest practice for privileged access passwords
- Network access approval is not decentralised but approved through 3CSS who do not own roles
- Service line (non-IT) management do not review or update the systems register
- Live AD accounts were identified which are not registered to current staff according to payroll data.

Key findings

Hardware & Software Asset Management

- The Council's ICT asset database did not contain a location for 3 out of the 25 assets tested an there are no arrangements in pace to review the database on a routine basis.
- The Council's software inventory does not include the licensing information of the software purchased
- Whilst we observed adequate ICT asset management practices there is no formal defined policy in place.
- The ICT Asset Database does not record ICT assets as lost or stolen.

Summary of key findings and good practice identified from 2018/19 Internal Audit reviews

Limited assurance

Purchase Order Compliance

Key findings

- Orders can be raised against any budget including that of another department
- Orders can be approved by any authoriser (not restricted to the budget holder of that particular budget or even an authoriser within the same dept)
- Authorisers are not shown remaining amounts in their budget before authorising a further purchase/commitment
- Orders under £100 are not [required to be] monitored
- Written procedures are not in place
- Retrospective orders are being made without any 'rules' around appropriateness/acceptability

Good practice

The TechOne Purchase Order system appears to be becoming embedded into normal working practice. Users reported that they are finding the system and its functionality quite easy to use now that they have had time to get used to it.

Delivery of Capital Schemes

Key findings

- There is a disconnect between the Project Management (PMGB) and Finance and Procurement (FPGB) Governance Boards. Typically, PMGB has been involved at too late a stage and communications between the two boards is not always effective.
- Internal decision making through the governance boards has historically impacted on project timescales and delays
- Challenge is weak, largely due to a lack of skills / knowledge
- There has been no "call-in" at FPGB, so delayed projects tend to flounder
- The roles of project sponsors and governance boards are unclear
- Some elements of the process are procedurally unclear
- Formal reporting requirements have not been clarified
- Service plans are not consistently reflective of capital plans / projects

Lone Working

Key findings

- Lone working procedures are haphazard and are locally, not corporately, designed
- New staff are not informed of lone working responsibilities and procedures at induction
- The Council Anyway project is not covering lone working
- Current risks assessments not in place for lone workers
- The Contracts Register is incomplete with regards to the CCTV software (including lone working software).

good practice

- In the absence of a corporate protocol on lone working, some Services have adopted their own local protocols to protect their staff.

- Staff are aware of lone worker risks and are willing and accepting of procedures to ensure colleagues are safe.

Land charges 18.19

Key findings

- It is not clear if the costs attributed against the land charges budget are complete and accurate as they could not be verified.
- Support cost fees are not clear.
- The spreadsheet used to calculate costs and fees is not supported by any guidance or procedure notes and is difficult to understand or interpret.

No opinion given – verbal feedback was given to the Senior Information Risk Officer (SIRO).

GDPR

Key findings

- No Info Governance Board meetings since June 2019. Past discussions and minutes are not very thorough about GDPR. Little evidence of any action.
- No follow up on actions and compliance towards GDPR since old IG manager left. Not known what IG team has done since June 2019 to date.
- Unclear what action plans, if any, are in place
- No evidence that all staff completed data protection an info security training

Annex A

Summary of key findings and good practice identified from 2018/19 Internal Audit reviews

Appendix B: Assurance definitions: for information

Substantial Assurance	There are no weaknesses in the level of internal control for managing the material inherent risks within the system. Testing shows that controls are being applied consistently and system objectives are being achieved efficiently, effectively and economically apart from any excessive controls which are identified in the report.
Adequate Assurance	There are minor weaknesses in the level of control for managing the material inherent risks within the system. Some control failings have been identified from the systems evaluation and testing which need to be corrected. The control failings do not put at risk achievement of the system's objectives.
Limited Assurance	There are weaknesses in the level of internal control for managing the material inherent risks within the system. Too many control failings have been identified from the systems evaluation and testing. These failings show that the system is clearly at risk of not being able to meet its objectives and significant improvements are required to improve the adequacy and effectiveness of control.
Little Assurance	There are major, fundamental weaknesses in the level of control for managing the material inherent risks within the system. The weaknesses identified from the systems evaluation and testing are such that the system is open to substantial and significant error or abuse and is not capable of meetings its objectives.

Internal control environment

The control environment comprises the systems of governance, risk management and internal control. The key elements of the control environment include:

- establishing and monitoring the achievement of the organisation's objectives
- the facilitation of policy and decision-making ensuring compliance with established policies, procedures, laws and regulations – including how risk management is embedded in the activity of the organisation, how leadership is given to the risk management process, and how staff are trained or equipped to manage risk in a way appropriate to their authority and duties
- ensuring the economical, effective and efficient use of resources and for securing continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness
- the financial management of the organisation and the reporting of financial management
- the performance management of the organisation and the reporting of performance management.

System of internal control

A term to describe the totality of the way an organisation designs, implements, tests and modifies controls in specific systems, to provide assurance at the corporate level that the organisation is operating efficiently and effectively.