APPENDIX A

Internal Audit
Quarter 2 Internal Audit Report
2017/18
London Borough of Haringey

Mazars Public Sector Internal Audit Ltd.
October 2017

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Executive Summary

Introduction

This is our second report to the Corporate Committee for the 2017/18 financial year including details of all reports which are now at final stage. The report provides information on those areas which have achieved full or substantial assurance and gives an indication of the direction of travel for key systems work which will provide Members with information on how risks are being managed over time. The format of this report is also designed to highlight the key risks facing individual departments and the Council which have been identified during the course of our internal audits. A more detailed summary of the limited assurance audit findings is included for information. The report draws together the summary information which is provided on a monthly basis to Members of the Corporate Committee. Members of the Committee will also be provided with full copies of our audit reports upon request.

All recommendations are agreed with Council officers, and any disputes are discussed prior to the final report being issued. All recommendations to address any control weaknesses highlighted within this report have been agreed. Officers' actions to address the recommendations, including the responsible officer and the deadline for completion, are fully detailed in the individual final audit reports.

The attached tables reflect the status of the systems at the time of the audit, and recommendations may already have been implemented by Council officers by the time the final report is issued and reported to the Corporate Committee.

As a reminder, our recommendations are prioritised according to the following categories:

Priority 1	-	major issues for the attention of senior management
Priority 2	-	other recommendations for local management action
Priority 3	-	minor matters and/or best practice recommendations

Key Highlights/Summary of Quarter 1 and 2 2017/18:

2016/17 Internal audits finalised in the quarter

- Pension Fund Investments
- Information Governance

2016/17 Draft Internal Audit Reports issued this quarter

- Welfare Reform

2017/18 Internal Audit Reports finalised in the quarter:

- IR35

- A team
- High Road West
- Hornsey School for Girls
- Bruce Grove Primary School
- Chestnuts Primary School
- Mulberry Primary School
- Rokesly Infants School

2017/18 Draft Internal Audit Reports issued this quarter

- Direct Payments
- Capital Delivery
- Crowland Primary School
- Lancasterian Primary School

Audit Progress and Detailed Summaries

The following table sets out the audits finalised in Quarter 2 of 2017/18 financial year and the status of the systems at the time of the audit. It must be noted that the recommendations may already have been implemented by Council officers by the time the final report is issued and reported to the Corporate Committee. Detailed summaries of all audits which do not receive 'Full' or 'Substantial' assurance ratings are also provided for Members' information.

Audit Title	Date of Audit	Date of Final Report	Assurance Level	Direction of Travel	Number of Recommendations (Priority)		
					1	2	3
2016/17							
Pension Fund Investments	June 2017	Aug 2017	Full	⟺	0	0	0
Information Governance	May 2017	Aug 2017	Limited	N/A	2	8	0
2017/18							
IR35	June 2017	Sept 2017	Substantial	N/A	0	2	0
A team	May 2017	Sept 2017	Limited	N/A	7	11	2
High Road West	June 2017	Sept 2017	Substantial	N/A	0	1	0

APPENDIX A

As part of the 2017/18 Internal Audit Plan we have visited the following schools, completed a probity audit and during Quarter 2 issued a final report.

School	Date of Audit	Date of Final Report	Assurance Level	Number of Recommendations (Priority)		
				1	2	3
2017/18						
Hornsey School for Girls	June 17	Sept 17	Substantial	1	3	0
Bruce Grove Primary School	June 17	July 17	Limited	3	9	5
Chestnuts Primary School	June 17	July 17	No	10	10	1
Mulberry Primary School	July 17	Sept 17	Substantial	0	4	0
Rokesly Infants School	July 17	Sept 17	Limited	0	5	5

Audit area	Scope	Status/key findings	Assurance
		Ad-Hoc Audits	
Information Governance	Audit work was undertaken to cover the following areas: • Strategy • Compliance • Information Storage • Information Sharing • Communication & Training • Risk Management • Performance Monitoring & Reporting	While there is a basically sound system of internal control, there are weaknesses, which put some of the client's objectives at risk. There is evidence that the level of non-compliance with some of the control processes may put some of the client's objectives at risk. The key findings are as follows: • The Council has policies covering the Information Governance, Freedom of Information and Data Protection Policy, which are published on the intranet although all these policies were last updated in December 2011. We were informed that there is at present no plan for the policies to be reviewed and updated. • There is no Information Governance strategy. • Information is defined in the Information Governance Policy as all information irrespective of where or how it is held, and provides examples such as databases, electronic files, paper files, microform, emails, voicemails, transient documents, works in progress, visual images (such as photographs, scanned images & CCTV), web 2.0 documents (such as blogs, wikis and Facebook), discussion threads (such as Twitter) and other social media sites. The policy also notes that it will cover formats that may be developed and used in the future. • Adherence to the Transparency Code is provided through the Council's Publication Scheme, which is published on the website and identifies 10 classes of information with links to the actual data. We were informed that responsibility for keeping the actual data up to date lies within individual services, and ensuring that all required data is published lies with the Feedback & Information Governance team.	**Limited**

Audit area	Scope	Status/key findings	Assurance

		• IT Services are certified to ISO 27001/2013 and which is subject to external accreditation once every three years. The most recent accreditation was completed by the Lloyds Registrar Quality Assurance (LRQA) with a certificate issued on 15 December 2016.
		• Responsibilities for Information Governance have been assigned as follows:
		  o The Senior Information Risk Owner (SIRO) is the Head of Audit & Risk Management; and
		  o The Data Protection Officer is the Feedback & Information Governance Team Manager.
		• There is a dedicated Feedback & Information Governance Team which consists of the Team Manager and an Information Governance Officer.
		• Responsibility for Information Governance arrangements resides with the Information Security & Business Manager for IT issues and the Feedback & Information Governance Team Manager for non-it issues, with oversight by the Head of Audit & Risk Management. This is not documented in the Information Governance Policy.
		• There is an IT Security Forum, consisting of the SIRO and IT Officers which meets once a quarter and reviews information security issues.
		• There is no dedicated Corporate Forum for Information Governance issues, other than the Statutory Officers Group (SOG).
		• There are no officers identified in individual Directorates or services with responsibility for Information Governance.
		• Individual services are required to maintain an Information Asset Register (IAR) in which they record all information assets for	

Audit area	Scope	Status/key findings	Assurance
		which they are responsible. The IAR shall also identify for each information asset, whether it is shared with any external agency. • There are no Information Sharing principles set out, other than the procedures as identified in the model Information Sharing Protocol developed in September 2009. • In addition, an IT Asset Inventory is maintained by IT Services. This was obtained and examined and confirmed the following: o 98 information assets were recorded; o The definition of each asset included whether it held personal data or commercial in confidence data, information owner, the purpose for which it was held, whether it was a legal or business need, its classification (as Official or Official Sensitive) and data retention guidelines; o 93 of the assets were last reviewed in either June, July or November 2016. The other five was last reviewed in June 2006; and o Each asset was identified as whether it was shared internally in the Council, and externally. Where it was identified as being shared externally, the inventory recorded the direction the information is shared, approximate number of records shared, sharing method, security controls in place to protect data and an assessment of the impact/consequence of a breach of confidentiality. • We selected six of the 18 services headed by an Assistant Director, and requested that the IAR be provided. We confirmed the following: o IAR are held for Strategy & Communications, Public Health, and individual services within Adult Services and	

Audit area	Scope	Status/key findings	Assurance
		Children Services (Safeguarding); o There is no IAR for Housing & Growth or for Customer Services. We were informed that any data recorded by Customer Services is held on systems 'owned' by other services; o While the IAR allowed for the classification of information assets, the classification used was Restrict, Protect, Classified and Unclassified. It was further noted that some assets were not so classified, and others only marked as 'password protected'. This was the case for all IAR apart from Strategy & Communications; o The IAR did specify retention guidance for information assets recorded, apart from some of the assets listed on the Public Health IAR, and for some of the Adult Services IAR; and • The IAR identified whether information assets re shared, apart from some assets on the Adult Services IAR. The Council does not have a Data Retention Schedule, although there is a link from the intranet Data Protection pages to the London Government Association (LGA) website on which is provided guidance on data retention requirements. • As part of the end of year annual assurance process, Assistant Directors are required to confirm that they have produced and maintained an IAR. • E-learning courses have been developed and are available on the intranet covering Information Handling, Data Protection and IT Security. In the 12 months to June 2017 there have been 390 staff who completed the Data Protection and 56 staff who completed the IT Security courses.	

Audit area	Scope	Status/key findings	Assurance
		• A Corporate Risk Register is maintained for the Council, though there were no specific risks related to Information Governance included. • Information Technology Services maintain a Risk Treatment Plan covering Information Security which is monitored fortnightly. As a result of our audit work we have raised two Priority 1 and eight Priority 2 recommendations which should assist in improving the control environment. Our priority 1 recommendations are as follows An Information Governance Strategy should be developed by which the requirements of the GDPR are achieved. This will include the review and update of all policies and the Information Sharing Protocol, and communication of such requirements to all staff A project is currently being scoped that addresses the impacts of the GDPR requirements. This will be addressed as part of this project. Deadline May 2018 Assistant Directors should be required to identify an officer within their service who will take responsibility for liaising with the FIG Team and implementing all information governance requirements. Elements of this recommendation will be resolved through the GDPR project. In addition, a review of staffing and structure for information-related roles is currently underway. One outcome of this review will be to identify information lead (including governance) responsibilities in each Priority Outcome area of operation, and thereby in service teams. Deadline May 2018. Our priority 2 recommendations are as follows: An officer should be made responsible for the updating of The Information Governance, Freedom of Information and Data Protection Policy. The Information Governance Policy should be reviewed to	

Audit area	Scope	Status/key findings	Assurance
		ensure that it reflects current staffing structures and responsibilities. Such policies should be reviewed on an annual basis. The FOI Policy was reviewed in September 2015. A further review will form part of the GDPR Project which will also set out guidelines for further (annual) reviews. All roles will be identified through this project. Deadline May 2018 An Information Governance Forum should be established for the Council as a whole, including representatives from all Directorates through which all Information Governance issues can be addressed and co-ordinated across the Council. This will be resolved as part of the GDPR Project which will also set out guidelines for meeting attendees and frequency. Deadline May 2018. The IAR submitted annually by services should be reviewed to confirm the classification is consistent with the latest regulations. Where it is found that it is not, further guidance should be issued to the relevant service. Current IARs will be reviewed and, where necessary, reclassified, in response to this audit. Deadline December 2017 IAR should be reviewed and where they do not specify whether the information asset is shared, the service should be contacted to clarify. Current IARs will be reviewed and, where necessary, reclassified, in response to this audit. Deadline December 2017 The IAR should be reviewed and where an IAR identifies an information asset as shared, the service should be requested to confirm that a protocol is in place and is up to date This will be resolved as part of the GDPR Project, which will also set general guidelines for IARs along with review schedules. Deadline May 2018.	

Audit area	Scope	Status/key findings	Assurance
		The model Information Sharing Protocol should be reviewed to bring into line with current legislative requirements This will be resolved as part of the GDPR Project Deadline May 2018. Periodic reports of staff who have not completed e-learning courses should be produced and forwarded to the FIG Team. Reports on completion of such courses should be made to the SOG. HR will investigate if it is possible to give the FIG team reporting access to the learning system (Fuse) so that they can extract the required reports as and when required (i.e. self service). If this is not possible we can agree reporting schedule. As part of a new 'middle manager' programme, the council will be developing 'Haringey Essential' courses/learning, which all staff will need to undertake; we will as part of that larger exercise also agree the monitoring and escalation process for non-compliance, which may or may not include regular reporting to SOG. Deadline December 2017	
Outstanding for All (Adult services)			
A team	Audit work was undertaken to cover the following areas: • Governance • Staffing • Complaint Handling • Financial Management • Ordering and Invoicing • Assets • Business Continuity • Management Information • User experience	While there is a basically sound system of internal control, there are weaknesses, which put some of the client's objectives at risk. There is evidence that the level of non-compliance with some of the control processes may put some of the client's objectives at risk. The key findings are as follows: • It was established that there is currently no agreed Constitution in place for the A Team. • We obtained a draft Business Plan which we were informed has since been abandoned. Discussions with the Clarendon Recovery College Manager confirmed that a new business plan is being compiled in partnership with Bridge Renewal Trust (Haringey Council's Strategic Partner for the Voluntary and Community Sector), but this is in the very early stages of development and a draft was not available for examination. • It was established that operational procedures have not been	**Limited**

Audit area	Scope	Status/key findings	Assurance
		compiled. No documents were obtainable during the course of the audit that highlighted the roles and responsibilities of specific members of staff. • It was established that the A Team have adopted Haringey Council's official Complaints Policy. Any official complaints are received by Haringey Council, passed on to the Clarendon Recovery College Manager, who will then interview the Employment & Training Worker regarding the matter, and take corrective action where necessary. There is no record of any complaints received with regard to the A Team according to the Clarendon Recovery College Manager. • It was established that the current recruitment process used to take on volunteers does not include a preceding Disclosure & Barring Service check. • There is no documented Scheme of Delegation in place. The Clarendon Recovery College Manager is the only Budget Holder. All money earned by the A Team service is managed by the Employment & Training Worker, however, this is not considered Haringey Council income and Haringey Council receives no benefit from this. • It was established that Purchase Orders are not used for any goods or services ordered by the A Team. • Examination of the Accounts and Invoices file provided by the Clarendon Recovery College Manager revealed no evidence of any Goods Received Notes being obtained and retained for items that appear in the asset register. • From a random sample of 10 invoices, it was confirmed that in two cases (accounting reference numbers 99 and 95A-D), the amount recorded as paid in the cashbook did not match the invoiced amount. It is, however, our understanding that the money used here has been generated within the A Team and that the Council bears no financial risk. • We were unable to confirm that an adequate segregation of duties is taking place with regard to ordering and invoicing as there is no Scheme of Delegation and no clear management trail to show who	

Audit area	Scope	Status/key findings	Assurance
		has been responsible for what. • We obtained an Asset Register. According to the document the most recent stock take exercise was completed on 28/10/2014, and there was no tangible evidence obtainable to suggest that spot checks have been completed at all. It was confirmed that the asset register does include valuable and portable assets. Some detail is given regarding make and model number of assets, however there is no indication of unique ID numbers, serial numbers, initial/replacement cost or location/storage of assets in the Asset Register. • It was established that the A Team are in the process of security marking all of their assets. The Clarendon Recovery College Manager explained this will be done by late July 2017. We have not been able to confirm that this was done due to a key officer being on leave when we completed fieldwork. • It was established that management reports have not been regularly received by the Clarendon Recovery College Manager for the past 18 months. Updates are given on an informal basis, however, in the absence of any tangible evidence we could not confirm this. No Key Performance Indicators have been established to measure against the service performance and delivery. • We could not obtain any evidence to suggest customer feedback is reported to senior management for their consideration. As a result of our audit work we have raised seven Priority 1, 11 Priority 2 and two priority 3 recommendations which should assist in improving the control environment. Our priority 1 recommendations are as follows Senior Management within the A Team should establish an agreed Constitution that sets out the fundamental principles according to which the A Team is to be governed. Agreed - Deadline December 2017 Operational procedures should be compiled, agreed by management,	

Audit area	Scope	Status/key findings	Assurance
		and reviewed on a periodic basis. Agreed – Deadline November 2017 Roles and responsibilities should be defined in either individual job descriptions or the operational procedure notes. Agreed – Deadline November 2017 The A Team should develop a Scheme of Delegation document which includes delegated financial responsibilities and financial limits. There is Scheme of Delegation in the council however a bespoke one for The A–Team is necessary. Agreed – Deadline November 2017 All invoices should be certified by an independent authorised signatory, according to the Scheme of Delegation. Agreed – Deadline October 2017 Management reports should be submitted to the Clarendon Recovery College Manager by the Employment & Training Worker on a monthly basis. Manager needs to formulate monthly report template that will highlight how many jobs have been undertaken and how much has been earned how many have worked and how much has been spent. Agreed – Deadline December 2017 Customer feedback should be summarised and reported back to management as part of the monthly management reporting process Agreed – Deadline December 2017 Our priority 2 recommendations are follows A Business Plan which conveys the services management structure and procedures needed to meet its targets, should be developed by the A Team and agreed with the Council. Agreed – Deadline March 2018 A Recruitment Policy should be developed that states the entry requirements for new starters and ensures that all safeguarding checks including DBS are completed prior to any contract start dates. Agreed – Deadline November 2017 Staff rotas should be developed and used on a regular basis. Agreed – Deadline October 2017	

Audit area	Scope	Status/key findings	Assurance
		Timesheets should be completed by staff on a regular weekly basis and approved by the Employment & Training Worker to confirm their accuracy. Agreed – Deadline October 2017 All new starters should complete induction training before providing any service to customers. A record should be maintained of all new starters who have completed induction training Agreed – Deadline December 2017 All staff fulfilling specific duties that require training should complete their training prior to delivering the service. Agreed – Deadline December 2017 Official Purchase Order forms should be raised for all purchases, where appropriate, and retained on file. Agreed – Deadline November 2017 Goods Received Notes should be obtained and retained upon receipt of all goods and services ordered by the A Team. Checks should be carried out on receipt to ensure that goods received match those ordered. Agreed – Deadline November 2017 The A Team should maintain a record of its inventory and this should be held collectively by a delegated member of staff. The records should provide information on: the type of asset, make, model, serial number, date of purchase, approximate value, location, and date of disposal (where appropriate). Agreed – Deadline November 2017 Annual inventory checks should be undertaken and signed off by the person carrying out the check. Once completed, this should be independently checked and signed off by the Clarendon Recovery College Manager. Agreed – Deadline November 2017 Customer feedback should be recorded electronically on receipt Agreed – Deadline December 2017	

Statement of Responsibility

We take responsibility for this report which is prepared on the basis of the limitations set out below.

The matters raised in this report are only those which came to our attention during the course of our work and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made. Recommendations for improvements should be assessed by you for their full impact before they are implemented. The performance of our work is not and should not be taken as a substitute for management's responsibilities for the application of sound management practices. We emphasise that the responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management and work performed by us should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify all circumstances of fraud or irregularity. Even sound systems of internal control can only provide reasonable and not absolute assurance and may not be proof against collusive fraud. Our procedures are designed to focus on areas as identified by management as being of greatest risk and significance and as such we rely on management to provide us full access to their accounting records and transactions for the purposes of our work and to ensure the authenticity of such material. Effective and timely implementation of our recommendations by management is important for the maintenance of a reliable internal control system.

Mazars Public Sector Internal Audit Limited

London

October 2017

In this document references to Mazars are references to Mazars Public Sector Internal Audit Limited.

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