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To: Councillor Stevens (Chairman)
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16 January 2019

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NOTICE OF MEETING - AUDIT AND GOVERNANCE COMMITTEE 24 JANUARY 2019

A meeting of the Audit and Governance Committee will be held on Thursday, 24 January 2019 at 6.30 pm in the Council Chamber, Civic Offices, Reading. The Agenda for the meeting is set out below.

		WARDS AFFECTED	Page No
1.	**DECLARATIONS OF INTEREST**		
2.	**MINUTES OF THE COMMITTEE'S MEETING HELD ON 27 SEPTEMBER 2018**		**5 - 10**
3.	**QUESTIONS**		
4.	**RECRUITMENT UPDATE - PRESENTATION** To receive a presentation updating the Committee on recruitment.	**BOROUGH WIDE**	
5.	**INTERNAL AUDIT QUARTERLY PROGRESS REPORT** This report provides an update on key findings emanating from Internal Audit reports issued since the last quarterly progress report in September 2018.	**BOROUGH WIDE**	**11 - 74**
6.	**INTERNAL AUDIT PLAN 2019 - 2020** This report sets out the work Internal Audit plans to undertake during the financial year 2019/2020.	**BOROUGH WIDE**	**75 - 98**
7.	**STRATEGIC RISK REGISTER Q3**	**BOROUGH WIDE**	**99 - 118**

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This report provides an update on the Council's 2018/19 Strategic Risk Register, in line with the requirements of the Council's risk management strategy.

8.	**TREASURY MANAGEMENT HALF YEARLY REPORT**	**BOROUGH WIDE**	**119 - 130**

This report provides an update on the activity of the Treasury Management function for 2018/19 as at 30 September 2018.

9.	**IMPLEMENTATION OF AUDIT RECOMMENDATIONS TRACKER**	**BOROUGH WIDE**	**131 - 156**

This report sets out a summary of those high and medium risk Internal Audit recommendations which remain outstanding together with an updated management response.

10.	**UPDATE ON 2016/17 AND 2017/18 ACCOUNTS**	**BOROUGH WIDE**	**157 - 160**

This report updates the Committee on the progress made towards completing the 2016/17 audit since the last meeting in September 2018.

11. EXTERNAL AUDITOR UPDATE

To receive a verbal update from the Council's external auditor EY.

12. EXCLUSION OF THE PRESS AND PUBLIC

At this point, the following motion will be moved by the Chair:

"That, pursuant to Section 100A of the Local Government Act 1972 (as amended) members of the press and public be excluded during consideration of the following item on the agenda, as it is likely that there would be disclosure of exempt information as defined in the relevant Paragraphs of Part 1 of Schedule 12A (as amended) of that Act"

13.	**HOUSING BENEFITS AND COUNCIL TAX SUPPORT SCHEME - RISK-BASED VERIFICATION POLICY 2019/20**	**BOROUGH WIDE**	**161 - 172**

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AUDIT AND GOVERNANCE COMMITTEE MINUTES – 27 SEPTEMBER 2018

Present: Councillors Stevens (Chairman), Brock, Davies, Gittings, McKenna, Terry & Warman.

Also in attendance:

Councillor Lovelock	Leader of the Council
Councillor Page	Deputy Leader of the Council
Adrian Balmer	EY LLP
Matt Davis	Head of Finance
Maria Grindley	EY LLP
Paul Harrington	Chief Auditor
Jackie Hooper	Service Manager, LAC Leaving Care
Rachel Kennedy	EY LLP
Kevin Parker	Principal Auditor
Jean Stevenson	Chief Accountant
Jackie Yates	Director of Resources

10. MINUTES

The Minutes of the meeting of 1 August 2018 were confirmed as a correct record and signed by the Chairman.

11. EQUAL PAY UPDATE

Jackie Yates, Director of Resources, presented a report on the management of the equal pay claims and giving a current position on discussion, settlement of cases and future litigation. The report stated that approximately 180 employees or former employees had made an equal pay claim. This equated to approximately 258 claims, as some claimants were claiming in respect of more than one job role. Of the claims received, 56% were represented by Thompsons Solicitors (Unison) and 44% were being represented by Doran Law, a no win no fee solicitor.

The report stated there were now no outstanding claimants being represented by Thompsons, all claims had been settled and monies paid. There were 13 Doran claimants that were still going through a process. Firstly, there were claimants from mixed roles where further discussions were being entered into regarding schedules of loss; and secondly claimants whose claims had been struck out at a jurisdictional tribunal because of time issues but where Doran had indicated an appeal would be lodged. In addition, there were currently three claimants who were no longer represented by Thompsons or Doran. The Tribunal service had written to the claimants and if they wished to proceed with their claims, the Council would need to liaise with them directly or through their new representative(s).

A hearing had been scheduled for 15-17 October 2018 where the remaining claims would be determined if they could not be resolved beforehand. Any appeal by Doran Law against the jurisdictional claimant decision would be likely to be heard in 2019, as would any applications for costs from either side and any further steps if Doran Law chose to pursue their remaining challenge to the 2011 pay and grading arrangements.

The Council had made provision for equal pay claims to be funded via capital receipts with £14m set aside in the 2016/17 accounts. As part of finalising the 2017/18 accounts the provision would be increased through additional capital receipts. During 2017/18, £5m had been paid out to claims and a further £7.1m had been paid out so far in 2018/19 with another £1m committed to date. The remaining liability was forecast to be £2.3m. To date the Council had spent £1,935,443.19 on legal fees including disbursements.

Resolved: That the progress on the management of the equal pay claims and the programme of litigation be noted.

12. INTERNAL AUDIT QUARTERLY PROGRESS REPORT

Paul Harrington, Chief Auditor, submitted a report providing an update on key findings emanating from Internal Audit reports issued since the last quarterly progress report in August 2018.

The report set out a summary of the audit reports in respect of Additional Payments; Payment Card Industry Data Security Standard; Network Security; South Reading Leisure Centre; and Journal Testing Q1. The report also contained details of the school audits and the follow-up audit of Right to Buy. The audit of Additional Payments had been given limited assurance, and the full report was therefore included in a report to be considered in Part 2 of the agenda (Minute 17 refers).

The report also listed the audits that were currently in progress, or were planned for the remainder of 2018/19, and gave a summary of investigations work between April and June 2018.

Resolved: That the report be noted.

13. ACCOUNTS 2016/17 & 2017/18 UPDATE

Further to Minute 3 of the meeting held on 1 August 2018, the Head of Finance submitted a report providing an update on progress with the audit of the 2016/17 and 2017/18 accounts. The Committee noted that the 2016/17 Accounts should originally have been audited and signed off by 30 September 2017, and that regular reports had been made to the Committee since then providing updates on progress.

The report stated that a revised set of accounts had been presented to the Committee on 1 August 2018 and formally submitted to the External Auditor subsequent to the meeting. The External Auditors had recommenced the audit following the Committee meeting and the audit was still ongoing. Following detailed discussions with the Auditors, it had been agreed that identifying sufficient evidence to substantiate some creditor and debtor balances was not viable given the passing of time and the turnover of officers at the Council. Consequently, the External Auditor had indicated that this aspect of the 2016/17 accounts would need to be qualified.

There were also a number of fixed asset and capital accounting issues still to be resolved with EY. These would impact on the value of Property, Plant and Equipment and two of the unusable reserves. Council's expert consultants were working through

these issues and the proposed amendments to deal with EY's concerns had been presented to the Auditors. The Council's consultants had recommended further changes to the accounts for the Council's two Public Finance Initiative (PFI) Schemes and had provided EY with details of the changes. The amendments to the accounts would be made as soon as agreement had been reached with EY.

The report anticipated that EY's external audit field work would be completed in early October 2018. However, the draft opinion would be subject to consultation with the Council and review by EY's Professional Standards Panel. Given the delay in the audit and the potential qualification, it was likely that a review by Public Sector Audit Appointments would also be required. Therefore, EY did not expect to be in a position to give an opinion on the accounts until late October or early November 2018 at the earliest.

Additionally, EY had confirmed that if the opinion on the 2016/17 accounts was qualified, the 2017/18 opening balances would also be qualified due to uncertainties around the creditor and debtor balances. To ensure the qualification was lifted on the balances at 31 March 2018, the Finance Team had commenced a full review of all year end balances on creditor and debtor ledger codes in 2017/18 to ensure that they were fully evidenced and correctly calculated. Until the issues with fixed asset and capital accounting in 2016/17 had been resolved with EY it would not be possible to finalise the entries in the ledgers for 2017/18. EY had advised that the 2017/18 accounts should not be finalised until they had finalised their opinion on the 2016/17 accounts. This did not prevent the finalisation of transactions in 2017/18 ledgers and officers would finalise this work as soon as the exercise on creditors and debtors was complete, which would enable the outturn figures already reported to members to be confirmed. It was anticipated that the 2017/18 accounts would be ready for issue to EY in late November 2018.

Resolved: That the progress made by the External Auditor and officers in finalising the 2016/17 accounts be noted.

14. IMPLEMENTATION OF AUDIT RECOMMENDATIONS TRACKER

Further to Minute 8 of the meeting held on 1 August 2018, Jackie Yates, Director of Resources, submitted a report setting out, at Appendix 1, the Implementation of Audit Recommendations tracker report.

The report explained that each recommendation was marked with a percentage complete which correlated to a red/amber/green rating (up to 25% complete: red, between 26% and 75%: amber, over 75% complete: green). Any recommendations that were less than 50% complete but had exceeded their agreed completion date were also marked red. In the tracker report at Appendix 1 there were 106 high and medium risk recommendations from Internal Audit, of which 44 (42%) were currently green, 19 (18%) were amber and 43 (41%) were red. This was a significant improvement on the previously reported position on 1 August 2018.

Due to the lack of information available on the Foster Care recommendations at the previous meeting, the Service Manager responsible for Foster Care, Jackie Hooper attended the meeting to explain progress on implementing those recommendations.

Resolved:

(1) That the high and medium risk Internal Audit recommendations and the responses to those risks be noted as set out in Appendix 1 to the report;

(2) That a written update be provided to members of the Committee on the progress made so far to implement the audit recommendations in relation to Foster Care and a further report be submitted to the Committee, in the New Year once the Foster Care Handbook had been updated in accordance with Audit Recommendation 45, as set out in Appendix 1 to the report.

15. EXTERNAL AUDITOR UPDATE

The Committee noted that the external auditor had commented, as necessary, during consideration of the items listed above and had no further contributions to make.

16. EXCLUSION OF THE PRESS AND PUBLIC

Resolved –

That pursuant to Section 100A of the Local Government Act 1972 (as amended), members of the press and public be excluded during consideration of the following item below as it was likely that there would be a disclosure of exempt information as defined in the relevant paragraphs specified in Part 1 of Schedule 12A to that Act.

17. INTERNAL AUDIT QUARTERLY PROGRESS REPORT – ADDITIONAL PAYMENTS

Paul Harrington, Chief Auditor, submitted a report on the findings emanating from the audit report in respect of Additional Payments. Additional payments covered a range of areas including acting up allowances, honoraria for undertaking a discrete project or piece of work over and above normal duties, overtime and market supplements. The Council had spent approximately £2.287m on additional payments, excluding overtime, in 2017/18. In addition, around £1.6m had been paid in both 2016/17 and 2017/18 in overtime. The aim of the audit had been to review the systems and processes which govern honoraria and additional payments, including checking that they were consistently applied, robust, appropriate and complied with HR policies. Although HR policies were largely in place for the various types of additional payments such as acting up allowances, honoraria and market supplements, most of these policies had not been updated recently. However, the 'limited assurance' had not been derived from a lack of HR rules and procedures, but from a lack of adherence to them. The full internal audit report was attached to the report as an appendix, which included five recommendations to address the risks that had been identified.

Resolved –

(1) That the review of employment policies, which would ultimately be presented to the Personnel Committee for approval, which was being carried out by the Head of HR & Organisational Development be noted and endorsed;

(2) That the Chief Auditor's recommendations set out in the internal audit report be endorsed and the Management responses to those recommendations be noted;

(3) That a further report on the progress made to address the risks set out in the Internal Audit report be submitted to the Committee's meeting on 16 April 2018.

(Exempt information as specified in paragraph 3)

(The meeting commenced at 6.30pm and closed at 7.50pm).

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READING BOROUGH COUNCIL
DIRECTOR OF RESOURCES

TO:	**AUDIT & GOVERNANCE COMMITTEE**		
DATE:	**24th January 2018**	**AGENDA ITEM:5**	
TITLE:	**INTERNAL AUDIT QUARTERLY PROGRESS REPORT**		
LEAD COUNCILLOR:	**COUNCILLOR BROCK**	**PORTFOLIO:**	**CORPORATE AND CONSUMER SERVICES**
SERVICE:	**FINANCE**	**WARDS:**	**N/A**
LEAD OFFICER:	**PAUL HARRINGTON**	**TEL:**	**9372695**
JOB TITLE:	**CHIEF AUDITOR**	**E-MAIL:**	**Paul.Harrington@reading.gov.uk**

1. PURPOSE OF THE REPORT

1.1 This report provides the Audit & Governance Committee with an update on key findings emanating from Internal Audit reports issued since the last quarterly progress report in September 2018.

1.2 The report:

- Provides assurance, commensurate with the control environment evidenced by audits conducted in the last quarter.
- Advises on significant issues where controls need to improve to effectively manage risks.
- Tracks progress on the response to audit reports and the implementation of agreed audit recommendations.

1.3 Please note audit reviews specific to children and education (including schools) will be reported directly to the children's company (Brighter Future for Children).

1.4 The following document are appended:

- Appendix 1 – Delayed Transfer of Care Audit Report
- Appendix 2 – Continuing Healthcare Audit Report
- Appendix 3 – Residents Parking Audit Report

2. RECOMMENDED ACTION

2.1 The Audit & Governance Committee re requested to consider the report.

3. ASSURANCE FRAMEWORK

3.1 Where appropriate each report we issue during the year is given an overall assurance opinion. The opinion stated in the audit report provides a brief objective assessment of the current and expected level of control over the subject audited. It is a statement of the audit view based on the terms of reference agreed at the start of the audit; it is not a statement of fact. The opinion should be independent of local circumstances but should draw attention to any such problems to present a rounded picture. The audit assurance opinion framework is as follows:

Substantial	 GREEN	**Substantial assurance** can be taken that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.
Reasonable	 YELLOW	We can give **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** expose until resolved.
Limited	 AMBER	**Limited assurance** can be taken that arrangements to secure governance, risk management and internal control within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.
No assurance	 RED	There is **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

3.2 Grading of recommendations

3.2.1 In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows:

Priority	Current Risk
High	Poor key control design or widespread non-compliance with key controls. Plus a significant risk to achievement of a system objective or evidence present of material loss, error or misstatement.
Medium	Minor weakness in control design or limited non-compliance with established controls. Plus some risk to achievement of a system objective
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration

3.2.2 The assurance opinion is based upon the initial risk factor allocated to the subject under review and the number and type of recommendations we make.

3.2.3 It is management's responsibility to ensure that effective controls operate within their service areas. However, we undertake follow up work to provide independent assurance that agreed recommendations arising from audit reviews are implemented in a timely manner. We intend to follow up those audits where we have given limited or 'no' assurance.

4. HIGH LEVEL SUMMARY OF AUDIT FINDINGS

4.1	Delayed Transfer of Care	2	4	1	

4.1.1 Delayed Transfers of Care (DToC) refers to patients who are ready to leave hospital or similar care provider, but are still occupying a bed. This covers patients in all NHS settings irrespective of who is responsible for the delay. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice.

4.1.2 The scope of this audit was to review the governance arrangements and relationships with NHS providers, ensuring they were clear, understood and formally documented.

4.1.3 We found officers to be actively engaged and highly motivated to ensure that performance with respect to Delayed Transfer of Care continued to improve. Officers interviewed during our audit communicated openly and demonstrated a detailed knowledge of issues and challenges.

4.1.4 Discussions with the Trusts that account for the majority of delays attributed to RBC reflected the challenges, as have been reported nationally, of ensuring effective working between different parties and IT systems. In particular officers will have to engage in a continuous process of reviewing live data that, could reasonably, be assumed to contain errors of various forms and that clarification and codification of the processes should benefit in increasing accuracy and resilience.

4.1.5 Officers have undertaken to develop formal policies and procedures with respect to various aspects of DToC and are engaged with improving the performance. However, at the time of the review these documents were either still unapproved or in a state that would benefit from expansion and further detail. Where there are no formally documented and approved processes that are readily available to all staff, there is a risk that standardised process will not be followed, upon staff changes institutional knowledge will be lost and opportunities for challenge and improvement may be lost.

4.1.6 Officers demonstrated that they are aware the spreadsheet based system for the recording of individuals ready to be discharged from hospital was resource intensive and issues with data quality were known. As a result officers have undertaken to utilise Mosaic[1] as a replacement system with the benefit of standardising data entry and allowing for advanced reporting.

4.1.7 Although, at the time of the audit, only limited assurance could be provided, the direction of travel is one of improvement, which is further confirmed through the recent CQC inspection.

[1] Social Care Case Management System

4.2	Continuing Healthcare	2	5	1	

4.2.1 Continuing Healthcare (CHC) is the name given to a package of care that is arranged and solely funded by the NHS for individuals who are not in hospital and have been assessed as having a 'primary health need'. It is known and established that historically Reading CCG has had amongst the lowest number of people who have been assessed as eligible to receive Continuing Healthcare funding. Hence there is a risk the Council is not identifying potential CHC cases and so may be contributing for the costs of care for people, when other parties should be financially responsible instead, or as well.

4.2.2 The purpose of the audit was to ensure that as far as possible all reasonable attempts have been made to identify CHC cases, for Clinical Commissioning Group (CCG) funding to be secured. Furthermore if an application had been made, but rejected by the NHS, then the Council has sought to consider and, where appropriate, to challenge or dispute these instances.

4.2.3 There are national criteria governing entitlement for CHC support funding and it was found that these are generally known, clear and understood. However, although there are some Berkshire wide procedures, there is an absence of up to date documented procedures regarding local systems employed in RBC. As a consequence it was noted that there is a lack of consistency both in terms of the approach to and standards of record keeping that was evident during testing. In particular this weakness applied to actions being recorded and updated on Mosaic and so there is an incomplete trail of documentation being copied or saved on to Mosaic.

4.2.4 The directorate has identified that training on CHC should be mandatory for its staff. This is very much supported as it was established during the audit that there is a variety of practice and understanding in place across the service to determine how entitlement to CHC should be assessed and recorded. A survey of a number of staff highlighted that some staff are not confident about how cases should be flagged, assessed, submitted for review and documented. The same applies to staff awareness and confidence about the appeal process in the event of a CHC application being refused by the CCG.

4.2.5 Possibly as a consequence of a lack of local training and systems documentation, it was established that there is a variety of standards in the quality of CHC checklists being undertaken, before these are submitted to the CCG. It was also found that although there is a system used to try to keep a record of (the status of) each CHC application, its effectiveness is limited as some staff are bypassing this and dealing with the CCG direct. This is exacerbated further as there is currently no simple way to interrogate Mosaic to find out details about pending, successful or refused CHC cases or other relevant management information.

4.2.6 In addition to the CHC training programme offered by the CCG and as part of the recent initiative by the Directorate to address some of the known issues around CHC, the directorate has commissioned specific CHC training for staff from (and recently delivered by) an external provider.

4.2.7 The bulk of the review was undertaken earlier in the 2018/19 financial year, since when it is understood that considerable work has been done, jointly with the CCG, to improve knowledge, systems and control. Despite this there were a number of findings and recommendations arising from the audit to further improve controls around the administration and management of CHC.

4.3	Revenue Budget Setting (Hyperion)	0	3	2	

4.3.1 The Planning and Budgetary Control System (PBCS), formerly called Hyperion, is an Excel and web based planning, budgeting and forecasting tool used by the Council to build its budget. An incremental budget can be produced, based on the previous year's figures, which contains information for a number of years, thereby facilitating the production of multiple year budgets. Once the budget has been formally approved and input into the system, it is uploaded into Oracle Fusion, the Council's finance system. Subsequently agreed changes, such as budget savings, are also uploaded into the system.

4.3.2 The aim of the audit was to verify the integrity of internal controls, specifically around data input.

4.3.3 There are policies, procedures and a timetable in place for the budget process and a post budget review was also conducted to identify issues and amendments required going forward. However, documentation does need to be reviewed and updated to reflect current practice and realistic timeframes.

4.3.4 Access to Hyperion was amended during the 2018/19 budget process to restrict the number of people who were able to upload, input and amend data. Also a clear segregation of duties has been put in place between producing the budgets (Budget Managers assisted by Finance Business Partners), approving them (Policy Committee and Council), uploading them (Financial Systems Accountant) and reconciling them (Finance Business Partners at directorate level and Financial Analysis and Planning Lead at organisational level).

4.4	Journal Testing Q2	0	0	0	

4.4.1 Throughout the 2018/19 financial year we will be performing quarterly tests on journals transactions. We have now validated a sample of journals from Quarter 1 and 2 of financial Year 2018-19 and have found these to have been properly evidenced and supported by working papers. We will undertake further testing of Q3 journals in January/February 2019.

4.5	Residents Parking	3	5	0	

4.5.1 This audit primarily focused on the (software) application structure for managing and supporting the management and administration of penalty charges for on-street parking. This entailed reviewing access controls, separation of duties, management of privilege (access levels) and service user account activities and the control of physical permits.

4.5.2 The PermitSmarti application, provided by Imperial Civil Enforcement Solutions Limited is used to provide the administrative and back office solution, whilst a separate software solution (3Sixty) is used for the management of penalty charge notices.

4.5.3 During the audit, it was not possible to establish any overarching governance documents, setting out the management and administrative arrangements for maintaining the applications. Neither could we identify that any consistent or formal process is applied to the monitoring of user activity on either applications reviewed. There is also no system documentation that details the operation and function of the two applications.

4.5.4 There are no system reports showing the roles performed by users accessing the applications, along with their permissions and access rights, thus increasing the risk that inappropriate activity could go unnoticed. As a consequence management have limited assurance that controls are functioning effectively. In addition there are no records of the training undertaken by RBC staff or contractors or evidence to show there has been some form of verification and review, in which user accounts and permissions are validated.

4.5.5 In reviewing the applications against the requirements of the RBC "ICT Standards Expected of Third Parties Policy," it was found that the applications do not meet the password complexity requirements. Where the applications in use by Parking Services do not have in place password requirements that meet RBC standards they may be subject to challenge as to whether they have taken appropriate action to secure the application and the data held.

4.5.6 Parking services are committed to address the audit concerns identified, and have given assurances that procedures will be implemented and controls tightened.

4.6	Declarations of Interest, Employee Gifts & Hospitality	0	4	2	

4.6.1 The purpose of the audit was to ensure that the Council has a clear and consistent process for advising new and existing staff of their responsibility to declare interests and register gifts or hospitality. This was achieved by selecting a sample of employees and managers from each directorate to assess their understanding of process to be followed.

4.6.2 The Council's written policies and procedures for managing and recording Gifts, Hospitality and Declarations of Interest are detailed in three key documents (the Employee Handbook, the Constitution and the Code of Conduct) and although these were up-to-date, we found a number of inconsistencies around the practical reporting and recording arrangements.

4.6.3 With each directorate working independently, each process for the recording of Gifts, Hospitality and Declarations of Interests varies. Although there are registers in place, there is sometimes a lack of supporting documentation to back up the information required on each register.

4.6.4 The directorate registers are apparently reviewed within each directorate; however there is no evidence to substantiate this and no central report on activity is currently required.

4.6.5 Staff in each directorate highlighted conflicting understanding(s), in particular about whether gifts of different values should be accepted or reported, where to access information and whose responsibility it is to promote and enforce policies.

4.6.6 For certain corporate applications users are required to make specific declarations where there could be some potential conflicts of interest arising. For example, staff who have access to Academy, the system used for Revenue and Benefits are required to complete a Declaration of Interest prior to gaining access to the system.

4.6.7 In the case of all new staff a declarations of interest form is sent to them prior to commencing employment as part of the new employment pack. However, there is no corporate procedure for making new declarations of interests arising for existing staff (or staff in potentially targeted services) and similarly there are no regular reminders to staff members to declare any interests.

4.6.8 The Head of HR and Organisational Development has advised that there may be potential for i-Trent to be used to record Gifts, Hospitality and Declarations of Interest. Although this is still at an early stage, there could be significant advantages for the Council if this is progressed, as this is likely to be more efficient, by streamlining the registration, recording and reporting. In turn thus would demonstrate good governance and commitment to the Nolan Principles, as following varied practices restricts the Council to confidently demonstrate each directorate has acted responsibly.

4.7	Bus Subsidy Grant 2017/18	0	0	1	

4.7.1 This audit focused on providing assurance that the conditions of the grant determination had been complied with. Expenditure was reviewed against the relevant conditions set down for the grant and was certified to the Department for Transport as having been spent appropriately.

4.7.2 The council was paid £74,192 by the Department for Transport under the grant to be used only for the purposes of supporting bus services (including community transport services run under a section 19 permit), or for the provision of infrastructure supporting such services in that authority's, or a neighbouring authority's area. We can confirm the grant for 2017/18 was spent in accordance with the determination notice for the purposes of supporting the bus services and infrastructure within the authority.

4.8	Transport Capital Grant funding 2017/18	0	0	1	

4.8.1 This audit focused on providing assurance that the conditions of the grant determination had been complied with. Expenditure was reviewed against the relevant conditions set down for the grant and was certified to the Department for Transport as having been spent appropriately.

4.8.2 The Local Transport Capital Block Funding (integrated Transport and Highways Maintenance) Specific Grant was settled in 2015/16 to be paid over a 5 year period. In 2017/18 as part of this arrangement, the council received £3,790,000, of which £2.210m related to highway maintenance.

4.8.3 Having carried out appropriate investigations and checks, in our opinion, in all significant respects, the conditions attached to Local Transport Capital Block Funding (Integrated Transport, Highway Maintenance, Pothole Action Fund, National Productivity Investment Fund and Flood Resilience fund) have been complied with.

4.9 Commercial lease (Nursey)

4.9.1 The Chief Executive requested Internal Audit undertake a lesson learned review at a detailed level on how a Nursery was allowed to occupy a Council building without paying rent or agreeing a lease, since 2011. In addition we were asked to ascertain the likelihood of there being similar properties across the Council's estate where rent is not being collected.

4.9.2 Clearly there was a significant drift and delay and inter-service confusion over the lease which was compounded by conflicting priorities. Officers appear to have been reluctant to start eviction proceedings, because the Nursery provided an important service in an area of need and the Council wanted and needed to support their work at the same time as ensuring a fair rental income to the Council.

4.9.3 Decisions were taken at an operational level, without strategic oversight and coordination. Hence there were competing service pressures, which subsequently prevented a successful resolution e.g. meeting Early Years' needs, versus the need to secure a proper financial return to the Council that were not adequately resolved. This was probably compounded during the period where there was a lack of consistent senior managerial (at Head of Service level) oversight in Education.

4.9.4 There was an assumption that the Nursery couldn't pay a commercial rent, because they hadn't submitted a business case or audited accounts. However, the Nursery had a sufficient surplus cash balance since 2014.

4.9.5 From the documentation and evidence made available, we concluded that all officers involved in this matter had to accept a degree of culpability, in that there was a collective corporate failure to manage this situation over the years. There are obvious lessons to be learnt, such as giving consideration to central oversight of property management, rather than individual services with potentially conflicting priorities, being responsible for their own property portfolio. Having one central team charged with oversight of property management would lead to speedier decisions with less conflict and deliberation. In addition property visits by the Valuation team, Health & Safety and Facilities Management (condition surveys) need to be better coordinated to ensure each property is inspected more regularly, otherwise similar situations may arise and go unnoticed.

4.9.6 The fixed asset register is still administered using an Excel spreadsheet and limited by this and is not reconciled to other property databases. We therefore do not have confidence in the completeness of records and the ability to identify gaps in the information held. There also appears to be a lack of capacity within the Valuation Team, with the service appearing stretched and under resourced.

4.9.7 In order to address some of the issues identified the CIPFA Asset manager software for accounting for fixed assets has been procured and is in the process of being implemented. We've been informed that once this core functionality has been established additional asset management models of the same software will be assessed with a view to providing integrated capacity to proactively manage the council's property asset register.

4.9.8 In addition the proposed new management restructure creates a Deputy Director post, which will include an integrated Corporate Assets Team. The detailed structure and responsibilities will be reviewed when the post is recruited to.

5 AUDIT REVIEWS 2018/2019

5.1 The table below details those audit reviews in progress and the reviews planned for the next quarter. Any amendments to the plan to reflect new and emerging issues or changes in timing have been highlighted.

	Timing							Res			
Audit Title	**Q1**	**Q2**	**Q3**	**Q4**	**Start Date**	**Draft Report**	**Final Report**	**P1**	**P2**	**P3**	**Assurance**
Continuing Health Care (CHS)	●				Apr-18	Aug-18	Nov-18	2	5	1	Limited
Delayed Transfer of Care	●				Apr-18	Jul-18	Sep-18	2	4	1	Limited
Entitlement & Assessment	●				Jan-19						
Revenue Budget Setting (Hyperion)	●				Jun-18	Oct-18	Nov-18	0	3	1	Substantial
Additional Payments	●				Apr-18	Jul-18	Sep-18	1	3	1	Limited
PCIDSS	●				Jun-18	Aug-18	Sep-18	0	3	0	Reasonable
Data Storage	●				Jun-18	Dec 18					
Network Infrastructure Security	●				Apr-18	Sep-18	Sep-18	0	3	2	Reasonable
Residents Parking	●				Jun-18	Oct-18	Dec-18	3	5	1	Limited
Use of CCTV - Urban Traffic Control	Deferred until 2019/2020										
Homes for Reading	●				Jun 18	Sep-18	Jan-19	0	6	3	Reasonable
Right to Buy (follow up)	●				Apr-18	Jun-18	Aug-18	0	1	3	Reasonable
Norcot Nursery School	●				Jun-18	Jul-18	Jul-18	0	3	5	Reasonable
New Bridge Nursery School	●				Jun-18	Jul-18	Sep-18	0	1	1	Reasonable
Commercial Leases (Nursery)*	●				May-18	Jul-18	Sep-18	2	1	1	N/A
General Ledger Q1 Journal testing		●			Aug 18	Aug 18	Aug 18	0	0	0	Substantial
Bank and Cash Reconciliations (follow up)		●			Dec-18						
Budgetary Control & Savings		●			Dec-18						
Section 106 Agreements		●			Jan-19						
South Reading Leisure Centre		●			Jul-18	Sep 18	Sep-18	0	1	0	Substantial
LTP Capital Settlement (Grant Certification)		●			Sep-18	Oct-18	Nov-18	0	0	1	Substantial
Bus Subsidy Grant		●			Sep-18	Oct-18	Nov-18	0	0	1	Substantial

	Timing							Res			
Audit Title	**Q1**	**Q2**	**Q3**	**Q4**	**Start Date**	**Draft Report**	**Final Report**	**P1**	**P2**	**P3**	**Assurance**
General Ledger Q2 Journal testing		●			Oct-18	Jul-18	Jul-18	0	0	0	Substantial
Employee Gifts & Hospitality & Declarations of Interest			●		Sep-18	Nov-18	Jan-19	0	4	2	Reasonable
Creditors (Accounts Payable)			●		Dec 18	Jan 19					
Troubled Families Grant Sign Off			●		Sep-18	Sep-18	Sep-18	0	0	0	Substantial
Direct Payments (f/up)			●		Jan-19						
Commissioning (Adults)	Deferred until 2019/2020										
Business Rates			●		Nov-18						
Sundry Debtors			●		Oct-18	Dec-18					
Payroll			●								
Commercialisation			●		Oct-18	Jan-19					
Redlands Primary School**			●		Nov-18	Nov-18	Dec-18	0	0	2	Substantial
The Hill Primary School**			●		Sep-18	Oct-18	Nov-18	0	3	5	Reasonable
Whitley Park Primary School**			●		Jun-18	Jul-18	Jul-18	0	3	3	Reasonable
Stronger Together Partnership*			●		Sep-18	Oct-18	Oct-18	0	0	0	N/A
Births Deaths & Marriages (spoil certificates & counterfoils)*			●		Oct-18	Oct-18	Oct-18	0	0	0	Substantial
General Ledger Q3 Journal testing				●	Jan-19						
Public Health Grant (f/up)				●							
Blessed Hugh Farringdon Catholic Secondary School**				●	Oct-18	Oct-18	Nov-18	0	0	3	Substantial
Christ the King Catholic Primary School**				●	Jan-19						
St Michael's Primary School**				●	Feb-19						
Foster Care (follow up)**				●							
Administration of looked after children**				●							
Child Exploitation & Missing Children (follow up)**				●							

*This audit was added as was not part of the original planned programme of audits

**Outcome of audit to be reported directly to BfFC

6 INVESTIGATIONS (April 2018 – December 2018)

6.1 Housing Benefit and Council Tax Support Investigations

6.1.1 For the period the Council Tax Support Overpayment is **£13,672.47**. One case generated a Housing Benefit overpayment of **£34,360.95**. The team investigated an allegation of fictitious tenants; this resulted in the return of **£13,503.42** in owned Council Tax payments.

6.2 Single Person Discount

6.2.1 Following a data matching exercise matching **21,918** address records against tracing and occupier lookup databases to determine the strength of residency for all individuals in a household within the borough, investigations officers are working with Council Tax reviewing the very high risk data matches and high risk matches. From the matches investigated to date **£195,247.80** has been identified for CTAX recovery.

6.3 Housing Tenancy Investigations

6.3.1 Since 1st April 2018 Investigation Officers have assisted in the return to stock of **18** Council properties. At present we have **21** ongoing tenancy investigations.

6.3.2 It is difficult to quantify the financial implications of these types of investigations, however the RBC agreed figure of £15,000 is considered to be the average cost for retaining a family in temporary accommodation. Using this figure (18 x £15,000), to date notional savings of **£270,000** have been made as a result of tenancy investigations.

6.4 Right To Buy (RTB)

6.4.1 There are organisations and individuals that offer tenants money to apply to buy the home on their behalf. Money laundering is also a risk for property transactions. Money is paid by a third party who has no obvious link with the transaction. Money launderers often use front buyers to enter into transactions on their behalf. The money for a deposit or even to pay a mortgage may have come from someone other than the customer and could very well be the proceeds of crime.

6.4.2 We are working with Housing Officers to check applications against Council tax and other records and will investigate any applications that look suspicious. Improper applications can result in eviction and criminal prosecution. Since 1 April 2018 one application has been refused as a result of our investigations. This property transaction would have been entitled to the maximum of **£80,900**.

6.5 Internal Investigations

6.5.1 Following authorised surveillance at one of the Council's leisure establishments, a now former member of staff was arrested on the suspicion of theft of cash. The matter was heard at Reading Magistrates Court on the 6th April 2018 and the defendant pleaded guilty to all charges. Full costs were awarded to the Council and the defendant has since paid **£13,198**.

6.6 Social Care Fraud & Investigations

6.6.1 The team were involved in a complex investigation relating to allegations of Direct Payment[2] Fraud in excess of **£62,000**. On the 21st December 2018 the defendant was found guilty on three accounts of fraud by false representation, three accounts of furnishing false information and one account of fraud by abuse of position and concealing criminal property (money laundering). The defendant is due to be sentenced on the 16th January 2019.

6.6.2 This is a very difficult offence to identify and prove; and shows just how much effort went into concealing this particular fraud. This was a very complex offence and great care was taken by the defendant to ensure she wouldn't be found out. It was only when she became increasingly greedy that she started to slip up. In our view, there was very little anyone could have done to detect this earlier, and it was well spotted by the Direct Payment team. The defendant went to great lengths to deceive the Council RBC, and other large organisations.

6.7 New Homes Bonus

6.7.1 The New Homes Bonus (NHB) is a grant paid by central government to local councils to reflect and incentivise housing growth in their areas. It is based on the amount of extra Council Tax revenue raised for new-build homes, conversions and long-term empty homes brought back into use.

6.7.2 Investigations officers, under the direction of the Council's Empty Homes Officer, worked in partnership with CTAX officers to maximise potential income, by reducing empty properties recorded on the CTAX database. A reward of 4-years' worth of Band D council Tax is paid for each reduction in "long term empty" homes registered on Academy[3].

6.7.3 The project team reduced the registered CTB1[4] figure from 502 to 387. The 'net reduction' of 115 long term empty properties earns the Council an NHB payment of **£106,467** for 2020/21, part of the 4-year NHB reward of **£425,870**.

[2] Direct payments are payments for people who have been assessed as needing help from social services, and who would like to arrange and pay for their own care and support services instead of receiving them directly from the Council.
[3] Revenues and Benefits data management system
[4] Local authorities are required to return the Council Tax Base Return (CTB1) form each year.

6.7.4 The majority of the work was undertaken by the Empty Homes Officer and Council Tax Visiting Officer, with investigators supporting by undertaking fact finding enquiries (credit references etc.) and visits.

6.8 Disabled Persons Parking Badges (Blue Badges)

6.8.1 A Blue Badge is issued to a person with a disability where they have difficulty using public transport; it allows them to park closer to where they need to go. Since the 1st April 2018 (to the 31st December 2018) the team have received 24 referrals with regards to the potential misuse of a Blue Badge. Of these, there have been 2 successful prosecution cases with respect to the misuse of a Blue Badge, and 2 further Blue Badges have been seized and taken out of circulation. There is one outstanding case which is due in court on the 18th January 2019.

7. CONTRIBUTION TO STRATEGIC AIMS

7.1 Audit Services aims to assist in the achievement of the strategic aims of the Council set out in the Corporate Plan by bringing a systematic disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes. In particular audit work is likely to contribute to the priority of remaining financially sustainable to deliver our service priorities.

8. COMMUNITY ENGAGEMENT AND INFORMATION

8.1 *N/A*

9. LEGAL IMPLICATIONS

9.1 Legislation dictates the objectives and purpose of the internal audit service the requirement for an internal audit function is either explicit or implied in the relevant local government legislation.

9.2 Section 151 of the Local Government act 1972 requires every local authority to "make arrangements for the proper administration of its financial affairs" and to ensure that one of the officers has responsibility for the administration of those affairs.

9.3 In England, more specific requirements are detailed in the Accounts and Audit Regulations in that authorities must "maintain an adequate and effective system of internal audit of its accounting records and of its system of internal control in accordance with proper internal audit practices".

10. FINANCIAL IMPLICATIONS

10.1 N/A

11. BACKGROUND PAPERS

11.1 N/A

Internal Audit Final Report

Delayed Transfer of Care

To: Seona Douglas, Director of Adult and Health Care Services

From: Amondeep Basra, Senior Auditor

Date: 1 November 2018

Limited Assurance

Ref: 11/18

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1 Purpose and Scope of Review

1.1 Delayed Transfers of Care (DToC) refers to patients who are ready to leave hospital or similar care provider, but are still occupying a bed. This covers patients in all NHS settings irrespective of who is responsible for the delay. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice.

1.2 The Community Care (Delayed Discharges etc.) Act 2003 introduced statutory duties on the NHS and councils with the aim of strengthening joint working and encouraging clear and timely communication, and reducing the numbers of people waiting for alternative care arrangements once they were ready to move from the NHS setting. This legislation has now been repealed by the Care Act 2014.

1.3 Where the sole reason for the delay lies with the local authority and the delay relates to an acute patient, the daily amount that may be payable has been set at £130 in respect of local authorities outside of London (previously the lower rate was £100). The legislation was amended such that the mandatory system of reimbursement became a discretionary one. It was felt that the introduction of a financial incentive would lead to improvement in the assessment process and the provision of community care services for people in hospital.

2 Main Conclusions

2.1 The audit has shown that Reading officers are actively engaged with and appear highly motivated to ensure that performance with respect to Delayed Transfer of Care improves. The officers interviewed have communicated openly and demonstrated a detailed knowledge of issues and challenges. In addition since February 2018 the Director of Adult and Health Care Services personally reviews and authorises DToC performance, providing greater oversight.

2.2 Interviews with the two Trusts that account for the overwhelming majority of delays attributed to Reading Borough Council (RBC) were requested, only one meeting was held. The meeting reflected the challenges, as have been reported nationally, of ensuring effective working between different parties and IT systems. In particular the meeting highlighted that RBC will have to engage in a continuous process of reviewing live data that, could reasonably, be assumed to contain errors of various forms and that clarification and codification of the processes should benefit in increasing accuracy and resilience.

2.3 The audit has identified that RBC has adopted a number of different governance and reporting structures. It has been evidenced that senior RBC staff are focused on reducing delays in the transfer(s) of care and have been a part of an approach of working collaboratively within RBC but also with health partners and other local authorities for the purpose of seeking to improve performance. It has been noted that there is a potential risk where forums e.g. project group meetings are disbanded as these may impact upon the quality of reporting.

2.4 There is an informal agreement with partners not to impose financial penalties, but to instead work cooperatively to find practical ways to reduce delays. It was found that a single payment in respect of a fine in had been made to the Royal Berkshire Hospital Foundation Trust in early 2017, however it is understood this was an oversight.

2.5 RBC officers have undertaken to develop formal policies and procedures with respect to various aspects of DToC. These documents however were either still unapproved or in a state that would benefit from expansion and further detail. Given the complexity of the activity undertaken and the variety of parties involved there has been a lack of both awareness and availability of documents setting out the policies and procedures within RBC.

2.6 It has been evidenced that RBC staff are engaged with improving the performance of DToC beyond the requirements of the High Impact Change Model. It was not possible however to assess the adequacy of the model itself nor possible to evidence that RBC staff had analysed data available from NHS England to identify areas for potential improvement.

2.7 RBC has identified that it was aware that the spreadsheet based system that it had in place for the recording of individuals ready to be discharged from hospital was resource intensive and issues with data quality were known. RBC has undertaken to utilise Mosaic as a replacement system with the benefit of standardising data entry and allowing for advanced reporting.

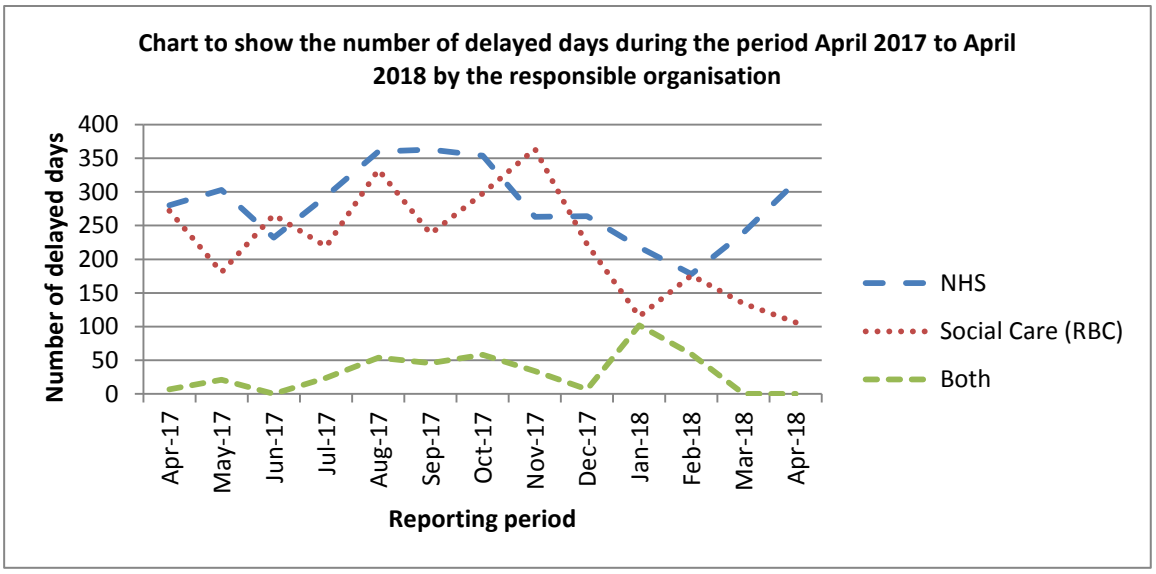
2.8 A total of 6 recommendations have been raised, of which 1 has been considered a high priority. The full detail of these recommendations and the corresponding management action plan are attached to this report as Appendix 1.

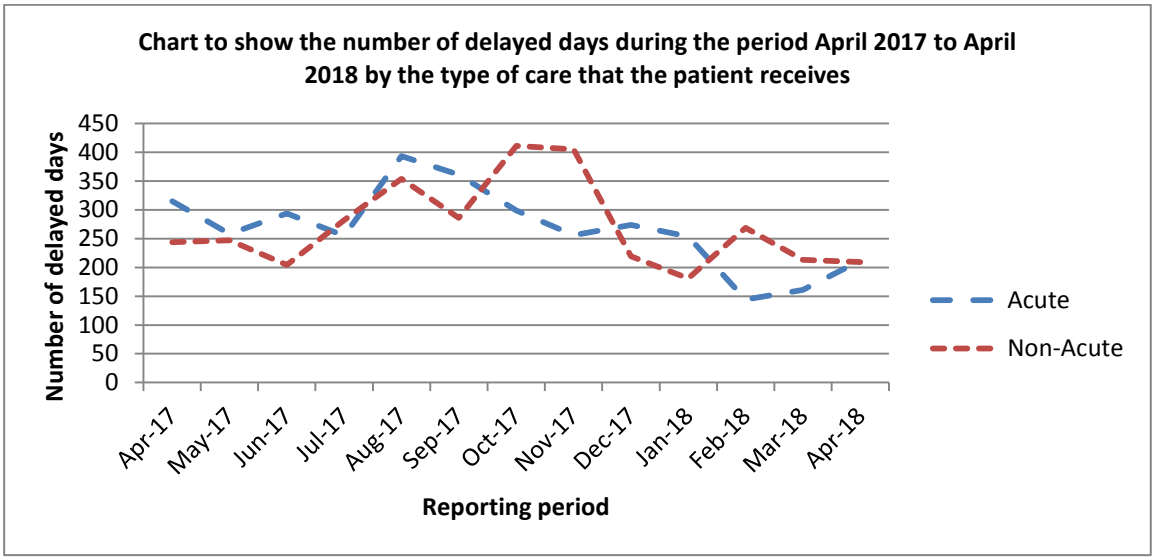
3 Summary of Findings

3.1 Analysis of nationally available data

3.1.1 NHS England makes available via its website data collected through the Monthly Situation Reports. The information is organised such that the agency responsible for any delay in the transfer of care (i.e. NHS, Social Services or both) can be seen.

3.1.2 An analysis for the period April 2017 to April 2018 shows that there has been a general trend towards improving DToC performance figures by the Council. Whilst it is a perception that the majority of DToC delays can be attributed to delays occurring as a result of social care, the graph below shows that for the past 13 months this is not an accurate assessment of the delays attributed to Reading. Where delays have been attributed to "Both" however further investigation as to the cause of the delays should be made.





3.2 Governance

3.2.1 The National Audit Office (NAO)[1] has identified local governance arrangements as an issue that can affect local health and social care from working effectively together. It has stated that nationally it has found issues with *"Unclear accountability within local systems for discharging older patients. One-third of group chairs in our survey said no individual person or organisation was accountable for ensuring delays to patients were minimised."* The NAO report also found that "*planning was not always coordinated in practice."*

3.2.2 A key aspect of activity undertaken by RBC in order to improve DToC performance has been identified as the implementation of the High Impact Change Model. This model has been given prominence by the Government as the Integration and Better Care Fund Planning Requirements for 2017-19[2] set out that one of the required four national conditions is that *"All areas to implement the High Impact Change Model for Managing Transfer of Care to support system-wide improvements in transfers of care."*

3.2.3 The High Impact Change Model was developed in order to focus on a year round approach to supporting timely hospital discharge. The model was itself developed by partners including the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS), NHS England, the Department of Health (DH), the Emergency Care Improvement Programme (ECIP), Monitor and the Trust Development Authority.

3.2.4 From discussions with key personnel and review of minutes of the Berkshire West 10 Integration Board, it has been identified that the governance arrangement for the management of the implementation of the High Impact Change Model has gone through multiple iterations, although this has not been separately or critically reviewed as part of this audit.

3.2.5 It has been established that project groups and the Integration Project Board, that had been established to provide a line of reporting and forum for discussion with regards to implementation status and to inform the content of update reports have been disbanded. It is understood that the project group meetings formed the basis of preparing Highlight reports which were to be reported to the Project Integration Board and then subsequently the Reading Integration Board.

3.2.6 The reason for disbanding the groups was that following the Local Government Association (LGA) Peer review the decision was taken that a more effective approach would be for the Berkshire West 10 localities to work jointly as opposed to in isolation and as such, project group meetings were no longer held.

[1] National Audit Office: Discharging older patients from hospital May 2016
[2] Department of Health: Integration and Better Care Fund planning requirements for 2017-19

3.2.7 In addition the Director of Adult and Health Care Services has instigated weekly meetings with the Head of Adults to review DToC performance generally in order to understand and sign off delays personally.

3.2.8 At this time it is understood that the Urgent Care Operational Group has been the vehicle for developing and delivering a plan in relation to the High Impact Change Model and the Highlight Reports prepared within RBC have been reported to Reading transformation boards and Reading Integration Board. Note that Internal Audit have not reviewed or critically assessed this model.

3.2.9 It was advised, by the Integration Programme Manager (RBC), that the appropriate individuals to contact in order to obtain Urgent Care Operation Group (UCOG) meeting minutes were the Urgent Care Support Manager and Urgent Care Lead at the Berkshire West CCG and North & West Reading CCG. A request was made for the meeting minutes but no response was received. It is understood from discussion with the Transformation Project Manager (RBC), that at the most recent meeting of the UCOG that it had been discussed that in future the intended arrangements will be that the Berkshire West 10 Delivery Group will become the governing body for how the High Impact Change Model is being implemented. The LGA conducted a Peer Challenge for Berkshire West in early 2018. The output of the challenge included a self-assessment performed by the Local Authorities involved in which the self-assessed progress against the High Impact Change Model was recorded. For RBC the progress recorded at the time was based upon a workshop conducted in 2017. In discussion with the LGA Programme Manager it appeared that the self-assessment did not necessarily accurately reflect the status of RBC. It has been evidenced that within RBC that the Transformation Project Manager (RBC) and the Integration Project Manager (RBC) undertook to update the RBC understanding of its actual position with respect to the High Impact Change Model, to identify the criteria necessary to record having reached a particular stage of implementation and where possible to verify the evidence necessary to confirm that the assessment was accurate.

3.2.10 The Highlight and Dashboard Reports that have been made available show that within the governance and reporting structures that have been described RBC set out an approach where there is a format for reporting progress against an identified action plan. The reporting structure and format allow for RAG ratings alongside a summary of activity and progress and a narrative description of issues encountered and resources required.

3.2.11 It has been advised, by the Integration Programme Manager (RBC), however that in the absence of project groups and the Integration Project Board as a facilitator for the updating of reports, that the quality and detail of information reported may be impacted. There has additionally been a change in focus away from local authorities attempting to implement changes in isolation to one in which a joint approach is taken. **(R1)**

3.2.12 With respect to the governance and arrangements in place within RBC to record and monitor progress against the High Impact Change Model, it has been noted that whilst there have been a various methods for recording and forums for reporting there have been recorded concerns with respect to the speed of implementation. **(R1)**

3.2.13 The Berkshire West 10 meeting minutes reviewed demonstrate that the parties involved have sought, over an extended period of time, to identify evidenced based reasons for the variations in performance between the local authorities. The meeting minutes for 11th October 2017 record that there had been some difficulty in establishing an evidence based action plan as well as arranging information sharing with respect to best practice. The meeting on 11th April 2018 additionally identified that the parties involved with the group would need to shortly arrive at a position as to the basis that their involvement would take. **(R1)**

3.3 Communication

3.3.1 Communication and co-ordination between health and local government has been recognised as a long standing barrier to achieving DToC objectives at a national level. NHS England has identified that it has re-written its guidance documentation as it had found that differences in interpretation had created operational issues and concerns.

3.3.2 It has been evidenced that the Integration Project Manager (RBC) has undertaken activity to improve the process of approving monthly DToC performance figures by seeking to formalise and document it, within a process flow diagram, in order that the operation can be conducted efficiently and with responsibilities clearly identified.

3.3.3 The Information Analyst (BHFT) identified that working with a wide array of personnel within his organisation as well as external partners often required clarification as to processes. When asked to identify whether the Trust had formally communicated the requirements that it has for local authorities, in order to effectively review data, it was noted that it had not and that this could be beneficial in reducing the duplication of work and assisting in the identification of errors.

3.3.4 In addition to seeking to formalise the process for data review and approval the Operational Manager for Adult Social Care (RBC) and the Senior Social Worker – Intermediate Care team (RBC) have both identified that adopting an approach of having hospital workers present on wards to signpost patients has allowed RBC to become far more proactive as it has removed a barrier that was present in the form of the flow of information and communication. This presence on the ward was additionally identified by the Program Manager (LGA) as a key component as to how improvement could be achieved.

3.3.5 The Care Act 2014 has now made it discretionary for Trusts to fine Local Authorities for a delayed transfer of care for which they are responsible. In RBC's case most patients are usually resident within the borough and hence the agreement reached between RBC and Royal Berkshire Hospital Trust is not to invoke this process, but to focus instead on fostering a cooperative approach to solving practical barriers. The statutory guidance states that fining should not be used by NHS bodies as a first approach to address any local difficulties around delayed transfers.

3.3.6 At the time of testing it was not possible to identify the existence of formal agreements between RBC and Berkshire Healthcare Foundation Trust (BHFT) or Royal Berkshire NHS Foundation Trust (RBH) with respect to the charges being applied against RBC as a result of social care delays.

- It has been identified from discussion with staff at BHFT that the Trust had itself, historically, experienced some issues with respect to the records it held internally and the figures that were reported nationally with respect to DToCs. The issues concerned an internal need to clarify the reason why the data held on RiO, the patient record system, differed from that which was reported nationally.
- Having discussed the matter with the Information Analyst (BHFT) it was not possible to clarify on what basis or data BHFT may base any charges.
- It was not possible to determine the basis upon which the RBH bases its calculations of charges to a Local Authority.

3.3.7 For the reason(s) outlined in para 3.3.5 above it has not been possible to establish any documented record of the payments that have been made as a result of DToC fines. Although Fusion shows that a single payment was made to the RBH for £10,790 as a result of charges for the period December 2016 to January 2017, it was not possible to ascertain whether other invoices have also been paid with respect to the Trust or any other. The Director of Adult and Health Care Services has confirmed that this was an oversight and was raised and paid in error.**(R2)**

3.4 Policies and Procedures

3.4.1 Requests have been made for copies of formal policies and procedures within the RBC with respect to any and all aspects of the operation of DToC. It has been identified by various officers within RBC that in their experience that such documents have not been produced and that the need to determine and formalise current practices is an area that they have sought to improve.

3.4.2 Some work has been undertaken by various officers to formally document processes and provide clarity as a means to improve performance, although knowledge of these documents did not seem to be commonly known. Work that has been undertaken includes but is not limited to:

- At the time of the audit the Integration Project Manager (RBC) was able to share work that had been undertaken with partners in order to document and agree a process with which RBC and partners would agree and approve monthly DToC delays prior to submission to Unify, which is the system that is run by NHS England for the collection of data. At the time of the audit it is understood that this process had not been formally agreed. The formalisation of this process has the potential to reduce the administrative burden on staff of multiple levels of data verification and could improve data quality and ensure the opportunity to scrutinise data prior to submission.
- The Operational Manager for Adult Social Care (RBC) has provided access to a Standard Operating Procedure with respect to Delayed Transfer of Care at Reading Borough Council. This document provides useful background information to the topic of DToC as well as more specific and pertinent information to elements of the processes in place at the Council. The document however has significant potential to be expanded and updated to record current practices. It is notable that of the people within the Council that were interviewed there was no awareness of this document prior to attention being drawn to it. **(R3)**

3.4.3 Issues with respect to the way in which hospitals report figures has been identified nationally and NHS England has sought to update guidance in order to reduce the likelihood of this occurring. Additionally, however, based upon the meetings taken with the Information Analyst (BHFT) it is apparent that the configuration and use of the RiO may result in data being submitted to RBC that is not accurate and will have to be challenged for several different reasons. In order to ensure that knowledge is not lost due to staff changes and that RBC can continue to effectively challenge, a formal document record of the agreed challenge process should be kept. **(R4)**

3.5 Staff training

3.5.1 It has been noted by officers interviewed that they had themselves encountered an absence of structured DToC training as well as a lack formal process and guidance with respect to the RBC DToC systems and operations.

3.5.2 The Operational Manager for Adult Social Care (RBC) has supplied a Standard Operating DToC Procedure document that has been drafted, although none of the people interviewed as a part of this audit were aware of this. The spreadsheet that was in use for the purpose of tracking delayed transfers of care additionally contained some guidance as to how it should be completed. Other than this and the training that the Senior Social Worker – Intermediate Care Team (RBC) undertakes as a part of one to ones, there has been limited evidence of a formal agreed approach to DToC that is communicated to staff through training. **(R5)**

3.6 Performance Benchmarking

3.6.1 Through the review of available evidence and from meeting staff it is clear and understandable that the implementation of the High Impact Change Model has been a significant focus for how RBC intends to improve its DToC performance figures. It is noted however that staff have also acted beyond the requirements of the High Impact Change Model to implement changes that could bring about improvement. However there does not appear to have been any identifiable exercise undertaken to analyse the DToC data available from NHS England or data available locally to identify causes of DToCs. Whilst the staff interviewed all demonstrated a detailed understanding of various causes for DToC's there was none that was able to draw attention to a root cause analysis of the issue. **(R6)**

3.6.2 The Berkshire West 10 meeting minutes dated 11 October 2017 record the need to develop evidenced based action plans. The minutes also reflect the difficulty that has been faced in achieving this goal.

3.7 Reliability of Records

3.7.1 There is a requirement upon Trusts that prior to uploading monthly data with respect to health, social care and joint delays that data should be validated, agreed and signed by the trust and the Local Authority social care service. Information was sought from the BHFT and RBH in respect of the process of verification that they undertake, however it was only possible to hold a discussion with BHFT. Neither Trust was able to provide access to a stated policy or procedure document outlining the steps that they take although the Information Analyst and Head of Information at BHFT freely and openly discussed the approach that they take with all Local Authorities that they work with. The process undertaken by the Trusts has relevance for the nationally reported figures and the potential for financial charges to RBC.

3.7.2 Interviews were held with the Operational Manager for Adult Social Care (RBC), Performance Analyst (RBC) and the Business Systems Analyst (RBC) to discuss the system that RBC has in place for the tracking of individuals who are being discharged from hospital and may be experiencing a delay. At the time of the audit the system in place had been recognised as being insufficient to meet the requirements placed upon it. The Business Systems Analyst (RBC) presented a completed Business Requirements document that detailed an intention on the part of RBC, to move from the current system which was spreadsheet based to one in which the Mosaic Social Care Records System would be used. The process in place during the course of the audit required that Adult Social Care track individuals who are being discharged from hospital and in instances where there may be a delay to the discharge to agree a reason for this with the health partner. This involved the recording of

discharges and delays via a spreadsheet and this created a large administrative burden in order that the data could be used in regular checkpoints with health partners. The administrative responsibility for the completion of the spreadsheet was undertaken by the Assistant Team Mangers (ATM) (RBC) in the Short Term Team. During the course of the review the ATM (RBC) with primary responsibility had recently vacated her post and spreadsheet was being administered by multiple members of staff.

3.7.3 In discussions with officers it was raised that the implementation of the spreadsheet, whilst initiated as an improvement upon the previous approach, is resource intensive and that ensuring a consistent approach to inputting data had been difficult. When reviewing the spreadsheet it was evident that officers had taken different approaches as to the information that would be input. Officers also related that they experienced considerable difficulty in utilising RBC held data, in order to scrutinise the information that was provided by Trusts on a weekly basis prior to uploading to Unify. The additional benefit of migrating to Mosaic could be the requirement and added functionality of being able to run "live" reports which will be used to agree DToC figures with Health colleagues. The "next steps" identified within the Business Requirements document include: prototyping workshop; user acceptance testing; training; go.no go decisions and go live (including communication to staff and go-live support).

3.7.4 From discussions with the Information Analyst (BHFT) it was identified that their internal process regarding the preparation of figures for month end reporting to Unify broadly followed a process of continuous revision and correction of data held on RiO. RiO is the electronic patient record solution used to record and report on DToC figures The process was outlined as follows:

- Each Tuesday the Information Analyst (BHFT) will extract from RiO the records held, as at that date, showing all DToC figures.
- The data that is extracted will be reviewed for possible errors and any identified will be marked as such.
- The data is then sent in spreadsheet format on Tuesday to the wards where the appropriate NHS staff will be asked to check the data and correct any errors that are required on RiO. The ward staff are informed that they have until Wednesday night to perform these checks and make these amendments.
- On Thursday each week the Information Analyst (BHFT) will run the script against RiO again and produce an updated report with the most current data, not all changes will necessarily have been made by NHS staff. This report will then be distributed to the Local Authorities to scrutinise and challenge.

- This process will continue throughout each week in the month in order to capture, cleanse and correct the data at each opportunity with the intention that the report provided in the final week should contain a record of DToC that all parties agree with.

3.7.5 The process outlined allows for multiple opportunities, for RBC, to make corrections to data in order that RBC and the Trust can reach agreement on the position at the end of the month. Awareness of the potential weaknesses of the system in operation is of potential benefit to RBC as it may assist in the design of its own verification processes in order that attributed delays are reduced where possible. Issues that were identified include:

- The RiO system allows for health staff to make entries into the database using invalid combinations of codes.
- The RiO system allows health staff to create records with respect to DToC that do not contain complete information.
- The Information Analyst (BHFT) is not able to make amendments to RiO data and instead changes must be made by ward staff, yet these changes are not always made.
- The RiO system can be amended with respect to the way in which information is recorded. During the course of the audit an amendment to the system resulted in the RBC Performance Analyst making contact with the Trust in order to determine the potential ramifications for DToC figures.
- The script that the Information Analyst (BHFT) uses to extract DToC data from the RiO system draws information from within a specific database table. The Information Analyst (BHFT) believes that it may be possible for Trust staff to create a DToC record within RiO without it appearing on this table.
- It is not always possible to make amendments to RiO data as records may have been created subsequent to the initial error and therefore the error becomes fixed in place.
- As a result of instances occurring where agreed changes cannot be made to RiO data the information that is uploaded to Unify is based upon data that has been extracted from RiO and then subsequently amended. A consequence of this is that the data held on RiO does not in fact reflect the data that is reported in national statistics.

3.7.6 The final point is of particular relevance because the Information Analyst (BHFT) related that the Trust had itself experienced an issue where NHS Senior Management had queried the data that they held as they could not reconcile the information held on RiO to the information that is reported nationally. The compatibility of IT Systems is known to have affected DToC performance at a national level. A number of RBC Officers have expressed the belief that direct access to Health IT Systems may improve performance,

therefore it may be beneficial to further develop an understanding of these systems.

3.7.7 It has not been possible to arrange a meeting with staff at the RBH or to obtain a response to the Internal Control Questionnaire that was submitted. From meeting with the RBC Performance Analyst however attention was drawn to the fact that the current process in place involves the trust providing a weekly snapshot of delays each Thursday. It was stated however that the way in which this data is formatted such that the date on which an individual ceases to be a delay may impact on the ability of RBC to challenge the number of days attributed to it. Additionally the approach to preparing the snapshot data creates the possibility that individuals who have been classed as a DToC delay following the issue of one snapshot report and then ceased to be a delay prior to the issue of the next snapshot report may not be drawn to the attention of RBC. **(R7)**

Appendix A - Report Distribution

Staff Interviewed

- Paula Johnston, Acting Locality Manager (RBC)
- Naomi Cambridge, Performance Analyst (RBC)
- Mechelle Adams, Operational Manager for Adult Social Care (RBC)
- Samm Mills-Hutchinson, Business Support Team Leader (RBC)
- Shaun Rogers, Senior Social Worker Intermediate Care Team (RBC)
- Michael Beakhouse, Integration Programme Manager (RBC)
- Lewis Willing, Integration Project Manager (RBC)
- Ben Fisher, Business Systems Analyst (RBC)
- Jacob Obadara, Information Analyst Berkshire Healthcare NHS Foundation Trust (BHFT)
- Duncan Simpson, Head of Information Berkshire Healthcare NHS Foundation Trust (BHFT)
- Stephanie Clark, Berkshire West 10 Integration Programme Manager (RBC)
- Marcus Coulson, Program Manager at the Local Government Association (LGA)

Additional information sought from

- Jacqueline Tanner, Performance Analyst Royal Berkshire NHS Foundation Trust (RBH)
- NHS Improvement (NHS)
- Unify2 (NHS)

Draft Report Distribution

- Paula Johnston, Acting Locality Manager
- Seona Douglas, Director of Adult & Health Care Services

Final Report Distribution

- Paula Johnston, Acting Locality Manager
- Seona Douglas, Director of Adult & Health Care Services

Auditor Contact Details

- Amondeep Basra, Senior Auditor - (0118) 937 2693
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For further details on our assurance opinions please click this link

Audit Management Action Plan
Delayed Transfer of Care

Ref	Risk	Recommendation	Priority	Management Response	Responsible Officer(s)	Target Date
1	Where the format and forums for reporting progress and improvement with respect to DToC performance are not sufficient for the purpose of reporting management information there may be an increased risk that: - Opportunities to enact improvement may not be implemented as quickly as possible. - Management may have insufficient opportunity to review progress and determine an appropriate course of action. Where the Council does not have regularly updated and accurate information recording the current status of implementing high impact changes, and impediments to doing so, management may encounter difficulty strategically allocating resources and improving performance.	The following recommendations are made: - RBC should review the reporting lines, formats and forums to identify and improve performance as well as current impediments to performance identified. - In particular RBC should identify the governance and reporting structures in place that allows for transparency and likelihood of successful implementation. - RBC review the process they have in place to monitor and record progress against targets as well as barriers to doing so in order to determine whether they have access to sufficiently up to date information that has been verified against available evidence.	Priority 2	Agreed – An action plan for Reading Borough Council is in progress in response to the LGA peer review. Where any decisions are taken as a part of this process with respect to reporting or governance the decision will be formally recorded and available to evidence. Progress locally against the High Impact Change model is being monitored through the Reading Integration Board. The dashboard to monitor progress against targets continues to be monitored at the Reading Integration Board. Reading has it's own governance and reporting structures to monitor delayed transfers of care and progress against targets. The Berkshire West 10 is the governance and reporting structure for the implementation of the High Impact Change model across the	Michael Beakhouse, Integration Programme Manager	14/12/2018

Ref	Risk	Recommendation	Priority	Management Response	Responsible Officer(s)	Target Date
2	Where RBC does not have formally documented and approved processes that are readily available to all staff there is an increased risk that: - Standardised processes will not be followed. - Upon staff changes institutional knowledge will be lost. - Opportunities for challenge and improvement may be lost.	It is recommended that the Council develop and approve comprehensive formal policies and procedures concerning the operation of all aspects of DToC with respect to the activities undertaken by the Council and in conjunction with partner organisations. Additionally: - Documentation should be stored in a location where it will be available to all staff involved with DToC operations and data verification work. - Policies and procedures should be regularly reviewed and updated. - Documentation should identify key roles and responsibilities of staff and establish accountability. - The processes in place where the Council is required to work with third parties should be recorded.	Priority 1	Agreed. A Standard Operating Procedure will be developed to inform staff members of the tasks involved in the activities related to DToC. This will be kept in a shared folder in the S drive accessible to all staff managing hospital discharges. It is challenging to keep policies and procedures up to date as the processes with partner agencies are frequently changing and is being developed both locally and across the West of Berkshire. This Standard Operating Model will be in place by 1/11/2018 and will be reviewed and updated every two months, monitored by the Team Manager.	Paula Johnston, Acting Head of Service Older and Physically Disabled People	01/11/2018
3	Where the Council does not have a formally recorded approach to the review and challenge of data received from trusts there is an increased risk that: - the approach taken will not be sufficiently robust as to incorporate all known opportunities / requirements for challenge. - where staff changes occur there will be a loss of institutional knowledge. - the process adopted will be inefficient and create duplication of administrative effort.	The Council is advised to: - Formally document and make available to staff the process that is to be undertaken when challenging data from health partners. - The Council should ensure that the documented process incorporates an understanding of the features of the systems used by health partners and is updated to reflect changes to those systems.	Priority 2	Agreed. The Standard Operating Procedure will include what constitutes a DToC, what data to check, and how to challenge the data.	Paula Johnston, Acting Head of Service Older and Physically Disabled People	01/11/2018

Ref	Risk	Recommendation	Priority	Management Response	Responsible Officer(s)	Target Date
4	Where the Council does not have formally documented and approved processes that are readily available to all staff there is an increased risk that: - Standardised processes will not be followed. - Upon staff changes institutional knowledge will be lost. - Opportunities for challenge and improvement may be lost.	The Council should review the Standard Operating Procedure and: - Ensure that the document is expanded in order to provide a robust reference document incorporating processes set in place by the Council. - Is publicised and made known to officers involved with the DToC process either through specific training or else through 1 to 1 supervision(s) - Is regularly updated to reflect changes made in the approach taken by the Council and partners.	Priority 2	Agreed. The Standard Operating Procedure will incorporate all processes related to hospital discharges. It will be kept in the Team Hospital Discharge folder, launched in a Team meeting and be incorporated in the team induction.	Paula Johnston, Acting Head of Service Older and Physically Disabled People	01/11/2018
5	Where RBC has not made use of available data to determine whether there are causes for attributable delays outside of those currently known the opportunity for improvement may be lost.	The Council is advised to consider a periodic analysis of the available data from NHS England or local partners, as it pertains to the causes of delays, in order to determine whether there are any causes of delays that it can act upon to bring about an improvement in performance.	Priority 3	Agreed that analysis of data is required, but of local data rather than the national data, as this is more detailed, enabling specific actions to be identified. Analysis will be retained and made available during the course of any follow up review.	Lewis Willing, Integration Project Manager	31/10/2018 and ongoing

Ref	Risk	Recommendation	Priority	Management Response	Responsible Officer(s)	Target Date
6	Where the idiosyncrasies of systems used by partners to record information that forms the basis of DToC figures are not understood and formally documented by RBC staff: - There is an increased risk that the Council will not identify all opportunities in which it would be appropriate to challenge partners as to the accuracy or appropriateness of the information. - There is an increased risk of RBC being assigned inappropriate DTOC delays. - Where the process and basis of challenge is not formally recorded and updated to record new developments there is an increased risk that there will be duplication of work. - Where the process and basis of challenge is not formally recorded and updated there is an increased risk that there will be an institutional loss of knowledge that impacts efficient functioning in the event of staff changes.	It is recommended that officers meet with health partners in order to: - Agree and document an understanding of the systems used for the recording of DToC figures and any limitations and restrictions of those systems. - Agree and document the internal processes of the partner with respect to making alterations to data at the request of the local authority. - Agree and document the error checking / audit processes of the health partner with respect to the data that they hold. - Agree and document the types of error that the health partner generated data is capable of generating - The information obtained as a result of meetings should be documented, retained and added where changes occur in order that the Council is able to challenge effectively in the event of staff changes. - The Council should where possible negotiate with the Trusts to ensure that the data provided within the month is sufficiently detailed to allow for a complete picture of attributed delays and also to allow for challenge. - The Council should review and agree with health partners the processes it intends to put in place utilising the Mosaic reporting functionality in light of an understanding of the limitations with the health partners reporting capabilities.	Priority 2	Partly agree. We monitor the accuracy of the Social Care DToC data on a weekly basis, checking the figures that we have agreed against those recorded on the RBH and BHFT systems. When we find inaccuracies, we then request changes to this data. The process in place with the RBH is robust, however the process in place with BHFT is currently being refined and will be in place by 1st November 2018. These processes will be included in the Standard Operating Procedure.	Paula Johnston, Acting Head of Service Older and Physically Disabled People	01/11/2018

NB: Your management response is your commitment to treat the risk identified as part of the review. The standard response time to draft recommendations is 15 working days; any failure to meet this target could be reported to the Audit & Governance Committee.

The management response to recommendations will be reported to both CMT & The Audit & Governance Committee as part of our quarterly monitoring arrangements. Audit recommendations and agreed actions will be followed up during the year, where deemed appropriate by the Audit Management Team. All outstanding recommendations will also be reported through CMT as part of the Council's monthly performance monitoring.

Reading Borough Council
Working better with you

Internal Audit Report - Final

Continuing Healthcare (CHC)

To: **Seona Douglas, Director, DACHS**
Paula Johnstone, Acting Head, Older People and Physically Disabled People
Jo Purser, Acting Head of Adult Social Care
Mechelle Adams, Acting Head, Operational Manager, Short Term Team

Limited Assurance

From: **Kevin Parker, Principal Auditor**

Date: **27 November 2018**

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1 Purpose and Scope of Review

1.1 Continuing Healthcare (CHC) is the name given to a package of care that is arranged and solely funded by the NHS for individuals who are not in hospital and have been assessed as having a 'primary health need'. Until mid-October 2017 Wokingham BC had been commissioned to manage and handle potential RBCs CHC cases. The Director of DACHS made the decision in September 2017 to bring CHC back into RBC's administration for efficiency and cost saving reasons. Responsibility for CHC cases within ASC was assigned to the Older Persons team and a resource identified to administer this on a part time basis.

1.2 The purpose of the audit was to ensure that as far as possible all reasonable attempts have been made to identify CHC cases, and where justified, for the relevant Clinical Commissioning Group (CCG) funding to be secured. Furthermore if an application had been made, but rejected by the NHS, then the Council has sought to consider and, where appropriate, to challenge or dispute these instances. The audit also sought to establish whether training is available to all adult social care staff covering statutory duties and legislation with regard to Continuing Health Care together with the values and principles of carrying out a good assessment, key issues, the process, completing the checklist & decision support tool and informing service users.

1.3 The bulk of the review was undertaken earlier in 2018, since when it is understood that considerable work has been done, jointly with the CCG, to improve knowledge, systems and control. This will be reviewed as part of the follow up audit scheduled for early 2019/20.

2 Main Conclusions

2.1 It is known and established that Reading CCG has amongst the lowest number of people who have been assessed as eligible to receive Continuing Healthcare funding. It was not the purpose or objective of this review to specifically ascertain the reasons for this, as these have been reported to Committee and are being investigated further and this is to be welcomed. This is important as potentially the Council may be contributing for the costs of care for people when other parties should be financially responsible instead, or as well. Despite this there are a number of findings and recommendations arising from the audit that are made in this report to further improve controls around the administration and management of CHC.

2.2 There are national criteria governing entitlement for CHC support funding and it was found that these are generally known, clear and understood. However, although there are some Berkshire wide procedures, there is an absence of up to date documented procedures regarding local systems employed in RBC. As a consequence it was noted that there is a lack of consistency both in terms of the approach to and standards of record keeping that was evident during testing. In particular this weakness applied to actions being recorded and updated on Mosaic and so there is an incomplete trail of documentation being copied or saved on to Mosaic.

2.3 The directorate has recently identified that training on CHC should be mandatory for its staff. This is very much supported as it was established during the audit that there is a variety of practice and understanding in place across the service to determine how entitlement to CHC should be assessed and recorded. A survey of a number of staff highlighted that some staff are not confident about how cases should be flagged, assessed, submitted for review and documented. The same applies to staff awareness and confidence about the appeal process in the event of a CHC application being refused by the CCG.

2.4 Possibly as a consequence of a lack of local training and systems documentation, it was established that there is a variety of standards in the quality of CHC checklists being undertaken before these are submitted to the CCG. It was also found that although there is a system used to try to keep a record of (the status of) each CHC application, its effectiveness is limited as some staff are bypassing this and dealing with the CCG direct. This is exacerbated further as there is currently no simple way to interrogate Mosaic to find out details about pending, successful or refused CHC cases or other relevant management information.

2.5 In addition to the CHC training programme offered by the CCG and as part of the recent initiative by the Directorate to address some of the known issues around CHC, the directorate has commissioned specific CHC training for staff from (and recently delivered by) an external provider.

2.6 Our attention was drawn to the fact that there has not always been consistent, and regular management support and engagement over the CHC process, particularly since responsibility for this came back in house. It seems likely that the turnover of senior management in the directorate was unlikely to have helped in this respect.

2.7 A total of 8 recommendations have been raised in respect of this review, of which 2 have been considered a high priority. The full detail of these recommendations and the corresponding management action plan are attached to this report as Appendix 1.

2.8 The quality assurance process has confirmed that this internal audit review was conducted in conformance with the Public Sector Internal Audit Standards, a copy of which can be found on the Internal Audit Team's intranet page on Iris.

3. Summary of Findings

3.1 Criteria governing entitlement to CHC support funding are clear and understood

3.1.1 The processes and principles of Continuing Healthcare are set out in a National Framework issued in 2012 and which is to be superseded by a revised Framework in October 2018. It is intended that these updated guidelines should clarify details and better reflect the changes introduced by the Care Act 2014.

3.1.2 The guidance defines the key information and eligibility thresholds necessary to define whether CHC funding entitlement is met, although there is no agreement between RBC and the CCG(s) that defines local operating standards of practice, such as the response times for making and reporting decisions. **R1**

3.1.3 The NHS Berkshire West Clinical Commissioning Group (CCG) covers the Reading area (as well as the Newbury and Wokingham areas). National data released by NHS England has, for some years, shown that approved applications for CHC funding by Reading CCG have been amongst the lowest in the country. It was not the purpose or objective of this review to specifically ascertain the reasons for this, as it is understood there have been (and remain) ongoing efforts to investigate this specific aspect further. **R2**

3.1.4 The statistics relating to CHC funding continue to demonstrate the apparent disparity of CHC funded cases between the Reading CCG and other CCG areas.

3.1.5 The Council has for some time recognised the apparent poor CHC funding rates and this issue has been regularly reported through to Members, most recently in July 2018. As part of that report a number of improvement targets were detailed for further action.

Number of standard and fast track CHC eligible cases per 50,000 population *****

CCG	Standard		Fast tracked	
South Reading	7	8	2	3
North & West Reading	14	14	4	5
Comparator CCGs	42	39	10	11

*****NHS England CHC statistics May 2018 as reported to ACE Committee 11/07/2018

3.1.6 Audit testing of a sample of ongoing CHC applications and supporting documentation held on Mosaic was undertaken to assess whether these complied with existing national guidelines. It was noted that:

a) There was no clear path or single record (such as on Mosaic) that provided an evidential trail to support all actions surrounding a case
b) In particular it was noted there is currently no way of tracking dates for / of action(s) concerning CHC cases
c) one instance was noted where an application for CHC funding was made directly by a social worker to the CCG that resulted in a comprehensive rejection of the application by the CCG because of a fundamental failure (by the social worker) to properly understand the CHC criteria. **R3**

3.2 Policies and procedures governing the assessment and administration of CHC cases are up to date and agreed by both the CCG and the Council and reflect national guidelines

3.2.1 Although there is a wealth of detail in the National Framework guidelines concerning how to assess or determine CHC cases, no local guidance or written procedures have been recently produced for staff within the Council that prescribe the local standard operating procedures for the assessment and administration of potential CHC cases. There are some procedures but these are Berkshire wide procedures, rather than borough specific.

3.2.2 In particular the type of issue(s) that should be detailed might be around the workflow recording of cases and in particular could track dates that assessments and checklists have been submitted to the CCG, the dates and outcomes of the CCG's decisions and also any subsequent appeal process(es). **R3**

3.3 Relevant staff have been trained to identify potential CHC cases, to undertake necessary assessments and correctly make the necessary referral process

3.3.1 The national guidelines concerning the identification and assessment of potential CHC cases define the principal standards and protocols that are intended to ensure consistency of standards for administration and assessment of cases. The standards are then reinforced by (mandatory) training, delivered by the CCG, for relevant practitioner staff within the Council. The Council's position is that training in CHC is mandatory for all Adult Social Care staff.

3.3.2 To assess that training had been delivered a simple questionnaire was devised by Audit and sent to a sample of care practitioner staff within Adults. Each respondent confirmed that they had attended (or were due to do) this training, although two people advised the training was not particularly helpful.

3.3.3 The Acting Head of Adult Social Care and Operational Team Manager (Adults) advised getting CCG training for RBC staff has been delayed in the past due to resource issues within the CCG and that, although no cases found as part of the audit sample testing where staff had not been trained, there were instances where some other staff had not been trained at the time. **R4**

3.3.4 However, it is evident that the Directorate recognised some of these weaknesses and recently commissioned specific training *'Continuing Healthcare: law and practice'* from an external provider that was delivered in September and November 2018. This is in addition to the training delivered through the CCG.

3.3.5 The Workforce Development Manager has advised that where details of this training are known then these are recorded on iTrent. Although this was not specifically tested as part of this audit review, the Learning & Development Officer has advised that she has the details of staff who attended the specific CHC training referred to above (para 3.3.4).

3.3.6 Interestingly, one of the respondents to the same audit questionnaire commented that "I believe it should be part of the induction process from the beginning to ensure there is an understanding of the process. Training is very rare for CHC and when we did have a session it was not helpful at all. It has encouraged me to complete my own learning in my own time as it is not robust in RBC. It would be very helpful to have more training and even split as it is quite an extensive topic to cover." **R4**

3.3.7 Other points to arise from the completed survey were:

a) Although respondents were aware there exists an appeals process, most were unsure how it operates;
b) About 50% of the respondents indicated they had not made a recent referral;
c) For the few practitioners who have evidently made CHC applications or referrals to the CCG direct, it was not clear whether they would also monitor the subsequent assessment outcome by the CCG. **R4**

3.3.8 It is recognised within the directorate that CHC training is key. The recent report to the ACE Committee on CHC funding highlighted that CHC training is mandatory for all staff in Adult Social Care, as well as being covered as part of the induction process. Moreover it advised that further specific CHC-focused training would be delivered in September 2018.[1]

3.4 New and ongoing assessments routinely identify whether there is any potential entitlement to CHC funding

3.4.1 The process for when screening or assessment for potential CHC eligibility should be undertaken is not clear. According to the Acting Head of Adult Social Care and the Operational Team Manager (Adults), social care practitioner staff should definitely be considered as part of any assessment or re-assessment, but that there are occasions where potential entitlement is discussed, raised or applied for in between re-assessments.

3.4.2 Although assessments are generally recorded on Mosaic, currently there is no way on Mosaic to flag CHC cases (either applications or agreed cases). **R3**

3.5 There is a reliable record keeping system that is used to track the status / progress of each potential CHC case

3.5.1 As per 3.4.2 above there is no process on Mosaic to be able to categorise and therefore easily identify and report on all CHC cases. As a result a local procedure and record keeping system is in operation. The established - but not documented – RBC procedure is that for any potential referral for CHC assessment is supposed to be notified to the CHC Administrator so that progress on the application can be tracked. This is important because national guidance specifies clear deadlines for the submission, assessment and turnaround of applications for CHC funding. Currently these are not tracked and the situation is complicated by the fact that apparently applications are sometimes made directly to the CCG(s) by social care staff, so there is no reliable single record of all CHC related applications, whether successful or otherwise. **R3**

[1] Agenda item 14, Adult Social Care, Children's Services and Education Committee , 11 July 2018

3.5.2 The summary spreadsheet devised and maintained by the CHC Administrator is a simple but effective record of names, case numbers together with a few details about the status of each case. In turn these may / may not be supported by copies of documentation and correspondence on Mosaic. Whilst an improvement on the records handed back by Wokingham BC, this control spreadsheet could be improved to record with more detail its precise status. For example the dates of application submissions and returned assessment outcomes could also be usefully recorded, as the National Framework for CHC makes it clear that there are targets for assessments to be made, decisions to be reported etc. **R5**

3.6 There are clear records detailing the outcomes of CHC assessments

3.6.1 As above the principal tool recording the assessments of CHC cases, Mosaic should be used to record and store copies of documents and correspondence internally but importantly also with the CCG.

3.6.2 Those cases currently on the CHC Administrator's control spreadsheet of cases were tested to ensure that the Checklist (and Decision Support Tool if appropriate) and supporting documentation and correspondence was recorded or copied on Mosaic, together with key information relating to the outcomes of the assessment(s). It was found that generally there was a lack of a complete and clear audit trail to support the status of those cases. In particular:

a) Instances where found where key records (i.e. final copies of checklists) were not attached on Mosaic
b) Notes on Mosaic of actions or conversations (with the CCG) were not detailed enough to demonstrate or support outcomes.

3.6.3 An important finding was that in instances where the CCG had rejected applications (either at the preliminary or later stages) there was no evidence on Mosaic that the CHC decision reasons had been understood and analysed by RBC staff (and attached to Mosaic) and when appropriate for these decision(s) to then be appealed or challenged. Despite an increase in the number of cases being appealed by the Council, this approach needs to be more robust in future and the records around this need to be more detailed and visible. **R6**

3.6.4 As part of the recommended improvements to the system(s) to coordinate the submission and receipt of applications, documentation and communication, the service needs to consider how to improve recordkeeping so that there is a complete audit trail to support each application. Essentially the current system is fragmented and weak which means the Council is limited in its options in the event of a negative assessment by a CCG to an application lodged by the Council. **R3, R6**

3.7 There is effective communication between RBC and CCG staff

3.7.1 Judging from copies of correspondence and notes recorded on Mosaic it is evident that there is regular communication between RBC and CCG staff and mostly this *appears* to be professional and adequately recorded on Mosaic. However examples were noted during audit testing which demonstrated or suggested that there were frequent gaps in records, some of which were significant, meaning that the likelihood of a successful application could be impacted. **R3**

3.7.2 This situation is compounded further by the fact that some of the social care practitioners are evidently communicating directly with CCG staff with the result that any record(s) are less likely to be captured on Mosaic. It needs to be established who should communicate directly with the CCG (staff) and then this is agreed with all staff as standard procedure. **R7**

3.8 Progress of all CHC cases is reviewed by appropriate ASC management

3.8.1 The role of senior ASC management in the workload and treatment of CCH cases is important given the potential cost sharing / savings that could potentially be achieved for RBC. However it was apparent that the lack of consistent and ongoing support from senior management has not contributed to develop a coherent approach to systematically identifying potential CHC cases that clearly meet national CHC eligibility criteria and that can be confidently presented to the CCG. Equally outcomes of the initial or detailed assessments refused by the CCG are not being assessed and challenged by senior ASC management, again possibly in part due to the absence of regular senior manager awareness or support. **R7**

3.9 Non – ASC CHC clients and records

3.9.1 This review only reviewed Adult CHC cases and not any in the Children's directorate, so it is not known how systems work within the directorate, but it might be worthwhile for both services to learn how the other operates to see whether any lessons can be learnt and best practice shared. **R8**

Appendix A - Report Distribution

Staff Interviewed

- Mechelle Adams, Operational Team Manager, Adult Social Care
- Paula Johnston, Acting Head of Service, Older and Physically Disabled People
- Natalie Chamberlain, CHC Support Administrator
- Various social care practitioners within ASC

Draft Report Distribution

- Seona Douglas, Director of Adult and Health Care Services
- Paula Johnston, Acting Head of Service, Older and Physically Disabled People
- Mechelle Adams, Operational Team Manager, Adult Social Care

Final Report Distribution

- Seona Douglas, Director of Adult and Health Care Services
- Paula Johnston, Acting Head of Service, Older and Physically Disabled People
- Jo Purser, Acting Head of Adult Social Care
- Mechelle Adams, Operational Team Manager, Adult Social Care
- Melissa Wise, Head of Transformation - DACHS
- Lorraine Goude, Head of Strategic Commissioning and Personal Budgets

Auditor Contact Details

- Kevin Parker, Principal Auditor - (0118) 937 2694
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For further details on our assurance opinions please click this link

Audit Management Action Plan
Continuing Healthcare

Ref	Risk	Recommendation	Priority	Management Response	Responsible Officer(s)	Target Date
1	The lack of an agreed local protocol or specification between the Council (RBC) and the Berkshire West Clinical Commissioning Group (CCG) for the application, assessment and administration of CHC applications means that there is no local framework around which standards can be set and adhered.	It is recommended that the Head of Service works with CCG partners to establish and agree a locally set of documented specifications and standards that detail what the joint arrangements for the procedures and timescales for the application, assessment and recording of CHC cases should be. Once agreed these should be signed off by both parties and all relevant staff advised accordingly.	Priority 2	Agreed, following the implementation of the revised CHC Framework in October 2018, the Acting Head of Adult Social Care will work with the CCG and partners to review the current Berkshire wide joint policy for CHC.	Jo Purser, Acting Head of Adult Social Care	1.1.2019
2	Unless there is senior officer support and resource devoted to analysing the reasons for the disparity of CHC eligible cases with similar local authorities there is remains a risk that the real reasons for the low rates locally may not be fully understood with the result that the financial burdens for care provision of these people may not be fairly met.	Ongoing efforts to further research and understand the disparity rates in local CHC funding should be fully and consistently backed by senior management in order that the reasons can be properly understood, and any changes made. Resources to do this may have to be found from existing budgets but the work should have senior officer support and the outcomes should be shared with other parties if necessary. Any system changes made as a consequence should be regularly monitored to establish their future effect.	Priority 1	Partly agreed. NHS England are responsible for auditing the application of the CHC framework. The Local Authority can refer to NHS England if there are specific concerns around the implementation of the framework locally but not research how the framework is being implemented across other areas. Senior management are focusing on ensuring that applications have robust evidence to support individuals to achieve CHC funding. This is a priority for Reading as if the process and framework is not followed there is a lack of evidence for NHS England. Whilst we accept that the current level of success in this area remains low there are required actions for Reading to implement before highlighting this with NHS England.	Jo Purser, Acting Head of Adult Social Care	1.1.2019

3	Without a recordkeeping system to provide a complete and consolidated audit trail of all activity in respect of a (potential) CHC case there is a risk that a key record or outcome could be missed or overlooked.	It is important that, as the corporate system, Mosaic is used to fully capture and record all activity relating to CHC cases, including copies of correspondence, official reports as well as meeting notes and notes arising from telephone conversations, as well as completed Checklists and Decision Support Tools. Mosaic should be used by all staff to provide important (date) tracking information so that can be used to by the CHC Administrator and management to view activity on individual CHC cases, as well as to be able to apply high level monitoring of CHC cases.	Priority 1	Agreed, Mosaic has the functionality to record the CHC process and related documents, but some minor amendments are required before being this is launched across Adult Social Care.	Jo Purser, Acting Head of adult Social Care Kelly Roberts, Mosaic Support Officer	1.4.19
4	Inadequate training or understanding about how to understand, assess and apply how criteria governing potential CHC cases could result in appropriate or incomplete applications being made to the CCG.	Although there is already recognition that there is a need to bring all CHC training up to date, it is important that in future all staff are adequately trained on CHC procedures, that they are clear they understand these and that a record of this training (and any future updated training) is kept on iTrent. The Head of Service may wish to consider making this training mandatory and to sign this off by formally launching the initiative across the directorate. It is further recommended that any CHC training guides or documentation are kept up to date and located in an appropriate place (e.g. on a shared drive or on IRIS).	Priority 2	Mandatory CHC training delivered to Adult Social Care staff, they are required locally to attend CCG training to submit checklists. All checklists are being scrutinised by Head of Service. An Assistant Team Manager is being recruited to lead operationally and to support workers at MDT's. CHC is included in the inductions of new staff - this will be reviewed by the Assistant Team Manager who will keep all training guides and material up to date and accessible in the S drive. Additional information is being shared with staff regarding key points of reference in the framework and a process flow chart is being developed by the Head of Service.	Jo Purser, Acting Head of Adult Social Care	1.12.2018
5	Currently there is no quick way to determine the status of a CHC case (i.e. dates checklists or Decision Support Tools submitted or returned) which means there is a potential risk that CHC applications are not progress on a timely basis.	It is recommended that the current control spreadsheet record maintained by the CHC Administrator is expanded to also capture dates key documents are submitted to / received from the CCG. This should then be regularly updated and checked to ensure each case is progressed on a timely basis. Where it is found that a case has not progressed then the relevant social work practitioner should follow this up and record this as an action on Mosaic.	Priority 2	Agreed, a dashboard to be devised to hold all information in relation to the staged process to easily identify individuals progress through a CHC application. The dashboard will be updated by the Health Liaison Business Support Officer, and monitored by the Assistant Team Manager who will follow up with the allocated social care practitioner if progress is not timely.	Jo Purser, Acting Head of Adult Social Care Natalie Chamberlain, CHC Support Administrator	1.12.2018

6	In instances where applications for CHC funding have been made to but rejected by the CCG, the reasons for this need to be understood to ensure consistency of understanding between the Council and the CCG and to ensure that all parties are aware of their (financial) commitments.	Where an application for CHC support and funding has been rejected by the CCG the reasons for this need to be properly understood and (any lessons) absorbed for consideration with future cases. Where appropriate decisions should be formally challenged. It is therefore recommended that all rejected cases go through a formal review process by an appropriate senior officer so that any lessons can be learnt (and challenged, where appropriate) and outcomes fed back to social care colleagues.	Priority 2	The Assistant Team Manager will review all rejected cases, who will advise the worker how to challenge if appropriate. If issues arise this will be escalated to the Head of Service. Quarterly information will be collated and shared with DMT about the number of checklists completed, MDT's, successful and unsuccessful applications and disputes. Learning pointes will be collated and shared with Adult Social Care staff to improve consistency and learning.	Jo Purser, Acting Head of Adult Social Care	1.4.2019
7	Currently there is a lack of clarity over roles and responsibilities in communicating with the CCG (staff) which means the recognised process can be confused.	It should be determined as part of the review of procedures recommended in R1 above, which RBC staff should communicate with CCG staff over the submission, assessment, determination and follow up of CHC cases. This should then be disseminated to relevant staff. Similarly the role and profile of senior management (eg the Head of Adult Care) in relation to CHC cases needs to be visible so that there is a sufficiently high level presence on any joint board or forum to ensure that the Council's position and role is adequately	Priority 2	Agreed. Since 22.10.18, all checklists are ratified by the Head of Service. This will transfer to the Assistant Team Manager when they are in post. The Health Liaison Business Support Officer submits all checklists to the CHC team and is the main channel for communication. The Head of Service has met with staff regarding CHC and the application of the framework offering support if and when required, this will then be lead operationally by the ATM. The Head of Service attends the CHC panel.	Jo Purser, Acting Head of Adult Social Care Assistant Team Manager	1.12.18
8	Although the incidence of CHC related cases within the RBC Children's directorate there is a risk that good practice and procedure in Adults may not be known and shared.	It is recommended that the Adults and Children's services within RBC share best practice in relation to the handling, administration and management of CHC cases.	Priority 3	Agreed. Once Brighter Futures has become established the Head of Service will meet with their Head of Service to ensure that consistency of practice is embedded across Children's and Adult's services.	Jo Purser, Acting Head of Adult Social Care	01/09/2019

NB: Your management response is your commitment to treat the risk identified as part of the review. The standard response time to draft recommendations is 15 working days; any failure to meet this target could be reported to the Audit & Governance Committee.

The management response to recommendations will be reported to both CMT & The Audit & Governance Committee as part of our quarterly monitoring arrangements. Audit recommendations and agreed actions will be followed up during the year, where deemed appropriate by the Audit Management Team. All outstanding recommendations will also be reported through CMT as part of the Council's monthly performance monitoring.

Reading Borough Council
Working better with you

Internal Audit Report - Final

Residents Parking

To: **Cris Butler – Strategic Transport Programme Manager**
Simon Beasley – Network & Parking Manager
Elizabeth Robertson – Civil Enforcement Manager
Alison Bell – Director, DENS

From: **Amondeep Basra, Senior Auditor**

Date: **06/12/18**

Limited Assurance

Ref: **17/18**

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1 Purpose and Scope of Review

1.1 Reading Borough Council introduced Parking Enforcement in 2000, when responsibility for enforcement of parking contraventions passed from Thames Valley Police to the Local Authority. The current legislation that allows for Reading to enforce parking and waiting restrictions is under The Traffic Management Act 2004. This also permitted local authorities to enforce restrictions by other methods which are now known as 'Civil Parking Enforcement'. Parking offences are classified as civil offences rather than criminal offences under Civil Parking Enforcement.

1.2 Reading Borough Council has an integrated Parking Service, which manages both on-street and off-street activities. The Council introduced Civil Parking Enforcement under Part 6 of the Traffic Management Act 2004 from 31st March 2008.

1.3 The current guiding transport policy document is its Local Transport Plan (LTP) 2011- 2026. The Local Transport Plan includes a 15-year strategy document and a rolling 3-year implementation programme. The LTP programme is reviewed annually to ensure the aims and objectives are being delivered.

1.4 Permit Parking Zones came to Reading in the mid 1970's with the intention to enable residents to park in streets that would have otherwise been occupied by shoppers or commuters parking in the town centre. As levels of car ownership and traffic patterns have developed, the zones have spread away from central Reading to other parts of the town affected by parking problems.

1.5 In 2011/2012, the parking permit service and the zoning system was updated with zones becoming larger and a better split between the number of permits

being issued and the number of on-street parking spaces being made available. Changes to the permit scheme are made so it is vital people continue to check the signs and lines where they park.

1.6 There are currently three main types of permits available, resident, visitor and business, however temporary permits and other discretionary permits are also available.

1.7 Reading Borough Council utilises the PermitSmarti application, as provided by Imperial Civil Enforcement Solutions Limited, to provide the administrative and back office solution for the application for residents parking permits.

1.8 Parking enforcement is conducted both on- and off-street by Reading Borough Council Parking Services through Civil Enforcement Officers employed through a contractor.

1.9 Penalty Charge Notices are issued when people contravene the parking code. Penalty Charge Notice tickets can be categorised as higher or lower depending on the seriousness of the contravention. Penalty Charge Notices can be paid either online, by post or by phone.

1.10 Reading Borough Council is currently using the 3Sixty application for the management of penalty charge notices.

2 Main Conclusions

2.1 A total of 9 recommendations have been raised in respect of this review, of which 3 have been considered a high priority. The full detail of these recommendations and the corresponding management action plan are attached to this report as Appendix 1.

2.2 In the course of the audit it has not been possible to establish any formal documentation that sets out the governance, management and administrative arrangements for maintaining the PermitSmarti and 3Sixty applications, further there was no Separation of Duties (SoD) table documented recording roles, responsibilities nor how segregations of duties will be enabled. Additionally it has been identified that there is no record in place of the training undertaken by RBC staff or contractors.

2.3 It has not been possible to evidence that there has been a complete identity management review, in which user accounts and permissions were validated, with respect to either PermitSmarti, 3Sixty or their predecessor applications.

2.4 In reviewing the applications against the requirements of the RBC "ICT Standards Expected of Third Parties Policy," it has been found that the applications do not meet the password complexity requirements. Further the policy also requires that any third party provider is “compliant with the ISO27001/2013 standards," whereas the Imperial Civil Enforcement Solutions Limited has stated that they are not ISO27001 certified but that they do observe the principles.

2.5 In was not possible to establish that there was a consistent and formal process applied to the monitoring of user activity on either applications reviewed, and there was no evidence presented of the performance of user activity audits. It was noted however that in 2017 that the Civil Enforcement Manager had identified anomalous activity on the penalty charge notice application that was in place at the time via a review of user activity that had been performed in July 2017.

2.6 With respect to the limited quantity of Temporary and Tradespersons it has been identified that whilst a record is kept where a package of permits is made available for distribution there is no reconciliation performed of those permits issued to the stock that is held.

3 Summary of Findings

3.1 Governance

3.1.1 The PermitSmarti application which is in use at RBC for the purposes of providing an administrative solution for residents parking permits went live within the Council on the 31st October 2017. The 3Sixty application which is currently in place for the management of penalty charges notices went live on the 5th June 2018.

3.1.2 It has not been possible as a part of this audit to identify any formal documentation that sets out the governance, management and administrative arrangements for maintaining the PermitSmarti and 3Sixty applications. RBC does currently retain a copy of the original contract and supporting documents that were put in place with NSL Limited in 2014, which relate in part to the predecessor applications. It has not however been possible to identify a document that identifies specific roles and responsibilities related to the operation of controls and procedures that support the PermitSmarti and 3Sixty applications. **(R1)**

3.1.3 RBC has in place a number of Council wide information security policies and mandatory training that staff are required to review and undertake. The training includes Information Security Training, General Data Protection Regulations and Information Security and ICT Use of Equipment Policy. Parking Services does not have in place any application specific policies and instead places reliance upon the mandatory training. There is no training log or record maintained to demonstrate that users of the service have reviewed and completed the training. **(R2)**

3.1.4 There is currently no system documentation in place that has been prepared by Parking Services that details the operation and function of the PermitSmarti and 3Sixty applications. The NSL Client Account Manager was asked whether it would be possible to provide access to system documentation and the responses that he obtained from NSL and the sub-contractor Imperial were that there are no generic user guides and that all training is based on the customer requirement from the system configuration. The Civil Enforcement Manager (RBC) has advised that there is no formal programme of training for application users and that any training is provided via the inductions process.

3.1.5 It is noted however that Imperial has provided a "Guide to The Most Frequently Asked Questions by Users of the 3Sixty Application," that concerns the use of the Security Config module that allows for the management of the application.

3.1.6 The Civil Enforcement Manager (RBC) has stated that preliminary work has commenced on documenting some of the processes in place with respect to the systems, but it was not possible to review the work that had been completed to date.

3.2 Access to the system, information and resources / Enforcing Segregation of Duties

3.2.1 There was not found to be an independent list of authorised personnel that were approved to have system access to either application at the time of the audit.

3.2.2 It was not possible to obtain direct from the applications itself a report showing all users on the system and the current permissions and access rights that have been enabled for them. Whilst the 3Sixty Security Config module did allow for a display of all users of the system the Civil Enforcement Manager was unaware of how this information could be exported into a useable and manageable format. **(R3)**

3.2.3 The Civil Enforcement Manager (RBC) has advised and provided access to a document that has been prepared by the Civil Enforcement Supervisors in order to review user accounts. At the time of the audit the review of user accounts was not complete, and the Civil Enforcement Manager advised that the process involved the Supervisors manually typing out the user accounts and determining whether they should be deleted. There was no evidence available to demonstrate that user access reviews had been undertaken on the predecessor applications. **(R3)**

3.2.4 There is no Separation of Duties (SoD) table that exists for either the PermitSmarti or 3Sixty application or equivalent document setting out how functions and processes have been enabled to ensure that there is appropriate segregation of duties. **(R4)**

3.2.5 The Civil Enforcement Manager (RBC) has advised that PermitSmarti has approximately 7 users based on the first floor of the Civic Offices and a number of users based in the reception of the Civic Offices. It has additionally been advised that the 3Sixty application has approximately 30 users, of these 16 are employees of RBC and the remaining are contractors. The Civil Enforcement Manager (RBC) has advised that contractors are not required to undertake RBC mandatory training or to review RBC Information Security policies.

3.2.6 With respect to the PermitSmarti application the response received from Imperial has advised that "staff have appropriate data protection and confidentiality clauses in their contracts," and "all new members of staff are provided with data protection training as part of their induction. Members of staff whose role necessitates a more thorough level of training are provided with is at the start of their employment and then refreshed at regular intervals (usually annually unless changes in legislation require additional training)."

3.2.7 The response received with respect to the 3Sixty application from NSL states that "Training is provided by ICES – NSL staff are trained by then in the operation of the product – the training is based on Job of work and specific to

the functional requirements of RBC." RBC does not retain any records or detailed information with respect to the training undertaken by contractors. **(R5)**

3.2.8 The Reading Borough Council "ICT Standards Expected of Third Parties Policy," version 1.4 last reviewed August 2016 states that "Reading Borough Council will expect any Third Party to have formal Information Security Management Policies and Procedures written to provide ICT Services compliant with ISO27001/2013 and therefore deliver services which are legally compliant and of a consistent high standard and quality."

3.2.9 The response received from Imperial Civil Enforcement Solutions Limited with respect to their Information Management Security Policies stated "We are not ISO27001 certified. We observe ISO 27001 principles and in accordance with the standard the different risks to the business are analysed and either resolved, mitigated or accepted," and "We are Cyber Essentials certified (certification number 2170553)," and "We are also members of the CiSC (Cyber Security Information Sharing Partnership)." **(R6)**

3.2.10 The response received from NSL Limited with respect to their Information Management Security Policies stated that "NSL Data is hosted in the Microsoft Azure Cloud. The Azure Cloud is ISO27001 certified." Additionally they have provided a copy of a certification received from Exova BM TRADA that identifies NS Centrality has having "been audited and found to meet the requirements of standard ISO/IEC 27001:2013 Information Management Systems Requirements. The date of the initial certification is recorded as the 5th September 2017 and is valid until the 4th September 2020.

3.3 Management and monitoring of privilege and service user account activities

3.3.1 There is no formally defined process or procedure with respect to the detail or frequency with which management will review the user activity on either the PermitSmarti or 3Sixty applications. There have been no documents available to evidence that management review of user activity has taken place on either the current or previous applications. It is noted that the Civil Enforcement Manager (RBC) has advised that periodic and informally defined review does take place and this statement is supported by an investigation that was undertaken within the RBC in August 2017 as a result of anomalous activity identified by the Civil Enforcement Manager during the course of a review. **(R7)**

3.3.2 The Civil Enforcement Manger and Supervisors have available to them within the 3Sixty application an audit tab within the Security Config module and the ability to generate management information, regarding user activity, via the use of User Activity Letters. This combination of management information allows for the monitoring of activity on the 3Sixty application. The Civil

Enforcement Manager has advised that the Supervisors will utilise the User Activity Letters to monitor the processing activity of personnel on the application for discussion at one to ones. There is no formal documentation or procedure outlining how this information should be used or how frequently and it was not possible to evidence its use in one to one documents.

3.3.3 The Civil Enforcement Manager has advised that the PermitSmarti application does not have a management reporting function equivalent to 3Sixty or an available audit tab showing all user activity. Whilst all information required for the purposes of supervision and management review is recorded and available within PermitSmarti the system does not allow for a search to be performed on the basis of activity undertaken by a specific user. The Civil Enforcement Manager has additionally advised that to her knowledge a review of user activity has not been undertaken and there has not been a process in place by which the available management information has been used to review a sample of all activity, regardless of user, at identified periods.

3.3.4 The Reading Borough Council "ICT Standards Expected of the Third Parties Policy," version 1.4 reviewed August 2016 states that the RBC expectation of third parties with respect to passwords is that they will "…follow CESG password formats (9 minimum, combinations of alpha and numeric etc). The NSL Client Account Manager has advised that the current settings with respect to the 3Sixty application are; a minimum length of 4 characters, 0 digits required, 0 uppercase letters required, 0 lowercase letters required, and 0 symbols required.

3.3.5 In response to the enquiry as to the password requirements for the PermitSmarti application Imperial Civil Enforcement Solutions responded, via the NSL Contract Manager, that the current requirements are that "Passwords must contain at least 8 character including one lower case and one numeric character." **(R8)**

3.4 Management and monitoring of physical permits held by Reading Borough Council

3.4.1 The RBC Parking Annual Report 2016-17 shows that the permits issued by the Council can be sub-divided into 19 different categories. The current system in place is such that where an online application is made for a permit and approved via PermitSmarti the permit itself will be printed by the contractor and mailed directly to the applicant. RBC does however maintain control of a small volume of physical permit stock that fall into the Temporary and Traders permit category.

3.4.2 The processing of Temporary and Traders permits occurs on the PermitSmarti application as do other permit types and the serial number of each permit issued is recorded in a free entry text box with the application as well as the application itself assigning a system generated reference number of the

permit. The physical stock of permit is held primarily on the 1st floor of the Civic Offices and is distributed to the staff within the reception area of the Civic Offices as and when a request is made of additional stock. The permits are batched in groupings of 199 permits.

3.4.3 The Parking Services team maintain 2 different logs in excel spreadsheet format for the Temporary Permit stock and Tradesperson stock of permits that are distributed. The logs record the serial number range of the batch of permits issued, the person that issued them, the date on which they were issued and the person to whom they were issued. The Civil Enforcement Manager has confirmed that at the current time there is no reconciliation performed or stock check taken of the permits that are held and the records for those that have been issued. **(R9)**

Appendix A - Report Distribution

Staff Interviewed

- Cris Butler, Strategic Transport Programme Manager
- Elizabeth Robertson, Civil Enforcement Manager

Draft Report Distribution

- Cris Butler, Strategic Transport Programme Manager
- Elizabeth Robertson, Civil Enforcement Manager

Final Report Distribution

- Alison Bell, Director, DENS
- Simon Beasley – Network & Parking Manager
- Cris Butler, Strategic Transport Programme Manager
- Elizabeth Robertson, Civil Enforcement Manager

Auditor Contact Details

- Amondeep Basra, Senior Auditor - (0118) 937 2693
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Audit Management Action Plan
< DENS 0035 Residents Parking

Audit Management Action Plan
DENS 0035 Residents Parking

Ref	Risk	Recommendation	Priority	Management Response	Responsible Officer(s)	Target Date
1	a) Where there is no formal documentation that sets out the governance, management and administrative arrangements for maintaining the PermitSmarti and 3Sixty applications there is an increased risk that control activities being duplicated or not fully completed where roles are not properly understood. b) The system may not be properly maintained leading to service/performance issues or system failure.	Parking Services should develop a formal policy document that sets out the governance, management and administrative arrangements for maintaining the PermitSmarti and 3Sixty applications.	Priority 1	Recommendations accepted. Parking Services will develop formal policy documentation that sets out the: - Governance - Management - Administrative Arrangements with respect to the PermitSmarti and 3Sixty applications. The documentation will set out the controls that are in place with respect to the applications and will be subject to periodic review.	Elizabeth Robertson – Civil Enforcement Manager, Emma Benger – Civil Enforcement Supervisor, Halima Khan – Civil Enforcement Supervisor, Pritam Surdhar – Civil Enforcement Supervisor, Gurpreet Vig - Civil Enforcement Supervisor	31/03/2019
2	a) Where there is no formal record in place to record that system users have undertaken required and appropriate training the Council cannot have assurance that it has undertaken appropriate action to ensure that all users are adequately equipped to meet their responsibilities as required and of the expectation upon them.	Parking Services should develop a training log to demonstrate, provide oversight of and assurance as to the training undertaken by the users of the PermitSmarti and 3Sixty application.	Priority 2	Recommendations accepted. Training logs will be updated and maintained in order to demonstrate that the application users have been informed as to the use of the systems and their responsibilities with respect to access.	Elizabeth Robertson – Civil Enforcement Manager, Emma Benger – Civil Enforcement Supervisor, Halima Khan – Civil Enforcement Supervisor, Pritam Surdhar – Civil Enforcement Supervisor, Gurpreet Vig - Civil Enforcement Supervisor	31/03/2019

3	a) Where an identity management review of users accounts on applications are not performed at regular intervals there is an increased risk that the application may be subject to unauthorised or inappropriate access.	Parking Services should perform periodic identity management reviews of the user accounts for the PermitSmarti and 3Sixty applications and will document that these have occurred and the changes that have occurred as a result.	Priority 2	Recommendations accepted. Parking Services in conjunction with NSL services will perform bi-annual identity management reviews of the PermitSmarti and 3Sixt applications. The identity management reviews will review user account access and permissions within the application.	Elizabeth Robertson – Civil Enforcement Manager, John Evans – NSL Client Account Manager	31/03/2019
4	a) Where an applications does not have the separation of duties set out and formally documented there is an increased risk that users will be provided with inappropriate system access or that segregation of duties will not be maintained.	Parking Services should set out a Separation of Duties (SoD) table for the PermitSmarti and 3Sixty applications demonstrating how users have been assigned permissions in a manner that demonstrates appropriate segregation of duties.	Priority 2	Recommendations accepted. A review will be performed of settings within both applications. Additionally a review will be performed of user access within the applications a record maintained within the training log to demonstrate their access levels.	Elizabeth Robertson – Civil Enforcement Manager, Emma Benger – Civil Enforcement Supervisor, Halima Khan – Civil Enforcement Supervisor, Pritam Surdhar – Civil Enforcement Supervisor, Gurpreet Vig - Civil Enforcement Supervisor	31/03/2019
5	a) Where the RBC is not aware or has not reviewed the training undertaken by users that have access to applications that it utilises then it cannot have assurance that those users have met an appropriate standard.	Parking Services should, periodically, liaise with the NSL Contract Manager in order to ensure that non-RBC personnel that have system access have received adequate training and meet the requirements of the RBC "ICT Standards Expected of Third Parties Policy." Evidence of this action will be retained.	Priority 3	Recommendations accepted. The NSL Contract manager will be contacted in order to establish: - The training that is undertaken by non-RBC personnel - That the training provided meets the requirements of the RBC "ICT Standards Expected of Third Parties Policy." Evidence of this activity will be retained.	Elizabeth Robertson – Civil Enforcement Manager, John Evans – NSL Client Account Manager	31/03/2019

6	a) Where a third party provider is not ISO27001 certified but observes the principles they may not have complied with the RBC "ICT Standards Expected of Third Parties Policy."	Parking Services should seek guidance from the RBC Corporate ICT Services as to whether Imperial Civil Enforcement Solutions Limited observing ISO 27001 but not being certified is sufficient for meeting RBC requirements. Parking Services should ensure that it advises RBC Corporate ICT Services of the Cyber Essentials certification and membership of CiSC that Imperial has referenced.	Priority 2	Recommendations accepted. RBC Corporate ICT Services will be contacted in order to discuss and to confirm the approach to observing standards by the current application provider is sufficient to meet the requirement of the RBC "ICT Standards Expected of Third Parties Policy." The conclusions of the discussions will be documented and held on file as confirmation that Parking Services has acted with appropriated care and in compliance with Council standards.	Elizabeth Robertson – Civil Enforcement Manager	31/03/2019
7	a) Where there is no formally documented approach to the review of user activity of applications there is an increased risk that the activity when performed will not identify all potential activity of interest as the activity may be performed inconsistently or inadequately. b) Where records are not retained of the performance of user activity reviews on a periodic basis management cannot have assurance that controls are functioning effectively and anomalous activity will be detected or prevented.	Parking Services should formally define the requirements for the review of user activity, who is to perform the review and with what frequency.	Priority 1	Recommendations accepted. Supervisors have been tasked with reviewing the current arrangements in place for the review of user activity. They will formally document the current processes that are in place. Additionally Supervisors will review the possibility of implementing reviews and discussions in one to one minutes.	Elizabeth Robertson – Civil Enforcement Manager, Emma Benger – Civil Enforcement Supervisor, Halima Khan – Civil Enforcement Supervisor, Pritam Surdhar – Civil Enforcement Supervisor, Gurpreet Vig - Civil Enforcement Supervisor	31/03/2019
8	a) Where the applications in use by Parking Services do not have in place password requirements that meet RBC standards they may be subject to challenge as to whether they have taken appropriate action to secure the application and the data held.	Parking Services should liaise with the NSL Contract Manager to ensure that password access rights are set within the PermitSmarti and 3Sixty applications to meet RBC standards.	Priority 1	Recommendations accepted. The NSL Contract Manager will be contact with respect to ensuring that the PermitSmarti and 3Sixty applications meet the RBC password requirements.	Elizabeth Robertson – Civil Enforcement Manager, John Evans – NSL Client Account Manager	31/01/2019
9	a) Where reconciliations are not periodically performed between the permit stock that is held and that which is issued management there is an increased risk of the misappropriation of stock.	Parking Services should perform periodic reviews of the physical inventory of permits that it holds and document that it has done so.	Priority 2	Recommendations accepted. Periodic review of permit inventory will be performed and documented by the Supervisors Pritam Surdhar and Gurpreet Vig.	Elizabeth Robertson – Civil Enforcement Manager, Pritam Surdhar – Civil Enforcement Supervisor, Gurpreet Vig - Civil Enforcement Supervisor	31/01/2019

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The management response to recommendations will be reported to both CMT & The Audit & Governance Committee as part of our quarterly monitoring arrangements. Audit recommendations and agreed actions will be followed up during the year, where deemed appropriate by the Audit Management Team. All outstanding recommendations will also be reported through CMT as part of the Council's monthly performance monitoring.

Audit Management Action Plan
DENS 0035 Residents Parking

Ref	Risk	Recommendation	Priority	Management Response	Responsible Officer(s)	Target Date
1	a) Where there is no formal documentation that sets out the governance, management and administrative arrangements for maintaining the PermitSmarti and 3Sixty applications there is an increased risk that control activities being duplicated or not fully completed where roles are not properly understood. b) The system may not be properly maintained leading to service/performance issues or system failure.	Parking Services should develop a formal policy document that sets out the governance, management and administrative arrangements for maintaining the PermitSmarti and 3Sixty applications.	Priority 1	Recommendations accepted. Parking Services will develop formal policy documentation that sets out the: - Governance - Management - Administrative Arrangements with respect to the PermitSmarti and 3Sixty applications. The documentation will set out the controls that are in place with respect to the applications and will be subject to periodic review.	Elizabeth Robertson – Civil Enforcement Manager, Emma Benger – Civil Enforcement Supervisor, Halima Khan – Civil Enforcement Supervisor, Pritam Surdhar – Civil Enforcement Supervisor, Gurpreet Vig - Civil Enforcement Supervisor	31/03/2019
2	a) Where there is no formal record in place to record that system users have undertaken required and appropriate training the Council cannot have assurance that it has undertaken appropriate action to ensure that all users are adequately equipped to meet their responsibilities as required and of the expectation upon them.	Parking Services should develop a training log to demonstrate, provide oversight of and assurance as to the training undertaken by the users of the PermitSmarti and 3Sixty application.	Priority 2	Recommendations accepted. Training logs will be updated and maintained in order to demonstrate that the application users have been informed as to the use of the systems and their responsibilities with respect to access.	Elizabeth Robertson – Civil Enforcement Manager, Emma Benger – Civil Enforcement Supervisor, Halima Khan – Civil Enforcement Supervisor, Pritam Surdhar – Civil Enforcement Supervisor, Gurpreet Vig - Civil Enforcement Supervisor	31/03/2019
3	a) Where an identity management review of users accounts on applications are not performed at regular intervals there is an increased risk that the application may be subject to unauthorised or inappropriate access.	Parking Services should perform periodic identity management reviews of the user accounts for the PermitSmarti and 3Sixty applications and will document that these have occurred and the changes that have occurred as a result.	Priority 2	Recommendations accepted. Parking Services in conjunction with NSL services will perform bi-annual identity management reviews of the PermitSmarti and 3Sixt applications. The identity management reviews will review user account access and permissions within the application.	Elizabeth Robertson – Civil Enforcement Manager, John Evans – NSL Client Account Manager	31/03/2019

4	a) Where an applications does not have the separation of duties set out and formally documented there is an increased risk that users will be provided with inappropriate system access or that segregation of duties will not be maintained.	Parking Services should set out a Separation of Duties (SoD) table for the PermitSmarti and 3Sixty applications demonstrating how users have been assigned permissions in a manner that demonstrates appropriate segregation of duties.	Priority 2	Recommendations accepted. A review will be performed of settings within both applications. Additionally a review will be performed of user access within the applications a record maintained within the training log to demonstrate their access levels.	Elizabeth Robertson – Civil Enforcement Manager, Emma Benger – Civil Enforcement Supervisor, Halima Khan – Civil Enforcement Supervisor, Pritam Surdhar – Civil Enforcement Supervisor, Gurpreet Vig - Civil Enforcement Supervisor	31/03/2019
5	a) Where the RBC is not aware or has not reviewed the training undertaken by users that have access to applications that it utilises then it cannot have assurance that those users have met an appropriate standard.	Parking Services should, periodically, liaise with the NSL Contract Manager in order to ensure that non-RBC personnel that have system access have received adequate training and meet the requirements of the RBC "ICT Standards Expected of Third Parties Policy." Evidence of this action will be retained.	Priority 3	Recommendations accepted. The NSL Contract manager will be contacted in order to establish: - The training that is undertaken by non-RBC personnel - That the training provided meets the requirements of the RBC "ICT Standards Expected of Third Parties Policy." Evidence of this activity will be retained.	Elizabeth Robertson – Civil Enforcement Manager, John Evans – NSL Client Account Manager	31/03/2019
6	a) Where a third party provider is not ISO27001 certified but observes the principles they may not have complied with the RBC "ICT Standards Expected of Third Parties Policy."	Parking Services should seek guidance from the RBC Corporate ICT Services as to whether Imperial Civil Enforcement Solutions Limited observing ISO 27001 but not being certified is sufficient for meeting RBC requirements. Parking Services should ensure that it advises RBC Corporate ICT Services of the Cyber Essentials certification and membership of CiSC that Imperial has referenced.	Priority 2	Recommendations accepted. RBC Corporate ICT Services will be contacted in order to discuss and to confirm the approach to observing standards by the current application provider is sufficient to meet the requirement of the RBC "ICT Standards Expected of Third Parties Policy." The conclusions of the discussions will be documented and held on file as confirmation that Parking Services has acted with appropriated care and in compliance with Council standards.	Elizabeth Robertson – Civil Enforcement Manager	31/03/2019

7	a) Where there is no formally documented approach to the review of user activity of applications there is an increased risk that the activity when performed will not identify all potential activity of interest as the activity may be performed inconsistently or inadequately. b) Where records are not retained of the performance of user activity reviews on a periodic basis management cannot have assurance that controls are functioning effectively and anomalous activity will be detected or prevented.	Parking Services should formally define the requirements for the review of user activity, who is to perform the review and with what frequency.	Priority 1	Recommendations accepted. Supervisors have been tasked with reviewing the current arrangements in place for the review of user activity. They will formally document the current processes that are in place. Additionally Supervisors will review the possibility of implementing reviews and discussions in one to one minutes.	Elizabeth Robertson – Civil Enforcement Manager, Emma Benger – Civil Enforcement Supervisor, Halima Khan – Civil Enforcement Supervisor, Pritam Surdhar – Civil Enforcement Supervisor, Gurpreet Vig - Civil Enforcement Supervisor	31/03/2019
8	a) Where the applications in use by Parking Services do not have in place password requirements that meet RBC standards they may be subject to challenge as to whether they have taken appropriate action to secure the application and the data held.	Parking Services should liaise with the NSL Contract Manager to ensure that password access rights are set within the PermitSmarti and 3Sixty applications to meet RBC standards.	Priority 1	Recommendations accepted. The NSL Contract Manager will be contact with respect to ensuring that the PermitSmarti and 3Sixty applications meet the RBC password requirements.	Elizabeth Robertson – Civil Enforcement Manager, John Evans – NSL Client Account Manager	31/01/2019
9	a) Where reconciliations are not periodically performed between the permit stock that is held and that which is issued management there is an increased risk of the misappropriation of stock.	Parking Services should perform periodic reviews of the physical inventory of permits that it holds and document that it has done so.	Priority 2	Recommendations accepted. Periodic review of permit inventory will be performed and documented by the Supervisors Pritam Surdhar and Gurpreet Vig.	Elizabeth Robertson – Civil Enforcement Manager, Pritam Surdhar – Civil Enforcement Supervisor, Gurpreet Vig - Civil Enforcement Supervisor	31/01/2019

NB: Your management response is your commitment to treat the risk identified as part of the review. The standard response time to draft recommendations is 15 working days; any failure to meet this target could be reported to the Audit & Governance Committee.

The management response to recommendations will be reported to both CMT & The Audit & Governance Committee as part of our quarterly monitoring arrangements. Audit recommendations and agreed actions will be followed up during the year, where deemed appropriate by the Audit Management Team. All outstanding recommendations will also be reported through CMT as part of the Council's monthly performance monitoring.

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READING BOROUGH COUNCIL
DIRECTOR OF RESOURCES

TO:	**AUDIT & GOVERNANCE COMMITTEE**		
DATE:	**15 January 2019**	**AGENDA ITEM:6**	
TITLE:	**Internal Audit plan 2019 - 2020**		
LEAD COUNCILLOR:	**COUNCILLOR BROCK**	**PORTFOLIO:**	**CORPORATE AND CONSUMER SERVICES**
SERVICE:	**FINANCE**	**WARDS:**	**N/A**
LEAD OFFICER:	**PAUL HARRINGTON**	**TEL:**	**9372695**
JOB TITLE:	**CHIEF AUDITOR**	**E-MAIL:**	**Paul.Harrington@reading.gov.uk**

1. PURPOSE OF THE REPORT

1.1 This report sets out the work Internal Audit plans to undertake during the financial year 2019/2020. In preparing the plan the adequacy and outcomes of the Council's risk management, performance management and other assurance processes have been taken into account. Where the outputs from these processes are not judged to be sufficiently reliable, the plan has been informed using an internal audit risk assessment.

1.2 It is internal audit's responsibility to form opinions about the risks and controls identified by management and annually to give a formal opinion on the control environment. In the context of the Public Sector Internal Audit Standards[1], 'opinion' does not simply mean 'view', 'comment' or 'observation'; it means that internal audit will have done sufficient, evidenced work to form a supportable conclusion about the Council's activities that we have examined. Internal audit will word its opinion appropriately if it cannot give reasonable assurance (e.g. because of limitations to the scope of, or adverse findings arising from, its work).

1.3 The attached audit plan (appendix 1) will allow for the effective discharge of this responsibility. In accordance with the Accounts and Audit regulations[2] and the Public Sector Internal Audit Standards the Council's Audit and Governance Committee is required to approve (but not direct) and monitor progress against, the internal audit plan.

1.4 A separate internal audit plan will be prepared for Brighter Futures for Children (BFfC), which will cover children's related services, Education and Schools. This plan will be presented separately to the Audit Committee of BFfC.

[1] The Public Sector Internal Audit standards – Applying the IIA International Standards to the UK Pubic Sector 2013

[2] A relevant authority must undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance.

1.5 Accompanying the audit plan is the internal audit charter which sets out the purpose, authority, responsibility and scope of internal audit. The Public Sector Internal Audit Standards (PSIAS) intend to ensure sound corporate governance and set out roles and responsibilities with regard to the delivery of internal audit services. The PSIAS require an Internal Audit Charter to be in place which will be reviewed periodically and presented to the Corporate Governance and Audit Committee for approval.

1.6 The following document is attached to this report:

- Internal Audit plan for 2019/2020 (appendix 1)
- Internal audit charter (appendix 2)

2. RECOMMENDED ACTION

2.1 That the Audit & Governance Committee approves the audit plan for the period April 2019 to March 2020 and notes the content of the Internal Audit Charter.

3. INTERNAL AUDIT PLAN

3.1 Internal audit contributes to the Council achieving its key priorities by helping to promote a secure and robust internal control environment, which enables a focus on achieving the key priorities. It also also supports the Director of Resources in discharging his/her statutory duties. The following are two key pieces of legislation that internal audit supports the Director of Resources to comply with:

i. Section 151 of the Local Government Act 1972. The Director of Resources, as the council's Section 151 Officer, is responsible under the Local Government Act for ensuring that there are arrangements in place for the proper administration of the authority's financial affairs. The work of internal audit is an important source of information for the Section 151 officer in exercising his/her responsibility for financial administration.

ii. The Accounts and Audit Regulations state that 'A relevant authority must undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance'. The work of internal audit provides a substantial element of this requirement.

3.2 'Effective internal audit' is defined as compliance with the Public Sector Internal Audit Standards (PSIAS) and CIPFA's Local Government Application Note for the PSIAS.

3.3 In preparing the plan I have taken account of the adequacy and outcomes of the Council's risk management, performance management and other assurance processes. I have consulted with stakeholders, such as Directors and Heads of Service, and the Head of Finance.

3.4 The audit plan needs to be deliverable within available resources and the achievement of the audit plan is based on the assumption that the current internal audit structure will remain essentially unaltered and intact throughout the year. The current structure allows for five internal auditors, all of whom have varying degrees of experience and as a consequence the complexity of audits to be undertaken is based on the experience and resources available. This is factored into the audit planning.

3.5 A recent high turnover of staff has resulted in a reduction in experience, with recent recruits either new to local government and/or internal audit. This does leave the internal audit function with little or no real resilience.

3.6 The audit plan is fixed for a period of one year; however it must at the same time be fluid, kept under continuous review and amended to take into account emerging risks and areas where assurance work is required to be provided. Any significant changes will be reported back to the Audit & Governance Committee.

3.7 CMT and the Audit and Governance Committee will also be advised of performance against the audit plan and be kept informed of the results of those audit reviews undertaken.

3.8 The plan may be subject to changes, between now and the start of the new financial year, if new risks emerge which require internal audit focus.

4. AUDIT CHARTER

4.1 A relevant authority must undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance.

4.2 The Public Sector Internal Audit Standards (PSIAS) require an Internal Audit Charter to be in place which will be reviewed periodically and presented annually to the Corporate Governance and Audit Committee for approval.

4.3 The main objective of Internal Audit is to provide a high quality, independent audit service to the Council which provides annual assurance in relation to internal control and overall governance arrangements.

4.4 The PSIAS recognises that Internal Audit's remit extends to the entire control environment of the organisation and not just financial controls.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 Audit Services aims to assist in the achievement of the strategic aims of the Council set out in the Corporate Plan by bringing a systematic disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes. In particular audit work is likely to contribute to the priority of remaining financially sustainable to deliver our service priorities.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 *N/A*

7. LEGAL IMPLICATIONS

7.1 Legislation dictates the objectives and purpose of the internal audit service the requirement for an internal audit function is either explicit or implied in the relevant local government legislation.

7.2 Section 151 of the Local Government act 1972 requires every local authority to "make arrangements for the proper administration of its financial affairs" and to ensure that one of the officers has responsibility for the administration of those affairs.

7.3 In England, more specific requirements are detailed in the Accounts and Audit Regulations in that authorities must "maintain an adequate and effective system of internal audit of its accounting records and of its system of internal control in accordance with proper internal audit practices".

8. FINANCIAL IMPLICATIONS

8.1 N/A

9. BACKGROUND PAPERS

9.1 N/A

Appendix 1

Internal Audit Plan

(2019/2020)

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Internal Audit Plan

1. Background

1.1 The definition of internal audit is set out in the Public Sector Internal Audit Standards (PSIAS): "*Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes*."

1.2 Internal audit contributes to the Council achieving its key priorities by helping to promote a secure and robust internal control environment, which enables a focus on achieving the key priorities.

1.3 Internal audit also supports the Director of Resources in discharging his/her statutory duties. The following are two key pieces of legislation that internal audit supports the Director of Resources to comply with:

i. Section 151 of the Local Government Act 1972. The Director of Resources, as the council's Section 151 Officer, is responsible under the Local Government Act for ensuring that there are arrangements in place for the proper administration of the authority's financial affairs. The work of internal audit is an important source of information for the Director in exercising his/her responsibility for financial administration.

ii. The Accounts and Audit Regulations state that 'A relevant authority must undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance'. The work of internal audit provides a substantial element of this requirement.

1.4 'Effective internal audit' is defined by the Department for Communities and Local Government as compliance with the Public Sector Internal Audit Standards (PSIAS) and CIPFA's Local Government Application Note for the PSIAS.

1.5 The PSIAS set out the standards for internal audit and include the need for risk-based plans to be developed for internal audit and for plans to receive input from management and the 'Board'. Within the Council, the Audit & Governance Committee fulfils the key duties of the Board laid out in the PSIAS. This document sets out the proposed plan for 2019-20.

2. The Planning Process

2.1 The overall purpose of the Internal Audit work plan is to provide the framework for the use of audit resources and a yardstick for measuring audit performance.

2.2 The PSIAS Performance Standard 2010 - Planning states that: '*The Chief Audit Executive must establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals.*' Within Reading Borough Council (RBC), the role of Chief Audit Executive is undertaken by the Chief Auditor.

2.3 The standards refer to the need for the risk-based plan to take into account the requirement to produce an annual internal audit opinion and report that is used by the organisation to inform its governance statement. The annual internal audit opinion must conclude on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. To support this, the risk-based plan needs to include an appropriate and comprehensive range of work. There also needs to be a balance between breadth (taking a broad look at governance and risk management) and depth (drilling down into specific areas where internal audit can provide valuable insight.)

2.4 In line with the PSIAS the proposed audit plan has been devised adopting a risk based approach. The information which has been used to prepare our risk assessment and proposed internal audit plan has been collected and collated from a number of different sources. The starting point for a risk based audit approach is an understanding of the Council's objectives and risks. This has been achieved by reviewing the Councils Strategic risk register, Corporate Plan and minutes of officer and Council meetings. Directors and Heads of Service were consulted for areas to be included in the audit plan and our own knowledge and experience of Council services was also used to inform our subsequent risk assessment. This information is used to inform and design the audit plan.

3. The Internal Audit Plan

3.1 The outputs from the planning process have been prioritised to produce a plan that balances the following:

- the requirement to give an objective and evidenced based opinion on aspects of governance, risk management and internal control;
- the time required for anti-fraud and corruption activity
- the requirement for internal audit to add value through improving controls, streamlining processes and supporting corporate priorities;
- the need to retain a contingency element to remain responsive to emerging risks; and
- the resource and skill mix available to undertake the work.

3.2 The Chief Auditor in liaison with the Director of Resources (sec 151 Officer) will keep progress against the audit plan, and the content of the plan itself under review. The Corporate Management Team and the Audit and Governance Committee will also be advised of performance against the Audit Pan and be kept informed of the audits undertaken.

3.3 The indicative Internal Audit programme for 2019-2020 has been prepared in line with the PSIAS. A risk-based approach has been used to prioritise internal audit work and ensure there is sufficient coverage and internal audit resource to provide an evidence-based assurance opinion that concludes on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

3.4 The plan is responsive in nature and all efforts will be made to maximise coverage to provide the most effective and agile internal audit service possible that focuses on those key risks facing the organisation throughout the year.

3.5 A separate internal audit plan will be prepared for Brighter Futures for Children (BFfC), which will cover children's related services, Education and Schools. This plan will be presented separately to the Audit & Risk Committee of BFfC.

4. Resources

4.1 The audit plan needs to be deliverable within available resources and the achievement of the audit plan is based on the assumption that the current internal audit structure will remain essentially unaltered and intact throughout the year. Resource requirements are reviewed each year as part of the audit planning process and are discussed with the sec 151 officer. The current structure allows for five internal auditors at varying degrees of experience. A recent high turnover of staff has resulted in a reduction in experience with the recent recruits either new to local government and/or internal audit. This does leave the internal audit function with little or no real resilience. This is factored into the audit planning, with the planned reviews based on the experience and resources available.

5. Individual Audits

5.1 When we scope each review, we will reconsider our estimate for the number of days needed to achieve the objectives established for the work and to complete it to a satisfactory standard. Where revisions are required we will obtain approval from the appropriate Corporate Director prior to commencing fieldwork.

5.2 In determining the timing of our individual audits we will seek to agree a date which is convenient and ensures the availability of key management and staff.

5.3 All formal internal audit assignments will result in a published report. The primary purpose of the audit report is to provide an independent and objective opinion to the Council on the framework of internal control, risk management and governance in operation and to stimulate improvement. Any key (serious) issues arising during the course of the audit review will be promptly reported to the Chief Auditor to determine impact on the scope of the review. Key issues will also be promptly brought to management's attention during the course of the review to enable appropriate remedial action to be taken prior to being formally published in the audit report.

5.4 The auditor will draft a report and arrange to meet with management, to ensure factual accuracy of the audit observations and findings and to ensure a proper understanding of the risks to which any action plan relates. These meetings should take place in accordance with dates agreed in the terms of reference or within two weeks of completion of the audit fieldwork, whichever is the sooner.

5.5 Management will be required to provide a response to the action plans. Any areas of disagreement between the auditor and management, regarding audit's observations and/or the auditor's assessment of current risk exposure, which cannot be resolved by discussion, will be recorded in the action plans.

5.6 Following discussion of the draft report the auditor will draft a clear, concise and constructive report, following a standard format, outlining:

- the overall level of assurance opinion, based on the auditor's professional judgement of the effectiveness of the framework of internal control, risk management and governance;
- audit recommendations, along with management response and implementation date
- an executive summary of the key findings and conclusions
- Details of findings, to include an explanation of the risk and the identified control weaknesses.
- The final report will be issued in the name of the auditor conducting the review and the Chief Auditor.

6. Follow up Reviews

6.2 Whether or not and audit review is scheduled for a follow up is reliant on the assurance opinion given at the time of the audit. Where significant gaps in the control environment have been identified then the audit will be subject to a follow up by the audit team. The timing of the follow up is very much dependent on available resources, but our aim to complete the follow up within six to twelve months of completion of the audit.

6.3 A summary of those high and medium risk Internal Audit recommendations which remain outstanding is reported to the Audit & Governance Committee Quarterly. The status of these recommendations is updated by the action owners and hasn't necessarily been followed up by internal audit. Internal Audit will only follow up those recommendations relating to a report which has been assigned limited assurance.

6.4 Prior to reporting to Committee officers responsible for implementing the specific recommendations are asked to update the 'implementation tracker'. Each recommendation is marked with a percentage complete which correlates to a red/amber/green rating depending on the percentage of completeness. Up to 25% complete is marked red, between 26% and 75% complete is amber and over 75% complete is green. However, any recommendations that are less than 50% complete but have exceeded their agreed completion date are also marked red.

6.5 Where there is a lack of progress with implementation, e.g. successive missing of implementation dates etc. The Head of Service and responsible officer (if they are different) will be asked to attend a meeting of the Committee to explain the difficulties with implementation and the steps they are taking to address them.

7. Reports to C.M.T. and the Audit & Governance Committee

7.1 A status report on internal audit work will be presented to CMT and the Audit and Governance Committee on a quarterly basis (approximately). The purpose of these reports is to provide an update on the progress made against the delivery of the Internal Audit Plan. The report will provide details of audits completed to date, the assurance opinions given and the number and type of recommendations made. The report will also provide a summary of internal audit performance, planning and resourcing issues.

8. Annual Assurance Report

8.1 A formal annual report to the Audit & Governance Committee and CMT, presenting the Chief Auditor's opinion on the overall adequacy and effectiveness of the framework of governance, risk management and control, will be published to enable it to be taken into account within the annual review of the effectiveness of the system of internal audit and in preparing the Corporate Annual Governance Statement. The format of the Chief Auditor's report will follow that set out in the Public Sectors Standards for Internal Audit and will include:

- an opinion on the overall adequacy and effectiveness of the Council's framework of internal control, risk management and governance;
- disclose any qualifications to that opinion, together with the reasons for qualification;
- present a summary of the audit work from which the opinion is derived, including reliance placed on work by other assurance bodies;
- any issues considered by the Chief Auditor to be particularly relevant to the Annual Governance Statement;
- A comparison of work undertaken with that planned, with a summary of internal audit performance for the year; and
- Comment on compliance with the Public Sector Standards on Internal Audit and internal audit's quality assurance programme.

Securing the economic success of Reading

Audit Title	Scope of Audit Work	Q1	Q2	Q3	Q4
Commercialisation	This audit will build upon the work we completed in 2018/19 and will focus on the governance framework in place which is used to oversee the Council's current and future trading activity.				●
Contract Management	This audit will focus on mid value contracts between £500k and £2m and assess how these are managed in terms of whether the contract in place is robust and effective, variations to contracts are approved and embedded promptly, performance management is clear, understood and reported. This review will include highways, heating drainage, and housing contracts.		●		
Governance review of Council owned businesses	The overall objective of this review is to consider the design and operation of the governance arrangements in place for Council owned Companies (Reading Buses, Brighter Future for Children & Homes for Reading)			●	●
Residents Parking (follow up)	Following a review in 2018/2019 the audit concluded that the existing processes required enhancement. This follow-up audit will aim to provide assurance that the actions taken by management put forward to address the recommendations made, have been implemented.			●	
Car Parks (off street)	To review the operational controls and processes with regards to setting tariffs, issuing tickets and income collection (including electronic card payments). Assessment of whether the Council have taken effective steps to maximise the economic activity through its parking strategy and have met legislative requirements over the use of income toward the support of transport related activity.	●			
Local Transport Plan Capital Settlement & Bus Subsidy (Grant Certification)	This audit will provide assurance to the Chief Executive and Head of Finance who are required to confirm to the DfT that, in all significant respects, the conditions of the specific grant determination have been complied with.		●		
Business Rates	This review will seek to determine whether there are effective arrangements in place for ensuring that all hereditaments within the council's boundaries are included within the Valuation list. We will also review controls over overpayments (refunds) and charge reductions due to reliefs, exemptions or rateable value deductions. The audit will also review the arrangements to identify all business rates liabilities.				●
Investment Properties	Review arrangements for procuring investment properties, rent is received and accounted for, insurance cover is in place, data is accurate and the portfolio is reported on and monitored sufficiently.			●	

Protecting and enhancing the lives of vulnerable adults and children

Audit Title	Scope of Audit Work	Q1	Q2	Q3	Q4
Client Contributions Adult Care & Deferred Income	To review how fees and charges are set, and in particular how these take into account the cost of providing services or the requirement to make a specific contribution. Review whether processes are sufficiently robust and clear from the initial referral through to the financial assessment and collection of contribution. Verify how the monies are recovered from the proceeds of sale once the property is sold. The Care Act (2014) places a new duty to provide deferred payments and charge interest on these. Verify the system and controls for managing this process				●
Eligibility, Risk and Review Group	To assess whether there is robust challenge over the placement identification process and pricing and whether all information is required by and received by the Panels. The audit will review the decision making process, constitution of the panel (skills & expertise), evidence maintained to support decisions and review process.	●			
Commissioning & Contract Management (Adults)	Review governance relating to placement contracts commissioned with external providers (Dom Care/Supported living/Residential & Nursing Care) to evaluate the effectiveness contract review and management processes to ensure effective challenge and performance management processes are in place. Analyse spend on spot purchasing to identify emerging trends and how VFM is obtained (spot purchasing v block provision)				●
Third party contributions (top up fees)	This audit will look at how the Council processes third party contributions to ensure processes are fully compliant with the Care Act.			●	
Learning Disability and Mental Health Placements	This audit will review how we commission (specialist) out of borough places for L&D and Mental Health. The audit will assess what options have been explored, placements provide VFM and are kept under regular review.		●		
Continuing Health Care (CHC)- Follow up review	Following a review in 2018/2019 the audit concluded that the existing processes required enhancement. This follow-up audit will aim to provide assurance that the actions taken by management put forward to address the recommendations made, have been implemented.			●	
Delayed Transfer of Care - Follow up review	Following a review in 2018/2019 the audit concluded that the existing processes required enhancement. This follow-up audit will aim to provide assurance that the actions taken by management put forward to address the recommendations made, have been implemented.			●	

Keeping Reading's environment clean, green and safe

Food Hygiene Inspections	This review will seek to determine whether there is a robust framework in place for ensuring that timely food safety inspections are being conducted.	●			
Thames Valley New Energy	This audit will provide assurance that, in all significant respects, the conditions of the specific grant determination have been complied with.			●	
Cemeteries & Crematorium	This audit will provide assurance that remains are disposed of legally and safely. Income is received and recorded. Expenditure is adequately controlled. Service Demand is monitored and modelling techniques are used to anticipate future capacity requirements.	●			

Ensuring the Council is fit for the future

Pre-employment verification (DBS)	This review will seek to ensure that there are satisfactory basic and enhanced checks are undertaken for appropriate RBC employees through the Disclosure and Barring Service (DBS).	●			
Travel and Subsistence	Review excessive claims ensure compliance with statutory arrangements (e.g. taxation). Ensure that payments are appropriate supported and that payments are being made in accordance with the Council's policies and procedures e.g. within appropriate time limits. The audit will also cover the online booking system for train travel		●		
Oracle Fusion Cost Centre Manager Data Analysis	The audit will review Cost Centre Manager/Approver span of control, and ability to provide appropriate scrutiny spend on a transactional basis. The audit will also review the company structures on fusion, to ensure structures are fit for purpose, the hierarchy and coding structure is working properly and users have appropriate access.		●		
Purchasing cards	To ensure that the controls surrounding the issue, administration and monitoring of purchase cards are operating as expected.		●		
CT Support	The purpose of this review is to ensure that the systems and processes for the assessment, calculation and payment of local council tax support are effective. The audit will verify the "means-test" calculation function is correct, applied consistently and there is documentary evidence to substantiate both the claimant's and partner's income and capital.		●		

Audit Title	Scope of Audit Work	Q1	Q2	Q3	Q4
Secure communications	Internal Audit will review the arrangements for the control and movement of sensitive via electronic communications (email) following the removal of GCSX in March 2019	●			
Cash collection - web payments	Review of systems used to take online payments from customers, such as credit card and bank transfer. Includes compliance with regulations and also systems interfaces.	●			
Sundry Debtors	Accounts receivable will move from ACADEMY to Oracle FUSION from March 2019 with the management of this function transferring to the accounts payable manager. This review will seek to review the process for transferring balances and AR history from the current system to Fusion and verify controls have been set up properly.		●		
General Ledger	Using a data analysis and file interrogation tool we will carry out checks during the year to test the appropriateness of journal entries recorded in the general ledger. This will include various fraud detection tests and trend analysis. We will provide a short synopsis of our findings with any unusual transactions subject to further analysis and investigation.		●		●
Bank & Cash Rec inc control account reconciliations	The audit will verify the reconciliation of the bank account and all control accounts and review the process to ensure these are completed in a timely way.			●	
Accounts Payable	The audit will ensure there is adequate control over the requisition and purchase order, receiving the invoice and making the payment. Mechanisms are in place to ensure that duplicate payments are avoided and/or detected. There are appropriate authorisation levels, management reporting, reconciliations are timely, payments are correctly coded to the cost centre and subjective codes and VAT is accounted for.				●
Data Storage - follow up review	Following a review in 2018/2019 the audit concluded that the existing processes required enhancement. This follow-up audit will aim to provide assurance that the actions taken by management put forward to address the recommendations made, have been implemented.			●	
Additional Payments - Follow up review	Following a review in 2018/2019 the audit concluded that the existing processes required enhancement. This follow-up audit will aim to provide assurance that the actions taken by management put forward to address the recommendations made, have been implemented.			●	

Improving access to decent housing to meet local needs

Audit Title	Scope of Audit Work	Q1	Q2	Q3	Q4
Rent Accounting	Confirm that all properties are identified and accurately recorded in the rent accounting system, the gross rent and other charges have been correctly calculated in respect of each dwelling and correctly credited to tenants rent accounts. All tenancy charges are correctly approved and recorded. Rent and service charges are correctly identified in the HRA and general fund and are subject to reconciliation. Ensure that effective procedures are in place to pursue and recover current and former tenant arrears.		●		

Internal Audit Charter

(2019/2020)

We aim to provide a high quality cost-effective service, which adapts and responds to the Authority's needs based on achieving a high standard of professionalism and expertise in service delivery and also to contribute in achieving best value public services.

1. Background

1.1 The Public Sector Internal Audit Standards (PSIAS) requires that an Internal Audit Charter is in place for each local authority. The Charter must be consistent with the Definition of Internal Auditing, the Code of Ethics and the Standards contained in the PSIAS.

1.2 This Charter establishes the purpose, authority and responsibilities for the internal audit service for Reading Borough Council (RBC) and has been drawn up in line with the PSIAS requirements and is further informed by the CIPFA Local Government Application Note (April 2013) published to assist in the implementation of the PSIAS.

1.3 This Internal Audit Charter is subject to approval by the Audit and Governance Committee of Reading Borough Council (RBC) on an annual basis, in line with PSIAS requirements.

2. Role

2.1 Internal auditing is an independent and objective assurance and consulting activity that is guided by a philosophy of adding value to improve the operations of Reading Borough Council ("RBC" or "the Council"). It assists the Council in accomplishing its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of the organisation's risk management, control, and governance processes.

2.2 The Internal Audit function's main purpose is to provide independent, objective assurance and advisory services designed to add value and improve the Council's operations. It helps the Council accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes. The function provides independent and objective evaluation of, and opinion on, the overall adequacy and effectiveness of the framework of governance, risk management and control in.

2.3 This includes identification of risks and assessment of their management, and implementation of changes to strengthen the governance framework. The Chief Auditor's opinion is a key element of the framework of assurance that the Chief Executive and Leader of the Council needs to inform the completion of the Annual Governance Statement.

3. Purpose, Responsibilities and Objectives of Internal Audit

3.1 Internal Audit is an independent appraisal function established within the authority – as part of the Corporate Support Services Directorate - with the following objectives[1]:

- To provide an effective Internal Audit Service, on behalf of the Director of Finance (sec 151 officer), in line with legislation and the appropriate audit standards;
- To provide an independent, objective assurance and consulting activity designed to add value and improve the organisation's operations;
- To help the organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

3.2 It is the responsibility of the Chief Auditor to provide an independent and objective opinion on the overall adequacy and effectiveness of the Council's framework of governance, risk management and control.

3.3 The Chief Auditor reports to the Audit and Governance Committee on a regular basis in line with the agreed work programme for the Committee. There are a number of standard items reported including the annual Internal Audit plan, an annual opinion on the control environment and regular updates on reports issued. The Chief Auditor's annual report is presented to those charged with governance and should be used to support the Council's Annual Governance Statement.

3.4 Internal Audit employees will ensure that they conduct work with due professional care and in line with the requirements of the PSIAS and any other relevant professional standards.

3.5 Internal auditors will treat as confidential the information they receive in carrying out their duties. There must not be any authorised disclosure of information unless there is a legal or professional requirement to do so. Confidential information gained in the course of an audit will not be used to affect personal gain.

4. Scope of Internal Audit Activities

4.1 The scope for Internal Audit is the control environment comprising risk management, control and governance. This effectively includes all of the council's operations, resources, services and responsibilities in relation to other bodies. This description shows the wide potential scope of Internal Audit. In order to translate this description into individual audit reviews, a risk assessment methodology is applied that allows high-risk review areas to be prioritised (also see Section 8.)

[1] Financial Regulations –Section 2.8 'Internal Audit'

4.2 To enable Internal Audit to meet its objectives, it will undertake work within a scope of activities including:

- review of controls within existing systems and systems under development
- compliance with policies and procedures including Financial Regulations
- transactions testing to ensure accuracy of processing
- contract audit
- establishment reviews
- computer audit including data analytics
- anti-fraud work
- investigation of suspected fraud and irregularities
- value for money reviews and transactions testing
- provision of advice to Directorates and services including consulting services
- provision of audit services to external clients.

5. Definition of Consulting Services

5.1 The PSIAS defines consulting services as follows: *"Advisory and client related service activities, the nature and scope of which are agreed with the client, are intended to add value and improve an organisation's governance, risk management and control processes without the internal auditor assuming management responsibility. Examples include counsel, advice, facilitation and training."*

5.2 The PSIAS requires that approval must be sought from the Audit & Governance Committee for any significant additional consulting services not already included in the audit plan, prior to accepting the engagement (Standard 1130.).

6. Arrangements for Appropriate Resourcing

6.1 As stated in the CIPFA Application Note, *"No formula exists that can be applied to determine internal audit coverage needs. However, as a guide, the minimum level of coverage is that required to give an annual evidence-based opinion. Local factors within each organisation will determine this minimum level of coverage."*

6.2 The annual audit plan lays out the planned audit resources for the year with the objective of giving an evidence-based opinion.

6.3 Internal Audit must be appropriately staffed in terms of numbers, grades, qualification levels and experience, having regard to its objectives and to the standards. Internal Auditors need to be properly trained to fulfil their responsibilities and should maintain their professional competence through an appropriate on-going development programme.

6.4 In the event that the risk assessment, carried out to prepare the annual plan, identifies a need for more audit work than there are resources available, the Chief Auditor will identify the shortfall and advise the Director of Finance followed by the Audit & Governance Committee as required to assess the associated risks or to recommend additional resources are identified.

6.5 The audit plan will include a contingency allocation to address unplanned work including responding to specific control issues highlighted by senior management during the year.

6.6 Internal audit work is prioritised according to risk, through the judgement of the Chief Auditor, informed by the Council's risk registers and in consultation with senior management and External Audit.

6.7 Progress on the annual plan is reported to the Audit & Governance Committee on a regular basis throughout the year. Should circumstances arise, during the year, that resources fall or appear to be falling below the minimum level required to provide an annual evidence based opinion the Chief Auditor will advise the Director and Head of Finance and the Audit & Governance Committee.

7. Organisational Independence of Internal Audit

7.1 The PSIAS requires that reporting and management arrangements must be put in place that preserve the Chief Auditor's independence and objectivity, in particular with regard to the principle that the Chief Auditor must be independent of the audited activities.

7.2 PSIAS Standard 1110 requires that the Chief Auditor reports to a level within the organisation that allows the internal audit activity to fulfil its responsibilities. CIPFA and the Chartered Institute of Internal Auditors expect that the Chief Auditor should report to at least corporate management team level.

7.3 Within RBC, the Chief Auditor reports functionally to the Audit & Governance Committee and administratively to the Director of Finance (Sec 151 Officer) and has direct right of access to the Chief Executive. The Chief Auditor also has direct access to the Chair of the Audit & Governance Committee.

7.4 The Internal Audit team will ensure that independence and objectivity are maintained in line with the PSIAS including where non-audit work is undertaken. To manage potential conflicts of interest, internal auditors have no operational responsibilities and any independence issues are highlighted at the planning stage for individual audit assignments.

7.5 If independence or objectivity is impaired in fact or appearance, the details of the impairment must be disclosed in the first instance to the Chief Auditor and reported to the Section 151 officer as appropriate.

7.6 Internal Audit will have no executive responsibilities. It is not an extension of, or a substitute for, the function of management. Responsibility for internal control rests fully with managers, who should ensure that arrangements are appropriate and adequate. It is for management to accept and implement audit recommendations or to accept the risk resulting from not taking any action.

7.7 The Chief Auditor will confirm to the Audit and Governance Committee on an annual basis, within the Annual Report, the organisational independence of the Internal Audit Service.

7.8 The Chief Auditor will report audit findings to the Council's Corporate Management Team and Audit & Governance Committee.

8. Planning

8.1 The annual audit plan will be submitted to the Audit and Governance Committee at the beginning of the financial year for approval. The plan will be compiled following consultation with the Chief Executive, the Director of Finance, individual Directors and other senior officers as appropriate.

8.2 The risk-based plan will outline the audit assignments to be carried out.

8.3 The audit plan is dynamic in nature and will be reviewed and realigned on a regular basis to take account of new, emerging and changing risks and priorities. It will be based on a risk assessment covering the impact and likelihood of the inherent risk for each auditable area. It will be responsive, containing an element of contingency to accommodate assignments which could not have been reasonably foreseen.

8.4 Internal Audit will consult with the Council's external auditor and with other relevant inspection and review bodies, as required, in order to co-ordinate effort and avoid duplication.

8.5 As part of the planning process, the Chief Auditor will identify other potential sources of assurance and will include in the risk based plan the approach to using other sources of assurance and any work required to place reliance upon those other sources.

8.6 For each audit assignment, Internal Auditors will develop and document a plan including the objectives of the review, the scope, timing and resource allocations. In planning the assignment, auditors will consider, in conjunction with the auditees, the objectives of the activity being reviewed, significant risks to the activity and the adequacy and effectiveness of the activity's governance, risk management, including risk of fraud and control processes.

9. Reporting and Follow Up

9.1 A written report will be prepared by the appropriate auditor for every audit review and distributed in line with established and agreed reporting protocols. This will include an opinion on the adequacy of controls in the area that has been audited.

9.2 The draft report will be discussed with the auditees and a response obtained for each recommendation stating their response to each recommendation along with a timescale for implementation. The final report will include the management responses and will be issued to the relevant Director and other officers in line with directorate protocols.

9.3 Any reports where limited or no assurance has been provided for the control environment and/or compliance with the control environment will be subject to a follow up review to determine whether the recommendations made have been implemented.

9.4 Regular update reports to Audit and Governance Committee will show the activity of the Internal Audit Section, progress achieved against plan and a summary of significant audit findings.

9.5 The annual report will incorporate the annual opinion, a summary of the audit work that supports the opinion and a statement on conformance with the PSIAS and the results of the Quality Assessment and Improvement Programme (QAIP.)

9.6 The PSIAS also requires the Chief Auditor to establish a follow up process to monitor and ensure actions have been effectively implemented. This is an established process within RBC, with a follow up review being undertaken on any assignments with limited assurance/no assurance, to ensure recommendations have been adopted and suggested controls are working well in practice.

10. Assurance to external organisations

10.1 The format and scope of any assurances provided to external organisations will be agreed in advance with the recipient organisation and will be documented in contract terms/service level agreement or equivalent. The work carried out to provide such assurances will be conducted in accordance with Internal Audit's quality procedures and service standards. These will be included in the annual audit plan.

11. Fraud and Corruption

11.1 Managing the risk of fraud and corruption is the responsibility of management; Internal Audit will assist management in the effective discharge of this responsibility.

11.2 Audit procedures alone, even when performed with due professional care, cannot guarantee that fraud or corruption will be detected. Internal Audit does not have the responsibility for the prevention or detection of fraud and corruption. Internal Audit will, however, be alert in all their work to risks and exposures that could allow fraud and corruption.

11.3 In line with Financial Regulations (Section 6.5 – Preventing Fraud and Corruption), whenever any matter arises that involves, or is thought to involve irregularities concerning cash, stores or other property of the council or any suspected irregularity in the exercise of the functions of the council, including bequests, trust and client monies, it must be immediately brought to the attention of the respective Director. Where the irregularity is thought to involve fraud, corruption or impropriety the Director must ensure that the matter is reported to the Chief Auditor. If the irregularity or suspected irregularity involves theft or suspected theft of assets, it must also be referred to the Police. In addition where a break-in is suspected, the Police must be informed immediately.

12. Authority of Internal Audit

12.1 Internal Audit is a statutory requirement in local government. The Accounts and Audit (England) Regulations 2015 which came into force on the 1st April 2015 state that:

(i) *A relevant authority must undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance.*

(ii) *Any officer or member of a relevant authority must, if required to do so for the purposes of the internal audit—*

(a) *make available such documents and records; and*

(b) *supply such information and explanations; as are considered necessary by those conducting the internal audit.*

(iii) *In this regulation "documents and records" includes information recorded in an electronic form.*

12.2 The statutory role is recognised and endorsed within the Council's Financial Regulations[2], which provides the authority for access as follows:

Directors must ensure that Internal Audit is allowed to:

(i) *Enter any council premises or land at all reasonable times;*
(ii) *Access all records, documents, data held on computer media, and correspondence relating to all transactions of the council, or unofficial funds operated by an employee as part of their duties;*
(iii) *Receive such explanations as are necessary concerning any matter under examination.*
(iv) *Require any employee of the council to produce cash, stores or any other property under their control, belonging to the council or held as part of the employee's duties.*

13. Code of Ethics

13.1 All our Internal Auditors must conform to the Chartered Institute of Internal Auditors Code of Ethics. The code promotes an ethical culture in a profession founded on the trust placed in its objective assurance about risk management, control and governance.

13.2 The Code of Ethics includes 2 essential components – the Principles and Rules of Conduct (which are an aid to interpreting the Principles into practical applications.)

13.3 Internal Auditors will adhere to RBC relevant policies and procedures (including the Employee Code of Conduct) and local Internal Audit procedures.

13.4 All Internal Auditors will be qualified by experience, hold a professional qualification, or be training towards a professional qualification.

13.5 In addition, all internal auditors have a personal responsibility to undertake a programme of continuing professional development (CPD) to maintain and develop their competence. This is fulfilled through the requirements set by professional bodies and through the Council's appraisal and development programme.

[2] Financial Regulations – Section 2.8 'Internal Audit'

14. Review of the Effectiveness of Internal Audit

14.1 The Accounts and Audit (England) Regulations 2011 required councils to conduct, at least once a year, a review of the effectiveness of its internal audit. Within RBC, the internal audit annual report and opinion provides an overview of the work and performance of Internal Audit throughout each year. The annual report, along with independent reviews by the external auditors, provides an assurance of the effectiveness of the Internal Audit service during the year.

14.2 These 2011 regulations have now been superseded by the Accounts and Audit Regulations 2015 which maintain the requirement for an effective internal audit function and state that:

A relevant authority must, each financial year—

(a) conduct a review of the effectiveness of the system of internal control

14.3 Internal Audit will continue to provide assurance on the effectiveness of the function through the annual reporting process.

15. Quality Assurance and Improvement Programme (QAIP)

15.1 The PSIAS requires that a quality assurance framework be established, which will include both internal and external assessment of the work of Internal Audit.

15.2 The Chief Auditor is responsible for providing periodically an internal quality assessment (IQA) on the internal audit activity as regards its consistency with the requirements of the PSIAS. This will be carried out through annual self-assessment using the checklist in the CIPFA Application Note. Results of these IQAs will be communicated to the Director of Finance and the Audit and Governance Committee.

15.3 Internal Audit issues a customer satisfaction questionnaire following each audit assignment. The results are used to determine areas for improvement and inform the continuing personal development training programme for Internal Audit staff.

READING BOROUGH COUNCIL
DIRECTOR OF CORPORATE RESOURCES

TO:	**AUDIT & GOVERNANCE COMMITTEE**		
DATE:	**24th January 2019**	**AGENDA ITEM:**	**7**
TITLE:	**STRATEGIC RISK REGISTER Q3**		
LEAD COUNCILLOR:	**COUNCILLOR BROCK**	**PORTFOLIO:**	**CORPORATE AND CONSUMER SERVICES**
SERVICE:	**FINANCE**	**WARDS:**	**N/A**
LEAD OFFICER:	**PAUL HARRINGTON**	**TEL:**	**9372695**
JOB TITLE:	**CHIEF AUDITOR**	**E-MAIL:**	**Paul.Harrington@reading.gov.uk**

1. PURPOSE OF REPORT

1.1 This report outlines the Q3 update of the Strategic Risk Register.

1.2 The Register is presented to the Council's Audit & Governance Committee a minimum of six monthly or quarterly in the case of any risks where the position has worsened or for residual red risks where the Audit & Governance Committee shows a particular interest. It was last presented to the Committee in Aug 2018.

1.3 The following documents are appended:

Appendix 1 - the Council's Corporate (Strategic) Risk Register.

2. RECOMMENDED ACTION

2.1 The committee are requested to consider the Council's strategic risks as of Dec 18 (end of Q3).

3. KEY ISSUES

3.1 Risk management is a key part of corporate governance. Good risk management will help identify and deal with key Strategic risks facing the Council in the pursuit of its goals and is a key part of good management, not simply a compliance exercise. Risk management and internal control are important and integral parts of a performance management system and crucial to the achievement of outcomes. They consist of an ongoing process designed to identify and address significant risks involved in achieving the Council's outcomes.

3.2 The Strategic Risk Register has been developed to provide a concise, focused and high level overview of Strategic risks that can be easily communicated to

all staff, councilors and stakeholders (e.g. Council's Insurers). It should, however, always be supplemented by the more detailed directorate/service/project risk registers.

3.3 Although guidance is provided in relation to the scoring of risks, with a view to providing as much consistency as possible, it still remains very much a subjective process. The primary aim of the Strategic Risk Register is to identify those key vulnerabilities that CMT consider need to be closely monitored in the forthcoming months and, in some instances, years ahead. In many cases this will be because the risk is relatively new and, whilst being effectively managed, the associated control framework is yet to be fully defined and embedded. In such circumstances it follows that not only will the potential impact be large, but the risk of likelihood of occurrence could also be increased. Furthermore, it is possible that the likelihood can be influenced by events outside of the Council's control e.g. the economic climate and its impact on financial planning, or severe weather etc.

3.4 Risk appetite was introduced to our risk register in 2018. This is consistent with the Institute of Risk Management which advises that risk appetite should be identified for each risk. ***Risk appetite is the amount of risk that an organisation is willing to seek or accepts in order to meet its long term objectives.***

3.5 Given the revised format identifies risk appetite for each individual risk, the previous colour coding of red, amber and green based on a single assessment of risk tolerance would be confusing and hence the analysis of red, amber and green will now be based on the extent of the gap between the current residual risk and the risk appetite.

3.6 In order to focus senior management and Member attention on areas of greatest risk, the Register should include only the key current risks that have not been mitigated down to the risk appetite level. Hence it is proposed that where risks have been rated as green for 2 or more consecutive quarters they should be removed from the Register. These can be re-instated should the risk rise again.

4. CONTRIBUTION TO STRATEGIC AIMS

4.1 Regular review of the Strategic Risk Register is an integral part of effective risk management arrangements and corporate governance. Identifying risk appetite enables the Council to clarify the extent of risk mitigation required in order to achieve its strategic aims.

5. COMMUNITY ENGAGEMENT AND INFORMATION

5.1 N/A

6. LEGAL IMPLICATIONS

6.1 There are no specific legal implications arising from the recommendations in this report"

7. FINANCIAL IMPLICATIONS

7.1 N/A

8. BACKGROUND PAPERS

8.1 Appendix 1 – the Council's Corporate (Strategic) Risk Register.

Risk 1: *The council does not create and deliver a sustainable Medium Term Financial Plan and/or achieve a balanced budget.*

Risk Owner: CMT

Corporate Priority: *Ensuring the Council is fit for the future*

Risk Rating (Impact x Likelihood)

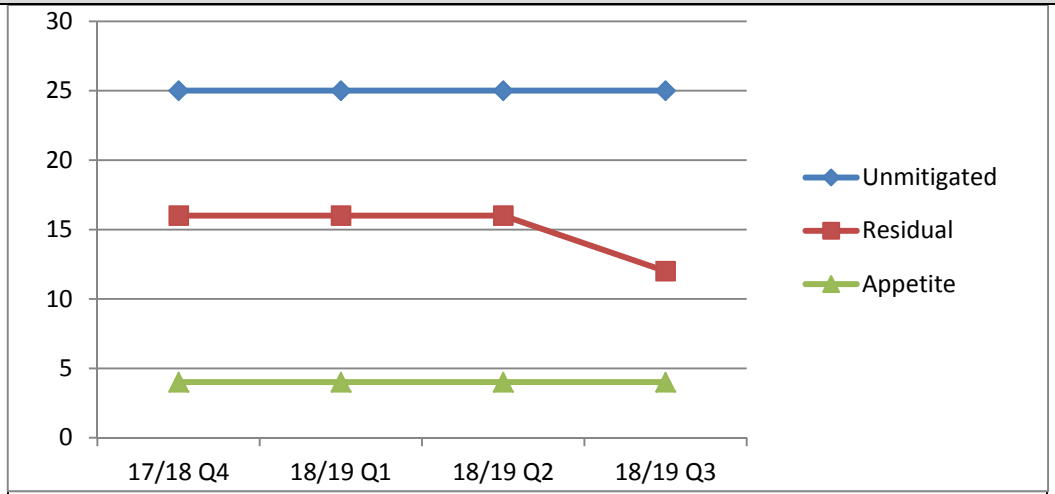
Unmitigated 5 x 5

Current Residual 4 x 3

Appetite 4 x 1

Potential Impact

Strategic objectives and statutory duties not met. Council unable to set legal budget. Service or services failure



Rationale for current score:

The £40m of savings over 3 years will require robust management to deliver. Particularly there is a need to take early and robust action on longer term initiatives to ensure that the Council remains a going concern. The General Balances will need to be improved and a reserve is created to manage future years' volatility.

Rationale for risk appetite

Achieving a sustainable financial position is essential in order to be a going concern and deliver priorities. Careful planning is essential and the risk appetite is low.

Current RAG rating	**RED**

Current Actions *(What we are currently doing about the risk – Causes Unmitigated Score to reduce to Residual)*

- MTFS for the period 2018-2021 has now been approved by Council
- Robust monitoring arrangements are in place re delivery of savings and tracking of budget pressures
- Savings being managed by 8 Corporate Programme Boards with CMT sponsor
- Delivery Fund allocations have been aligned with Programme Boards on gateways to access funding which are managed via the Board structure. Spend is agreed where appropriate
- A revised strategy for use of Capital Receipts was submitted to Policy Committee in June
- The annual refresh of the MTFP is underway.

Further Mitigation (what more should we do to reduce residual risk to our risk appetite level) and opportunities	**Officer (s) responsible**	**Target date**
Revision of 2018/19 budget and MTFS completed. It takes account of actual and emerging pressures with an appropriate contingency. Robust monitoring and early delivery of savings is now required to give confidence that the MTFS is deliverable.	Head of Finance/ CMT	Ongoing
Thorough review of all savings proposals for current and future years being undertaken as part of the Autumn Budget Setting Process and any potential shortfall will be built into the identified gap / need for risk provision	CMT	Complete
Budget monitoring incorporates the savings delivery plan as a separate report, with mitigation plans to be implemented for those savings at risk (Red/Amber RAG status)	CMT	Ongoing
Review of MRP requirement for current and future years being picked up as part of Autumn Budget setting process incorporating both capital and revenue forecasts. Implications of Feb 2018 Capital Finance Regulations has been assessed with relation to Homes for Reading / Investment Property proposals and report being written as to how the Council may continue its previous policy of making such investments to generate a return	Head of Finance	Jan 2018/19

Risk 2: *Insufficient or lack of capable staff resources to deliver our services in an effective and efficient manner*	**Risk Owner:** Head of HR & Organisational Development

Corporate Priority: *Ensuring the Council is fit for the future*

Risk Rating (Impact x Likelihood)

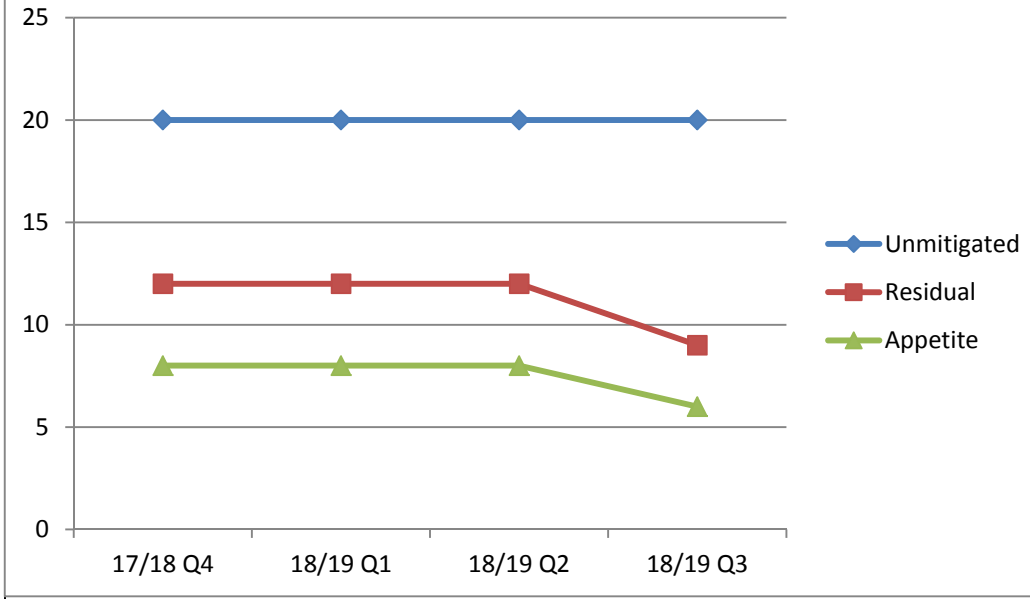
Unmitigated 4 x 5

Current Residual 3 x 3

Appetite 3 x 2

Potential Impact

Failure to meet demand. Statutory duties not met. Negative impact on staff motivation and stress related illness.



Rationale for current score:

Managing delivery of ongoing services during a period of significant change with reduced staffing resources due to redundancy, retirement, sickness, staff resources diverted to the transformation programme and difficulties in recruiting to certain specialist posts

Rationale for risk appetite

In order to implement the Transformation Programme it will be necessary to reduce staffing levels and is accepted that will put pressure on managing and delivering services hence appetite is high.

Current RAG rating	**AMBER**

Current Actions*(What we are currently doing about the risk– Causes Unmitigated Score to reduce to Residual)*

- Ensure that managers are carrying out 1:1's, appraisal and team meetings at a local level
- 90% of staff had appraisals for 17/18 completed by March 2018 (next appraisals due by end of February 2019).
- Staff are reminded regularly of HR guidance on stress management and about the Employee Assistance Programme.
- Reviewing approach to Organisational Development and training
- Reviewing HR policy framework
- Service restructures Finance & HR completed
- Recruitment resource and skills enhanced together with wider advertising of posts in order to attract high calibre staff to the Council

Further Mitigation (what more should we do to reduce residual risk to our risk appetite level) and opportunities	**Officer responsible**	**Target date**
Update HR policies and procedures	Head of HR	December 19
Implement OD strategy and introduce Team Reading programme board to oversee the delivery plan	Head of HR & Director of Resources	Complete
Appointments to vacant posts all made and staff now either in post or due to commence shortly (with pro-tem agency cover in the meantime). Two posts have subsequently become vacant due to resignation / internal moves – both of which are out to advert	Director of Resources & Head of Finance	Mar 19
Reduce agency spend	CMT	Ongoing

Risk 3: *Information created, accessed, handled, stored, protected and destroyed by the Council and its service areas is not managed in compliance with legislation or local policies. Council services do not fully understand or manage the risks such non-compliance involves therefore not making informed, risk based decisions.*

Risk Owners: Head of Legal/ Head of Customer Services

Corporate Priority: *Ensuring the Council is fit for the future*

Risk Rating (Impact x Likelihood)

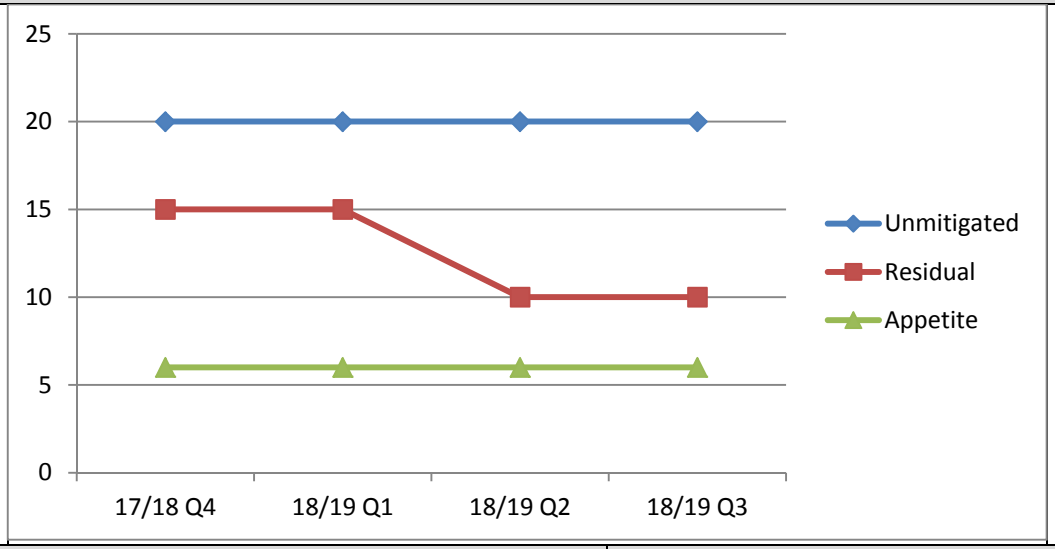
Unmitigated 5 x 4

Current Residual 5 x 2

Appetite 3 x 2

Potential Impact

Fines/penalties, reputation damage, service failure.



Rationale for current score:

The likelihood has reduced slightly following staff awareness training, however fines are increasing, hence potential impact remains high.

Rationale for risk appetite

In addition to the financial risk, financial penalties are now very high, hence the Council will seek to minimise the risk of these being incurred.

Current RAG rating	RED

Current Actions*(What we are currently doing about the risk– Causes Unmitigated Score to reduce to Residual)*

- Ongoing corporate training programme for data protection, raising awareness with staff groups of the need to handle personal data securely and properly. Data Protection Training is mandatory for all staff.
- GDPR Project team established and working towards GDPR compliance so as to avoid large penalties and fines.
- Data Protection Officer in place following staff resignation.
- GDPR e-learning module has been rolled out to staff and made mandatory for staff to complete. Face to Face Data Protection refresher training is available for staff as and when needed. GDPR briefing sessions were also held for staff by the GDPR team and each session was fully attended by staff. These sessions outlined the changes in legislation and what was required for compliance.
- Data Protection policy and Breach Management policy completed and on the Information Governance Pod for staff to access. Subject Access Request guide updated also. These will be reviewed annually. Monitoring awareness will be ongoing.
- Privacy Notices have been updated for each service area and made available to service users. This will be under constant review and updated

Further Mitigation (what more should we do to reduce residual risk to our risk appetite level) and opportunities	**Officer responsible**	**Target date**
Need to test application of training by officers and monitor both the effectiveness and that the right staff handling sensitive data is prioritised.	CMT	Ongoing
GDPR introduces increased fines and data subjects' legal right to compensation. The latter is likely to create a spawn of litigation that will be very costly and labour intensive to manage, plus reputational damage	CMT	Ongoing

should there be any change as to how personal is processed. • Teams have completed DPIA's documenting what personal they are processing. These are to be reviewed annually. • The Council now has retention schedules for each directorate. All retention schedules have been updated and will be reviewed to ensure they are compliant with any future updates. The retention schedules are available to all staff and all directorates are expected to follow them to ensure compliance.	

Risk 4: *The Council does not follow its own governance procedures leading to failure to deliver services and/or value for money and/or it can be challenged through a legal process*

Risk Owners: Head of Legal/ Director of Resources

Corporate Priority: *Ensuring the Council is fit for the future, Securing the economic success of Reading. Improving access to decent housing to meet local needs. Protecting and enhancing the lives of vulnerable adults and children, Keeping Reading's environment clean, green and safe. Promoting great education, leisure and cultural opportunities for people in Reading*

Risk Rating (Impact x Likelihood)

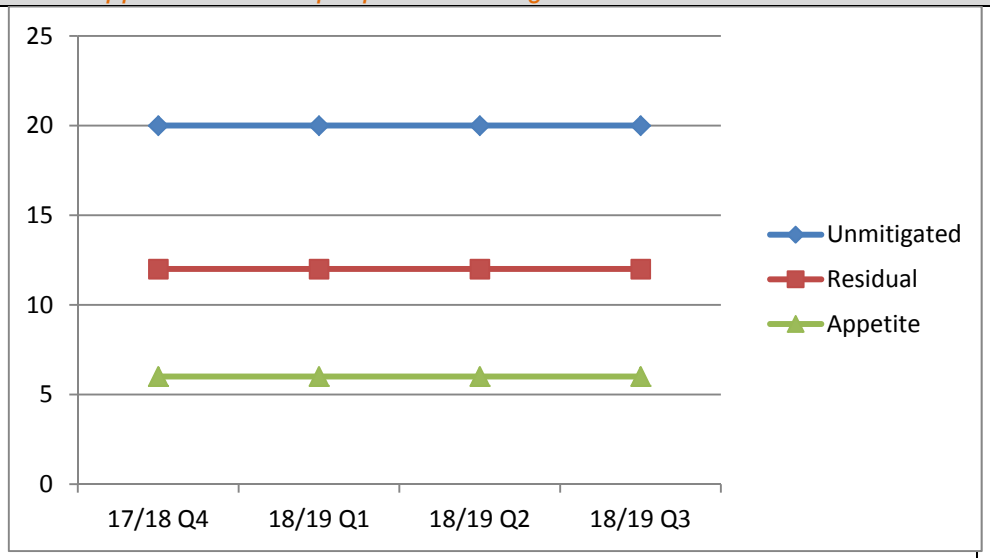
Unmitigated 5 x 4

Current Residual 4 x 3

Appetite 3 x 2

Potential Impact

Breach of governance procedures could lead to adverse Ombudsman, Ofsted, External Audit, Care Quality Commission opinions and/or Legal challenge from those who interact with the Council



Rationale for current score:

While controls are in place, they are not always being followed. Processes are improving as are training and policies, but the impact of this is not yet proven. The Council's AGS suggests progress still needs to be made to reduce the residual risk.

Rationale for risk appetite

A Council should be a model of propriety and control to ensure confidence in its handling of public assets. Hence the likelihood of non-compliance should be at a minimal level.
Good governance underpins all work to achieve the Council's targets

Current RAG rating	RED

Current Actions *(What we are currently doing about the risk– Causes Unmitigated Score to reduce to Residual)*

- Follow up on Audit Recommendations to ensure that they are all dealt with fully so that systems, processes and compliance are improved. Recommendation tracker presented to A&G along with limited assurance audit reports in full.
- The induction programme for new members of staff includes guidance to certain key governance policies (including the Code of Conduct);
- Staff code of conduct issued with contracts of employment for all staff
- Strategic risk register to be kept up to date and reviewed promptly.
- Roll out of net consent for policy management; recently used for GDPR training.
- Risk management training completed or planned for Heads of Service & Directors
- Code of Conduct relaunched.
- Budget managers trained in Nov 17
- Refreshed anti-fraud & corruption and anti-money laundering policy approved by policy committee in April 2018.

Further Mitigation (what more should we do to reduce residual risk to our risk appetite level) and opportunities	**Officer responsible**	**Target date**
A new budget management training module is in progress of being prepared and will be rolled out across the organisation in the Autumn	Head of Finance	Jul 18
Local Code of Corporate Governance for RBC to be updated to conform to CIPFA/SOLACE guidelines.	Policy Officer	Sept 18
Continue to use the Directorate Performance Steering Groups to drive compliance	Head of Finance	Continuous
Financial Regulations are currently being updated and will be rolled out as soon as approved	Head of Finance/ Director of Resources	Q3
HR policies and procedures are being reviewed and updated	Head of HR	December 2019

Risk 5: *Failure of major contract causes financial, service delivery, legal and H&S issues which directly impact the Council - (Care Homes, Home Care, ICT, OOH Call Handling, EDS etc)*	**Risk Owners:** Head of Strategic Commissioning, Quality and Wellbeing (DACHS)

Corporate Priority: *Ensuring the Council is fit for the future, Securing the economic success of Reading. Protecting and enhancing the lives of vulnerable adults and children.*

Risk Rating (Impact x Likelihood)

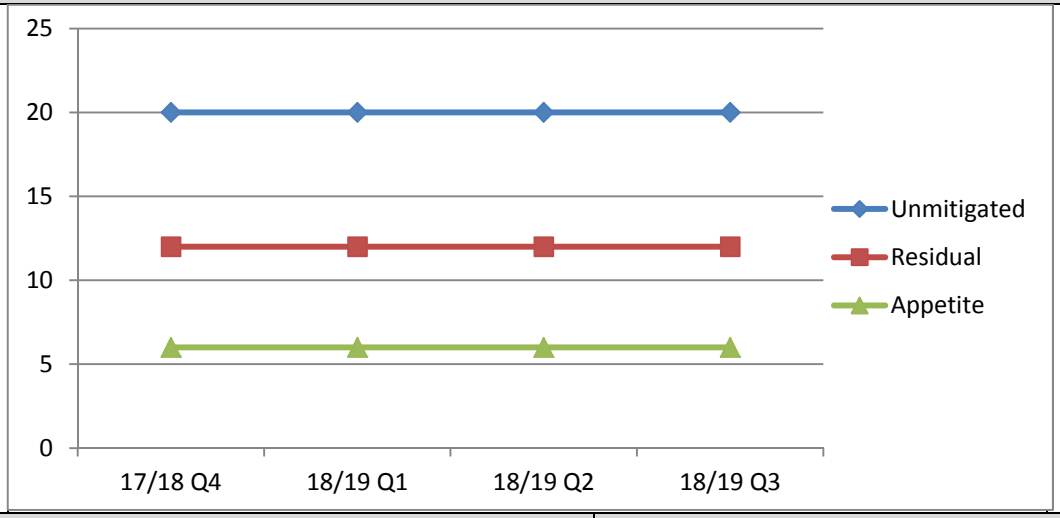
Unmitigated 5 x 4

Current Residual 4 x 3

Appetite 3 x 2

Potential Impact

Disruption to services. Failure to meet statutory duties



Rationale for current score:

Increasing pressure on children's/adults social care due to changing demographics.

Rationale for risk appetite

Tolerance is relatively low due to knock on effect on service delivery

Current RAG rating	**RED**

Current Actions*(What we are currently doing about the risk– Causes Unmitigated Score to reduce to Residual)*

- Providers are required to have a business continuity plan in addition where the provider is not an RBC run service the plans of each independent provider are checked as part of the ASC contract monitoring procedures.
- Contracts with the voluntary sector retendered and being implemented.
- Agreed a Section 75 for the Better Care Fund
- Business Continuity Plans reflect critical functions.
- Key contracts are monitored on a regular basis as part of the contract performance mechanisms in place for all contractors. This should address any capacity or performance issues that might indicate that there may be issues with financial/general viability
- Financial assessments of tenderers undertaken for all major contracts let by the Council and annual financial assessment checks where appropriate for major contractors
- To raise profile of having effective contract management in place
- The ASC provider failure protocol has recently been updated and approved

Further Mitigation (what more should we do to reduce residual risk to our risk appetite level) and opportunities	**Officer responsible**	**Target date**
Plans to shape the market place are progressing well – this includes community and faith sector, homecare, care homes and supportive living services across Reading – issue of new dynamic framework contracts that are fit for the future	Head of Commissioning - DACHS	Q1 19/20
The implementation of the Directorates Strategy for Adults and Health "Supporting Our Future", Three Year Commissioning Plan, and Market Position Statement.	Head of Commissioning - DACHS	Q4 18/19
Market engagement events in place – consulting the views of providers on cost of care modelling and quality monitoring.	Head of Commissioning - DACHS	Q4 18/19
Seeking solutions to work SMARTER across Children and Adults – commissioning under prevention frameworks.	Head of Commissioning - DACHS / Head of Procurement	2019/20

Risk 6: Insufficient vision and strategy for regeneration and economic growth leading to a lack of long-term investment in strategic infrastructure and consequential decline in economic growth and prosperity in Reading and the wider sub-region.

Risk Owners: Director of Environment & Neighbourhood Services

Corporate Priority: *Securing the economic success of Reading*

Risk Rating (Impact x Likelihood)

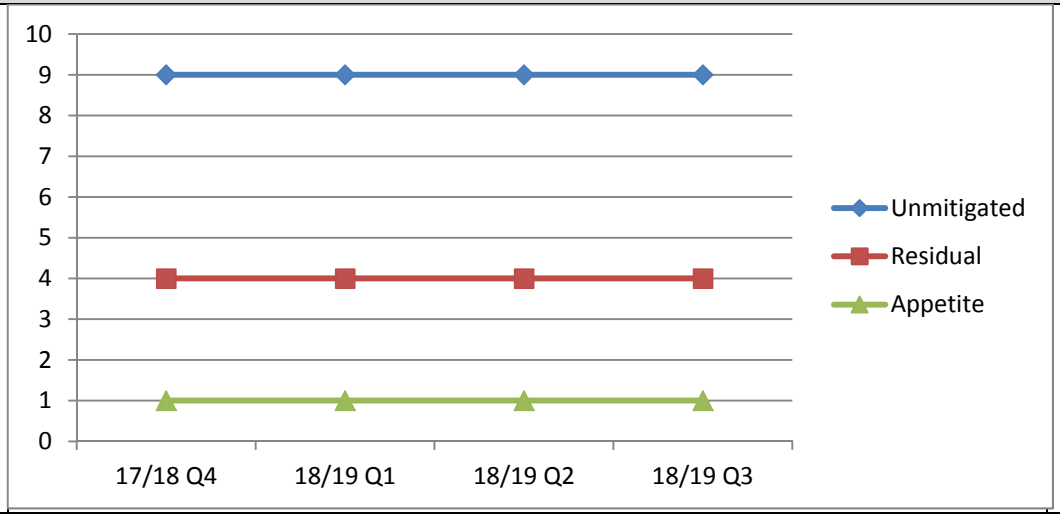
Unmitigated 3 x 3

Current Residual 2 x 2

Appetite 1 x 1

Potential Impact

Declining growth in Reading will present less job opportunities and a likely decline or stagnating incomes/living standards.



Rationale for current score:

Reading's (and the wider Thames Valley) economy remains relatively buoyant but will potentially be negatively affected by wider economic trends, including the impact of Brexit. The Council's role in creating the right conditions for growth is however significant.

Rationale for risk appetite:

The economic success of the town is critical to quality of life and also has an inherent link to demands on Council services as well as income.

Current RAG rating	RED

Current Actions*(What we are currently doing about the risk– Causes Unmitigated Score to reduce to Residual)*

- A33 MRT schemes underway – phases 1 & 2 delivered, phases 3 & 4 due for completion end 2019. (Future phases subject to funding).
- Green Park station project – site mobilisation works commenced in Autumn 2018 with station opening in Winter 2019
- Cow Lane Bridges widening – Work underway, scheduled to be re-open to 2 way traffic Summer 2019.
- East MRT – Revised planning application refused by Wokingham Borough Council. Approved capital grant funding from the Local Enterprise Partnership now has to be returned due to the inability to meet the approved programme and grant conditions. Next steps under review.
- Smart City Cluster Project – A 1.73million grant has been obtained to create an Internet of Things communication platform to gather and distribute data such an environmental and traffic information.
- The Council's new Local Plan setting out how Reading will develop up to 2036 ensuring housing, economic, environmental and social needs are met will be examined in September 2018.
- The full housing needs required up to 2036 cannot be delivered within the Borough. RBC is working with Councils within the Western Berkshire Housing Market Area through an agreed MoU to ensure that the full housing needs are accommodated.

Further Mitigation (what more should we do to reduce residual risk to our risk appetite level) and opportunities	Officer responsible	Target date
A project to install a 3rd Thames Bridge at East Reading at the base of the A329 is being worked up with neighbouring local Authorities. This would ease traditional bottlenecks at Reading and Caversham Bridges, also reducing Town centre congestion as traffic would no longer be required to travel from the A329 through the Town Centre to the current bridges	Strategic Transport Programme Manager	TBC – subject to funding
Visioning work and public consultation to be undertaken to inform the emerging Local Transport Plan	Head of Transport	Summer 2019
Continue to develop a comprehensive network of sustainable travel choices, such as Park and Ride, enhanced public transport cycling and walking routes.	Strategic Transport Programme Manager	Ongoing – forms a part of the Council's Local Transport Plan

Risk 6 continued

Current Actions*(What we are currently doing about the risk– Causes Unmitigated Score to reduce to Residual)*

- Joint work with Reading UK CIC to market and promote the town and proposals to expand the Business Improvement District to continue investment in a high quality town centre offer and explore opportunities to improve the public realm.
- Joint work with the TV Berkshire LEP to produce Local Industrial Strategy
- Delivery of a comprehensive cultural programme to raise Reading's profile, including for inward investors, with this being a key shared endeavour with the Council, Reading UK and the University as key partners, including:
  - Re-opening the Abbey Ruins to the public and as a venue for a range of events and activities;
  - Further development of the Abbey Quarter, including significant investment in the Town hall & Museum;
- Delivery of the three year 'Great Places' scheme, including a new annual Reading-on-Thames Festival.

Further Mitigation (what more should we do to reduce residual risk to our risk appetite level) and opportunities

Secure appropriate and high quality development / re-development of the Reading Prison site to enhance the attractiveness of the town centre / Abbey Quarter as a destination.	Head of Planning, Dev. & Regulatory Services	Ongoing and subject to MoJ
Further develop delivery plans to achieve the 2050 vision and to secure additional resources linked to these plans building on 'Smart City' investment already secured.	Head of Economic & Cultural Dev.	Ongoing

Risk 7: *The Council doesn't take adequate mitigation to reduce the risk of injury or death from incidents within Council residential accommodation and private high rise within the borough*

Risk Owners: Director of Environment & Neighbourhood Services

Corporate Priority: *Improving access to decent housing to meet local needs*

Risk Rating (Impact x Likelihood)

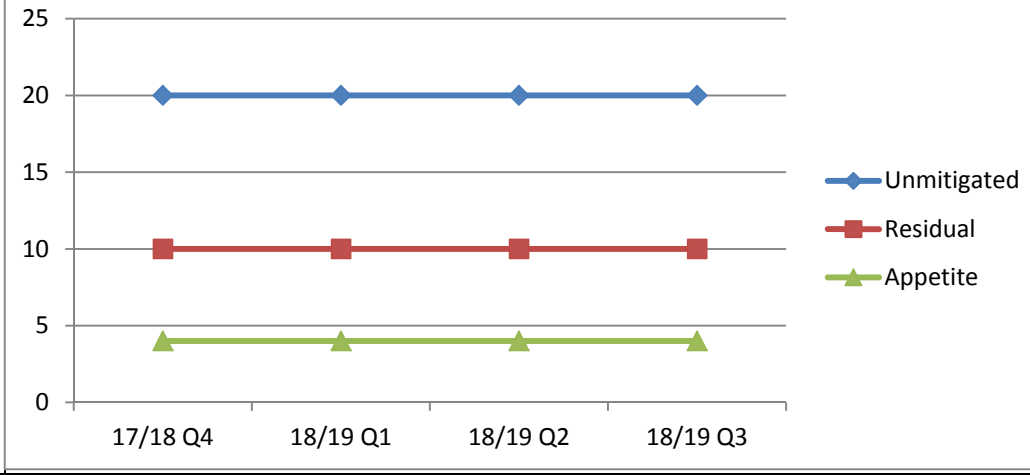
Unmitigated 5 x 4

Current Residual 5 x 2

Appetite 4 x 1

Potential Impact

Death/Injury to individuals and/or non-compliance with relevant legislation



Rationale for current score:
A significant amount of work has been undertaken and is underway (across the Council and Fire Service) following Grenfell Tower to address the issues raised by that incident. This has reduced the likelihood of a significant fire related incident but the impact remains high.

Rationale for risk appetite

The Council has a low appetite for injury or death to its residents tenants. Considering that the impact of an incident is potentially a fatality, the Council's residual risk score may never reach our appetite.

Current RAG rating	RED

Current Actions *(What we are currently doing about the risk– Causes Unmitigated Score to reduce to Residual)*

- Detailed Housing Service action plan completed in respect of fire safety post Grenfell Tower. H&S compliance monitoring has been reviewed and strengthened.
- Council 7x high rise housing blocks (post Grenfell Towerer fire): RBFRS have visited all high rise blocks; fire safety information sent to all tenants – visits to all over 65s completed Oct; an independent external review of Council Housing fire safety measures and systems in high rise blocks and wider management practice was commissioned and has now reported. This included Type 4 intrusive Fire Risk Assessments of sample high rise and other higher risk low rise blocks. Overall findings were positive. Advice re additional fire safety measures proposed to proactively improve safety in flatted blocks have been been costed and scheduled – this has resulted in a capital requirement over 5 years of circa £6-7m in the Housing Revenue Account. Report to HNL (14 March 2018) updated. Works have been or are being commissioned according to our 5 year programme of works.
- 350 RBC flatted residential blocks all had an FRA completed at end December 2017.
- A block inspector regularly checks all blocks and housing officers are on site most days to ensure frequent monitoring. From this year every flat within the blocks will have their smoke alarm tested every year and tenants are encouraged to check them weekly.
- Across housing tenures, a total of 86 residential buildings over 18 meters in height have been identified within the Reading Borough Council administrative area including the 7 local authority blocks. The Council agreed a memorandum of understanding (MoU) with the Royal Berkshire Fire and Rescue Service (RBFRS) and

Further Mitigation (what more should we do to reduce residual risk to our risk appetite level) and opportunities	Officer responsible	Target date
In 2018/19 a wider external audit of health and safety practice in Housing has been commissioned. It is intended that an annual audit will now be carried out with a different agreed focus each year. Audit completed – managers responding to draft report with clarifications. Report and action plan to be finalised:	Head of Housing and N'hoods	Jan 2019
Work with owners to remove cladding from three number high rise properties. Work to remove cladding on one building has commenced. Address issues raised following the joint RBRFS inspections.	Head of Planning Devp. & Regulatory Services.	Ongoing

completed joint visits on a risk based approach. Working with owners to remove ACM cladding on three number high rise buildings. Interim measures in place to secure safety of residents. Regular reporting to DHCLG. • Corporate working group set up to review, agree and implement actions arising.	

Risk 8: *Partnerships – Failure to develop and maintain key partner relationships results in failure to deliver key shared outcomes*	**Risk Owners:** Head of Customer Care and Transformation and Head of Strategic Commissioning and Wellbeing
Corporate Priority: *Securing the economic success of Reading. Improving access to decent housing to meet local needs. Protecting and enhancing the lives of vulnerable adults and children*	

Risk Rating (Impact x Likelihood)

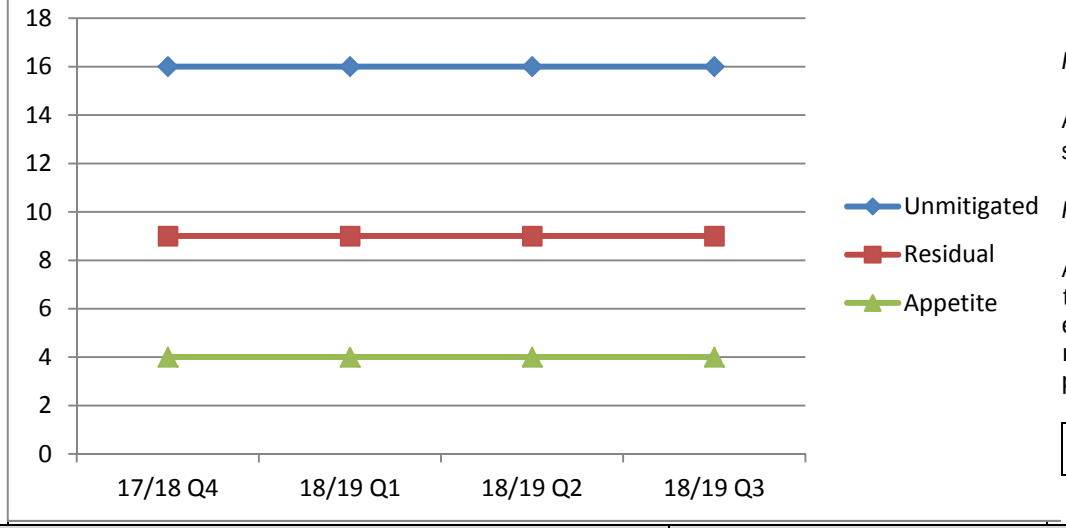
Unmitigated 4 x 4

Current Residual 3 x 3

Appetite 2 x 2

Potential Impact

Community needs not met Negative impact on community cohesion which could lead to extremism. Increased risk of failure of voluntary sector umbrella support



Rationale for current score:

A number of partnerships are embedded to secure strategic and operational outcomes.

Rationale for risk appetite

Appetite fairly low as the Council seeks to meet the needs of the community and maximise effectiveness and compliance with statutory requirements though working closely with key partners.

Current RAG rating	**RED**

Current Actions*(What we are currently doing about the risk– Causes Unmitigated Score to reduce to Residual)*

- Reading 2050 vision document sets out a shared view of key priorities for the future of Reading. We will be working with partners across the town to identify the actions needed to deliver this vision a Reading Futures Commission group made up of key partners is being set up to steer this.
- Community Safety Partnership – brings together the Council, Police and a wider range of partners and agrees clear joint strategic priorities with activity monitored through a number of delivery groups reporting to the partnership; regular and structured liaison is in place between RBC/Police at a range of tiers.
- Local Enterprise Partnership and joint working to influence investment in infrastructure, skills and private sector to support economic growth.
- Cultural Partnership and Cultural Education Partnership to drive delivery of a cultural renaissance and contribute to achieving priority social outcomes, including educational attainment, employment and employability, health and well-being (targeting more vulnerable groups / communities).
- We have set up quarterly meetings of the chief executives voluntary and community sector sounding board to identify areas for joint working on key areas of concern
- Key stakeholder meetings are held with key partners on an ongoing basis
- One Public Estate Partnership – to oversee and implement shared property ambitions

Further Mitigation (what more should we do to reduce residual risk to our risk appetite level) and opportunities	**Officer responsible**	**Target date**
Directors to identify key areas for working with the voluntary community and faith sector in the development of Reading new framework – supporting early intervention and prevention across all need groups.	Head of Strategic Commissioning - DACHS	April 19

across the public estate. • CSC – participation in statutory and strategic partnerships to include Local Safeguarding Board, Children's Trust Board, Children's Services Improvement Board, Health & Wellbeing Board. Strategic Management Group (TVP)	

Risk 9 : *Children's Company – Failure to make the successful transition to a viable independent local authority trading company to provide children's services*	**Risk Owners**: Chief Executive
Corporate Priority: *Protecting and enhancing the lives of vulnerable adults and children*	

Risk Rating (Impact x Likelihood)

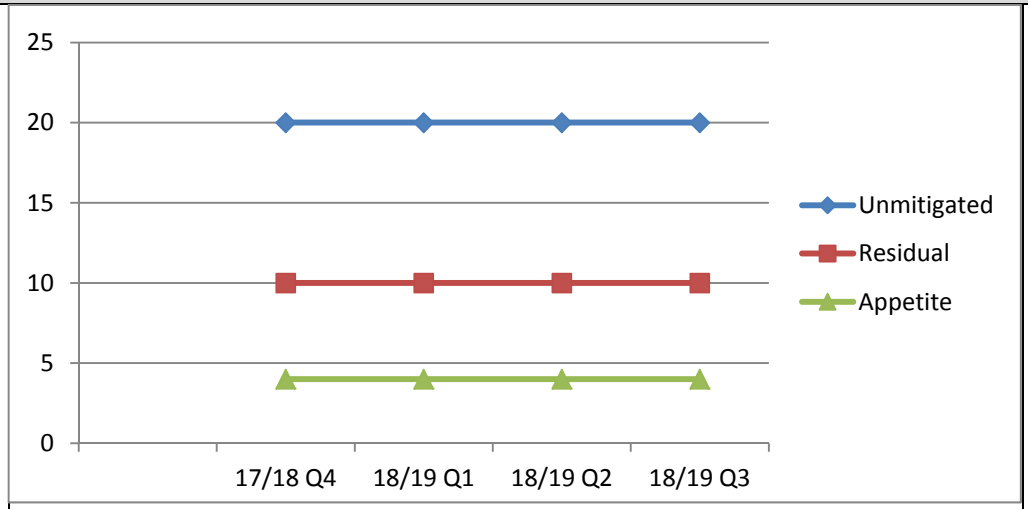
Unmitigated 5 x 4

Current Residual 5 x 2

Appetite 5 x 1

Potential Impact

Death/Injury to individuals and/or non-compliance with relevant legislation



Rationale for current score: The impact of not setting up the company given the direction from the DfE would be significant, potentially leading to the service moving to another Council. The risk is being mitigated via a robust governance process, engagement of specialist suppliers with a strong track record in this area and clearly identified internal work stream leads.

Rationale for risk appetite: Given the nature of the task, it would be difficult to reduce the risk appetite. We will expect as the programme progresses that the risk would remain moderate.

Current RAG rating	**AMBER**

Current Actions*(What we are currently doing about the risk– Causes Unmitigated Score to reduce to Residual)*

- A robust governance structure was put in place with the support of specialist support from Mutual Ventures who were engaged to provide programme management and specific expertise and track record in setting up a Children's Company.
- The Council has reviewed its own capacity to set up the company and engaged specific additional resources where identified to ensure operational capacity.
- Following a robust review of transition costs, a S31 grant was awarded by government to support to the work required to implement the company
- A detailed and comprehensive programme plan was developed to ensure that all the requirements of the new company were met and delivered to timescale.
- This was supported by detailed work stream plans which were updated regularly.
- A risk register for the project was developed to capture and assess all project risks by work stream.
- A chair with excellent experience was appointed along with other non-executive directors with a range of skills and experience to complete the board.
- Service level agreements in place between Council Services and Bffc

Further Mitigation (what more should we do to reduce residual risk to our risk appetite level) and opportunities	**Officer responsible**	**Target date**
Final tasks following go-live are being overseen by retained project resource within BFFC – working in conjunction with Council officers	Chief Executive	Feb 2019

Risk 9 continued	
Current Actions*(What we are currently doing about the risk– Causes Unmitigated Score to reduce to Residual)* • A director of children's services has been appointed • A Key Decisions document has been developed for the project. The purpose of this document is to act as a 'blue print' for all decisions required to set-up the company – capturing assumptions and in principle decisions to ensure project direction. • An MOU is in place between RBC and the DfE which provides a framework for the establishment of the company. • The development and signing of the contract between the Council and the Company was advised by legal firm Burges Salmon who had previous experience of a contract of this nature • A further £250k s31 grant has been agreed to support further the establishment of the company following go live on 1st December. • A project manager has been retained to oversee the final tasks to set up the company working with key workstream leads in the Council	

Risk 10: *Safeguarding* (incorporating *Criminal Exploitation & CSE) - Risk of death harm or injury to vulnerable persons for whom we have a responsibility*

Risk Owners: Director of Adult & Director of Children's

Corporate Priority: *Protecting and enhancing the lives of vulnerable adults and children*

Risk Rating (Impact x Likelihood)

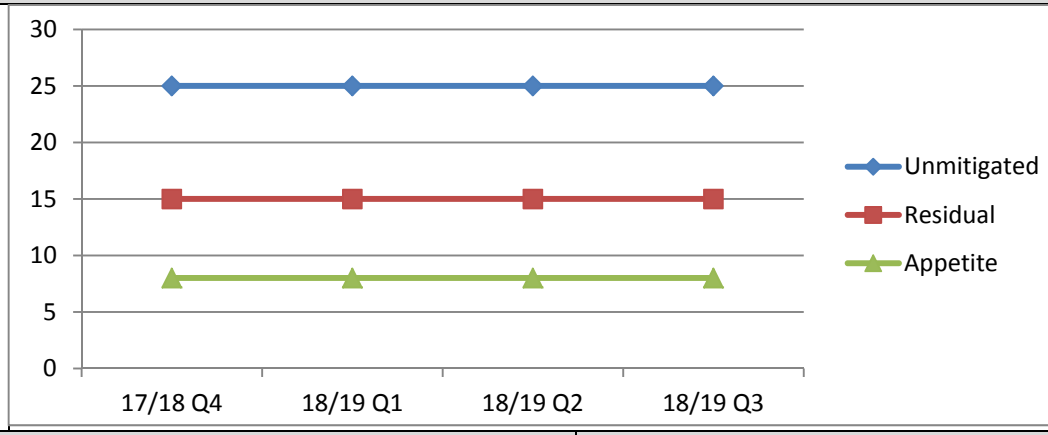
Unmitigated 5 x 5

Current Residual 5 x 3

Appetite 4 x 2

Potential Impact

Death or injury. Loss or reputation. Fines/penalties. Insurance claims



Rationale for current score:

Risk of death or serious injury

Rationale for risk appetite

Given the risk relates to the safeguarding of vulnerable individuals the risk appetite is low.

Current RAG rating	RED

Current Actions*(What we are currently doing about the risk– Causes Unmitigated Score to reduce to Residual)*

- From January 2018 Safeguarding Team Manager to sign off all Safeguarding cases before closure.
- In instances where there is a serious concern or death, in unexplained circumstances or where abuse is suspected, these cases are report to The Safeguarding Adults Board which has a Serious Concerns Group where consideration is given to further investigations, independently if required. If necessary, recommendations are referred back to the Local Authority or RBC. Service Improvement Plan in place to deliver service improvements across the whole of Children's Services reporting to an independently chaired Improvement Board
- Regular 3 monthly Ofsted visits to ascertain quality of service delivery to vulnerable children
- Reduction in open CSC cases achieved through successful step downs (1792 average 17/18 to 1472 Q1 18/19)
- Review of the Child Sexual Exploitation hub and realigned support. Managed jointly with senior partners within the LSCB, Pan Berks Child Exploitation sub group established. MERG and EMRAC providing a centralised multi agency case oversight to ensure timely response to children at risk of being exploited. Strategy meetings are held for all Criminal Exploitation referrals
- Bid submitted to Home Office for Trusted Relationships Fund unsuccessful. Partnership bid to Early Intervention Fund being coordinated by OPCC
- Maintaining dedicated exploitation social workers and co-ordinator
- Submission of Transformation Plan to Chief Executive
- Review of policies and procedures in Operations and Commissioning to ensure

Further Mitigation (what more should we do to reduce residual risk to our risk appetite level) and opportunities	Officer responsible	Target date
Delivery Early Intervention Strategy in DCEEHS to reduce demands on statutory services	Strategic Early Help Lead	Dec 18
Develop Readings Making Safeguarding Personal through Quality Assurance Framework with West Berkshire Partners – lead to - single operating framework, single reporting system and single governance. Will inform all new and current contracts.	Head of Strategic Commissioning - DACHS	April 2019
Develop Council wide response to Modern Slavery	Public Health Consultant	Ongoing
Align partners to focus resources and processes on high risk adolescents rather than just CSE	Strategic Early Help Lead	July 18
Weekly tracking of Adult Safeguarding referrals to commence in Jan 2019 and Adults Performance Boards in place to monitor and track the safeguarding pathway commencing September 2019.	Interim Head of Adult Social Care	Jan 19

a joint quality assurance framework in relation to providers where safeguarding concerns are raised.	

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READING BOROUGH COUNCIL
REPORT BY HEAD OF FINANCE

TO:	**AUDIT & GOVERNANCE COMMITTEE**		
DATE:	**24th JANUARY 2019**	**AGENDA ITEM:**	**8**
TITLE:	**TREASURY MANAGEMENT HALF YEARLY REPORT**		
LEAD COUNCILLOR:	**CLLR BROCK**	**AREA COVERED:**	**CORPORATE & CONSUMER SERVICES**
SERVICE:	**FINANCE**	**WARDS:**	**BOROUGHWIDE**
AUTHOR:	**MATT DAVIS**	**TEL:**	
JOB TITLE:	**HEAD OF FINANCE**	**E-MAIL:**	**Matt.davis@reading.gov.uk**

1. EXECUTIVE SUMMARY

1.1 The purpose of this report is to update Members on the activity of the Treasury Management function for 2018/19 as at 30 September 2018.

1.2 The report complies with CIPFA's Code of Practice on Treasury Management which requires that the Council receives a report on its Treasury Management activity at least twice a year. Specifically this report includes:

- a review of the Council's financial investment portfolio for 2018/19 as at 30 September 2018;
- a review of the Council's borrowing strategy for 2018/19;
- a review of compliance with the Council's Treasury and Prudential Limits for the first six months of 2018/19; and
- an economic update for the first part of the financial year.

1.3 The Council has complied with all elements of its Treasury Management Strategy Statement (TMSS) as agreed by Council in February 2018.

2. RECOMMENDED ACTIONS

That the Audit & Governance Committee:

2.1 Note the performance of the Treasury Management function for the six months to 30th September 2018 and the key issues emerging; and

2.2 Endorse the recommendations in the Treasury Management Strategy to Full Council in February 2019 to update the Minimum Revenue Provision policy and Commercial Investment policy set out in section 5. of this report.

APPENDICES

Appendix 1: Commentary on the economic backdrop for 2018/19.
Appendix 2: Approved counterparties and limits

3. BACKGROUND

3.1. The Local Government Act 2003 requires the Council to 'have regard to' the Prudential Code and to set Prudential Indicators for the next three years to ensure that the Council's capital investment plans are affordable, prudent and sustainable.

4. BORROWING

4.1. As at 30 September 2018 net borrowing was £328m, a decrease of £11m on the position at 31 March 2018. The decrease reflects the forecast pattern of the Authority's cash-flows and largely relates to the timing of grants, Council Tax and Business Rates received and capital programme slippage.

Table 1: Net borrowing position at 30th September 2018

	31 Mar 2018 £m	**30 Sep 2018 £m**
Total gross borrowing	382	382
Total cash invested	(43)	(54)
Net borrowing	**339**	**328**

4.2. As interest rates remain historically low, the Authority's main objective when borrowing is to strike a balance between securing low interest rates and achieving cost certainty over the period for which funds are required. This position provides short term savings with the flexibility to secure longer dated loans as and when financial forecasts indicate that external borrowing rates may increase.

4.3. Having raised the Base Rate in August 2018 to 0.75%, the Bank of England's Monetary Policy Committee has maintained expectations of a slow rise in interest rates over the next few years. Appendix 1 provides further commentary on the economic backdrop for 2018/19.

4.4. The Council's underlying need to borrow for capital purposes is measured by its Capital Financing Requirement (CFR), while usable reserves and working capital are the underlying resources available for investment. The Council's current strategy is to maintain borrowing and investment below their underlying levels, sometimes known as internal borrowing. In recent years this strategy has helped minimise the Council's net financing costs. Table 2 below sets out the CFR on the Council's Balance Sheet at 31.03.18, prior to Audit.

Table 2: Capital Financing Requirement at 31.03.18

	General Fund	**HRA**	**Total 31 Mar 2018 £m**
CFR	335	186	521
Less PFI liabilities	(27)		(27)
CFR / Underlying Borrowing Requirement	**308**	**186**	**494**
Less usable reserves and working capital	(155)		(155)
Net borrowing requirement	**153**	**186**	**339**

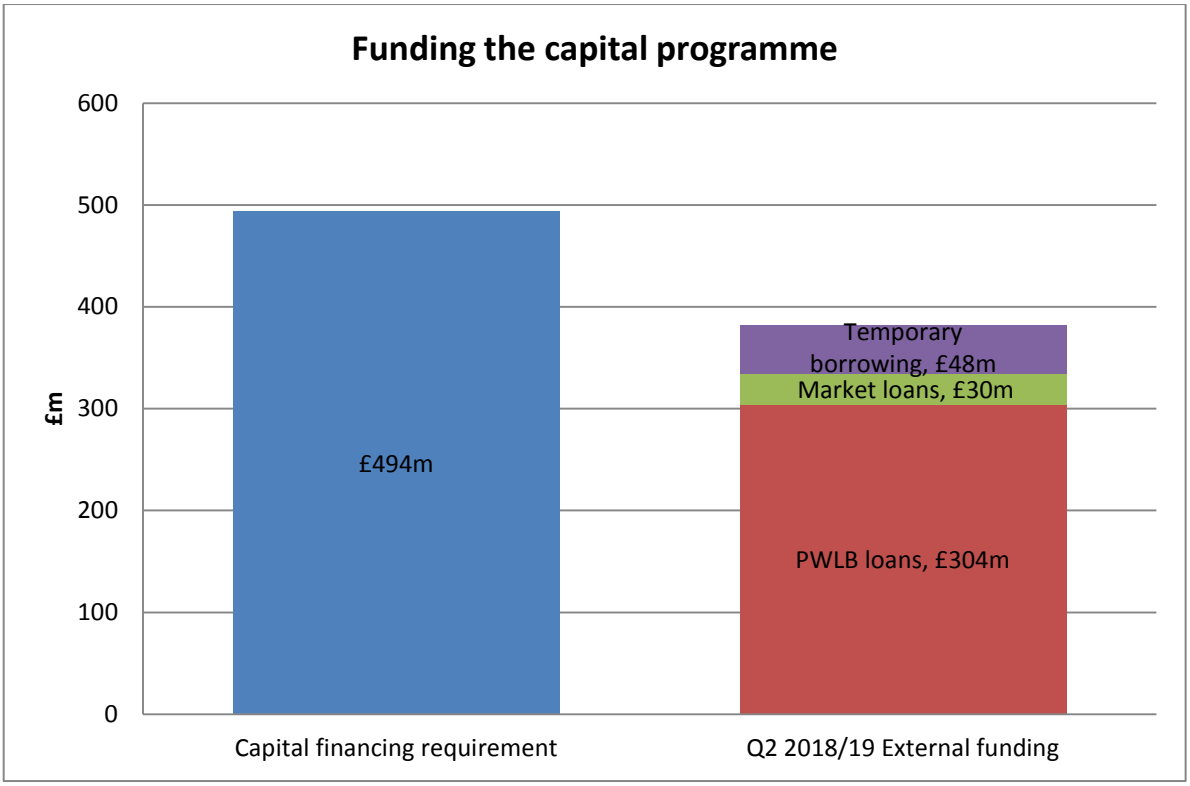
4.5. Table 3 below compares total external borrowing as at 30.09.18 to the position as at the end of the financial year 2017/18 and to the CFR available for borrowing after deducting PFI liabilities.

Table 3: Gross borrowing position

	31 Mar 2018 £m	**30 Sep 2018 £m**
PWLB	276	304
LOBO	25	25
Fixed term borrowing	5	5
Temporary borrowing – other LAs	76	48
Total Borrowing	**382**	**382**
CFR	494	494
Headroom	**112**	**112**

4.6. At £382m the Council's gross borrowing is well within the Prudential Indicator for external borrowing; £494m as set out in Table 3 above.

4.7. The graph below compares the Council's actual borrowing to its CFR after deducting PFI liabilities.



4.8. The Council sets both an annual Operational Boundary and Authorised Limit for borrowing. These limits are set above the CFR to accommodate day-to-day treasury operations and manage abnormal cash flows which may result in a temporary need to borrow. The Operational Boundary is the limit beyond which external borrowing is not normally expected to increase at any point during the year other than on a short term basis. The Authorised Limit is the limit beyond which external borrowing is prohibited.

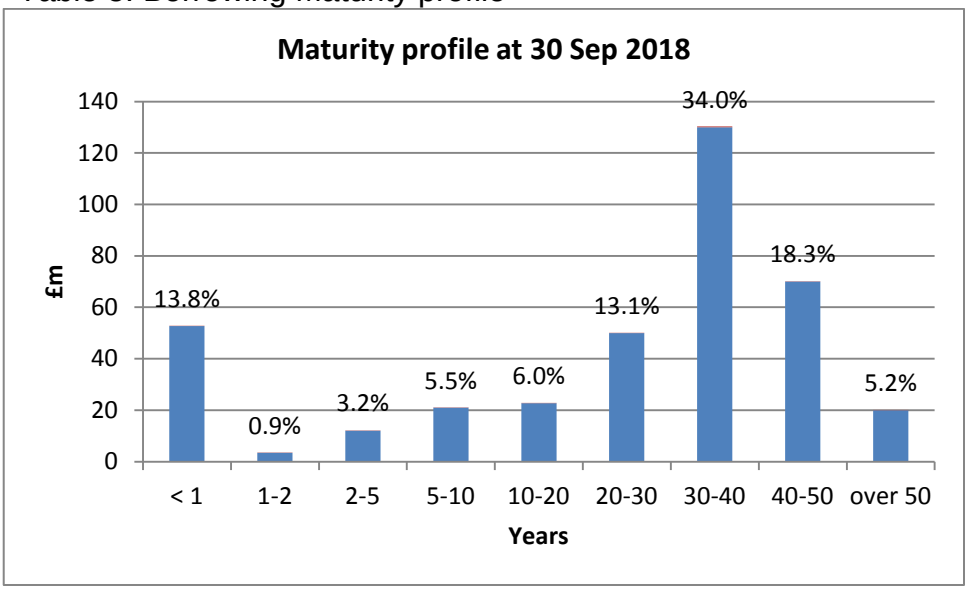
4.9. Table 4 below sets out the level of borrowing held as at 30 Sep 2018 against both the Operational Boundary and Authorised Limit for external borrowing. This demonstrates that the Council is comfortably within these limits.

Table 4: Borrowing vs. boundary/limits

	£m
External Borrowing as at 30 Sep 2018	382
Operational Boundary	540
Authorised Limit	560

4.10. Table 5 below sets out the maturity profile of the Council's borrowing portfolio as at the end of September 2018. As indicated in the graph at 4.7 above, the majority of loans are Public Works Loan Board (PWLB) loans and have a fixed interest rate and are long term in nature which limits the Council's exposure to interest rate fluctuations.

Table 5: Borrowing Maturity profile



4.11. The Treasury Management Strategy for 2018/19 anticipated new borrowing of up to £144m. To date the Council has so far just taken £30m of new borrowing. The additional borrowing has not been required because of slippage in anticipated capital spend, eg the Council have not made any further commercial property investments in 2018/19 and the capital programme anticipates £50m of spend.

5. REPAYING BORROWING – MINIMUM REVENUE PROVISION

5.1. Full Council approved the Minimum Revenue Provision (MRP) Statement for 2018/19 as part of its Council Tax and Budget Setting report in February 2018. This will be reviewed by Council in February as part of its consideration of the Council's Treasury Management Strategy alongside consideration of the Medium Term Financial Strategy 2019/20 – 2021/22.

5.2. It is proposed that the MRP Strategy is amended to reflect two specific changes:

- Not to charge MRP to the HRA on the basis that it has not been a mandatory requirement for a number of years and will allow greater freedom to spread the profile of HRA provision for debt repayment to later years, such that lower charges will be set aside in earlier years whilst broadly allowing for the same overall amount to be set aside over the 30 year planning horizon of the HRA Business Plan. This enables significant investment in additional social housing over the next few years. The business case and affordability of which sees rental income grow over the medium term, facilitating the financial benefits to mitigate debt financing costs.

- The Council's current Minimum Revenue Policy assumes no MRP charges will be made for the capital borrowing costs associated with

the purchase of investment properties. Such a policy contradicts the guidelines set out in the regulations updated by MHCLG in February 2018. The new Policy will address this contradiction and provide for an MRP charge on borrowing to fund investment property acquisitions, thereby allowing for repayment of debt in a similar manner to other capital expenditure funded by borrowing.

5.3. Audit and Governance Committee are requested to endorse these changes.

5.4. To date no investment property purchases have been made during 2018/19. Any further acquisitions will be in accordance with Counsel opinion and in line with the updated Treasury and Investment strategies being considered by Full Council in February 2019.

6. INVESTMENTS

6.1. The Council's Annual Investment Strategy forms part of its annual Treasury Management Strategy Statement (TMSS). The 2018-19 Strategy was approved by the Council on 28 February 2018. The objective of the Strategy is the prudent investment of balances to achieve optimum returns on investments subject to maintaining adequate security of capital and a level of liquidity appropriate to the Council's projected need for funds over time.

6.2. Table 6 below provides a breakdown of the Council's investments as at 30.09.18 compared to 31.03.18.

Table 6: Breakdown of investments

	31 Mar 2018 £m	**30 Sep 2018 £m**
Money Market Funds		
- Aberdeen	12	20
- Federated	9	4
CCLA property fund	15	15
Loan to Homes for Reading	4	12
Call Account	3	3
Total invested	**43**	**54**

6.3. The council budgeted to receive £1.3m from investments and is forecast to receive £1.4m for 2018/19.

6.4. Cash balances are managed through Money Market Funds providing same day access to funds while achieving a return on investment.

6.5. Other investments include the CCLA property fund and loans to Homes for Reading Ltd.

6.6. CCLA is a specialist investment management firm that acts on behalf of churches, charities and local authorities. The investment has produced quarterly returns ranging between 4% and 5%.

6.7. Although not currently classed as treasury management activities and therefore not covered by the CIPFA code, the Council also holds £26m of investments in directly owned investment property and £14m in loans to and shareholdings in its subsidiaries.

7. COMPLIANCE

7.1. During the financial year to September 2018, the Council operated within the Treasury Limits and Prudential Indicators set out in the TMSS approved by Council on 28 February 2018 as set out below.

PI ref	**Indicator**	**2018/19 indicator**	**Actual as at 30.09.18**	**Indicator met**
1	Capital Financing Requirement (CFR)	GF £425m HRA £190m	GF £335m HRA £186m	Met
2	Gross debt vs CFR less PFI liabilities	£112m under borrowed	£112m under borrowed	Met
3	Authorised limit for external debt	£560m	£382m	Met
4	Operational boundary	£540m	£382m	Met
5	HRA debt limit	£208m	£186m	Met
6	Limits for fixed interest rate borrowing maturity <10yrs	Upper limit 25% Lower limit 0%	23%	Met
7	Limits for fixed interest rate borrowing maturity >10yrs	Upper limit 100% Lower limit 40%	77%	Met
8	Investments in MMF (including CCLA)	Up to £20m each	See table 6	Met

8. FINANCIAL IMPLIACATIONS

8.1. Financial implications are contained in the body of this report

9. LEGAL IMPLICATIONS

9.1. The Local Government Act 2003 requires the Council to set out its Treasury Strategy for borrowing and to prepare an Annual Investment Strategy. This sets out the Council's policies for managing its investments and for giving priority to the security and liquidity of those investments. This report assists the Council in fulfilling its statutory obligation under the Local Government Act 2003 to monitor its borrowing and investment activities.

BACKGROUND PAPERS

- Treasury Management Strategy Statement for 2018/19 at Full Council 28 February 2018.
- CIPFA Code of Practice for Treasury Management in the Public Services 2018
- CIPFA The Prudential Code 2017

Appendix 1 – Economic background

Economy

A1 Oil prices rose by 23% over the six months to around $82/barrel. UK Consumer Price Inflation (CPI) for August rose to 2.7% year/year, above the consensus forecast and that of the Bank of England's in its August *Inflation Report*, as the effects of sterling's large depreciation in 2016 began to fade. The most recent labour market data for July 2018 showed the unemployment rate at 4%, its lowest since 1975. The 3-month average annual growth rate for regular pay, i.e. excluding bonuses, was 2.9% providing some evidence that a shortage of workers is providing support to wages. However real wages (i.e. adjusted for inflation) grew only by 0.2%, a marginal increase unlikely to have had much effect on households.

A2 The rebound in quarterly GDP growth in Q2 to 0.4% appeared to overturn the weakness in Q1 which was largely due to weather-related factors. However, the detail showed much of Q2 GDP growth was attributed to an increase in inventories. Year/year GDP growth at 1.2% also remains below trend. The Bank of England made no change to monetary policy at its meetings in May and June, however hawkish minutes and a 6-3 vote to maintain rates was followed by a unanimous decision for a rate rise of 0.25% in August, taking Bank Rate to 0.75%.

A3 Having raised rates in March, the US Federal Reserve again increased its target range of official interest rates in each of June and September by 0.25% to the current 2%-2.25%. Markets now expect one further rise in 2018.

A4 The escalating trade war between the US and China as tariffs announced by the Trump administration appeared to become an entrenched dispute, damaging not just to China but also other Asian economies in the supply chain. The fallout, combined with tighter monetary policy, risks contributing to a slowdown in global economic activity and growth in 2019.

A5 The EU Withdrawal Bill, which repeals the European Communities Act 1972 that took the UK into the EU and enables EU law to be transferred into UK law, narrowly made it through Parliament. With less than six months to go when Article 50 expires on 29th March 2019, neither the Withdrawal Agreement between the UK and the EU which will be legally binding on separation issues and the financial settlement, nor its annex which will outline the shape of their future relationship, have been finalised, extending the period of economic uncertainty.

Financial markets

A6 Gilt yields displayed marked volatility during the period, particularly following Italy's political crisis in late May when government bond yields saw sharp moves akin to those at the height of the European financial crisis with falls in yield in safe-haven UK, German and US government bonds. Over the period, despite the volatility, the bet change in gilt yields was small. The 5-year benchmark gilt only rose marginally from 1.13% to 1.16%. There was a larger increase in 10-year gilt yields from 1.37% to 1.57% and in the 20-year gilt yield from 1.74% to 1.89%. The increase in Bank Rate resulted in higher in money markets rates. 1-month, 3-month and 12-month LIBID rates averaged 0.56%, 0.70% and 0.95% respectively over the period.

Credit background

A7 Reflecting its perceived higher risk, the Credit Default Swap (CDS) spread for non-ringfenced bank NatWest Markets plc rose relatively sharply over the period to around 96bps. The CDS for the ringfenced entity, National Westminster Bank plc, has held steady below 40bps. Although the CDS of other UK banks rose marginally over the period, they continue to remain low compared to historic averages.

A8 The ringfencing of the big four UK banks - Barclays, Bank of Scotland/Lloyds, HSBC and RBS/Natwest Bank plc – is complete, the transfer of their business lines into retail (ringfenced) and investment banking (non-ringfenced) is progressing and will need to be completed by the end of 2018.

A9 There were a few credit rating changes during the period. Moody's downgraded Barclays Bank plc's long-term rating to A2 from A1 and NatWest Markets plc to Baa2 from A3 on its view of the credit metrics of the entities post ringfencing. Upgrades to long-term ratings included those for Royal Bank of Scotland plc, NatWest Bank and Ulster Bank to A2 from A3 by Moody's and to A- from BBB+ by both Fitch and Standard & Poor's (S&P). Lloyds Bank plc and Bank of Scotland plc were upgraded to A+ from A by S&P and to Aa3 from A1 by Moody's.

A10 Our treasury advisor Arlingclose will henceforth provide ratings which are specific to wholesale deposits including certificates of deposit, rather than provide general issuer credit ratings. Non-preferred senior unsecured debt and senior bonds are at higher risk of bail-in than deposit products, either through contractual terms, national law, or resolution authorities' flexibility during bail-in. Arlingclose's creditworthiness advice will continue to include unsecured bank deposits and CDs but not senior unsecured bonds issued by commercial banks.

Interest Rates

A11 Arlingclose's central case is for Bank Rate to rise twice in 2019. The risks are weighted to the downside. The UK economic environment is relatively soft, despite seemingly strong labour market data. GDP growth recovered somewhat in Q2 2018, but the annual growth rate of 1.2% remains well below the long term average

	Sep-18	Dec-18	Mar-19	Jun-19	Sep-19	Dec-19	Mar-20	Jun-20	Sep-20	Dec-20	Mar-21	Jun-21	Sep-21
Official Bank Rate													
Upside risk	0.00	0.00	0.00	0.00	0.00	0.00	0.25	0.25	0.25	0.25	0.25	0.25	0.25
Arlingclose Central Ca	0.75	0.75	1.00	1.00	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25
Downside risk	0.00	0.00	0.50	0.50	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75

A12 The view is that the UK economy still faces a challenging outlook as the minority government continues to negotiate the country's exit from the European Union. Central bank actions and geopolitical risks, such as prospective trade wars, have and will continue to produce significant volatility in financial markets, including bond markets.

Appendix 2 – Approved counterparties and limits

Counterparty		Cash limit	Time limit
Banks and other organisations and securities whose lowest published long-term credit rating from Fitch, Moody's and Standard & Poor's is:	AAA	£20m each	10 years
	AA+		5 years
	AA		4 years
	AA-		3 years
	A+		2 years
	A		1 year
	A-		
The Council's current account, Lloyds Bank plc should circumstances arise when it does not meet the above criteria		£1m	next day
UK Central Government (irrespective of credit rating)		unlimited	50 years
UK Local Authorities (irrespective of credit rating)		£20m each	50 years
UK Registered Providers of Social Housing whose lowest published long-term credit rating is A- or higher		£5m each	10 years
UK Registered Providers of Social Housing whose lowest published long-term credit rating is BBB- or higher and those without credit ratings		£2m each	5 years
UK Building Societies without credit ratings		£10m each	1 year
Money market funds and other pooled funds (including the CCLA Property Fund)		Up to £20m each	n/a
Any other organisation, subject to an external credit assessment and specific advice from the Council's treasury management adviser		£5m each	3 months
		£1m each	1 year
		£100k each	5 years

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF RESOURCES

TO:	**AUDIT & GOVERNANCE COMMITTEE**		
DATE:	**24 January 2019**	**AGENDA ITEM:**	**9**
TITLE:	**IMPLEMENTATION OF AUDIT RECOMMENDATIONS TRACKER**		
LEAD COUNCILLOR:	**COUNCILLOR BROCK**	**PORTFOLIO:**	**CORPORATE & CONSUMER SERVICES**
SERVICE:	**AUDIT**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**JACQUELINE YATES**	**TEL:**	**x74710**
JOB TITLE:	**DIRECTOR OF RESOURCES**	**E-MAIL:**	**Jackie.Yates @reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The outcomes of all internal and external audit reports are reported to this Committee.

1.2 Following discussion at the April Audit and Governance Committee it was agreed that to provide a greater focus on the importance of implementation of agreed audit recommendations an implementation tracker report would be reported to all future meetings of this Committee.

1.4 Appendix 1 attached sets out all of the current high and medium risk internal audit recommendations together with their latest agreed implementation date and the officer responsible for implementing them. Going forward all Internal and external audit recommendations will be added to the report.

Appendix 1 - Implementation of Audit Recommendations Tracker January 2019.

2. RECOMMENDED ACTION

2.1 The Committee are asked to note the report.

3. POLICY CONTEXT

3.1 This report supports the Council's objective of ensuring that it is fit for the future.

4. THE PROPOSAL

4.1 A summary of those high and medium risk Internal Audit recommendations which remained outstanding at the last Committee together with an updated management response is provided in Appendix 1 attached. 22 new recommendations have been added to the report since the last meeting. Going forward all new Internal and External audit recommendations will be

added to the tracker.

4.2 Prior to reporting to Committee officers responsible for implementing the specific recommendations are asked to update the 'implementation tracker'. Each recommendation is marked with a percentage complete which correlates to a red/amber/green rating depending on the percentage of completeness. Up to 25% complete is marked red, between 26% and 75% complete is amber and over 75% complete is green. However, any recommendations that are less than 50% complete but have exceeded their agreed completion date are also marked red.

4.3 Once recommendations are reported as being 100% complete to the Committee they will be removed from subsequent reports.

4.4 Where there is a lack of progress with implementation, e.g. successive missing of implementation dates etc. The Head of Service and responsible officer (if they are different) will be asked to attend a meeting of the Committee to explain the difficulties with implementation and the steps they are taking to address them.

4.5 There are 116 high and medium risk Internal Audit recommendations on the tracker attached at Appendix 1, of those

- 57 (49%) are currently green;
- 40 (34%) amber and
- 19 (16%) red

This is an improvement on the previously reported position, with the number of red status recommendations continuing to decline.
36 recommendations are completed and will be deleted from the next report.

The table below provides a comparison of progress against previous reports.

RAG Status	Audit & Governance meetings		
	August 18	September 18	January 19
Green	**24%**	**42%**	**49%**
Amber	**10%**	**18%**	**34%**
Red	**65%**	**41%**	**16%**

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The proposals contained in the report support the Council's Corporate Plan priority to:
Remain financially sustainable to deliver its service priorities.

8. LEGAL IMPLICATIONS

8.1 The Council has a duty under the Accounts and Audit Regulations to ensure it has in place a financial control framework which is fit for purpose. It also has a duty to ensure Value for Money in the provision of services.

9. FINANCIAL IMPLICATIONS

9.1 Whilst there are no specific financial implications arising directly from this report, the timely implementation of audit recommendations is critical in strengthening the Council's internal control and governance arrangements.

9.1 The Council's Chief Internal Auditor's reports have over several years repeatedly reported that audit recommendations made in previous audits have not been implemented. This does not represent value for money from either an audit or wider organisational perspective.

9.2 Poor systems of internal control and financial governance potentially leave the Council exposed to loss and will result in higher external audit costs due to the lack of assurance they provide and the consequential higher testing thresholds required by the Council's external auditors.

9.3 Whilst there are still a large number of recommendations that are rag rated red, there has been positive engagement with the new arrangements and significant improvement since implementing the new tracking and reporting process

10. BACKGROUND PAPERS

10.1 Internal Audit Reports presented to Audit and Governance Committee, Chief Internal Auditors Annual Report 2017 & 2018.

Rec No.	Dir	Audit Title	Recommendation	Rec Yr.	Original Audit Completion Date	1st Follow-up Date	Responsible Officer	Responsible Officer Latest Update	Updated on (date)	Status (% Complete)	Overall Status
1	DoR	**Bank rec & control account reconciliations**	1. A corporate approach for producing reconciliations, evidencing balances and for monitoring the completion status, issues and their resolution needs to be produced and agreed. 2. Greater staff/resource resilience is required to ensure the reconciliations are completed on a timely basis throughout the year. 3. Departments should be required to provide a reconciliation position statement each month. 4. Response will be addressed in rec 5 2017-18 action plan 5. In conjunction with recommendation 3, reconciliation needs to be brought up to date. 6. The completion and review of the bank reconciliation status MUST be a monthly key priority.	16/17	9-Feb-17	4-Oct-17	Matt Davis - Head of Finance, Jean Stevenson - Chief Accountant **Reconciliation officers:** Bank & cash – Jean Stevenson Creditors – Jean Stevenson Ctax, HB, NNDR, Debtors – Sam Wills Payroll – Sharon Brown Rents – Zelda Wolfle	Bank & Cash - The bank reconciliation is now up to date and the procedure notes are being finalised. (JS) Creditors - There is a small system problem between the Accounts Payable and General Ledgers (circa £4k) that is being investigated by Oracle. The historic manual journals were reconciled as part of the 2016/17 accounts process and are in the process of being resolved as part of the 2017/18 accounts process. (JS)	18-Dec-18	**76 or more**	
2	DoR	**Bank rec & control account reconciliations**	The Head of Finance should ensure there is sufficient resource available to properly and robustly plan, execute, test and implement the accepted bank and cash reconciliation process	16/17	9-Feb-17	4-Oct-17	Jean Stevenson - Chief Accountant / Matt Davis - Head of Finance	Resources remain tight following the Finance restructure and a review will be required once the 2017/18 accounts are closed to confirm where reconciliation work is best undertaken. A larger group of staff are now involved in the bank reconciliation processes. The new Technical Accountant has now taken over responsibility.	18-Dec-18	**51 to 75**	
3	DoR	**Bank rec & control account reconciliations**	Following implementation of recommendation 1 of last years action plan, business process documents should be written for each reconciliation process to include: • Purpose of the procedure (impact on council) • Clearly define the outcome of the process • Name the process in accordance with naming conventions • Define the start and end of the process • Outline who does what and responsibilities – not person specific but role specific • Tools to complete the process, Systems, printing, marking etc. • Exceptions – if process goes wrong, system down etc. • Individual steps to get from start to finish • Reports used etc. • What to do when completed – balanced and unbalanced, actions, financial levels, responsibilities and authority • Review and sign off by the Head of Finance • Reporting framework • Evidence • Storage & protection	16/17	9-Feb-17	4-Oct-17	Jean Stevenson - Chief Accountant / Matt Davis - Head of Finance	Procedures are now being finalised and they will then need to be tested in operation and reviewed by the Technical Accounting team.	18-Dec-18	**51 to 75**	
4	DoR	**Bank rec & control account reconciliations**	The Head of Finance should provide guidance and advice on the treatment of historic reconciling adjustment items for all system reconciliations. Likewise technical advice should be given in respect of those systems reconciliations that continue to have unreconciled balances.	16/17	9-Feb-17	4-Oct-17	Matt Davis - Head of Finance	The historic differences on the bank reconciliation have now been written out. Other discrepancies are in the process of being written off as part of the finalisation of the 2017/18 accounts. This process will be complete by the end of January. Monthly review will then be conducted to ensure that reconciling items are cleared promptly.	18-Dec-18	**51 to 75**	

Rec No.	Dir	Audit Title	Recommendation	Rec Yr.	Original Audit Completion Date	1st Follow-up Date	Responsible Officer	Responsible Officer Latest Update	Updated on (date)	Status (% Complete)	Overall Status
5	DoR	**Bank rec & control account reconciliations**	The 'unresolved' suspense items on Academy should be periodically (quarterly) checked to Academy to ensure correct recording. The Head of Finance should agree the treatment of historic unresolved items.	16/17	9-Feb-17	4-Oct-17	Matt Davis - Head of Finance/ Jean Stevenson - Chief Accountant	Reconciliations to the end of March 2018 are being reviewed as part of the closure of 2017/18 accounts and ongoing reviews will then need to be organised	18-Dec-18	**51 to 75**	
6	DCEEH	**Childcare**	It is recommended that the possibility of all settings using First Steps is investigated. It is recommended that enquiries are made to establish whether the current access can be used to differentiate between each childcare setting/business unit, as this may promote the opportunity to sharing a single finance resource and the associated cost.	16/17	20-Mar-17	30-Jan-18	Corinne Dishington - Children's Centre Team Manager	First Steps is being further investigated and will be purchased as budgets permit	17-Sep-18	**51 to 75**	
7	DoR	**Corporate Savings (Governance)**	The saving proposal template should be certified by the appropriate officers to confirm:- * compliance with professional and legal requirements for Human Resources, ICT & Financial matters * they have been reviewed and approved by the Directorate Management Team	17/18	06-Oct-17	10-May-18	Ashley Rogers Corporate Programme Manager	A new savings proposal in the form of a Business Case was introduced by finance for new savings in November 2018. Individual proposals were approved by Directors at Directorate Management Team meetings as part of the submission process. As these principles are now embedded into the savings proposal process this item can now be closed.	20-Dec-18	**Complete**	
8	DoR	**Corporate Savings (Governance)**	Milestone targets should be established for all proposals in accordance with Section 7 of the Proposal Template in order to confirm the completion of key activities are in accordance with the project schedule Any milestone deviations should be summarised/risk rated for managerial resolution and to act as a trigger is to activate any contingency or remedial actions	17/18	06-Oct-17	10-May-18	Lead Officers/ Directors/ Ashley Rogers Corporate Programme Manager Ashley Rogers Corporate Programme Manager	All Corporate Programme Work streams have an agreed 'Overview' document capturing key milestones. These milestones are reported on monthly through a new Highlight Report which is submitted to Work stream Board (chaired by a member of CMT) and then to Corporate Programme Board. Included in the template is a section for noting key risks, issues and mitigations, as well as action required from the Board. As these principles are now embedded into the monitoring process for the programme this item can now be closed.	20-Dec-18	**Complete**	
9	DoR	**Creditors/AP**	Formulate an action plan to address corporately the larger number of open purchase orders with a view to closing as many as possible.	18/19	1-May-18		Matt Davis - Head of Finance/ Christopher Beauchamp - Accounts Payable Manager Jennifer Bruce - Financial Systems Manager	New Accounts Payable Manager commenced 16th July and tasked with dealing with this. Further roll out of supplier portal includes the necessary cleansing of old orders as part of this process. Further review in process at present of open purchase orders, needs to be part of regular budget monitoring in future, Budget Managers to be encouraged to review.	28-Dec-18	**51 to 75**	
10	DoR	**Creditors/AP**	Operational issues identified should be addressed in new procedure manual to avoid reoccurrence.	18/19	1-May-18		Matt Davis - Head of Finance/ Christopher Beauchamp - Accounts Payable Manager Jennifer Bruce - Financial Systems Manager	Process manuals being written 5 Processes complete, 3 at first stage - Complete Manual 31/01/19	28-Dec-18	**51 to 75**	

Rec No.	Dir	Audit Title	Recommendation	Rec Yr.	Original Audit Completion Date	1st Follow-up Date	Responsible Officer	Responsible Officer Latest Update	Updated on (date)	Status (% Complete)	Overall Status
11	DoR	**Creditors/AP**	Documented processes for all areas of operation linked to clearly defined roles and responsibilities for members of staff. This would include identifying the business interfaces and expectations around processing, time taken volumes of business for areas like Mosaic payments or expenditure limits on cost centre codes etc.	16/17	25-Mar-17	1-May-18	Jean Stevenson - Chief Accountant Chris Beauchamp - Accounts Payable Manager	Good progress has now been made by the new AP Manager, most processes are now documented	18-Dec-18	**76 or more**	
12	DoR	**Creditors/AP**	Need to clearly identify the strategic contribution of AP to the authority and what is required to make AP business process(es) effective for efficient use of AP for the council.	16/17	23-Mar-17	1-May-18	Matt Davis - Head of Finance Chris Beauchamp - Accounts Payable Manager	Portal has been tested and is working, suppliers to be invited to use portal and to send invoices directly into the Fusion scanning/imaging solution, mass/auto matching within fusion to be considered once 75% of suppliers on-boarded with portal/scanning solution. Open PO's/receipts to be address for each supplier when invited to Supplier Portal. P2P is not voluntary and all invoices being processed through Fusion do have PO No.'s. The above is covered by the P2P compliance project.	28-Dec-18	**51 to 75**	
13	DoR	**Creditors/AP**	Further work needs to be done to ensure that goods are receipted promptly and for the correct amount or value. Reports need to be run on a regular basis to identify and tackle late payments.	16/17	23-Mar-17	1-May-18	Chris Beauchamp - Accounts Payable Manager	Procedures drawn up for processing Goods Received Notes and Service Level Agreement for Accounts Payable and Directorate processing drawn up including processing Mosaic holds. Agreement of users to address issues promptly. Needs implementation by organisation as a whole as Accounts Payable can't do it on their own. Letter being prepared to go to all Suppliers requesting invoices to be sent in centrally.	28-Dec-18	**51 to 75**	
14	DoR	**Creditors/AP**	Need to review the supplier database and cull inactive suppliers as well and consider if centralisation of procurement would be more cost efficient in terms of ordering and paying for goods and services.	16/17	23-Mar-17	1-May-18	Chris Beauchamp - Accounts Payable Manager	Reduced by over half number of suppliers on the system. Created supplier set up procedures. Introduction of portal. Need to close high number of open Purchase Order's on the system. Further report needed to complete tidy up of AP ledger	28-Dec-18	**51 to 75**	
15	DoR	**Debtors**	The various policies, guidance and procedure notes relating to the raising, monitoring and treatment of debt generally should be reviewed and where necessary brought up to date. In addition they should be clearly documented on Iris, if appropriate and all relevant staff and users advised of their location and the need for them to comply with these.	17/18	5-Jun-17	7-Feb-18	Samantha Wills - Interim Income & Assessment Manager	Project was delayed, consultation now commenced to move debtors to AP Team with effect from 01.10.2018. Decision was made to not update policies and procedures as decision now made to convert from Academy to Oracle Fusion. Project Migration scoping session undertaken. Project Plan now in place. Funding to be agreed. New policies and procedures will form part of the project migration plan. New completion date od 1st April 2019.	20-Dec-18	**25 or less**	
16	DoR	**Debtors**	The Income & Assessment Manager should review and formalise the strategy, techniques and records Income & Recovery staff should use in the identification and follow up actions used in respect of recovery of unpaid invoices. Once agreed this should be documented and followed by staff.	17/18	5-Jun-17	7-Feb-18	Samantha Wills - Interim Income & Assessment Manager	As above	20-Dec-18	**25 or less**	

Rec No.	Dir	Audit Title	Recommendation	Rec Yr.	Original Audit Completion Date	1st Follow-up Date	Responsible Officer	Responsible Officer Latest Update	Updated on (date)	Status (% Complete)	Overall Status
17	DoR	**Debtors**	All staff who raise invoices should be reminded that: a) invoices should be raised accurately and on a timely basis: b) each invoice should bear the necessary information or detail to reduce the likelihood of subsequent customer queries; c) as a principle services should not continue to be provided until outstanding invoices have been paid: d) there should be clear supporting records and information concerning the invoice that is easily accessible and understandable in the event of future query or need.	17/18	5-Jun-17	7-Feb-18	Andrew Withey - Acting Head of Customer Care and Transformation / Sam Wills - Interim Income & Assessment Manager	As above still delayed A detailed project plan is to be developed with the intention of moving the AR function onto Oracle Fusion by the 1 April 2019.	20-Dec-18	**25 or less**	
18	DoR	**Debtors**	It is further suggested that the role and work undertaken by Legal Services in the recovery of unpaid items is reviewed and re-evaluated to ensure it remains appropriate and fit for purpose. Once it is clear what is agreed it is recommended that this is defined in an SLA between Legal Services and Income & Assessment.	17/18	5-Jun-17	7-Feb-18	Samantha Wills - Interim Income & Assessment Manager	In hand ASC and Legal monthly meetings now scheduled	20-Dec-18	**51 to 75**	
19	DACH	**Direct Payments**	It is recommended that management re-affirms its commitments towards Direct Payments and reviews the existing strategy to accelerate the uptake of Direct Payments. Furthermore progress should be monitored and appropriately reported to ensure momentum towards achieving this is maintained.	17/18	24-Nov-17		Jo Purser - Acting Head of Adult Social Care	All personal budgets are provided as a direct payment, unless there is an specific, evidenced reason why not. Weekly Adult Social Care performance report includes the percentage of personal budgets agreed at panel which are provided as a direct payment. This is monitored at both the Eligibility Risk and Review Group and the Performance Board.	21-Dec-18	**Complete**	
20	DACH	**Direct Payments**	To confirm that all parties recognise and agree to the conditions within it, it is important that a copy of each agreement between RBC and the client is signed (and witnessed) by each party and then filed on Mosaic. Regular checks should be undertaken by management to ensure that data on the spreadsheet is correct and is supported by copies of up to date signed copies of agreements.	17/18	24-Nov-17		Lorraine Goude - Head of Strategic Commissioning and Personal Budget	Percentage of signed agreements continues to rise, now up to 87%. No new Direct Payments have been issued this year without a correctly signed agreement. Both the new agreements and the data on the spreadsheet are reviewed weekly by the team Principal Officer.	14-Dec-18	**Complete**	
21	DACH	**Direct Payments**	It is essential that records are updated accurately and in a timely fashion. Currently there are multiple records that need to be individually updated to provide a complete record of actions and transactions relating to individual DP clients. Therefore it is recommended that the current process is reviewed to assess whether a more streamlined record keeping system could be designed so that records agree, with the purpose of freeing PBST time for monitoring purposes.	17/18	24-Nov-17		Lorraine Goude - Head of Strategic Commissioning and Personal Budget	Processes and procedures have been updated resulting in a more streamlined approach which also enhances vigour in the monitoring process. New Mosaic form that captures all information required in one place is being tested and a number of amendments have been proposed to ensure it is fit for its purpose. Due to go live in Mosaic in early Jan'19	14-Dec-18	**51 to 75**	

Rec No.	Dir	Audit Title	Recommendation	Rec Yr.	Original Audit Completion Date	1st Follow-up Date	Responsible Officer	Responsible Officer Latest Update	Updated on (date)	Status (% Complete)	Overall Status
22	DACH	**Direct Payments**	In order to demonstrate appropriate controls over the use of public funds it is recommended that the strategy, resources and purpose of the current checking programme is reviewed. In particular it is important that the required validation regime (frequency, process etc.) is assessed to make sure that it provides a reasonable but effective challenge to check and agree the legitimacy of expenditure. A pivotal consideration should include an assessment of existing staffing resources and whether these are adequate in order to discharge the standards RBC should be expecting as the responsible body. If the assessment determines that (additional) changes are required then it should also be determined what (additional) resources are needed, if any.	17/18	24-Nov-17		Lorraine Goude - Head of Strategic Commissioning and Personal Budget	Processes and procedures have been updated resulting in a more streamlined approach which also enhances vigour in the monitoring process. Monitoring DPs on a Pre-paid card is a more effective way to check the legitimacy of expenditure, so the continued increase of the number of people on a Pre-paid card supports these processes. The previously vacant post in the team has been successfully recruited to.	14-Dec-18	**51 to 75**	
23	DACH	**Direct Payments**	It is strongly recommended that the strategy to deliver pre-paid cards is reviewed and where appropriate tightened so that (unless there are good and documented reasons not to do so that are assessed on a case by case basis) the principle of their adoption (of pre-paid cards) becomes understood and accepted as the norm. It is also recommended that management identifies whether there needs to be a programme of education or support across relevant areas in the directorate (including care management colleagues) so that the take up is increased and it is further suggested that targets are set for this to happen. An option may be for the Council to remove the choice aspect and explore moving all (new) clients straight on to Pre-paid cards, as some other local authorities already do.	17/18	24-Nov-17		Lorraine Goude - Head of Strategic Commissioning and Personal Budget	In January'18 the decision was made that unless there was good reason no to do so, all new Direct Payments would be made through a pre-paid card. As Direct Payment Service Users have been reviewed or monitored, where appropriate they have been moved on to pre-paid cards. Percentage of DPs on a Pre-paid card continues to increase, up from 62% in September to 71%.	14-Dec-18	**51 to 75**	
24	DACH	**Financial Deputies**	Serious consideration and management support needs to be given to moving to a direct payments system for clients, where feasible, to reduce the amount of cash handled and time required to administer.	17/18	16-Feb-18	01-Jun-18	Jo Purser - Acting Head of Adult Social Care	We are currently in the process of distributing Lloyds Cards, the Lloyds cards are not prepaid cards. • 27 Clients now using the cards Prepaid Cards: 40 waiting for commencement of prepaid cards, 2 up and running 131 bank cards The remainder of individuals will move over in the new year	14-Dec-18	**51 to 75**	
25	DACH	**Financial Deputies**	The premise of the team needs to be reviewed. If the team is to be cost neutral, this needs to be carefully costed out to ensure that this is achievable (particularly in terms of income targets).	17/18	16-Feb-18	01-Jun-18	Jo Purser - Acting Head of Adult Social Care	The budget is being reviewed; the reports that can be created on Caspar to help supply more precise predictions are being explored. Due to implementing the payment cards which has been priority, and waiting for the decision of the new post to be agreed, the predicted target for 2018/2019 is under review.	21-Dec-18	**51 to 75**	

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26	DCEEH	**Foster Care**	A number of key documents, including policies and procedures and the Foster Care Handbook, are out of date. These need to be reviewed and updated to reflect current practice and then reviewed on a regular basis going forward.	17/18	5-Mar-18		Jackie Hooper - Service Manager LAC Leaving care / Julie Kennewell - Team Manager Specialist Fostering	The Fostering Handbook has been updated. This will continue to be reviewed yearly . In readiness for 2019 the handbook will be reviewed by 8.2.19 in readiness for the new financial year. The Missing Person policy, Behaviour policy, Bullying policy, safeguarding policy, Statement of purpose and all other policies and procedures have been considered and updated to reflect Ofsted registration of the Fostering service as an IFA.	9-Jan-19	**76 or more**	
27	DCEEH	**Foster Care**	Initial inquiries from prospective foster carers should be followed up in a timely manner as per existing targets. Initial enquiries should be followed up within 24 hours, and an information pack dispatched within 2 days. Applicants who meet initial requirements should be seen within 10 days from their initial contact.	17/18	5-Mar-18		Julie Kennewell - Team Manager Specialist Fostering/ Jackie Hooper - Service Manager LAC Leaving care / Siobhan Egan - Service Manager – Performance and Data Intelligence	Since April 2018, RBC has received 119 Initial enquiries of which 94 have been responded to within 24hrs and we continue to aim to improve this. Information packs are dispatched at the enquirers request, either via email or by post. Since April 2018 27 Initial Visits have been undertaken of which 10 were c completed within 10 days from the Initial contact. Evidence suggests that where this timescale hasn't been met this is due to the enquirer requesting a delay in proposed visit. As of Jan. 2019 progression of enquiries have resulted in 11 new approvals of foster carers and 2 further new approvals being heard at fostering panel in January 2019. 2 active fostering assessments will be completed in the first quarter of the new financial year. 4 new applications are being progressed as of Jan 2019. In Jan. 2019 a skills to foster group will commence that will include 9 potential foster carer households.	9-Jan-19	**76 or more**	
28	DCEEH	**Foster Care**	All documentation relating to the Independent Fostering Panel should be held in a central location. This should include all annual reviews. Consideration should be given to adopting open advertising for panel vacancies to try to assist in obtaining a more diverse composition. Prospective applicants should be provided with a job description/specification of what is expected from incumbents.	17/18	5-Mar-18		Jackie Hooper - Service Manager LAC Leaving care / Julie Kennewell - Team Manager Specialist Fostering	All documentation is kept in a central location. The diversity of panel member has slightly improved. However, this remains ongoing in order for the panel to not only demographically reflect Reading but also to reflect the broad range of knowledge and experience . Going forward open advertising will be considered. The Coram BAAF Adoption & Fostering Academy job description and person specifcation is currently used and new applicants are provided with this.	9-Jan-19	**51 to 75**	
29	DCEEH	**Foster Care**	In house placements should be sought for all referrals unless there is a valid reason why this cannot be done (i.e. child's safety). Action taken on referrals should be clearly and consistently recorded, and this should be on Mosaic. Where there is a confidentiality issue, access to the record should be limited as appropriate. There should not be a single point of failure in the referral process.	17/18	5-Mar-18		Jackie Hooper - Service Manager LAC Leaving care	All placement referrals for fostering firstly considers appropriate matching and availability within the in house fostering service. All placement discussions with carers are recorded on the carers record.	9-Jan-19	**76 or more**	
30	DCEEH	**Foster Care**	Foster carers should be provided with the foster carer handbook on a regular i.e. annual basis. This needs to be reviewed and updated on a regular basis to ensure the information it contains is consistent with other documentation. It should have a clear version control and details of when it was last updated.	17/18	5-Mar-18		Jackie Hooper - Service Manager LAC Leaving care/ Julie Kennewell - Team Manager Specialist Fostering	The handbook will be provided to Foster Carers in April each year.	9-Jan-19	**51 to 75**	

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31	DCEEH	**Foster Care**	Foster carer fees and allowances should be regularly (i.e. annually) reviewed, benchmarked and formally approved.	17/18	5-Mar-18		Jackie Hooper - Service Manager LAC Leaving care	A yearly review of fostering allowances will continue to ensure that the payment fees are benchmarked and formally approved to ensure that the continued development of the service is not compromised by market forces that impact on recruitment and retention of our carers.	9-Jan-19	**76 or more**	
32	DCEEH	**Foster Care**	There should be a clear, central record of paid leave taken by foster carers to ensure that maximums are not breached.	17/18	5-Mar-18		Julie Kennewell - Team Manager Specialist Fostering	Paid leave is recorded on mosaic in supervision forms and case notes. This can't be pulled from mosaic as a central record. However, this will be developed by March with the view to go live in the new financial year.	9-Jan-19	**51 to 75**	
33	DCEEH	**Foster Care**	Mosaic records, particularly purchase orders, need to be updated in a timely manner to avoid foster carers being incorrectly paid. Notes and relevant documents should also be clearly labelled and attached to the relevant record in a timely manner.	17/18	5-Mar-18		Julie Kennewell - Team Manager Specialist Fostering	Clearly labelled notes are evident on mosaic. There is a formalised fortnightly payment run for Foster Carer payments which are documented and recorded on mosaic.	9-Jan-19	**76 or more**	
34	DoR	**General Ledger**	Need to clearly identify and document the business processes that support the General Ledger and identify what activity is being undertaken and who is responsible and how that activity is supported by valid secure audit trails for the same. This would include maintaining formal supporting records for financial transactions that are entered manually or via spreadsheet and ensuring where possible separation of duties is enforced for journal entry and approval.	17/18	6-Apr-17	31-May-18	Matt Davis - Head of Finance	Processes are now working well	18-Dec-18	**Complete**	
35	DoR	**General Ledger**	There needs to be consistent control over data entry from feeder systems that standardises and controls data input to reduce the need for journals to amend miscoded items. The number of Oracle Fusion codes needs to be reviewed with a view to identifying key codes and removing redundant or unused codes.	17/18	6-Apr-17	31-May-18	Matt Davis - Head of Finance	Daily reports produced and sent to owners of feeder systems for their checking that totals loaded correctly. Coding to be reviewed as part of the introduction of inter company accounting in time for 1st April 2019. New Children's Company Business Unit now in place and inter company accounting being tested.	18-Dec-18	**51 to 75**	
36	DoR	**General Ledger**	Journals produced between April and October 2017 will have to be reviewed and evidence sought for the need for creation.	18/19	4-Jun-18		Jean Stevenson - Chief Accountant	Verification of this is now completed.	18-Dec-18	**Complete**	
37	DoR	**General Ledger**	All Journals need to be reviewed and authorised in a timely fashion	18/19	4-Jun-18		Jean Stevenson - Chief Accountant	Journals now being reviewed and authorised in a timely fashion.	18-Dec-18	**Complete**	
38	DoR	**General Ledger**	All journals need proper designation as to the type of journal and its purpose.	18/19	4-Jun-18		Jean Stevenson - Chief Accountant	The significant reduction in the number of journals means there is more clarity as there are less inputters processing journals. However a review will be needed before the financial year end.	18-Dec-18	**51 to 75**	
39	DoR	**General Ledger**	The number of codes that are being used for one off transactions needs to be reviewed to ensure that this is the most efficient way to record financial information.	18/19	4-Jun-18		Jean Stevenson - Chief Accountant	This review is scheduled to be conducted by the Financial Systems Team as part of the overall review of codes for the introduction of inter company accounting. This should be completed by 1st April 2019, now the Children's Company Business Unit is active in Fusion.	18-Dec-18	**51 to 75**	

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40	DoR	**HB Subsidy**	It is recommended that: a) backfill for secondee positions needs to be in place earlier. b) consideration is given to the number of contractors in place in key positions within the team. c) a clear plan is put in place for quality checking going forward. This needs to include the identification and reporting of issues relating to individuals to allow them to be addressed in a timely manner.	16/17	17-Sep-17		Sam Wills - Interim Income & Assessment Manager	Monitoring in place, resilience contract in place, training provided 10% Quality in place with contractor	18-Jul-18	**76 or more**	
41	All	**Health & Safety**	In order to share instances of different and best practice(s) it is suggested that the directorate chairs of the health & safety periodically attend and observe other directorates' meeting to see whether specific techniques, formats etc. could be usefully shared between them.	16/17	8-Feb-17	29-Sep-17	H&S Committee Chairs: Resources - Shella Smith Adults - Steve Saunders Schools - Paul Wagstaff Children's - Paula Ward DENS - Sarah Gee Central - Peter Sloman	Meetings are underway - there have been several since December 2017. A further revised H&S Strategy is being presented to CMT in August and following this will be shared with the H&S Leads, which in turn will aid consistency in risk management approach.	15-Aug-18	**76 or more**	
42	DoR	**Health & Safety**	There needs to be confidence in the integrity of the staff health and safety training data held on I-Trent and that it is accurate and kept up to date so that reliance can be placed upon this. This may involve some further work to achieve this and possibly some prioritisation of resources by Training / HR.	16/17	8-Feb-17	29-Sep-17	L&D - Russell Gabbini	The Organisational and Workforce Development Manager is leading on the training actions. Data cleanse exercise has shown that information in iTrent is not accurate. New exercise underway to tie in with other iTrent work. Also Learning Pool dates is being corrected. New CMT target to get all L1 & L2 training completed by Q2 2019. Plus All staff will have to complete an online appraisal (knowledge check) or update session commensurate with their responsibility. If they fail this then they will have to go to repeat the appropriate level of on-line training or attend a classroom course to be recognised as compliant. Knowledge checks for levels 1 and 2 to be released to relevant staff April 2018	5-Dec-18	**51 to 75**	
43	All	**Health & Safety**	Once the exercise to cleanse data has been completed, where it has become flagged that staff training is not up to date, then a programme of training to remedy this should be implemented.	16/17	8-Feb-17	29-Sep-17	L&D - Russell Gabbini	As above	5-Dec-18	**51 to 75**	
44	DoR	**Information Governance and Data Protection**	The management framework needs to be documented (action plans and ToRs) and aligned with a strategy that identifies the key staff needed to implement and maintain it. This in turn needs approval and incorporation into the reporting framework of CMT who should receive regular reports on progress and any significant issues highlighted in work practices.	16/17	7-Oct-16	9-Apr-18	Chris Brooks - Head of Legal & Democratic Services	Management framework is encompassed in the GDPR project plan. Monthly reports have been to CMT. The last report to CMT went on 24.07.2018	No changes 21.12.18	**76 or more**	
45	DoR	**Information Governance and Data Protection**	All staff identified as being key to a properly managed information governance process should have their roles and responsibilities reflected In their job descriptions.	16/17	7-Oct-16	9-Apr-18	Chris Brooks - Head of Legal & Democratic Services	This is to be actioned. Discussions are in hand with HR to determine whether it is appropriate that the roles and responsibilities to Information Governance are to added to Job Descriptions	No changes 21.12.18	**25 or less**	

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46	DoR	**Information Governance and Data Protection**	Information Asset Owners (IAO) need to be formally appointed for each system that processes personal data with responsibility for ensuring that it operates within the policies and procedures governing information security and data protection including ensuring access to data is only by authorised persons.	16/17	07-Oct-16	9-Apr-18	Chris Brooks - Head of Legal & Democratic Services	The information case owners system is in place. IAO guide has been drafted and will be presented to Corporate Management Team (CMT) in February 2019	No change 21.12.18	**25 or less**	
47	DoR	**Information Governance and Data Protection**	There needs to be a formal risk management framework that incorporates a formal information risk register that records the location of personal data and the risks associated with it. IAOs should be tasked with managing the risks identified for their data.	16/17	7-Oct-16	9-Apr-18	Chris Brooks - Head of Legal & Democratic Services	The information case owners system is in place.	No change 21.12.18	**76 or more**	
48	DoR	**Information Governance and Data Protection**	Privacy Impact Assessments (PIA) should be completed for all data processing changes and new projects	16/17	7-Oct-16	9-Apr-18	Chris Brooks - Head of Legal & Democratic Services	Completed but PIA will be reviewed annually	No change 21.12.18	**76 or more**	
49	DoR	**Information Governance and Data Protection**	Information Security and data protection requirements need to be built into all Third Party contracts where setting out access to systems and data transfer safeguards.	16/17	7-Oct-16	9-Apr-18	Chris Brooks - Head of Legal & Democratic Services	For existing contracts there is a standardisation letter of variation in line with GDPR. Procurement have signed this off. Appropriate provisions are being added to future contracts that come through Legal Services. Guidance is now on the Intranet. It is up to Service Heads to ensure this is followed with assistance from the Legal Services Contracts Team	No changes 21.12.18	**26 to 50**	
50	DoR	**Information Governance and Data Protection**	Regular reviews of compliance with policy and reviews of data accuracy (paper and electronic) should form part of any managed approach to security and data processing. Reviews should also include whether records need to be retained, whether data is actually needed and whether adequate control and consent in place for its usage.	16/17	7-Oct-16	9-Apr-18	Chris Brooks - Head of Legal & Democratic Services	Retention schedules completed and available to services	No change 21.12.18	**76 or more**	
51	DENS	**Leisure (income collection)**	A formal procedure for reviewing and approving all promotions, discounts or free use of facilities should be put into place. This should include:- ***** The annual review of key documentation that indemnifies the Council and reconfirms the club's responsibilities. ***** The cost benefit analysis for such activity should be reviewed and approved by the appropriate officer responsible.	16/17	14-Jun-16		Ben Stanesby - Recreation & Leisure Manager / James Sadler - Operations Manager	Clubs are charged scheduled rates which are now included in the annual fee setting process. Free use of early morning use of swimming pools has ceased and centres now control all use and safety checks of facilities.	4-Dec-18	**Complete**	

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52	DENS	**Leisure (income collection)**	Unless authorised by management, in order to reduce the costs and debts attributed to the raising of sales invoices, arrangements should be put in place to ensure payment always is received at the point of use:- * Individuals or clubs continually book facilities with arrears should brought to management's attention. * Booking forms should be reviewed to ensure payment is always received in advance and is appropriately recorded as required, e.g. office use details should record payment details or the sales invoice details if authorised by management. * Unless specifically instructed by the person making the booking, all sales invoices should be made out to the club/body concerned.	16/17	14-Jun-16		James Sadler - Operations Manager	Invoices are made out to hiring organisations. A CRM system is being used to manage booking at Prospect park where ongoing problems with invoicing were being experienced. Full payment is taken at the time off booking for Prospect Park bookings now, and bookings are also available online which requires full payment at the time of booking. Block bookings are not renewed if bookers are not at a zero balance. If it is a high profile club and they have a debt but wish to renew so they do not loose their space while the debts is investigated, it is raised with the senior management team to decide an outcome. Small bookings are now booked and paid for at the time of booking through Legend. Some bookers invoices are raised for the year and are paid off in lump sums as and when player subs are taken. This is monitored and if a payment has not recently been made bookers are called and reminded to make a payment.	4-Dec-18	**Complete**	
53	DENS	**Leisure (income collection)**	Refund controls need to be strengthen to ensure the audit trail validates legitimacy:- * Refunds must not be made unless the initial payment can be substantiated e.g. same debit card and signed for. * The reason and frequency of refunds need be enforced and monitored. * Refunds should not be permitted unless the debit as been confirmed. The regularity of debit and credit transactions should be monitored.	16/17	14-Jun-16		James Sadler - Operations Manager	All refunds are recorded within the CRM system which also identifies the initial credit. A refund form is filled out by both the receptionist and Duty Manager and the refund can only be approved by the Duty Manager. Refunds will be included in the new journaling system and reviewed at the of journaling and investigated.	4-Dec-18	**76 or more**	
54	DENS	**Leisure (income collection)**	The cash handover procedures should be standardised so that the clear bags are signed as part of the safe check procedure.	16/17	14-Jun-16		James Sadler - Operations Manager	This has been implemented. Bags and serial numbers are checked and recorded at the time of site safe checks.	4-Dec-18	**Complete**	
55	DENS	**Leisure (income collection)**	Compliance controls to evidence separation of duties need to be enforced and monitored accordingly. This should include:- * The same operator opening and closing the till is the same person certifying the daily reconciliation. * Unless supported by a risk assessment and authorised by management, officers should not be permitted to operate LEGEND under another staff members User rights. * Duty Manager conducting the validation of the daily reconciliation must be independent of the operator.	16/17	14-Jun-16		James Sadler - Operations Manager	Each operator open and closes their till and certifies the reconciliation. This checked by a second member of staff. Staff only operate tills under their own login. Site Operations Managers conduct random till checks to using a report on what should be in the till at the time of checking. This helps identify discrepancies earlier.	4-Dec-18	**Complete**	
56	DENS	**Leisure (income collection)**	Separation of duties between Finance and LEGEND need to be reviewed and put in place.	16/17	14-Jun-16		James Sadler - Operations Manager	New process automating production of journals from the CRM system have been developed and is being audited to ensure appropriate separation of duties, implementation at Meadway imminent.	14-Aug-18	**51 to 75**	

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57	DACH/ DCEEH	**Mosaic Fusion Year end reconciliation audit**	Increased emphasis needs to be placed on the importance of ensuring that data held within Mosaic is of an appropriate quality. This includes ensuring that placements are reflected in a timely manner (purchase orders created, amended and closed), so that commitments are accurately reflected and discrepancies and missing invoices can be identified and addressed.	16/17	17-Oct-16	01-Nov-17	Seona Douglas - Director of & DMT DACHS/ Stephen Kitchman - Director of DCEEH/ Nick Penny Strategic Business Partner - DACHS	Acting Head of Service and Principal Social Worker working with mosaic team to build in processes to ensure changes are implemented to improve data quality and consistency of reporting. There has been a progressive improvement in the data recorded for Children's Services, but this needs to be cleansed further. This is a priority action in the move to the new Children's Company where high quality data will be required. LAC profiling has been introduced to improve the robustness of financial modelling and impact of the MTFS. The Business Partner for Children's Services is now having regular meetings to clarify queries and change MOSAIC accordingly to improve the data in MOSAIC. Further MOSAIC reports will need to be written but will be incorporated into the transition to the company's IT work stream. The projections for LAC expenditure was more accurate during 17/18 financial year. Acting Head of Service and Principal Social Worker working with mosaic team to build in processes to ensure changes are implemented to improve data quality and consistency of reporting. NP to review	16-Jul-18	**51 to 75**	
58	DoR	**Mosaic Fusion Year end reconciliation audit**	There should be clearly documented policies and procedures for the year end reconciliation and associated accruals process. These should be available to all relevant individuals and reviewed and updated as necessary on a regular basis to reflect current practice.	16/17	17-Oct-16	01-Nov-17	Nick Penny Strategic Business Partner - DACHS	2018 response: The issues with ongoing work on Closure of the 16/17 Accounts along with the Finance Restructure caused capacity issues within Finance which meant that it was not possible to produce procedures for this. As part of the 2017-18 Closedown process we have reviewed and changed the basis of the way in which the accrual for care costs are implemented. The working papers supporting the accruals show the methodology around the accrual and this will consolidated into procedure notes and guidance, so they are available for others to access. Procedure notes will be written once the 2017/18 accounts are finalised and the new Strategic Business Partner will ensure this is done at the earliest opportunity.	21-Dec-18	**26 to 50**	
59	DoR	**Mosaic Fusion Year end reconciliation audit**	A lessons learnt review should be conducted post year end which looks at issues encountered with the year-end reconciliation process and associated accruals and provisions. Outcomes from this should then feed into the following year's year-end process. This is particularly pertinent for Adult Services.	16/17	17-Oct-16	01-Nov-17	Nick Penny Strategic Business Partner - DACHS	Following appointment I am reviewing the current processes with the DACS finance team and will update further on the findings. The reconciliations seem very robust and fit for purpose on 1st inspection and I will be looking at how we add further value going forward.	21-Dec-18	**26 to 50**	

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60	DoR	**Mosaic Fusion Year end reconciliation audit**	Clear and regular in year and year end reconciliations should be performed between Mosaic and Fusion and review of the accruals/prepayment process to encompass the full financial year rather than since the last invoice received need to be conducted.	16/17	17-Oct-16	01-Nov-17	Nick Penny Strategic Business Partner - DACHS	Mosaic to Fusion reconciliations are currently undertaken on a monthly basis to ensure that the council are paying for the correct value of placement costs. These are reviewed within the DACS finance team and will provide the basis of the year end accruals for 18/19.	21-Dec-18	**51 to 75**	
61	DoR	**Overtime**	It is recommended that the monthly payroll return be reviewed and consideration given to including the following: • Employee contracted hours • Completed by field • How overtime is being paid for • Reason for overtime	16/17	23-Aug-16	28-Sep-17	Denise Burston - HR Partner - CRES/ Sharon Brown - Payroll Pensions and Data Manager/ Matthew Slater - Payroll & Data Systems Team Manager	A strategic review of the way iTrent is being used has been completed. A project is underway to roll out self-service forms through iTrent and one of these will be overtime claim forms which will enable information to be input regarding why overtime is being claimed and how it will be paid for.	12-Dec-18	**51 to 75**	
62	DoR	**Overtime**	It is recommended that the Head of Payroll reviews the overtime payment process, particularly the rates paid, of staff with multiple part time contracts with the Council. The Authority needs to be assured there is no discrimination or unfairness of the current process.	16/17	23-Aug-16	28-Sep-17	Shella Smith - Head of HR and OD	A review of all employment policies is already underway. The revised policies will need to be consulted on or negotiated with the recognised trade unions (as appropriate) and approved by Personnel Committee. The review is due for completion by December 2019. The policies covered in this audit will be prioritised.	12-Dec-18	**25 or less**	
63	DACH	**Public Health**	All current miscellaneous schemes run internally by RBC should be formally incorporated into a public health framework and subject to a process of challenge (bidding for approval) and subject to a monitoring framework that clearly identifies how successful outcomes are measured and then evidences those successful measurements.	17/18	29-Sep-17		Marion Gibbon Consultant in Public Health	Memorandum of Understanding are now in place for all departments who have Public Health funding. The Public Health Board meeting commenced in April 2018 to oversee the PH spend. The Public Health Board are monitoring the spend and performance. A tracking process has been developed with a dashboard showing outcomes.	8-Jan-19	**76 or more**	
64	DACH	**Public Health**	The recharge of central establishment costs to the public health grant should be done in a timely fashion and in such a way as those costs are transparent and commensurate with the resources employed by the authority to administer the grant monies.	17/18	29-Sep-17		Andy Stockle - Business Partner and Nick Penny - Strategic Business Partner	Corporate recharges have historically been treated 'below the line' and not charged to Public Health. Public Health has a credit budget to reflect this practice. Discussions have taken place with Corporate Finance and there is a review of CEC currently ongoing, which is expected to result in budgets for these being put against cost-centres across the Council. This will result in PH no longer having a credit budget. This is expected to be finalised during the remainder of 18/19.	21-Dec-18	**51 to 75**	

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65	DENS	**Right to Buy**	A copy of the Right to Buy Handbook should be available on the new RBC website. Right to Buy policies should be reviewed on a regular basis to ensure that they are still fit for purpose.	16/17	19-Jul-16		Sam Bainbrigge - RTB Team Leader	Although it was agreed that the Right to Buy Policy would be reviewed and published on the council's website by the end of July 2016, this has yet to be implemented. Although a copy of the draft January 2017 policy has been forwarded as confirmation we have been informed this has yet to be approved or published on the council's website. Reliance is placed upon general referral to central government's RTB policy and referral to this in the RTB Handbook published by the Council on the main website, this is drafted it just needs writing in a different format and can then be put for sign off and published - we hope to get this done by end February 19.	7-Jan-19	**51 to 75**	
66	DENS	**Right to Buy**	Sequencing check controls need to established to ensure application reference numbers can be accounted.	18/19	11-Jun-18		Sam Bainbrigge - RTB Team Leader	The Ohms system now generates the numbers so they can't be duplicated, this is now generated by OHMS and will therefore create the next sequence number automatically	7-Jan-19	**Complete**	
67	DENS	**Right to Buy**	A copy of CIT's findings should be scanned onto I@W and their findings should be analysed to ascertain what preventative (information) and detective (monitoring) controls are required to deter fraudulent applications in the future.	18/19	11-Jun-18		Sam Bainbrigge - RTB Team Leader	Request sent to CIT who now scan their findings back into housing systems so there is an audit trail, CIT now index directly into I@W and this will hit the officer responsible for the application to check and confirm.	7-Jan-19	**Complete**	
68	DENS	**Right to Buy**	The reasons why applications are withdrawn by the applicant or cancelled/denied by the council should be analysed by the RTB Team to help ascertain the common occurrences / problems. This will help ensure council resources and the applicant's time are not wasted.	18/19	11-Jun-18		Sam Bainbrigge - RTB Team Leader	Reasons now are kept in one place so they can now be easily analysed. Analysis takes place once a quarter, these are kept in a spreadsheet by the homeownership team and a review by that team carried out every quarter for info	7-Jan-19	**Complete**	
69	DENS	**Right to Buy**	Revised date: A number of improvements are required to ensure payments are fully accounted for:- * A copy of the RTB Offer and any sale revisions that confirm the final sale price should be forwarded to Finance. * In conjunction with the RTB Team and Legal, Finance should complete a certified periodic reconciliation between payments due, those received and the accounts on Fusion. The RTB application number should be recorded on Fusion to support the address of the property.	18/19	11-Jun-18		Jean Stevenson - Chief Accountant/ Sam Bainbrigge - RTB Team Leader	Process in place for RTB offers and sale revisions confirming the sale price to be sent to finance. Since process was introduced there have not been many sales, process will be tested as sales happen.	7-Sep-18	**51 to 75**	

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70	DENS	**S106**	The roles and separations of duties for the Policy Team and Administration Team need to be reviewed to ensure there is inclusion and oversight for the full monitoring of all S106 monies.	16/17	30-Sep-16	14-Jul-17	Kiaran Roughan - Planning Manager	In addition to new written procedures and staff training, the Planning service has now implemented a bespoke recording and monitoring system (Exacom) that coherently addresses the main control requirements for Section 106 processes. It continues to be the case that there is no regular or complete reconciliation between the respective record systems in Planning used to identify, track and manage S106 amounts and financial systems that record S106 amounts. This is mainly because of resource issues in Finance at the current time.	9-Jan-19	**76 or more**	
71	DENS	**S106**	The methodology for recording, collecting and monitoring the payment status of S106 monies need to improved urgently. In particular: a. It is strongly recommended the corporate debtor system should be used for the monitoring and collection of all S106 monies. Each sales requisition should be authorised by the PSM. In particular there is a need to establish clear separation of duties between the instigation, recovery and the monitoring of monies. b. The obligation index increases and revised amounts should always be recorded on Acumen. c. Provisional target dates should be established to monitor the status of payment triggers and for prompting the sales requisition. d. A monitoring procedure needs to be produced for reviewing the status of triggers and payments (who, how, when etc.). e. Oracle Fusion codes should be recorded on Acumen, and a record of receipts should also be recorded. Obligations, finance receipts and balances on Oracle Fusion balances should be regularly reconciled and reviewed by management. Evidence of reconciliations should be retained for an audit trail.	16/17	30-Sep-16	14-Jul-17	Kiaran Roughan - Planning Manager / Mark Worringham - Planning Policy Team Leader	The Exacom System and updated procedures are now in place and are used in operations. This provides an appropriate methodology for recording, collecting and monitoring the payment status of S106 monies. After discussions with Finance it was agreed by the Head of Finance that the corporate Academy system for raising invoices was not appropriate for the purposes of raising and monitoring S106 invoices' It offers no advantages over the use of the facilities and reporting functions of the Exacom system . Indexation and revised amounts area recorded in Exacom. Trigger dates are a function of Exacom. Monitoring of triggers and payments is being undertaken by the Planning Policy Team Leader. Oracle Fusion codes are recorded on Exacom and receipts/ transaction numbers are also recorded on the system. Attempts have been made to reconcile planning records with Fusion, but there remain challenges in obtaining data in a timely manner because of resource issues in Finance.	9-Jan-19	**76 or more**	
72	DACH	**Safeguarding (supervision)**	The 'Grandparent' should have overview of supervision records to ensure the expected process is being complied with and is performed in a consistent manner for all staff. A sample of records should be reviewed at least quarterly to identify any supervision that is not at the appropriate standard. Where supervision is not of the appropriate standard the Team Manager/Service Manager should address the issue.	17/18	18-Sep-17	13-Nov-17	Jo Purser -Acting Head of Adult Social Care	An audit was completed. Feedback was about having a tool for consistency, PSW developing an audit tool with RiPFA for best practice. Another audit will be completed as soon as the tool is finalised. Agreed with Team managers and Assistant Team managers that a supervision audit is completed in the month of December. JP to check	10-Dec-18	**76 or more**	

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73	DOR	**Subject Access Requests**	There should be a standard policy for all Subject Access/Access to Records Requests. The draft policy should be reviewed to ensure it still is relevant, legal review and formal approval obtained and then implemented and made available to all relevant parties as a priority. It also needs to contain more specific information relating to subject access requests. Going forward, it should also be reviewed on a regular basis to ensure it continues to meet all relevant legal and other requirements.	16/17	23-Jan-17	15-Mar-18	Chris Brooks - Head of Legal & Democratic Services	SAR policy was updated in line with GDPR and available for staff on the Information Governance Pod on IRIS.	21.12.18	**76 or more**	
74	DOR	**Use of Cash Vouchers & Cash Accounts**	Documented procedures should be produced to:- a) stipulate the purpose of petty cash accounts e.g. what is considered to be appropriate expenditure, and what is not b) specify the recording, reconciliation and reporting requirements including the transfer of details on to Oracle Fusion c) define the control requirements for the safeguarding of cash and vouchers.	16/17	2-Nov-16	14-Jul-17	Matt Davis - Head of Finance Christopher Beauchamp - Accounts Payable Manager	Process notes being produced, new upload form created to reduce workload/processing times. Petty cash to be closed down already identified, 4 closed, 3 more confirmed. Write off will be required and new accounts will be required in Fusion for remaining petty cash/voucher schemes - completion 28/02/19	11-Sep-18	**51 to 75**	
75	DOR	**Use of Cash Vouchers & Cash Accounts**	Controls need to be introduced within the APT to confirm the completeness and accuracy of the floats in circulation and to ensure that petty cash claims are appropriately authorised. This should involve:- a) Conducting an annual review to ensure the records are correct and up to date. b) Introducing a system for recording the issue, transfer and return of floats. Where floats are transferred between officers a copy of the transfer note must be forwarded to the APT. c) Introducing a check control whereby the APT confirms the accuracy of the float balance and of the authorisation details each time a claim is made.	16/17	2-Nov-16	14-Jul-17	Matt Davis - Head of Finance Christopher Beauchamp - Accounts Payable Manager	Process notes being produced, new upload form created to reduce workload/processing times. Petty cash to be closed down already identified, 4 closed, 3 more confirmed. Write off will be required and new accounts will be required in Fusion for remaining petty cash/voucher schemes - completion 28/02/19	11-Sep-18	**51 to 75**	
76	DOR	**Use of Cash Vouchers & Cash Accounts**	Finance should consider whether prepaid cards could be better used to control petty cash expenditure. Or alternatively departments / services could be encouraged to use Visa purchase cards instead of petty cash	16/17	2-Nov-16	14-Jul-17	Matt Davis - Head of Finance Christopher Beauchamp - Accounts Payable Manager	Prepaid have been introduced in some departments on a trail basis as a replacement for petty cash. Usage and controls and further roll out of the scheme to be included in the petty cash review to be completed by the end of October	11-Sep-18	**51 to 75**	
77	DENS	**Waste Operations**	Record keeping should be more thorough and documents regularly reviewed, updated, agreed as necessary and stored in a central location. This should include meeting paperwork (agendas, papers, minutes), training records, business continuity plans, holiday and sickness absence forms, health declarations and driving license checks.	16/17	12-Dec-16	24-May-17	Michelle Crick - Waste Services Manager/ David Moore - Neighbourhood Services Manager	Staff training master monitoring sheet in place. All records are now retained on the shared Neighbourhoods drive. Record Structure in place in Waste Operations shared folder Master monitoring sheet received.	4-Jan-19	**Complete**	

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78	DENS	**Waste Operations**	Driver vehicle checks should be conducted and recorded on a daily basis prior to vehicles commencing their rounds.	16/17	12-Dec-16	24-May-17	Michelle Crick - Waste Services Manager/ David Moore - Neighbourhood Services Manager	Informal audit carried out by Fleet department and 2 waste supervisors. Any discrepancies actioned. Supervisor carries out regular spot checks on driver vehicle checks record sheets. In cab system now forms part of the digital review programme. System chosen must integrate with route optimisation software, record vehicle check results, link to customer services and the web to facilitate self service and have a trade waste element. Discussions with external suppliers have started. In cab system not implemented as waste service subject of a savings proposal and investment not sensible until future of the service agreed.	4-Jan-19	**Complete**	
79	DENS	**Waste Operations**	Up to date approval should be obtained to confirm that Waste Operations have the ability to vary trade waste fees according to circumstances.	16/17	12-Dec-16	24-May-17	Michelle Crick - Waste Services Manager/ David Moore - Neighbourhood Services Manager	The trade waste service must have the ability to charge according to the type of waste, its weight and lift frequency. The waste operations review has produced accurate cost model and a trade waste charging structure which is now in use for all customers. We now have the capability to weigh bins and existing trade customer charging has been reviewed in relation to weight and lift frequency. Un-economic customers (heavy bins) have either had their charges increased or contracts terminated.	4-Jan-19	**Complete**	
80	DENS	**Waste Operations**	Trade waste contracts should contain accurate details of the number of bins and frequency of collection. This should agree with records in Flare. Care needs to be taken to ensure that charges made for trade waste as a minimum cover the costs of providing the service.	16/17	12-Dec-16	24-May-17	Michelle Crick - Waste Services Manager/ David Moore - Neighbourhood Services Manager	See response above. Also an order has been placed for a waste management software system which will be in operation by 01.04.2019.	4-Jan-19	**76 or more**	
81	DENS	**Right to Buy**	An annual deadline for reviewing and progressing the draft RTB policy needs to be established.	18/19	30-Sep-18		Sam Bainbrigge - RTB Team Leader	this will be reviewed at least every February or sooner should changes be required	07/01/2019	**Complete**	
82	DENS	**Right to Buy**	A copy of CIT's findings should be scanned onto I@W and their findings should be analysed to ascertain what preventative (information) and detective (monitoring) controls are required to deter fraudulent applications in the future.	18/19	10-Jul-18		Sam Bainbrigge - RTB Team Leader	this is reviewed each quarter to make sure we are dealing with any controls that are required but if something comes up sooner then this will be amended sooner.	07/01/2019	**51 to 75**	
83	DENS	**Right to Buy**	The reasons why applications are withdrawn by the applicant or cancelled/denied by the council should be analysed by the RTB Team to help ascertain the common occurrences / problems. This will help ensure council resources and the applicant's time are not wasted.	18/19	10-Jul-18		Sam Bainbrigge - RTB Team Leader	this is reviewed each quarter to make sure we are dealing with any controls that are required but if something comes up sooner then this will be amended sooner.	07/01/2019	**51 to 75**	

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84	DENS	**Right to Buy**	A number of improvements are required to ensure payments are fully accounted for:- * A copy of the RTB Offer and any sale revisions that confirm the final sale price should be forwarded to Finance. * In conjunction with the RTB Team and Legal, Finance should complete a certified periodic reconciliation between payments due, those received and the accounts on Fusion. The RTB application number should be recorded on Fusion to support the address of the property.	18/19	31-Jul-18		Sam Bainbrigge RTB Team Leader	an email now goes to accountancy before the sale so they can expect the funds that we are selling the property for. No money is removed from the sale price for overpaid rent - this is done in a separate transaction after the sale so as not to confuse matters	07/01/2019	**Complete**	
85	DoR	**Additional Payments**	There should be a clear policy for each type of allowance and additional payment. These should be reviewed on a regular basis and updated as necessary. All additional payments should be made in accordance with the relevant policy and be consistent across teams, departments and directorates and adhered to in every instance. Policies and procedures should be publicised and promoted to relevant staff and managers and be available on Iris.	18/19	31-Mar-19		Shella Smith - Head of HR and Organisational Development for all new payments HR Partners for existing payments Roger Morris Annette Paterson Kirsty Bennett Denise Burston	A review of all employment policies is already underway. The revised policies will need to be consulted on or negotiated with the recognised trade unions (as appropriate) and approved by Personnel Committee. The review is due for completion by December 2019. The policies covered in this audit will be prioritised.	12/12/2018	**26 to 50**	
86	DoR	**Additional Payments**	All relevant supporting documentation and information for additional payments should be retained/ documented on relevant personnel files. This should include justification for the payment, evidence of an open process being conducted and relevant sign off, discussion at relevant forums, union consultation/notification (where relevant) and details of calculations.	18/19	31-Oct-18		Shella Smith - Head of HR and Organisational Development for all new payments HR Partners for existing payments Roger Morris Annette Paterson Kirsty Bennett Denise Burston	All additional payments have been reviewed by the relevant HR Partner and the Head of Service. Where documentation has been missing this has now been added to the file. Since July 2018 the Head of HR approves all such payments to ensure that all the necessary documentation is on file.	12/12/2018	**Complete**	
87	DoR	**Additional Payments**	All additional payments should be for a specified period of time only and should be reviewed/challenged on a regular basis (as detailed in the relevant policy/procedure) to ensure that they are still appropriate and the most cost effective option. Where additional payments are long standing, consideration should be given to conducting a job re-evaluation and/or reviewing workload to determine if there is a more cost effective solution.	18/19	31-Oct-18		Shella Smith - Head of HR and Organisational Development for all new payments HR Partners for existing payments Roger Morris Annette Paterson Kirsty Bennett Denise Burston	A review of all additional allowances has been undertaken and allowances have ceased or an end date has been identified where appropriate. Since July 2018, all new requests for additional payments must be signed off by the Head of HR and OD and the CX.	12/12/2018	**Complete**	
88	DoR	**Additional Payments**	Market supplements should be detailed in all relevant employees' contracts and explicitly detailed that they can be amended and reviewed.	18/19	31-Oct-18		Roger Morris Annette Paterson Kirsty Bennett Denise Burston	Market supplements detailed in all new employee contracts	12/12/2018	**Complete**	
89	DoR / DENS	Network Security (ICT)	Full visibility of the transport sections ICT needs to be established to ensure that a consistent corporate standard for network security is applied	18/19	18-Oct-18		Andrew Withey - Acting Head of Customer Care and Transformation Cris Butler - Strategic Transport Programme Manager	Officers are in the process of engaging with the Council's IT teams in order to progress a programme of actions to apply the corporate network security requirements to the existing externally supported Transport systems	09/01/2019	**51 to 75**	

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90	DoR	Network Security (ICT)	Plan produced to carry out upgrades that require shut down of networks for firewall improvements and other major patching requirements.	18/19	18-Oct-18		John Barnfield - ICT Technology and Services Manager	**Management Action: Set & Issue Planned Maintenance Schedule.** November Planned downtime for FireWall Replacement and DR Tests completed successfully as planned. Future schedules for Planned W-E Maintenance Slots communicated to all staff by ISI, Staff News, and IRIS Intranet. M&PR Requested to also circulate reminders before each scheduled slot to remind staff and ICT will also issue further ISI reminders. Action therefore completed.	10/12/2018	**Complete**	
91	DoR	Network Security (ICT)	Council make Cyber Security and Cyber awareness training mandatory for staff	18/19	18-Oct-18		Russell Gabbini - Organisational and Workforce Development Manager	Work is currently underway to incorporate cyber security training into the ICT/Information security training required to be undertaken on mandatory Induction. Further work underway to update general cyber security training to be fit for purpose for release to all staff	08/01/2019	**25 or less**	
92	DoR	Network Security (ICT)	The council's disciplinary procedures are amended to reflect the seriousness of not ensuring that laptops are properly patched.	18/19	18-Oct-18		John Barnfield - ICT Technology and Services Manager	**Management Action: - Amend ICT Policy and Golden Rules to reinforce need to reload desktops and reissue via NetConsent. Issue Reminders to Staff to reload desktops via Corporate Comms.** ICT Policies amended for Desktop Reload, but now have to be further amended due to HR Policy Change on Social Media Access which has delayed approval and issue. ISI Reminders issued to staff. M&PR asked to issue reminders in Staff News.	10/12/2018	**26 to 50**	
93	DoR	Network Security (ICT)	There should be regular threat monitoring reports produced by Northgate that include potential hacking incidents and virus software activation to contain threats to enable RBC to take preventative action on staff activity if appropriate.	18/19	19-Sep-18		John Barnfield - ICT Technology and Services Manager	**Management Action: The Council's ICT Team will explore with Northgate what options there are for producing a dashboard from existing security products & how this info can be used more proactively to inform behaviour and managed Cyber Threats.** A Work Scoping request has been sent to Northgate requesting the above analysis and options appraisal. Northgate have not scheduled works as yet, and this has been escalated to the Programme Manager for urgent review.	10/12/2018	**25 or less**	

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94	DENS	South Reading Leisure Centre (Income)	a) For compliance purposes, the standards and operational requirements for the booking, payment and monitoring of all income streams should be documented. SRLC should then ensure its procedures are fully complied with by vigilantly monitoring the status of this. This should include: b) All administrative templates should be reviewed annually to ensure these comply with legal and service requirements e.g. booking forms, reconciliations and write off/discount authorisations etc. c) Separations of duties and access controls to Legend between the front of house team and the back office team should be reviewed. d) Check and cross-referencing controls need to be established to evidence the completeness and accuracy of information. This may include a register to confirm the review of all bookings, certification of reconciliations, use of management reports to investigate variances etc. e) Management should provide staff with feedback on the monitoring outcomes.	18/19	01-Nov-18		Ben Stanesby - Leisure & Recreation Manager	a)Processes are documented. b)initial review undertaken, further review of templates is required. c) Separation of duties was introduced immediately prior to the audit. The audit however examined a period prior to changes being made. d) booking review is still to be undertaken, e) is provided on an adhoc basis		**76 or more**	
95	**DACHS**	Delayed Transfer of Care	The following recommendations are made: - RBC should review the reporting lines, formats and forums to identify and improve performance as well as current impediments to performance identified. - In particular RBC should identify the governance and reporting structures in place that allows for transparency and likelihood of successful implementation. - RBC review the process they have in place to monitor and record progress against targets as well as barriers to doing so in order to determine whether they have access to sufficiently up to date information that has been verified against available evidence.	18/19	01-Nov-18		Paula Johnston, Acting Head of Adult Social Care	Progress locally against the High Impact Change model is being monitored through the Reading Integration Board. The dashboard to monitor progress against targets continues to be monitored at the Reading Integration Board. Reading has it's own governance and reporting structures to monitor delayed transfers of care and progress against targets. The Berkshire West 10 is the governance and reporting structure for the implementation of the High Impact Change model across the West of Berkshire	21/12/2018	**Complete**	
96	**DACHS**	Delayed Transfer of Care	It is recommended that the Council develop and approve comprehensive formal policies and procedures concerning the operation of all aspects of DToC with respect to the activities undertaken by the Council and in conjunction with partner organisations. Additionally: - Documentation should be stored in a location where it will be available to all staff involved with DToC operations and data verification work. - Policies and procedures should be regularly reviewed and updated. - Documentation should identify key roles and responsibilities of staff and establish accountability. - The processes in place where the Council is required to work with third parties should be recorded.	18/19	01-Nov-18		Paula Johnston, Acting Head of Adult Social Care	A Standard Operating Procedure is in place and has been shared with all staff this is located in the Sdrive	21/12/2018	**Complete**	

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97	**DACHS**	Delayed Transfer of Care	The Council is advised to: - Formally document and make available to staff the process that is to be undertaken when challenging data from health partners. - The Council should ensure that the documented process incorporates an understanding of the features of the systems used by health partners and is updated to reflect changes to those systems.	18/19	01-Nov-18		Paula Johnston, Acting Head of Adult Social Care	A Standard Operating Procedure is in place and has been shared with all staff this is located in the Sdrive	21/12/2018	**Complete**	
98	**DACHS**	Delayed Transfer of Care	The Council should review the Standard Operating Procedure and: - Ensure that the document is expanded in order to provide a robust reference document incorporating processes set in place by the Council. - Is publicised and made known to officers involved with the DToC process either through specific training or else through 1 to 1 supervision(s) - Is regularly updated to reflect changes made in the approach taken by the Council and partners.	18/19	01-Nov-18		Paula Johnston, Acting Head of Adult Social Care	A Standard Operating Procedure is in place and has been shared with all staff this is located in the Sdrive. It will be regularly updated as there are changes in the approach.	21/12/2018	**Complete**	
99	**DACHS**	Delayed Transfer of Care	The Council is advised to consider a periodic analysis of the available data from NHS England or local partners, as it pertains to the causes of delays, in order to determine whether there are any causes of delays that it can act upon to bring about an improvement in performance.	18/19	01-Nov-18		Paula Johnston, Acting Head of Adult Social Care	Local Data is analysed on a weekly basis and National Data is on a monthly basis when it is shared. This is presented at the Performance Board	21/12/2018	**Complete**	
100	**DACHS**	Delayed Transfer of Care	It is recommended that officers meet with health partners in order to: - Agree and document an understanding of the systems used for the recording of DToC figures and any limitations and restrictions of those systems. - Agree and document the internal processes of the partner with respect to making alterations to data at the request of the local authority. - Agree and document the error checking / audit processes of the health partner with respect to the data that they hold. - Agree and document the types of error that the health partner generated data is capable of generating - The information obtained as a result of meetings should be documented, retained and added where changes occur in order that the Council is able to challenge effectively in the event of staff changes. - The Council should where possible negotiate with the Trusts to ensure that the data provided within the month is sufficiently detailed to allow for a complete picture of attributed delays and also to allow for challenge. - The Council should review and agree with health partners the processes it intends to put in place utilising the Mosaic reporting functionality in light of an understanding of the limitations with the health partners reporting capabilities.	18/19			Paula Johnston, Acting Head of Adult Social Care	We monitor the accuracy of the Social Care DToC data on a weekly basis, checking the figures that we have agreed against those recorded on the RBH and BHFT systems. When we find inaccuracies, we then request changes to this data. These processes are incorporated in the Standard Operating Procedure.	21/12/2018	**Complete**	
101	ALL	PCI DSS	Although partly mitigated by the Lloyds Cardnet annual certification, the Council's ICT policies should be reviewed on an annual basis and before Learning and Development update and review its PCI DSS training course.	18/19	7-Nov-18		Andrew Withey - Acting Head of Customer Services & Transformation	ICT policies have been updated and need to be issued	04/01/2019	**51 to 75**	

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102	ALL	PCI DSS	Responsibility for controlling the acquisition of payment card devices and card payment solutions should be defined and centralised so that the council has complete oversight. This should include: * the deployment of payment card devices and card payment solutions, together with risk assessments are fully recorded etc. * the oversight and support of the Council wide PCI compliance programme.	18/19	7-Nov-18		Chris Beauchamp [Accounts Payable & Receivable Manager]	Completion of PCI DSS oversight policy 20/12/18 - Chris Beauchamp/ AP Manager to enforce policy going forward	28/12/2018	**Complete**	
103	DENS	Bus Subsidy Grant 17/18	Corporate Finance in conjunction with Services should ensure the accounts for funds received under the auspice of a grant determination are produced for certification on a timely basis.	18/19	7-Nov-18		Richard Johnson Strategic Business Partner	The Finance team will review all DENS revenue Grant claims within the Grants register and work with relevant individuals within the service to ensure that where they require an audit that the process is monitored closely and managed	17/12/2018	**25 or less**	
104	DENS	Integrated Transport Grant 17/18	Corporate Finance in conjunction with Services should ensure the accounts for funds received under the auspice of a grant determination are produced for certification on a timely basis.	18/19	7-Nov-18		Anna Barefoot [Capital Accountant] & Strategic Business Partner	The process in place with the RBH is robust, however the process in place with BHFT is currently being refined and will be in place by 1st November 2018.		**25 or less**	
105	DoR	Use of Hyperion - Revenue Budget Setting	Policies, procedures and timetables should be reviewed on a regular basis and updated as necessary to ensure they reflect current processes and timeframes.	18/19	26-Nov-18		Karen Ind, Financial Planning and Analysis Lead	The process and timetable was written for the 2019-22 MTFS process and circulated to staff and members. The timetable has been reviewed and updated throughout the process.	20/12/2018	**25 or less**	
106	DoR	Use of Hyperion - Revenue Budget Setting	Consideration should be given to reviewing access rights and consolidating/clarifying what each role/level can do.	18/19	26-Nov-18		Jenny Bruce, Financial Systems Manager	These processes have been included in the Standard Operating Procedure. Named individuals in the Systems Team and Analyst Team have admin rights to the system and all other users have read-only access as all forms have been locked.	20/12/2018	**25 or less**	
107	DoR	Use of Hyperion - Revenue Budget Setting	Consideration should be given as to whether another individual other than the inputter should review/authorise data uploaded into Hyperion and Fusion to ensure it has been completed correctly.	18/19	26-Nov-18		Jenny Bruce, Financial Systems Manager Karen Ind, Financial Planning & Analysis Lead	All data forms are locked so that changes can only be made by spreadsheet upload. Spreadsheet data can only be uploaded by named individuals in the Systems Team or the Analyst Team and those individuals reconcile the spreadsheet before upload.	20/12/2018	**25 or less**	
108	DoR	Use of Hyperion - Revenue Budget Setting	Clear evidence should be retained of what is loaded into Hyperion after the budget has been agreed and that it matches what has been agreed by Policy Committee/Council.	18/19	26-Nov-18		Karen Ind, Financial Planning and Analysis Lead	All changes to Hyperion are uploaded via spreadsheet which must be reconciled to the Medium Term Financial Strategy before upload. The spreadsheets are saved by date as evidence of the changes made to the budget.	20/12/2018	**25 or less**	
109	DACHS	Continuing Healthcare	It is recommended that the Head of Service works with CCG partners to establish and agree a locally set of documented specifications and standards that detail what the joint arrangements for the procedures and timescales for the application, assessment and recording of CHC cases should be. Once agreed these should be signed off by both parties and all relevant staff advised accordingly.	18/19	27-Nov-18		Jo Purser, Acting Head of Adult Social Care	Following the implementation of the revised CHC Framework in October 2018, the Acting Head of Adult Social Care will work with the CCG and partners to review the current Berkshire wide joint policy for CHC.	21/12/2018	**51 to 75**	

Rec No.	Dir	Audit Title	Recommendation	Rec Yr.	Original Audit Completion Date	1st Follow-up Date	Responsible Officer	Responsible Officer Latest Update	Updated on (date)	Status (% Complete)	Overall Status
110	DACHS	Continuing Healthcare	Ongoing efforts to further research and understand the disparity rates in local CHC funding should be fully and consistently backed by senior management in order that the reasons can be properly understood, and any changes made. Resources to do this may have to be found from existing budgets but the work should have senior officer support and the outcomes should be shared with other parties if necessary. Any system changes made as a consequence should be regularly monitored to establish their future effect.	18/19	27-Nov-18		Jo Purser, Acting Head of Adult Social Care	NHS England are responsible for auditing the application of the CHC framework. The Local Authority can refer to NHS England if there are specific concerns around the implementation of the framework locally but not research how the framework is being implemented across other areas. Senior management are focusing on ensuring that applications have robust evidence to support individuals to achieve CHC funding. Whilst we accept that the current level of success in this area remains low there are required actions for Reading to implement before highlighting this with NHS England	21/12/2018	**51 to 75**	
111	DACHS	Continuing Healthcare	It is important that, as the corporate system, Mosaic is used to fully capture and record all activity relating to CHC cases, including copies of correspondence, official reports as well as meeting notes and notes arising from telephone conversations, as well as completed Checklists and Decision Support Tools. Mosaic should be used by all staff to provide important (date) tracking information so that can be used to by the CHC Administrator and management to view activity on individual CHC cases, as well as to be able to apply high level monitoring of CHC cases.	18/19	27-Nov-18		Jo Purser, Acting Head of adult Social Care	Mosaic is now being used to record the CHC process	21/12/2018	**Complete**	
112	DACHS	Continuing Healthcare	Although there is already recognition that there is a need to bring all CHC training up to date, it is important that in future all staff are adequately trained on CHC procedures, that they are clear they understand these and that a record of this training (and any future updated training) is kept on iTrent. The Head of Service may wish to consider making this training mandatory and to sign this off by formally launching the initiative across the directorate. It is further recommended that any CHC training guides or documentation are kept up to date and located in an appropriate place (e.g. on a shared drive or on IRIS).	18/19	27-Nov-18		Jo Purser, Acting Head of Adult Social Care	Mandatory CHC training delivered to Adult Social Care staff All checklists are being scrutinised by Head of Service. An Assistant Team Manager is leading operationally and supporting workers at MDT's. CHC is included in the inductions of new staff - this will be reviewed by the Assistant Team Manager who will keep all training guides and material up to date and accessible in the S drive. Additional information is being shared with staff regarding key points of reference in the framework and a process flow chart is being developed by the Head of Service.	21/12/2018	**Complete**	
113	DACHS	Continuing Healthcare	It is recommended that the current control spreadsheet record maintained by the CHC Administrator is expanded to also capture dates key documents are submitted to / received from the CCG. This should then be regularly updated and checked to ensure each case is progressed on a timely basis. Where it is found that a case has not progressed then the relevant social work practitioner should follow this up and record this as an action on Mosaic.	18/19	27-Nov-18		Jo Purser, Acting Head of Adult Social Care	The information will be reported through mosaic	21/12/2018	**Complete**	
114	DACHS	Continuing Healthcare	Where an application for CHC support and funding has been rejected by the CCG the reasons for this need to be properly understood and (any lessons) absorbed for consideration with future cases. Where appropriate decisions should be formally challenged. It is therefore recommended that all rejected cases go through a formal review process by an appropriate senior officer so that any lessons can be learnt (and challenged, where appropriate) and outcomes fed back to social care colleagues.	18/19	27-Nov-18		Jo Purser, Acting Head of Adult Social Care	Data recorded in Mosaic to identify themes, challenge completed by ATM and Acting Head of Service	21/12/2018	**Complete**	

Rec No.	Dir	Audit Title	Recommendation	Rec Yr.	Original Audit Completion Date	1st Follow-up Date	Responsible Officer	Responsible Officer Latest Update	Updated on (date)	Status (% Complete)	Overall Status
115	DACHS	Continuing Healthcare	It should be determined as part of the review of procedures recommended in R1 above, which RBC staff should communicate with CCG staff over the submission, assessment, determination and follow up of CHC cases. This should then be disseminated to relevant staff. Similarly the role and profile of senior management (e.g. the Head of Adult Care) in relation to CHC cases needs to be visible so that there is a sufficiently high level presence on any joint board or forum to ensure that the Council's position and role is adequately reflected, safeguarded and represented.	18/19	27-Nov-18		Jo Purser, Acting Head of Adult Social Care	All submissions to the CHC team go via an RBC CHC GCSX account, these are all reviewed by the Acting Head of Service before submission	21/12/2018	**Complete**	
116	DACHS	Continuing Healthcare	It is recommended that the Adults and Children's services within RBC share best practice in relation to the handling, administration and management of CHC cases.	18/19	27-Nov-18		Jo Purser, Acting Head of Adult Social Care	Once Brighter Futures has become established the Head of Service will meet with their Head of Service to ensure that consistency of practice is embedded across Children's and Adult's services	21/12/2018	**Complete**	
									Status		
									25 or less	**14**	
							Red %	**16**	26 to 50	**5**	
							Amber %	**34**	51 to 75	**40**	
							Green %	**49**	76 or more	**21**	
									Complete	**36**	
								100	Total	**116**	

READING BOROUGH COUNCIL

DIRECTOR OF RESOURCES

TO:	**AUDIT & GOVERNANCE COMMITTEE**		
DATE:	**24 JANUARY 2019**	**AGENDA ITEM:**	**10**
TITLE:	**UPDATE ON 2016/17 AND 2017/18 ACCOUNTS**		
LEAD COUNCILLOR:	**COUNCILLOR BROCK**	**PORTFOLIO:**	**CORPORATE AND CONSUMER SERVICES**
SERVICE:	**FINANCE**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**MATTHEW DAVIS**	**TEL:**	
JOB TITLE:	**HEAD OF FINANCE**	**E-MAIL:**	**Matthew.Davis@reading.gov.uk**

1. EXECUTIVE SUMMARY

1.1 Regular reports have been received by the Committee providing updates on progress with completing the 2016/17 audit. This report updates the Committee on progress since its last meeting in September 2018.

1.2 In early October 2018, following discussions with EY's technical experts regarding the methodology previously used by the Council to value its Fixed Assets the Council tendered for fresh valuations of its property portfolio as at 1st April 2015, 31st March 2016 and 31st March 2017. It is expected that the new valuations, along with amendments to the historic accounting treatment of depreciation and impairment will resolve the outstanding queries on the 2016/17 accounts.

1.3 Officers have applied the learning from the 2016/17 process to the completion of the 2017/18 accounts. EY have now started preparatory work on the 2017/18 audit and the accounts will be handed to EY as soon as is practical once the 2016/17 accounts are finalised.

2. RECOMMENDED ACTION

2.1 To note the progress made by the External Auditor and officers in finalising the 2016/17 accounts.

2.2 To delegate authority to the Chair of the Committee to sign the final version of 2016/17 accounts, following consultation with the S151 Officer.

2.3 To note the progress made in closing the 2017/18 accounts.

3. BACKGROUND AND PROCESS

3.1 The External Auditors (EY) recommenced the audit in August and the audit is ongoing. EY have already indicated that they will need to qualify the Creditor and Debtor figures in the 2016/17 accounts. As previously reported this qualification results from issues in identifying sufficient evidence to substantiate some creditor and debtor balances given poor historic documentation, the passing of time and turnover of officers. Confirmation is still awaited from EY as to whether the qualification is on grounds of uncertainty of recognition (i.e. does the Council actually owe the liability or does it actually have an asset) and /or measurement (i.e. is what has been recognised appropriately valued in the Statement of Accounts). If the qualification is only on the grounds of uncertainty of recognition changes to the accounts will not be required.

3.2 Agreement has now been reached between the Council and EY regarding the accounting for the Council's two Public Finance Initiative (PFI) Schemes. The required changes will be made to the final version of the accounts and will not impact on the Council's usable reserves.

3.3 At the September meeting, it was anticipated that the outstanding issues regarding Fixed Assets would be resolved by early October. However, further concerns were raised by EY about the valuation of the council's assets and as outlined above new valuations were subsequently commissioned and further work undertaken.

3.4 The Code of Practice on Local Authority Accounting in the United Kingdom 2016/17 (the Code), requires "Where assets are revalued …. revaluations shall be made with sufficient regularity to ensure that the carrying amount does not differ materially from that which would be determined using the current value at the end of the reporting period."

3.5 Officers requested a market report from the valuation firm undertaking the 2017/18 valuations to address EY's concerns about property market movements since assets were last valued. This confirmed that whilst all assets were scheduled to be revalued once every five years, valuations were done as at 1st April in each year, not at 31st March, meaning that for 2016/17 some assets were last valued at 1st April 2012. It is accepted practice that all similar assets should be revalued at the same time; however this had not been the Council's practice, with a range of assets valued each year.

3.6 Consequently in early October new valuations were commissioned for a range of the Council's assets at the three balance sheet dates that are included in the 2016/17 accounts, 1st April 2015, 31st March 2016 and 31st March 2017. Valuations of all assets with a book value above £1m (64

properties) and a range of lower value assets (86 properties out of a total of approximately 300) have subsequently been completed.

3.7 In letting the contract it was also decided to revise the valuations for 2017/18 as well as include the valuations required for 2018/19 and 2019/20. Tenders were sought from three firms via a framework contract and the contract was awarded in the middle of November.

3.8 The valuation firm completed their fieldwork in December and started passing valuations to the Council in week commencing 16th December, with the bulk received before Christmas. The final valuation details were received early in week commencing 6th January and it is planned to pass the details of the valuations and the proposed amendments to the accounts to EY by Monday 14th January. A final version of the 2016/17 accounts will then be passed to EY by the beginning of the following week.

3.9 EY have indicated that they have completed all the other remaining audit work for 2016/17. It is anticipated that they should be able to complete the audit of the final changes to the accounts for Fixed Assets and PFI in early February.

3.10 EYs Associate Partner, Maria Grindley, has confirmed that her draft opinion will be subject to consultation with the Council and review by EY's Professional Standards Panel. Therefore, EY will not be in a position to give an opinion on the accounts until February.

3.11 The final accounts will need to be formally signed by the Chair of the Audit and Governance Committee, but as there may still be some final changes required following the auditors review, the accounts cannot be signed at this meeting. It is therefore recommended that the Committee delegate authority to sign the final version of the accounts to the Chair of the Committee in consultation with the Council's S151 Officer.

3.12 Discussions have taken place between EY and council officers about the content of their "Audit Results Report" and a draft report will be presented to the Committee, but at the time of writing the report is still being prepared by EY. Indications are that the report will cover at least fifteen material agreed changes, approximately thirty non-material agreed changes and over twenty other agreed presentational changes. These amendments have/are being taken into account in the preparation of the 2017/18 accounts.

3.13 Until the 2016/17 Accounts have been signed off by EY and the revised valuations for the 2017/18 accounts are received at the end of January it is not possible to finalise the 2017/28 accounts.

3.14 It is anticipated that the 2017/18 accounts and working papers will be ready for issue to EY by the middle of February 2019.

4. EQUALITY IMPACT ASSESSMENT

4.1 Not applicable.

5. LEGAL IMPLICATIONS

5.1 Part Five of the Accounts and Audit Regulations 2015 requires authorities to allow the public to inspect the accounts for a single period of 30 working days and stipulates that must include the first 10 working days of June of the financial year immediately following financial year. The Council were unable to comply with this requirement in respect of the 2017/18 Accounts as they were not ready for inspection. As soon as the 2017/18 accounts are ready, the Council will publish a formal notice on the website and open the accounts for the 30 working day inspection period.

6. FINANCIAL IMPLICATIONS

6.1 The indicative audit fee notified by EY in April 2016 for the 2016/17 audit was £108,938. This fee was in line with the scale fee set by Public Sector Audit Appointments Ltd. Due to the additional work that EY have undertaken on the audit over the last year, they have advised that the final fee is likely to be at least £300,000 more than the indicative fee.

6.2 The additional valuation work commissioned required to enable the completion of the 2016/17 and 2017/18 accounts has cost £139,000.

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