AUDIT & GOVERNANCE COMMITTEE 24 September 2014
AUDIT MONITORING REPORT: Apr – August 2014

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Acting S.151 Officer

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1.0 INTERNAL AUDIT WORK COMPLETED IN PERIOD (APRIL – AUGUST 2014)

1.1 This report summarises progress on internal audit work in the period (April – August 2014). Approximately 20 days in this period has been used in completing 2013/14 work in progress at the year-end and outcomes from these audits were reported to this Committee at its meeting on 25 June 2014.

1.2 Three final reports for 2014/15 have been agreed and the Executive Summaries and Action Plans are attached at ***Appendix A.*** Assurance levels were as follows:

External Funding – Reasonable (see Appendix A – 1)

Freedom of Information Act compliance – Partial (see Appendix A – 2)

Housing Options Follow Up – Reasonable (see Appendix A – 3)

1.3 Preliminary work has started on the National Fraud Initiative 2014/15 on updating contacts; arranging fair processing notices; and circulating data specifications and upload timetable. Data uploads will be required in October 2014 with matches available for investigation in January 2015. Data matching in order to identify Single Person Discount fraud is now being undertaken annually so relevant information will be included in October 2014 data upload (Council Tax and Electoral Roll data).

1.4 Progress against individual audits in the 2014/15 plan is set out in the table below. This is shown against the original planned schedule. The plan comprises 17 risk-based audits (R) and 3 cyclical audits (C) of fundamental systems. There is also provision for follow up work on 2 audits completed in 2013/14 where the assurance level was less than reasonable – these are Housing Options and Petty Cash.

1.5 Some work originally scheduled in Q1 and Q2 is being deferred at Copeland management's request. This may impact on the delivery of the full audit plan and the efficient use of Internal Audit resources. We are continuing to monitor the delivery of the plan closely. The current position on all planned work is set out below:

	Qtr 1 (Apr – June)	**Status**
R1	Freedom of Information Act compliance	Report agreed with previous Democratic Services Manager (who agreed this with new Democratic Services Manager). Issued to Chief Executive for final agreement/comment on 25 June 2014. Final report issued 15 September 2014.

R2	Change management	Client Notification issued 4 June 2014. Draft report due 29 Aug 2014 (4 week deferral of testing requested by Chief Executive following staff turnover and reallocation of responsibilities. The draft report date will now be 30 September)
R3	Refuse Collection*	Client Notification issued 13 June 2014 Draft report due 31 July 2014 (draft report date revised by IA and advised to management as 29 Aug 2014) Draft report issued 28 August 2014.
R4	Parks & Open Spaces*	To reschedule after Refuse Collection subject to management capacity in Copeland Services to accommodate review.
R5	External funding	Client Notification issued 14 May 2014. Draft report due 27 June 2014 (draft report date revised by IA and advised to management as 15 Aug 2014) Draft report issued 12 August 2014. Close out meeting 3 September 2014. Final report issued 11 September 2014
	Qtr 2 (July – Sept)	
R6	Customer Services/Access Strategy	Client Notification issued 2 July. Draft report due 30 Sept 2014
R7	Contract management – RBSS	Agreed with Acting S.151 Officer to move to Q4 to allow time for external consultant's (Liberata) review recommendations to be implemented.
R8	Information Security / Records management	Agreed with Acting S.151 Officer to move to Q4 as Council still unable to make appointment to manage this area.
R9	IT Strategy support to service plan -	Identified as risk for IA review in 13/14 but deferred pending development of IT Strategy. Scoping meeting held 11 August with interim Director of Resources & Strategic Commissioning. Audit scope issued 27 August 2014 (reflects fact that Strategy still in development). Draft report due 30 Sept 2014
R10	Communications	Internal Audit advised that CLT agreed in July 2014 a review of Communications including a replacement Head of Communications – so requested to move review to Q4. Chief Executive to agree scope
R11	NCL contract management	Client notification issued 11 August 2014. Draft report due 30 November 2014.

R12	Performance management	Scoping meeting held with Chief Executive on 14 July 2014. Scope agreed but request to defer work until Q3 so key managers not overburdened. Also more beneficial as will have greater activity in 2014/15 to review.
	Qtr 3 or 4 (Oct – Mar 2015)	
R13	Beacon - New operating arrangements	Scoping meeting requested for 1 October 2014.
R14	Accommodation strategy	Strategy to be drafted – still planned for Q3.
R15	Cemeteries & Crematorium	New system won't be implemented until summer so still planned for Q3. Scoping meeting scheduled for 23 September
R16	Partnership governance	Last audit only completed Apr 2014 so will be Q4.
R17	NCL Pool extension	Relates to Gym. Audit of procurement arrangements and project management. Client notification issued 11 August 2014. Draft report due 31 October 2014.
C1	Payroll	Cyclical audit but was previously done annually Q4 review.
C2	Sundry debtors	Cyclical audit but was previously done annually Plan to bring forward to Q3.
C3	Benefits	Cyclical audit but was previously done annually. To be done jointly to cover CBC and Carlisle Q4 review.

* CLT requested that these audits were not done in Q1 because of management changes in these areas. It was agreed that other audits would need to be brought forward to Q1 to ensure that work is reasonably spread across the year.

1.3 Overdue actions arising from audit reports

1.3.1 Priority 1 and 2 recommendations still outstanding, with a target date for completion of 31 July 2014, are set out at **Appendix B**. These include recommendations made by both internal and external audit and from AGS Action Plan (if due). There are 25 overdue recommendations overall which is a large reduction from 45 at the last report date (outstanding at March 2014) and reflects a review of old outstanding actions by the Acting S 151 Officer.

1.3.2 There are now only 2 overdue Priority 1 recommendations with most of the previous P1 recommendations from External Audit having been implemented. The recommendations still shown as outstanding on Covalent are:

Housing Options

- Improvements must be made to ensure the efficient and effective use of the rent deposit scheme by completing the 14 milestones.

  Internal Audit follow up work on Housing Options has shown that progress has been made on 7 of the 14 milestones within this recommendation.

Revs and Bens Shared Service (external audit recommendation)

- Review all modified schemes to confirm that expenditure to be included in the 2013/14 claim is correctly classified as modified schemes.

1.3.3 There are 23 Priority 2 overdue recommendations (were 40 at the last report date - end March).

2.0 INTERNAL AUDIT PERFORMANCE AGAINST AUDIT PLAN

2.1 Internal Audit performance measures are set out at Appendix C.

3.0 CONCLUSION AND RECOMMENDATION

3.1 It is recommended that Members note this report.

List of Appendices: Appendix A – Findings from final reports agreed in period
Appendix B – Overdue recommendations
Appendix C – Performance measures

Background papers: None

Consultees: Corporate Leadership Team

External funding

1. Background

1.1. This report summarises the findings from the audit of External Funding. This was a planned audit assignment which was undertaken in accordance with the 2014/15 Audit Plan.

1.2. This audit is linked to Copeland Council's Corporate Plan 2013-15 mission statement to provide "An effective Council that works with partners and communities to arrange services for residents in Copeland" and the priority to deliver efficient and effective statutory services.

1.3. The Medium Term Financial Strategy (MTFS) 2014/15 to 2017/18 states that "External funding opportunities will be considered to ensure that income is maximised to help deliver Council priorities and statutory services" and so it is paramount that adequate controls are in place for the governance of such funding.

1.4. Management has recognised the need for better control of this area and an external funding applications log is currently being developed by the Corporate Leadership Team (CLT) to record new funding bids, existing projects and those under which the Council is acting as accountable body. The current log records details of the project, the value, CLT sponsor, external funder, match funding requirement, whether legal contracts are required, etc. We recommend that the applications log is further developed through the use of a supplementary Governance Control record for each new project (see 5.1 below).

2. Audit Approach

2.1. **Audit Objectives and Methodology**

2.1.1. Compliance with the mandatory Public Sector Internal Audit Standards requires that internal audit activity evaluates the exposures to risks relating to the organisation's governance, operations and information systems. A risk based audit approach has been applied which aligns to the five key audit control objectives which are outlined in section 4; detailed findings and recommendations are reported within section 5 of this report.

2.2. **Audit Scope and Limitations**

2.2.1. The Audit Scope was agreed with management prior to the commencement of this audit review. The Client Sponsors for this review were Pat Graham (Director of Economic Growth) and Darienne Law (Head of Corporate Resources) [Darienne Law has subsequently left the Council] and the agreed scope areas for consideration were identified as follows:

- Governance over acceptance of external funding and inclusion in budget;
- Compliance with Financial Regulations; and
- Management arrangements for use of external funding to ensure it is only used for intended purposes i.e. compliance with terms and conditions.

2.2.2. There were no instances whereby the audit work undertaken was impaired by the availability of information.

3. Assurance Opinion

3.1. Each audit review is given an assurance opinion and these are intended to assist Members and Officers in their assessment of the overall level of control and potential impact of any identified system weaknesses. There are 4 levels of assurance opinion which may be applied. The definition for each level is explained in **Appendix A.**

3.2. From the areas examined and tested as part of this audit review, we consider the current controls operating for External Funding provide **REASONABLE** assurance.

Note: as audit work is restricted by the areas identified in the Audit Scope and is primarily sample based, full coverage of the system and complete assurance cannot be given to an audit area.

4. Summary of Recommendations, Audit Findings and Report Distribution

4.1. There are three levels of audit recommendation; the definition for each level is explained in **Appendix B**.

4.2. There is 1 audit recommendation arising from this audit review and this can be summarised as follows:

	No. of recommendations		
Control Objective	**High**	**Medium**	**Advisory**
1. Management - achievement of the organisation's strategic objectives achieved	-	-	-
2. Regulatory - compliance with laws, regulations, policies, procedures and contracts	-	1	-

3. Information - reliability and integrity of financial and operational information	-	-	-
4. Security - safeguarding of assets	-	-	-
5. Value - effectiveness and efficiency of operations and programmes	-	-	-
Total Number of Recommendations	-	1	-

4.3. **Strengths:** The following areas of good practice were identified during the course of the audit:

- Approval limits for the acceptance of offers of external funding are clearly defined in the Financial Regulations and Financial Procedure Rules;
- The Medium Term Financial Strategy 2014/15 to 2017/18 states the long term strategy for the use of external funding;
- The Change Programme Board monitors some of the externally funded projects when they are linked to transformational change;
- TOTAL financial information system provides the financial data required to identify each externally funded project and allow for the provision of timely, accurate and relevant accounting information;
- Budget monitoring reports are made regularly to the Corporate Leadership Team (CLT) and quarterly budget monitoring reports for revenue and capital budgets are made to the Executive;
- Capital projects are also monitored by the Capital Projects Board and reported on quarterly;
- Terms and conditions assigned to individual projects are monitored by the department implementing the project; and
- CLT are establishing an external funding applications log to provide a central register of externally funded projects.

4.4. **Areas for development**: Improvements in the following areas are necessary in order to strengthen existing control arrangements:

4.4.1. *High priority issues:*

- No issues identified.

4.4.2. *Medium priority issues:*

- There is currently no formal authorisation process in place for an initial application to be made. The Head of Service would usually provide this authorisation but this has not currently been recorded, although in future any new bid would be incorporated into the CLT applications log. The authorisation step should be incorporated into the Governance Control record to provide a full and detailed record of the various governance decisions;
- If the council accepts accountable body status for external funding the Financial Regulations and Financial Procedure Rules state that a management fee is charged for the costs of administration. However, there is no formal accountable body policy in place and political

considerations can mean that a management fee is deemed inappropriate. This decision is not formally recorded and should be incorporated into the Governance Control record; and

- Financial Services and Legal opinions are often only sought at the latter stages of the application process, usually when a report is going to committee to approve the acceptance of the funding offer. This advice should be sought at the initial stages of the process and formally recorded on the Governance Control record.

4.4.3. *Advisory issues:*

- No issues identified.

Comment from the Chief Executive

The audit is fair and reflects the strong record of the Council in applying for and managing external funding.

The one recommendation will enable consistent formal recording for an existing system of authorisations and managing of risks in this area. CLT will continue to manage and monitor external funding assisted by our strengthened corporate external funding log. This central logging of external funding includes for new, current and past funding applications and underpins the strategic risk management function of the CLT. The proposed Governance Control Record will provide a formal record held centrally against this corporate log.

Management Action Plan

5. Matters Arising / Agreed Action Plan

5.1. **Regulatory** - compliance with laws, regulations, policies, procedures and contracts.

● **Medium priority**

Audit finding	Management response
(a) **Governance Control Record** At present the externally funded projects are managed and monitored by the department responsible for the implementation of the project. The governance arrangements are dependent upon the value of the funding and any formal terms and conditions assigned by the funder. Although CLT are establishing a central external funding applications log of new funding bids, existing funded projects and those projects for which the Council act as accountable body, the addition of a supplementary Governance Control record would provide a formal record for each of the main governance stages and highlight those high risk projects which have specific terms and conditions assigned which could affect the draw down or claw back of the funding. The Governance Control record should provide the details for each of the key processes, for example: • Initial authorisation for an application bid to be made; • That Legal and Financial Services advice has been sought at the initial stages; • The decision and reasoning for whether a management fee will be charged on those occasions where the Council acts as accountable body; • The formal authorisation given for the acceptance of the funding; • Any specific terms and conditions assigned by the funder, especially if meeting specific project deadlines or reporting deadlines are required prior to funds being able to be drawn down; • Clearly identify those projects which have a risk of the funding being clawed back due to non-compliance with any specific terms and conditions; etc.	Agreed management action: A Governance Control Record will be designed by Diane Ward, taking advice as appropriate, and agreed by CLT.

Recommendation 1: That a Governance Control record is implemented to supplement the external funding applications log.	
Risk exposure if not addressed: • Time is spent on researching and making application bids which are not in line with the Corporate Plan and so would not be acceptable to the Council; • Authorisation for the acceptance of the funding is not in line with the Financial Regulations and Financial Procedure Rules; • Projects are not monitored effectively and spend is not in line with the terms and conditions of the project; • Specific terms and conditions assigned by the funder are not identified, monitored and achieved; • The draw down of funding is delayed because terms and conditions are not achieved by the required deadlines; and • Funding is clawed back because terms and conditions have not been complied with.	Responsible manager for implementing: **Julie Betteridge (Head of Customer and Community Services)** Date to be implemented: **31 Dec 2014**

Audit Assurance Opinions

There are four levels of assurance used; these are defined as follows:

	Definition:	Rating Reason
Substantial	There is a sound system of internal control designed to achieve the system objectives and this minimises risk.	The controls tested are being consistently applied and no weaknesses were identified. Recommendations, if any, are of an advisory nature in context of the systems and operating controls & management of risks.
Reasonable	There is a reasonable system of internal control in place which should ensure that system objectives are generally achieved, but some issues have been raised which may result in a degree of risk exposure beyond that which is considered acceptable.	Generally good systems of internal control are found to be in place but there are some areas where controls are not effectively applied and/or not sufficiently developed. Recommendations are no greater than medium priority.
Partial	The system of internal control designed to achieve the system objectives is not sufficient. Some areas are satisfactory but there are an unacceptable number of weaknesses which have been identified and the level of non-compliance and / or weaknesses in the system of internal control puts the system objectives at risk.	There is an unsatisfactory level of internal control in place as controls are not being operated effectively and consistently; this is likely to be evidenced by a significant level of error being identified. Recommendations may include high and medium priority matters for address.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes the system objectives to an unacceptable level of risk.	Significant non-compliance with basic controls which leaves the system open to error and/or abuse. Control is generally weak/does not exist. Recommendations will include high priority matters for address. Some medium priority matters may also be present.

Grading of Audit Recommendations

Audit recommendations are graded in terms of their priority and risk exposure if the issue identified was to remain unaddressed. There are three levels of audit recommendations used; high, medium and advisory, the definitions of which are explained below.

		Definition:
High	●	Significant risk exposure identified arising from a fundamental weakness in the system of internal control
Medium	●	Some risk exposure identified from a weakness in the system of internal control
Advisory	●	Minor risk exposure / suggested improvement to enhance the system of control

Recommendation Follow Up Arrangements:

- High priority recommendations will be formally followed up by Internal Audit and reported within the defined follow up timescales. This follow up work may include additional audit verification and testing to ensure the agreed actions have been effectively implemented.
- Medium priority recommendations will be followed with the responsible officer within the defined timescales.
- Advisory issues are for management consideration.

Freedom of Information Act compliance

1. Background

1.1. This report summarises the findings from the audit of the Council's compliance with the Freedom of Information (FOI) Act. This was a planned audit assignment which was undertaken in accordance with the 2014/15 Audit Plan.

1.2. This audit is linked to Copeland Council's Corporate Plan 2013-15 mission statement to provide "An effective Council that works with partners and communities to arrange services for residents in Copeland" and the priority to deliver efficient and effective statutory services.

1.3. The Council's compliance with the Freedom of Information Act was identified as a risk by management for 2012/13 plan but it was agreed to defer the audit pending changes to the Council's arrangements for dealing with FOI requests.
The Freedom of Information Act 2000 provides public access to information held by public authorities.

- public authorities are obliged to publish certain information about their activities; and
- members of the public are entitled to request information from public authorities.

The statutory response time for a Freedom of Information request is 20 working days. Failure to respond within this period can result in a complaint being made against the Council, and the Information Commissioner's Office being notified. This can also result in adverse publicity for the Council.

1.4 The volume of FOI requests to the Council has increased significantly over recent years as follows:

Period	Number of requests
2012	370
2013	459
2014 (year to date – mid Sept 2014)	441

Managements also informed Internal Audit that information provided in response to FOI requests is sometimes published by individuals on-line (on the website “mywhitehaven.net”) or on occasions in the local newspaper.

2. Audit Approach

2.1. Audit Objectives and Methodology

2.1.1. Compliance with the mandatory Public Sector Internal Audit Standards requires that internal audit activity evaluates the exposures to risks relating to the organisation’s governance, operations and information systems. A risk based audit approach has been applied which aligns to the five key audit control objectives which are outlined in section 4; detailed findings and recommendations are reported within section 5 of this report.

2.2. Audit Scope and Limitations

2.2.1. The Audit Scope was agreed with management prior to the commencement of this audit review. The Client Sponsor for this review was the Democratic Services Manager and the agreed scope areas for consideration were identified as follows:

- Leadership and Policy;
- Training and Awareness;
- Information and Records Management;
- Systems and Procedures;
- Performance monitoring and Reporting

2.2.2. There were no instances whereby the audit work undertaken was impaired by the availability of information.

3. Assurance Opinion

3.1. Each audit review is given an assurance opinion and these are intended to assist Members and Officers in their assessment of the overall level of control and potential impact of any identified system weaknesses. There are 4 levels of assurance opinion which may be applied. The definition for each level is explained in **Appendix A.**

3.2. From the areas examined and tested as part of this audit review, we consider the current controls operating within Freedom of Information Compliance provide **Partial** assurance.

4. Summary of Recommendations, Audit Findings and Report Distribution

4.1. There are three levels of audit recommendation; the definition for each level is explained in **Appendix B**.

4.2. There are 13 audit recommendations arising from this audit review and these can be summarised as follows:

	No. of recommendations		
Control Objective	**High**	**Medium**	**Advisory**
1. Management - achievement of the organisation's strategic objectives achieved	1	2	0
2. Regulatory - compliance with laws, regulations, policies, procedures and contracts	3	0	0
3. Information - reliability and integrity of financial and operational information	2	2	0
4. Security - safeguarding of assets	-	-	-
5. Value - effectiveness and efficiency of operations and programmes	1	2	0
Total Number of Recommendations	7	6	0

4.3. **Strengths:** The following areas of good practice were identified during the course of the audit:

- There is a good recording system in place for Freedom of Information requests.
- All FOI requests are reviewed by the Chief Executive and the Leader of the Council who request to see responses to any high risk requests prior to these being issued.

4.4. **Areas for development**: Improvements in the following areas are necessary in order to strengthen existing control arrangements:

4.4.1. *High priority issues:*

- There are currently insufficient resources in place to fully comply with the statutory timescales required for Freedom of Information responses. The Council has previously reviewed its ability to comply with statutory timescales and the risks this poses. A report was considered by CLT in June 2013 and it was agreed to provide funding through vacant posts to recruit an Information Management Officer on a 2 year fixed term contract. Part of their responsibilities would be to administer FOI compliance. The Council is currently recruiting to this post on a permanent basis, following the latest of three separate recruitment campaigns;
- The Council is not always compliant in responding to Freedom of Information requests;
- Staff training should be provided and this should include awareness of the importance of responding to Freedom of Information requests;
- Policies and Procedures should be created in relation to Freedom of Information requests;
- There needs to be regular monitoring of any outstanding requests to ensure they meet the required time frame;
- Requests should be checked and agreed by Department Managers prior to sending out. There also needs to be a Corporate sign off by the Monitoring Officer for all Freedom of Information requests;
- The charging policy should be publicised on the Council's website.

4.4.2. *Medium priority issues:*

- The role for coordinating complex requests needs to be defined. The time spent responding to FOI requests should also be recorded by staff;
- There needs to be a procedure in place for notifying the Freedom of Information Officer of staff leaving the Council. This will provide sufficient time for replacement Champion to be found. Ideally, there should be more than one Champion per Department to provide adequate Business Continuity;
- Management should ensure that there is a definition of what constitutes an FOI request compiled and this should be included in the Policy and Procedures document once produced;
- A register of frequent requests should be maintained in order that consistent responses are supplied and efficiency is maintained;
- A system should be developed and implemented which will identify duplicate and vexatious requests;
- The Publication Scheme requires updating to reflect staff changes.

4.4.3. *Advisory issues:*

- No advisory issues were noted.

Comment from the Chief Executive

The Council has seen a significant increase in the number and complexity of FOI's received over the last 12 to 24 months.

A review was undertaken by the Corporate Leadership Team in 2013 and the audit very much builds on the outcome of the review, which I welcome and provides a clear basis for improvement and consistent service delivery.
Resources and plans at both a strategic and operational level to ensure that the Council fulfils its requirements are now in place and performance will be monitored through regular and systematic reports to CLT.

Paul Walker
Chief Executive

Management Action Plan

5. Matters Arising / Agreed Action Plan

5.1. Management - achievement of the organisation's strategic objectives.

● **High priority**

<table>
<tr><th>Audit finding</th><th>Management response</th></tr>
<tr><td>(a) Insufficient resources for dealing with Freedom of Information Requests;
There are currently insufficient resources in place to fully comply with the statutory timescales required (20 working days) for Freedom of Information responses. The Freedom of Information role is currently carried out by the Member Services Officer but this role was incorporated into her post when the volume of requests was at a much lower level. The number of requests has significantly increased year on year and it is now recognised that the FOI role needs to be transferred. When the Member Services Officer is absent (including holidays / sickness) no Freedom of Information duties are carried out by another member of staff.</td><td rowspan="2">Agreed management action:
Sufficient resources will be made available to enable this statutory function to be carried out, including appropriate cover for staff absence.
The Member Services Officer has had in place for some time an agreement that she will work at home one day per week specifically to focus on FOI work.
A decision was recently taken to advertise the new Information Management Officer post on a permanent basis and the FOI work will transfer to this post once it has been filled. Interviews for the post are due to be held on 15th September 2014.</td></tr>
<tr><td>Recommendation 1:
Management should ensure there are sufficient resources in place to comply with the statutory timescales for Freedom of Information requests. Management should also ensure that there is an appropriate business continuity plan in place to cover for staff absence.</td></tr>
<tr><td>Risk exposure if not addressed:
• Non-compliance with legislation;
• Staff feeling pressured due to limited resources whilst trying to adhere to tight deadlines. This may lead to staff absence due to stress etc;
• Complaints being received by the Council / Information Commissioner's Office as the response is late due to limited / no resources;
• Adverse publicity for the Council.</td><td>Responsible manager for implementing:
Chief Executive
Date to be implemented:
30 November 2014</td></tr>
</table>

● **Medium priority**

Audit finding	Management response
(b) **Defining the Coordinating role for complex requests and recording of time spent on Freedom of Information Requests;** It was found that there is no definition of what is required for coordinating complex requests. A review of the practices found that the time spent working on Freedom of Information requests is not recorded by staff.	Agreed management action: • Detailed guidance on coordinating complex requests will be included in the FOI Procedures manual (when drafted); • Time will be recorded against each individual request – requirement to do this will be included in the FOI Procedures manual for staff guidance.
Recommendation 2: The role for coordinating complex requests needs to be defined. This should provide clarity on what is required when dealing with the request for the responsible officer. On receiving a Freedom of Information request a time should be estimated to ensure it is possible to respond to within the required timescale. The time taken responding to the requests should also be recorded as this will provide Management with information on how much of staff resources are being used responding to requests.	
Risk exposure if not addressed: • Lack of coordination may result in the statutory response time not being met. • No time is currently recorded for any Freedom of Information requests. Therefore, management are unaware of how much staff time is used responding to requests.	Responsible manager for implementing: **Democratic Services Manager** Date to be implemented: **30 November 2014**

● **Medium priority**

Audit finding	Management response
(c) **Replacing Freedom of Information Champions;** There are Freedom of Information Champions in place at Copeland Borough Council and a list is maintained by the Member Services Officer. However, when a member of staff leaves the Council's employment there is no procedure in place to inform the Member Services Officer (Freedom of Information Officer) of this fact. It was also noted that there is currently only one Champion per department which may cause issues if they are absent from work due to holidays / sickness.	Agreed management action: Human Resources to add the Democratic Services Manager to the distribution list of leavers.to ensure that new Freedom of Information Champions are appointed and that a reserve is also in place for each service area.
Recommendation 3: Human Resources should notify the Member Services Officer (Freedom of Information Officer) via the leaver's memo (memo - which is sent to the appropriate staff informing them of leavers of Copeland Borough Council / Shared Service employment). This will enable the Freedom of Information Officer sufficient time to make a suitable replacement and provide appropriate training. It would also be advisable for there to be more than one Freedom of Information Champion within each department, to ensure business continuity in times of absence (see previous Recommendation at 5.1 (a).	
Risk exposure if not addressed: • Not having sufficient time to find a replacement member of staff and provide appropriate training may result in a complaint being made against the Council if response is delayed.	Responsible manager for implementing: **Democratic Services Manager** Date to be implemented: **31 July 2014**

5.2. Regulatory - compliance with laws, regulations, policies, procedures and contracts.

● **High priority**

Audit finding	Management response
a) **Compliance with Freedom of Information Act;** A review of FOI requests found that the Council was not always compliant with the Act. This was evident in relation to late or no responses being provided to requests. It was also identified during the review that two complaints relating to Freedom of Information had been reported in the local press giving rise to adverse publicity for the Council.	Agreed management action: Guidelines on the statutory timescale and details of information which can/cannot be withheld will be included in the FOI Procedures manual for staff.
Recommendation 4: Management must ensure that there are satisfactory controls in place to ensure responses to Freedom of Information requests are dealt with effectively and that they comply with the statutory timescale of 20 working days. Clear guidelines need to be in place to provide staff with details of information which cannot be withheld (without proper reason), and issuing information which should have been withheld.	
Risk exposure if not addressed: • Non-compliance with legislation; • The Information Commissioner's Office being informed of non-compliance; • Information being withheld without proper reason; • Information being provided which should have been withheld; • All of the above may result in adverse publicity for the Council.	Responsible manager for implementing: **Democratic Services Manager (in her role as Monitoring Officer. The Monitoring Officer has a statutory duty around oversight of data protection and FOI's).** Date to be implemented: **30 November 2014**

● **High priority**

Audit finding	Management response
(b) **Staff Training;** During the audit a sample of 'Champions' were sent a questionnaire for completion. It was found that 100% of the returned sample stated that they had not received any training or they were	Agreed management action: Refresher training will be provided to relevant staff. This will be done after the FOI Procedures manual

unable to remember the initial training provided as it was carried out several years ago.	has been prepared so it can be used as training material.
Recommendation 5: Management should ensure adequate training is provided to all staff dealing with Freedom of Information Requests. This training should be carried out on a regular basis. There should also be policies and procedures in place for staff reference.	
Risk exposure if not addressed: • Staff dealing with requests, may miss the statutory deadline for the response as they are unaware due to lack of training; • Staff providing information which should be withheld; • Staff withholding information which should be provided; • Adverse publicity for the Council.	Responsible manager for implementing: **Democratic Services Manager** Date to be implemented: **30 November 2014**

● **High priority**

Audit finding	Management response
(c) **Policies and Procedures;** There are currently no written policies or procedures in place at Copeland Borough Council which explain to staff how to deal with FOI requests.	Agreed management action: As above - an FOI Procedures manual will be produced which explains to staff how to deal with FOI requests.
Recommendation 6: Policies and Procedures should be produced in relation to Freedom of Information requests. These should be made available for staff reference and adequate training provided to ensure all staff dealing with FOI requests are confident that they can provide an appropriate response.	
Risk exposure if not addressed: • Non-compliance with legislation; • Staff providing information which should be withheld; • Staff withholding information which should be provided; • Adverse publicity for the Council.	Responsible manager for implementing: **Democratic Services Manager** Date to be implemented: **30 November 2014**

5.3. Information - reliability and integrity of financial and operational information**.**

● **Medium priority**

Audit finding	Management response
(a) **Definition of requests;** It was noted during the review that there is no agreed definition of what constitutes an FOI request. This may mean that non FOI requests may be treated as FOI's and conversely routine information requests may be treated as FOI's.	Agreed management action: A definition of what constitutes an FOI request will be included in the FOI Procedures manual.
Recommendation 7: Management should ensure that there is a clear definition of what constitutes an FOI request so only genuine FOI requests are treated under FOI procedure. The definition should be included in the Policy and Procedure document once produced.	
Risk exposure if not addressed: • Inefficiency in providing responses.	Responsible manager for implementing: **Democratic Services Manager** Date to be implemented: **30 November 2014**

● **High priority**

Audit finding	Management response
(b) **Regular monitoring of Freedom of Information Requests;** There is currently no regular monitoring carried out in relation to Freedom of Information requests. It was ascertained that the Member Services Officer checks the outstanding requests whenever possible. Findings showed that during the period 01/01/14 -12/05/14, there had been 252 FOI requests received and 43 (17%) of these had passed the 20 working day timescale and no response had been provided. This may result in further complaints being received by the Council. A discussion was held with the Complaints Officer who has confirmed that a report on Freedom of Information Requests is to be presented at the Corporate Leadership Team (CLT) meetings on a	Agreed management action: • Resources to be put in place in order that regular monitoring of FOI requests can be undertaken; • Corporate Leadership Team now receives quarterly FOI monitoring reports. • Democratic Services Manager undertakes

six monthly basis (first report due in June 2014). However, as the time frame for Freedom of Information requests is twenty days the frequency of reporting to CLT does not appear to be sufficient.	weekly monitoring of FOI requests and status. • The Member Services Officer has worked, with the support of the DSM, to prioritise and tackle overdue FOI requests with the result that the historical backlog, which stood at 67 in June 2014 had reduced to just 3 by September 2014. • Monitoring arrangements (once agreed) to be included in FOI Procedures manual.
Recommendation 8: There needs to be regular monitoring of any outstanding requests. This task should be given dedicated weekly time to ensure the statutory time frame is met for all requests. This should assist in reducing the likelihood of any complaints being received by the Council in relation to late responses. The report which is to be presented to the Corporate Leadership Team should become a regular feature of the meetings, as a six monthly report cannot be considered sufficient reporting for Management purposes. The report should include performance information relating to all requests. This will provide Management with the current position of Freedom of Information requests and also inform them of any potential complaints.	
Risk exposure if not addressed: • Non-compliance with legislation; • Management unaware of any issues; • Complaints being received by the Council / Information Commissioners Office as the response is late; • Adverse publicity for the Council.	Responsible manager for implementing: **Chief Executive** Date to be implemented: **31 July 2014**

● **High priority**

Audit finding	Management response
(c) **Responses not checked and appropriately signed off;** All responses are checked by the Member Services Officer prior to sending out. However, only the wording is checked to ensure it is acceptable. It was confirmed by the Member Services Officer that reliance is placed on the staff member who has completed the response to ensure it is accurate and up to date. A further review was carried out and it was noted that a number of champions do not have their responses signed off by Managers within their departments.	Agreed management action: Departmental and Corporate sign off will become standard for FOI requests and this requirement will be included in the FOI Procedures manual. As an interim measure (prior to the IMO post being recruited to on a permanent basis), all FOIs that

It was confirmed that all FOI requests are initially reviewed by both the Chief Executive and the Leader of the Council who will identify any high risk requests. These are then reviewed by the Chief Executive prior to the response being issued. This is a good control over contentious/sensitive issues. No equivalent management sign off is required for other requests and ideally a similar QA process should be applied.	are deemed sensitive (of a political nature), vexatious and/or are from certain named individuals or organisations are managed by a process that requires sign off by the Monitoring Officer and the Chief Executive of any communication or response.
Recommendation 9: There needs to be a check carried out by Managers of any response which are sent from their departments to ensure that they are confident that the information provided is accurate and appropriate. The check carried out in relation to the response should be signed to indicate their approval. There needs to be a corporate sign off of all Freedom of Information requests. This should be by the Chief Executive for high risk areas (as per current practice) and by the Monitoring Officer for all other responses, to ensure that information provided is appropriate and consistent with other information previously provided.	
Risk exposure if not addressed: • Managers / Monitoring Officer unaware of responses being sent out; • Incorrect data /inconsistent information may be provided; • Adverse publicity;	Responsible manager for implementing: **Democratic Services Manager Manager** Date to be implemented: **30 November 2014**

● **Medium priority**

Audit finding	Management response
(d) **Inconsistent replies provided to similar requests;** The Member Services Officer confirmed that all requests are currently dealt with on an individual basis. This is a time consuming process with very limited resources. It was found that refusal of information requests are sent out using standard responses which is an efficient method of dealing with these.	Agreed management action: Improved maintenance of the Publication Scheme would reduce repeat requests more effectively than creating a register. A review of regularly requested data will be carried out and this will in future be

Recommendation 10: A register of frequent requests should be maintained and monitored (to ensure it is up to date). This should reduce time spent dealing with requests, it will also ensure consistent responses are provided.	placed on the Council's website. Links to this will be added to the Publication Scheme.
Risk exposure if not addressed: • Use of resources not used efficiently; • Inconsistent responses provided; • Adverse publicity.	Responsible manager for implementing: **Democratic Services Manager** Date to be implemented: **30 November 2014**

5.4. **Value** - effectiveness and efficiency of operations and programmes.

● **Medium priority**

Audit finding	Management response
(a) Identifying duplicate or vexatious requests; The current system for recording Freedom of Information Requests would not identify any duplicate or vexatious requests. It was established that the Member Services Officer has recently started to record requests by name.	Agreed management action: Develop recording system to identify frequent requestors in order to stop vexatious requests. As referenced in point 5.3 above, an interim procedure is now in place that requires all FOIs that are deemed sensitive (of a political nature), vexatious and/or are from certain named individuals or organisations are managed by a process that requires sign off by the Monitoring Officer and the Chief Executive of any communication or response.
Recommendation 11: A system should be implemented which will identify duplicate and vexatious requests.	
Risk exposure if not addressed: • Resources not used efficiently;	Responsible manager for implementing: **Democratic Services Manager** Date to be implemented: **30 November 2014**

● **Medium priority**

Audit finding	Management response
(b) Publication Scheme out of date; The Publication Scheme which is published on the external website requires updating to reflect changes in staff.	Agreed management action: The Publication Scheme is to be updated.

Recommendation 12: The Publication Scheme requires updating to reflect staff changes.	
Risk exposure if not addressed: • Publicised information remains incorrect; • Use of resources not used efficiently.	Responsible manager for implementing: **Democratic Services Manager** Date to be implemented: **30 November 2014**

● **High priority**

Audit finding	Management response
(c) The Council does not have a charging policy in place for Freedom of Information Requests; The current charging policy which was provided during the review is a template from the Information Commissioner's Office website. However, there is no published charging policy on the website of Copeland Borough Council, it was ascertained no charge for a Freedom of Information request has been made to date.	Agreed management action: To include a charging policy within the Publication Scheme on the external website.
Recommendation 13: The charging policy should be publicised on the Council website. This will provide the public with the necessary information with regards to charging for Freedom of Information requests. There is also a legislative requirement to do this as noted in the ICO (Information Commissioners Office) Guide to Information.	
Risk exposure if not addressed: • Non-compliance with legislation.	Responsible manager for implementing: **Democratic Services Manager** Date to be implemented: **30 November 2014**

Audit Assurance Opinions

There are four levels of assurance used; these are defined as follows:

	Definition:	Rating Reason
Substantial	There is a sound system of internal control designed to achieve the system objectives and this minimises risk.	The controls tested are being consistently applied and no weaknesses were identified. Recommendations, if any, are of an advisory nature in context of the systems and operating controls & management of risks.
Reasonable	There is a reasonable system of internal control in place which should ensure that system objectives are generally achieved, but some issues have been raised which may result in a degree of risk exposure beyond that which is considered acceptable.	Generally good systems of internal control are found to be in place but there are some areas where controls are not effectively applied and/or not sufficiently developed. Recommendations are no greater than medium priority.
Partial	The system of internal control designed to achieve the system objectives is not sufficient. Some areas are satisfactory but there are an unacceptable number of weaknesses which have been identified and the level of non-compliance and / or weaknesses in the system of internal control puts the system objectives at risk.	There is an unsatisfactory level of internal control in place as controls are not being operated effectively and consistently; this is likely to be evidenced by a significant level of error being identified. Recommendations may include high and medium priority matters for address.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes the system objectives to an unacceptable level of risk.	Significant non-compliance with basic controls which leaves the system open to error and/or abuse. Control is generally weak/does not exist. Recommendations will include high priority matters for address. Some medium priority matters may also be present.

Grading of Audit Recommendations

Audit recommendations are graded in terms of their priority and risk exposure if the issue identified was to remain unaddressed. There are three levels of audit recommendations used; high, medium and advisory, the definitions of which are explained below.

		Definition:
High	●	Significant risk exposure identified arising from a fundamental weakness in the system of internal control
Medium	●	Some risk exposure identified from a weakness in the system of internal control
Advisory	●	Minor risk exposure / suggested improvement to enhance the system of control

Recommendation Follow Up Arrangements:

- High priority recommendations will be formally followed up by Internal Audit and reported within the defined follow up timescales. This follow up work may include additional audit verification and testing to ensure the agreed actions have been effectively implemented.
- Medium priority recommendations will be followed with the responsible officer within the defined timescales.
- Advisory issues are for management consideration.

Housing Options follow up

1. Background

1.1. This report summarises the findings of the follow up review of the Housing Options – Homelessness 2013/14 Audit Action Plan. This was a planned assignment which was undertaken in accordance with the 2014/15 Audit Plan.

1.2. Housing Options – Homelessness is important to the organisation because the Homelessness Act 2002 requires every local authority to have a Homelessness Strategy for the purpose of coordinating activities and resources for tackling homelessness. Under Section 1 of the Homelessness Act 2002 it is the responsibility of the Local Housing Authority to formulate a Homelessness Strategy every five years unless it has been exempted from the requirement.

1.3. The Copeland Homelessness Strategy 2013-2018 was presented to the Strategic Housing Panel on 17/09/13. The Strategy was approved by the Executive on 22/10/13.

1.4. An audit review of Housing Options - Homelessness was included in the Audit Plan for 2013/14 and it had been the first review of the service.

1.5. A partial assurance level was allocated because the controls in place at the time of the audit were not working effectively and efficiently, particularly in relation to the rent deposit scheme. Controls were also not in place to safeguard sensitive personal data. The audit identified 4 recommendations to strengthen the control environment. One of the recommendations had 14 milestones attached to it to improve controls around the operation of the Rent Deposit Scheme.

1.6. This follow up review is to assess the implementation of these recommendations.

2. Audit Approach

2.1. **Audit Scope and Limitations**

2.2. The Audit Scope has been limited to a follow up review of the implementation of Housing Options - Homelessness 2013/14 Audit Action Plan. It was not a full audit review of the service area.

2.3. New working practices and documentation have been introduced as a result of the implementation of the Action Plan. Audit sample testing has been limited to five Rent Deposit Scheme cases as these were the only cases available which had followed the new process through to completion.

3. Assurance Opinion

3.1. Each audit review is given an assurance opinion and these are intended to assist Members and Officers in their assessment of the overall level of control and potential impact of any identified system weaknesses. There are 4 levels of assurance opinion which may be applied. The definition for each level is explained in **Appendix A.**

3.2. From the areas examined and tested as part of this follow up review, we consider the implementation of the Housing Options – Homelessness 2013/14 Audit Action Plan now provides REASONABLE assurance. 3 of the 4 recommendations have been implemented but the recommendation on the Rent Deposit scheme (comprising 14 milestones) still requires further action. The design of controls over this area is satisfactory but relevant documentation needs to be retained to evidence that actual controls have been applied. The sample available for audit was only small (5) but results indicated a need for improvement. Management should consider implementing their own QA checks to ensure the new controls are applied consistently.

Note: as audit work has been limited to a follow up review of the implementation of Housing Options - Homelessness 2013/14 Audit Action Plan full coverage of the system and complete assurance cannot be given to an audit area.

3.3. **Progress Made:** The following areas of progress were identified during the course of the review:

- The Copeland Homelessness Strategy 2013-2018 will be monitored and reported regularly to members to ensure progress against actions in the Delivery Plan are met. A verbal update was given to the Strategic Housing Panel in June 2014 and an update on prevention measures will go to September's meeting. A full report on the Delivery Plan will go to December's meeting and then be reported quarterly;
- Rent Deposit Scheme Guidance and Agreement Forms have been revised for both landlords and clients, and these contain the terms required for an application to be made and for the payment of the deposit, etc.;
- A Rent Deposit Scheme Checklist was been put in place to clearly identify the steps undertaken in the new process. However, testing has found the checklist has not been fully completed (1/3 of the sample) or held on file (2/5 of the sample). It has been suggested to the Senior Housing Options Advisor that the checklist should be held at the front of the case file for easy access and review and that the Checklist is initialled by the manager / team leader to confirm who has carried out the check;

- All homelessness case files are held securely in a locked cupboard and those cases waiting to be archived are also now held securely;
- A new policy has also been put in place so that only the client's initials are recorded on the department's whiteboard so that staff outside of Housing Options department cannot identify the client; and
- The department's Business Continuity Plan has been brought up to data and reflects the current structure and working practices.

3.4. **Work Still Required**: Improvements in the following areas remain outstanding:

- The new Rent Deposit Scheme Guidance and Agreement Forms are not currently available on the Council's website. However, there are plans to revise the Housing Options webpages by October and these will be incorporated at that time (subject to corporate support, which has been requested especially in terms of training);
- Landlords should notify the Council that the deposit is being held with a nationally recognised Deposit Protection Scheme. However in the sample testing evidence that this has taken place has not been placed on the case files or recorded on the database. Since the review, administrative procedures have been put in place so that within one month of the rent deposit being provided, the landlord is asked to provide proof of the Deposit Protection Scheme it has been placed in;
- Although identity checks are a requirement of the checklist, photocopies of the provided evidence have not been placed on the case file for 3/5 of the sample; and
- There are also further issues with documentation not being placed on the case file or referenced in the database, i.e. landlord agreements, evidence of income, safety certificates, etc. (See the Current Status comments for 4.1 - Housing Options - Homelessness 2013/14 Audit Action Plan Recommendation 2 for full details). Procedures are being addressed with training and communication.

Comment from the Head of Customer & Community Services

During the implementation of the Housing Options – Homelessness 2013/14 Audit Action Plan recommendations there have been significant staffing changes in the team and improved administrative procedures for monitoring the scheme are being put in place through a new part time administration post. The current milestones (Recommendation 2 Milestones 3-12) are being addressed through on-going communication, monitoring and training. The rent deposit scheme and its management will form part of all Housing Options Advisor's appraisals this year.

Some of the actions, e.g. website, require more corporate resources to assist. After two years planning an implementation date for a new departmental database, Arbitras, has been given This will be implemented in August 2015 and will ensure consistency of information on e-file and will end the need to keep duplicate paper and database records. Archiving remains a corporate issue and an issue for the team in the medium term due to available space. Arbitras will go some way to addressing this issue in the long term as the department moves towards a paperless system.

Recommendation 2 - Milestone 9. *Evidence of affordability checks; especially in relation to welfare reform and the bedroom tax should be kept on file and referenced on database* - it should be noted that the department cannot necessarily apply checks on welfare reform and spare room subsidy. There is a much wider policy issue and separate to the scheme. The affordability check will only consider the rent amount against an applicant's income. The criteria does also specify that Advisors will only consider lets that are a suitable size (e.g. a single person would not be given a rent deposit for a 3 bed house) but there are occasions when Advisors will consider a two bed rental for a single person because supply of one bed properties isn't there.

4. Previous Recommendations and Agreed Action Plan

4.1. Housing Options - Homelessness 2013/14 Audit Action Plan

● **Medium priority**

Previous Audit finding	Management response
Recommendation 1: The Copeland Homelessness Strategy 2013-2018 is monitored and reported regularly to members to ensure progress against actions in the Delivery Plan is met.	Agreed management action: Action Plan and progress to be reported to SHP quarterly.
Risk exposure if not addressed: • Members are unaware of progress against the Homelessness Delivery Plan.	Responsible manager for implementing: **Housing Services Manager** **Senior Housing Options Advisor** Date to be implemented: **10 June 2014** **9 September 2014** **18 December 2014** **10 March 2015**
Current status: The Performance Monitoring Report and Service Plan went to Strategic Housing Panel (SHP) in June 2014, but not the Delivery Plan of the Copeland Homelessness Strategy as per the recommendation, although a verbal update had been given.	
Conclusion: It has been confirmed with the Senior Housing Options Advisor that the full report will go to SHP in December 2014 and then be reported quarterly. An update on the prevention measures will go to SHP in September 2014. Although there has been a delay in the implementation of this recommendation due to staffing issues (which have now been resolved), steps are in place to provide the necessary monitoring and reporting.	Further action required? No

● **High priority**

Previous Audit finding	Management response
Recommendation 2: Improvements must be made to ensure the efficient and effective use of the rent deposit scheme by completing the following milestones: 1) A procedure relevant to the new scheme should be written and shared with landlords who take up a rent deposit, the procedure should be available on the CBC website for landlords and customers to view; 2) Landlords should be made aware of the requirement to inform the Council when a tenant leaves a property or is given Notice to Quit (NtQ)and that they should return the deposit to CBC and not the tenant, this should be in the form of a letter sent with the deposit; 3) Landlords should also notify the Council that the deposit is being held with a nationally recognised rent deposit scheme e.g. the deposit protection service, evidence of this should be requested and held on file and referenced on the database; 4) Application forms must be completed in full, ensuring that forms are signed and dated by the tenant and the case worker in respect of the Data Protection/Authority to disclose Information declaration – this is required if adequate checks are to be made prior to awarding the rent deposit; 5) No deposit should be awarded until case workers are satisfied that the criteria has been met, e.g. if a NtQ has been issued this must be seen and copied for the file and referenced on the database; 6) Case workers must ensure that they have evidence that customers are who they say they are, as one customer was recorded as Mr *** on the Application but the award, signed by this customer and agreeing to pay back deposit in instalments was under another name; 7) Database and file need to be kept up to date and this should be carried out promptly;	Agreed management action: Implementation of a new robust process and procedure which clearly identifies eligibility for the scheme and criteria and ensures recommendations 1 – 14 are actioned and implemented and will include: -Evidence requirements -Affordability checks -Requirements of prospective tenants and landlords including signed agreements by both parties -Information leaflets -Data management compliance This will be monitored and quality checked by the Senior Housing Options Advisor to manage compliance.

8) Relevant documents need to be kept on file and referenced on database, copies of evidence of income, (NtQ) etc.. any copies should be stamped as evidence of true copy seen by case worker; 9) Evidence of affordability checks; especially in relation to welfare reform and the bedroom tax should be kept on file and referenced on database; 10) Copy of tenancy agreement to be kept on file and referenced on database; 11) Inspections must be carried out prior to the customer signing an agreement for the property, copy of inspectors report – to confirm that the property is suitable for occupation should be kept on file and referenced on database; 12) Copy of safety certificates (or a declaration from the Technical Inspector that these have been seen at the time of the inspection, the renewal date should be recorded in all instances) should be kept on file and referenced on database; 13) Adequate inventory and photographic evidence should be collected and held on file/referenced on database of the property where a deposit will be awarded so that there are no issues with the repayment of the deposit when a tenant leaves the property; 14) Once a case is completed they should be closed on the database, this should be actioned promptly.	
Risk exposure if not addressed: • Reputational damage due to the improper use of public funds. • Less budget available to future vulnerable clients. •	Responsible manager for implementing: **Housing Services Manager** **Senior Housing Options Advisor** Date to be implemented: **1 May 2014** **31 July 2014 (quality check) and quarterly sample checks thereafter.**

Current status:

The status of each milestone is as follows:

1. Customer and Landlord Rent Deposit Guidance documents have been written and are available in the Council's Reception area. However, these documents are currently not available through the Housing Options webpages of the Council's external website. The Housing Options webpages will be totally revised and updated during October 2014 and the documents will be made available at that time (subject to corporate support, which has been requested especially in terms of training).

2. Landlord Rent Deposit Guidance and Rent Deposit Landlord Agreement Form include the requirements that they inform the Council when a tenant leaves a property and that they should return the deposit to CBC and not the tenant. However, 2/5 of the tested sample do not hold a landlord agreement form on file and 1/3 of the forms held has not been signed by the landlord.

3. Rent Deposit Landlord Agreement Form states that the deposit should be held with a nationally recognised rent deposit scheme. However, evidence that this has taken place has not been provided in 4/5 of the sample and the Rent Deposit Scheme database has not been updated to record any details.

4. The sampled applications forms had been completed with the relevant client details. However, 3/5 'Assessment of application' sections have not been completed and these application forms have not been signed by relevant Housing Options Advisor (the name of the interviewing Housing Options Advisor is recorded on the first page of the form). The Senior Housing Options Advisor stated that they wouldn't make an assessment as to suitability at the initial interview and so it was not an issue if the 'Assessment of application' sections were not complete. Internal Audit suggested that they review the design of the form if such information is not relevant at that stage.

5. Rent Deposit Scheme Checklist implemented to record each stage of the application process so that all the necessary criteria are met prior to the payment of the deposit. However, 2/5 of the sample did not have a Checklist held on file and 1/3 Checklist was not completed in full. Also 1/5 of the sample had no Rent Deposit Scheme Client Agreement held on file.

6. Identity checks have been incorporated into the Checklist; however, 3/5 of the sample did not have photocopied proof, that the check had been carried out, placed on file.

7. The database has not been kept up to date with references to relevant documents, 2/5 of the sample do not have the purchase order number used for the payment of the deposit recorded, no cases record that the Landlord has notified the Council that the deposit was being held with a nationally recognised rent deposit scheme and relevant documents are also not referenced on the database (see 9-13 below). The Senior Housing Options

Advisor has already raised this issue with the team.

8. Copies of relevant documents have not been kept on the case files in some cases and have not been referenced on the database (see 9-13 below).
9. 1/5 of the sample did not have the affordability check completed and 3/5 of the sample did not have copies of income held on file.
10. 5/5 copies of tenancy agreements were held on file; however 1/5 had not been signed by the customer.
11. Inspections had been carried out in all of the tested sample and copies of the reports were held on file. However, only 1/5 inspection report was referenced on the database.
12. 3/5 gas / electric safety certificates are not held on file nor a declaration made by the Technical Inspector that they had seen the certificates at the time of the inspection.
13. Photographic evidence had been placed on file for each of the sample but 1/2 had no inventory held on file (3 of the properties were unfurnished).
14. All of the sampled cases have been closed on the database.

Conclusion:	Further action required?
Although new working practices and documentation have been introduced there remain weaknesses within the application of these working practices. As such several of the milestones currently remain outstanding.	Yes – several milestone actions remain outstanding. Steps are taken to ensure officers understand and follow the new working practices and that all relevant documentation is held on the case file and the database is updated and referenced accordingly.

● **High priority**

Previous Audit finding	Management response
Recommendation 3: All homelessness case files must be held securely in a locked cupboard or drawer. Files awaiting archive must be transferred as soon as possible.	Agreed management action: Liaising with Kier Services to ensure all personal desk cabinets have working locks and communication to the Housing Options Team regarding the need to ensure compliance with this requirement. Spot checks to be undertaken.
Risk exposure if not addressed: • Personal data could be lost or misused resulting in reputational damage to the Council.	Responsible manager for implementing: **Housing Services Manager** **Senior Housing Options Advisor** Date to be implemented: **1 May 2014**
Current status: Pending and Closed files are held in lockable filing cabinets. Current cases are locked away overnight and staff follow a clear desk policy. Files waiting to be archived are now held securely. A new policy is also in place so that only customer's initials are recorded on the departmental whiteboard so that staff outside of the Housing Options department cannot identify the client.	
Conclusion: Recommendation has been implemented.	Further action required? No

● **Medium priority**

Previous Audit finding	Management response
Recommendation 4: The department's Business Continuity Plan should be brought up to data and reflect the current structure and working practices.	Agreed management action: To be updated and a procedure put in place for regular review in accordance with corporate procedures.
Risk exposure if not addressed: • Business-critical services would not be delivered in the event of loss of staff, premises and/or IT facilities.	Responsible manager for implementing: **Housing Services Manager** **Senior Housing Options Advisor** Date to be implemented: **31 May 2014**
Current status: The Business Continuity Plan has been revised and brought up to date.	
Conclusion: Recommendation has been implemented.	Further action required? No

Audit Assurance Opinions

There are four levels of assurance used; these are defined as follows:

	Definition:	Rating Reason
Substantial	There is a sound system of internal control designed to achieve the system objectives and this minimises risk.	The controls tested are being consistently applied and no weaknesses were identified. Recommendations, if any, are of an advisory nature in context of the systems and operating controls & management of risks.
Reasonable	There is a reasonable system of internal control in place which should ensure that system objectives are generally achieved, but some issues have been raised which may result in a degree of risk exposure beyond that which is considered acceptable.	Generally good systems of internal control are found to be in place but there are some areas where controls are not effectively applied and/or not sufficiently developed. Recommendations are no greater than medium priority.
Partial	The system of internal control designed to achieve the system objectives is not sufficient. Some areas are satisfactory but there are an unacceptable number of weaknesses which have been identified and the level of non-compliance and / or weaknesses in the system of internal control puts the system objectives at risk.	There is an unsatisfactory level of internal control in place as controls are not being operated effectively and consistently; this is likely to be evidenced by a significant level of error being identified. Recommendations may include high and medium priority matters for address.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes the system objectives to an unacceptable level of risk.	Significant non-compliance with basic controls which leaves the system open to error and/or abuse. Control is generally weak/does not exist. Recommendations will include high priority matters for address. Some medium priority matters may also be present.

Grading of Audit Recommendations

Audit recommendations are graded in terms of their priority and risk exposure if the issue identified was to remain unaddressed. There are three levels of audit recommendations used; high, medium and advisory, the definitions of which are explained below.

		Definition:
High	●	Significant risk exposure identified arising from a fundamental weakness in the system of internal control
Medium	●	Some risk exposure identified from a weakness in the system of internal control
Advisory	●	Minor risk exposure / suggested improvement to enhance the system of control

Recommendation Follow Up Arrangements:

- High priority recommendations will be formally followed up by Internal Audit and reported within the defined follow up timescales. This follow up work may include additional audit verification and testing to ensure the agreed actions have been effectively implemented.
- Medium priority recommendations will be followed with the responsible officer within the defined timescales.
- Advisory issues are for management consideration.

Audit Recommendations – Overdue (Sorted as Managed By)

Report Type: Actions Report
Report Author: Audit Manager

SUMMARY OF OVERDUE RECOMMENDATIONS		
	Priority 1	**Priority 2**
Total Overdue Recommendations as at 31/03/14	**6**	**39**
"New" Recommendations due in the period	2	12
TOTAL RECOMMENDATIONS TO BE IMPLEMENTED	**8**	**51**
IMPLEMENTED FROM LAST AUDIT REPORT	5	21
"NEW" BUT IMPLEMENTED BY PERIOD END	1	7
Total implemented in the Period	**6**	**28**
CANCELLED SINCE LAST AUDIT REPORT		
OUTSTANDING FROM LAST AUDIT REPORT	1	18
OVERDUE ADDED THIS PERIOD	1	5
Total Overdue Recommendations as at 15/09/14	**2**	**23**

Covalent holds all recommendations from Internal Audit, External Audit and those included in the AGS Action Plan.

Managed By Democratic Services Manager

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
	AR-LD_043 The rate of Dependants' Carers' Allowance should be increased to 100% in line with the Independent Remuneration Panel's recommendation in the interim review of Members' Allowances, March 2006.	2	Democratic Services Manager	0%	31-Oct-2013	Members' Allowances 2011/12	04-Sep-2013 During the Members' Allowances and Expenses 2013/14 Audit it was found that this recommendation had not been implemented. A new target of 31/10/13 has been agreed.
	AR-LD_044 The Mayor's and Deputy Mayor's allowances should be included in the Members' Allowances Scheme as per the recommendation of the Independent Remuneration Panel's review of Members' allowances 2008-09.	2	Democratic Services Manager	0%	31-Oct-2013	Members' Allowances 2011/12	04-Sep-2013 During the Members' Allowances and Expenses 2013/14 Audit it was found that this recommendation had not been implemented. A new target of 31/10/13 has been agreed.
	AR-LD_047 A reminder is issued to Managers that, if a meeting they organise is to be subject to claims for travel and subsistence by Members, then a record of attendance should be taken and passed to Member Services.	2	Democratic Services Manager	0%	31-Oct-2013	Members' Allowances 2011/12	04-Sep-2013 During the Members' Allowances and Expenses 2013/14 Audit it was found that this recommendation had not been implemented. A new target of 31/10/13 has been agreed.

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
	AR-LD_048 Member Services should ensure there are written agreements between Copeland and outside bodies on payment of Members travel and subsistence claims, and this should include an exchange of information on the annual amounts paid.	2	Democratic Services Manager	50%	31-Mar-2012	Members' Allowances 2011/12	12-Sep-2013 Only a small number of outside bodies and members involved. 09-Sep-2013 To be completed by December 2013. 13-Jul-2012 To be in place December 2012 05-Apr-2012 To be in place by October 2012
	AR-LD_053 The Scheme of Member Allowances 2013/14 is reviewed with regard to the recommendations re Dependant Carer's Allowance made by The Independent Remuneration Panel's Review of Members' Allowances 2012-15 (March 2012).	2	Democratic Services Manager	0%	31-Oct-2013	Members' Allowances and Expenses 2013/14	04-Sep-2013 Review and amend scheme.
	AR-LD_056 The Financial Regulations on the Council's Constitution need to be updated so that the latest version [2012] is shown.	2	Democratic Services Manager	0%	31-May-2014	Creditor Payments 2013/14	

Managed By Director of Resources & Strategic Commissioning

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
	AR-F&MIS_315 Responsibility for monitoring that aggregated orders do not exceed the tendering limit is appropriately assigned after the departure of the Interim Technical Accountant.	2	Director of Resources & Strategic Commissioning	0%	30-Apr-2013	Creditors 2012/13	22-Jul-2014 Will be completed as part of the review of the Procurement Strategy by the end of October.

Managed By Financial Reporting and Technical Accountant

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
	AR-F&MIS_330 The Finance Department should formalise a procedure with the RBSS department. The procedure should ensure the Finance Department are informed of any staff changes that may affect access to the finance systems.	2	Financial Reporting and Technical Accountant	0%	30-Jun-2014	Creditor Payments 2013/14	04-Apr-2014 User list to be circulated to RBSS to confirm changes and included within GT review sheet.

Managed By Financial Services Manager

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
	AR-F&MIS_321 S:151 Officer should consider Copeland's strategy/approach under proposed new legislation and the current level of debt at Copeland.	2	Financial Services Manager	0%	30-Sep-2013	Debt Management Audit 2012/13	11-Jun-2013 Management Reports will be reviewed by D Law, A Brown, M Toner and E Turner.

Managed By Head of Copeland Services; Director of Resources & Strategic Commissioning

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
	AR-DO_042 A central register of external contracts, undertaken by the Council, is established to provide a picture of its obligations (with due regard to commercially sensitive information). The register should be reviewed annually by CLT and available to Members.	2	Head of Copeland Services; Director of Resources & Strategic Commissioning	20%	31-Dec-2012	Landscape Management and Contracts 2011/12	22-Jul-2014 Interim Director of Resources is reviewing this as part of the Procurement Strategy 12-Sep-2013 Head of Corporate Resources has commissioned this work with Procurement, Work in Progress. 21-May-2012 Will be incorporated into the current review of the Constitution.

Managed By Head of Copeland Services; Head of Customer and Community Services; Strategic Nuclear & Planning Manager; Head of Policy & Transformation; Director of Resources & Strategic Commissioning

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
	AR-PP_104 Managers should update Covalent regularly as stated in the Performance Management Framework. 8 Milestones are recorded on Covalent System.	2	Head of Copeland Services; Head of Customer and Community Services; Strategic Nuclear & Planning Manager; Head of Policy & Transformation; Director of Resources & Strategic Commissioning	50%	31-Oct-2013	Performance Management 2012/13	22-Jul-2014 Being reviewed Summer 14 07-Oct-2013 Agreed – Update to be given to CLT & LMG regarding requirements.

Managed By Head of Customer and Community Services

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
	AR-DS_030 The Framework for Partnership Working should be made available on the Council's intranet for use by Managers.	2	Head of Customer and Community Services	0%	30-Jun-2014	Partnership Arrangements 2013/14	12-May-2014 To put the Framework for Partnership Working on the Council's intranet.
	AR-DS_035 Terms of Reference / Partnership Agreements for all the strategic partnerships should be held centrally for reference.	2	Head of Customer and Community Services	0%	30-Jun-2014	Partnership Arrangements 2013/14	12-May-2014 The recommendation has been split into Milestones.

Managed By Health & Safety Officer

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
	AR-LES_066 The Health and Safety Manual, Policy and all associated Procedures/Documents should be reviewed and updated in a timely manner.	2	Health & Safety Officer	80%	31-Jan-2014	Health and Safety 2013/14	09-Sep-2014 Several new documents have been produced and authorised and made accessible via the company intranet, these form the new Health and Safety File. 15-Jul-2013 The recommendation has been split into 4 Milestones and will require support by Policy and Performance for corporate document and version control and by IT and Communications for intranet changes.

Managed By Housing Services Manager; Housing Option Advisor Senior

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
	AR-DO_054 Improvements must be made to ensure the efficient and effective use of the rent deposit scheme by completing the 14 milestones.	1	Housing Services Manager; Housing Option Advisor Senior	50%	31-Jul-2014	Housing Options – Homelessness 2013/14	04-Sep-2014 Recommendation 2 Milestone 9. It should be noted that the department cannot necessarily apply checks on welfare reform and spare room subsidy. This is a much wider policy issue and separate to the scheme. The affordability check will only consider the rent amount against an applicant's income. The criteria does also specify that Advisors will only consider lets that are a suitable size (e.g. a single person would not be given a rent deposit for a 3 bed house) but there are occasions when Advisors will consider a two bed rental for a single person because supply of one bed properties isn't there.

Managed By HR Manager; Director of Resources & Strategic Commissioning

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
	AR-PP_069 All Managers are reminded that they should monitor personal calls made by employees using CBC mobile phones. The calls should be identified, verified and costs recorded.	2	HR Manager; Director of Resources & Strategic Commissioning	0%	31-May-2011	General Tax Issues 2010/11	22-Jul-2014 Ownership transferred to HR as part of the HR policy review. 12-Sep-2013 Head of Corporate Resources to progress with Shared HR Manager when in post. 02-Oct-2012 Amended the Managed By responsibility from the Director of Resources and Transformation to the Head of Corporate Resources from 02/10/12. 21-Jul-2011 Reminder of policy on acceptable use of Council-provided phones included in corporate information section of Latest Word on 1 July 2011. Separate note still required for Managers with staff who have council mobiles to review usage and agree re-

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
							imbursement.
	AR-PP_070 Managers ensure that the Payroll Officer is informed of any deductions that are required for personal calls in a timely manner. This must be the next available pay date from when the Vodafone invoice is received.	2	HR Manager; Director of Resources & Strategic Commissioning	0%	31-May-2011	General Tax Issues 2010/11	22-Jul-2014 Transferred to HR. 12-Sep-2013 Head of Corporate Resources to progress with Shared HR Manager when in post. 02-Oct-2012 Amended the Managed By responsibility from the Director of Resources and Transformation to the Head of Corporate Resources from 02/10/12.

Managed By Legal Services Manager

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
	AR-LD_050 Legal Services should review the Bribery Act legislation and determine its application to the Council, and the extent to which adequate procedures are in place to mitigate the risk of prosecution. This might include amendment to existing codes of conduct.	2	Legal Services Manager	20%	31-Dec-2011	Register of Gifts/Hospitality & Disclosure of Interests 2011/12	01-Aug-2014 Links to the Counter Fraud and Money laundering. 11-Oct-2013 As 13/14.LEG.06. Work on policies ongoing with further officer meeting scheduled for 16/10/13. Likely completion date 30/11/13. 12-Sep-2013 The Bribery Act Legislation will be incorporated into a revised Counter Fraud Policy for consideration by the Audit & Governance Committee 07/11/13. Following this it will be presented to the Executive and Full Council. 08-Apr-2013 Several measures already exist to prevent bribery – financial regulations, code of conducts, vetting of staff as

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
							part of recruitment, transparency in publishing transactions over £500, contract procedure rules, etc. A risk assessment reviewing the risks which the Council might continue to be exposed to will be completed by the end of May. This review will identify any further amendments necessary to corporate documentation with approval then being sought to those amendments. The review will also identify any further training and publicity necessary and consider the timescale for future reviews of the prevention measures. It is aimed to have this process complete by the end July.
							05-Apr-2012 05/04/12: The Bribery Act 2010 affects three areas:

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
							(a) the Council's codes of conduct; (b) the Council's procurement procedures; (c) the Council's anti-fraud and corruption policies. The emphasis of the Act is to be proactive and avoiding the conditions of bribery. The Democratic Services, Legal Services and Audit Shares Services Managers are undertaking work on these three aspects with the work currently being scoped out. It is anticipated that the work in these three areas will be completed by the 30/09/12. There is a linked issue of money laundering and work on this matter will be completed by the 30/09/12.

Managed By Parks Manager

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
	AR-LES_046 Look at all options for the collection of income for Book of Remembrance applications.	2	Parks Manager	90%	31-Jan-2013	Bereavement Services 2012/13	03-Sep-2013 Currently looking at Electronic registers system that would allow links for info needed to process BOR applications from Copeland Direct 08-Apr-2013 Extension of time has been given for this recommendation to 30/11/13 to allow for works to be carried out to the Copeland Centre reception area. 03-Apr-2013 The preferred option for all applications for B.O.R to be taken at the Copeland Centre with a new target date set for November 2013 10-Jan-2013 Currently being looked at as part of transformation programme 02-Oct-2012 Look at options

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
							with finance.
	AR-LES_061 Ensure that members of the public, especially the recently bereaved are informed that all Book of Remembrance applications will only be accepted at the Copeland Centre or via post to the Copeland Centre.	2	Parks Manager	10%	30-Nov-2013	Bereavement Services Follow Up Audit 2012 13.	22-May-2013 Working with transformation team and crematorium staff to progress over the coming months 08-Apr-2013 Link in to transformation programme.

Managed By Revenues & Benefits Shared Services Manager

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
	AR-CS_158 The RBSS should ensure that all data, held electronically (including archived) or physically, is only retained as long as there is a business need to do so.	2	Revenues & Benefits Shared Services Manager	0%	30-Jun-2014	Civica Comino Application 2013/14	16-Oct-2013 The existing arrangements for data retention are to be reviewed to determine actions required to comply with the recommendation. Implementing the actions identified will be scheduled subject to workload and appropriate IT support.
	AR-CS_159 The RBSS should ensure that retention schedules are consistent across all 3 Councils. All staff involved with the handling of data (whether electronic or physical) should be aware of data protection and retention requirements.	2	Revenues & Benefits Shared Services Manager	0%	31-Jan-2014	Civica Comino Application 2013/14	16-Oct-2013 The proposed retention period outlined of 6 previous years and current year data is to be considered for adoption by the Shared Service Joint Operational Board

Managed By Revenues & Benefits Team Leader (TC)

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
	AR-CS_133 The Sundry Debtor Handbook needs to be updated to reflect changes to the Council Structure.	2	Revenues & Benefits(TC) Team Leader	80%	31-May-2012	Sundry Debtors 2011/12	13-Aug-2014 have been unable to obtain information regarding current Nominated Debt Officers I'll ask Department Managers who their current officer is when I sent the Aged Debt Report at the beginning of September 2014 12-Feb-2014 will update changes to Council Structure and amend procedures by end of March 2014 05-Apr-2013 Awaiting details from Finance re the Nominated Debt Officers for each Department. 16-Jan-2013 will contact Finance Section for update on Departments still raising invoices and names of Nominated Debt Officers for each Department

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
							13-Jul-2012 will make a start on this ASAP

Managed By Shared Services Performance Manager

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
	AR-AC_048 Review all modified schemes to confirm that expenditure to be included in the 2013/14 claim is correctly classified as modified schemes.	1	Shared Services Performance Manager	0%	31-Mar-2014	Grant Thornton Certification Report 2012/13 February 2014	15-Jul-2014 100% Accuracy checks being undertaken, on a phased approach in 2013/14.

Managed By Transformation Programme Manager

Status Icon	Action Code & Title	Priority	Managed By	Progress Bar	Due Date	Description	All Notes
	AR-PP_089 The appropriate training is given to Copeland Direct Officers prior to Book of Remembrance applications being accepted at the Copeland Centre.	2	Transformation Programme Manager	20%	30-Nov-2013	Bereavement Services Follow Up 2012 13	03-Jul-2014 The project has been delayed but scheduled for the end of September.

APPENDIX C
AUDIT & GOVERNANCE COMMITTEE 24 September 2014
INTERNAL AUDIT PERFORMANCE MEASURES (Q1 2014/15)

KPI	Measure of Assessment	Target	***Actual performance data***
Output Measures			
Planned audits completed To enable an annual opinion to be provided on the overall systems of risk management, governance and internal control.	% of planned audit reviews (or approved amendments to the plan) completed in respect of the financial year.	95% (annual per shared service agreement, 95% target reflects need for audit plans to be dynamic and respond to emerging risks). This indicator will be monitored and reported quarterly to ensure the plan is on track to be delivered.	***Number of final reports planned in Q1 -2*** ***Actual final reports – 2, 100% achieved*** Reviews of FOI and external funding completed. 20 reports in plan – estimate of reports to be issued as follows – Q1 – 2; Q2 - 3 ; Q3 - 7; Q4 - 8. In addition there will be 2 follow up reports for work done in 2013/14. 1 follow up on housing options completed. ***Q1 planned days – 80 Actual days -51*** 500 days in full plan – estimated profile as follows (Q1 -80, Q2 - 109, Q3 - 126, Q4 - 185)
Audit scopes agreed	% of audit scopes agreed with management and issued before commencement of the audit fieldwork	100% Reported quarterly	***Actual – 100%***
Draft reports issued by agreed deadline	% of draft internal audit reports issued by the agreed deadline or formally approved revised deadline agreed by	80% (target is a reflection that this is a new way of working and deadlines may be impacted by several factors including client availability)	***Actual -100%***

APPENDIX C
AUDIT & GOVERNANCE COMMITTEE 24 September 2014
INTERNAL AUDIT PERFORMANCE MEASURES (Q1 2014/15)

KPI	Measure of Assessment	Target	***Actual performance data***
	Audit Manager and client.	Reported quarterly	
Timeliness of final reports	% of final internal audit reports issued for Corporate Director comments within 5 working days of management response or closeout.	90% (target recognises that there may on occasion be delays in finalising reports, eg where further work is required to resolve matters identified at closeout meeting) Reported quarterly	***Actual – 100%***
Recommendations agreed	% of recommendations accepted by management	95% quarterly (target reflects that it is management's responsibility to assess their risks and take final decision on whether risk may be accepted)	***Actual – 100%***
Follow up	% of high priority audit recommendations implemented by target date	100% Quarterly	***See Appendix B – overdue actions arising from audit reports***
Assignment completion	% individual reviews completed to required standard within target days or prior approved extension by Audit Manager	75% (target reflects that this is a new way of working for the audit service and systems for monitoring time spent on assignments may need to be further developed) Reported quarterly.	***Actual – 67% (2 out of 3 completed reports)*** ***FOI review will exceed budget as a result of delays/additional work in agreeing report.***
Quality Assurance checks completed	% QA checks completed	100%. Reported quarterly	***Actual – 100%. QA checks completed as required.***

APPENDIX C
AUDIT & GOVERNANCE COMMITTEE 24 September 2014
INTERNAL AUDIT PERFORMANCE MEASURES (Q1 2014/15)

KPI	Measure of Assessment	Target	***Actual performance data***
Customer Measures			
Post audit customer satisfaction survey feedback	% of customer satisfaction surveys scoring the service as 'good'	80% (target reflects the need for internal audit to strive to deliver a customer focused service, but that due to the nature of internal audit roles and responsibilities, may not always elicit positive feedback) Reported quarterly	***Have issued 2 surveys to date re 2014/15 but no completed surveys yet.***
People Measures			
Efficiency	% chargeable time	80% (target takes account of non-chargeable activities such as staff holidays, service development projects and team meetings. Reported quarterly	***Actual Q1 – 67%*** ***This percentage is for all staff across IA Shared Service and is lower than target mainly because of time spent on relocation of Carlisle office, restructure of Finance Department and set up costs for new risk-based audit approach.***