BUSINESS ASSURANCE

Final Internal Audit Assurance Report 2016/17

Effectiveness of Internal Audit

7th July 2016

Overall IA Assurance Opinion:

REASONABLE

Recommendation Overview:

High Risk	0
Medium Risk	2
Low Risk	3
Notable Practice	2

Review Sponsor:

Paul Whaymand	Corporate Director of Finance

Report Distribution:

Muir Laurie	Head of Business Assurance
Martyn White	Senior Internal Audit Manager

Ownership of all final Internal Audit assurance reports rests with the relevant Audit Sponsor. However, we will disclose final Internal Audit assurance reports to the Audit Committee upon their specific request.

HILLINGDON
LONDON

1. Introduction

1.1 This risk based Internal Audit (IA) assurance review forms part of the 2016/17 Quarter 1 Operational IA Plan presented to Audit Committee on 15th March 2016. The purpose of this review is to provide assurance to the Corporate Management Team (CMT) and the Audit Committee over the following key risks in relation to the IA function:

- The Council's assurance requirement is not satisfied and the Head of Business Assurance maybe unable to provide an opinion in the AGS;

- Gaps between what IA agrees to deliver and the expectation of the audit sponsor/management/auditee;

- Non-compliance with professional standards and IA's own policies and procedures;

- Control weaknesses are not identified accurately or fully, failing to fulfil the role of IA as the third line of defence;

- Work delivered does not fulfil the coverage defined in the terms of reference; and

- Budget over runs resulting in financial loss and audits not completed in a timely manner impacting on the remainder of the audit plan and potentially undermining the usefulness of audit recommendations.

2. Background

2.1 IA provides an independent assurance and consultancy service that underpins good governance, which is essential in helping the Council achieve its strategic objectives and realise its vision for the borough of Hillingdon. It is also a requirement of the Accounts and Audit (England) Regulations 2011 that the Council undertakes an adequate and effective IA of its accounting records and of its system of internal control in accordance with the proper practices in relation to internal control.

2.2 The UK Public Sector IA Standards (PSIAS) came into force on 1st April 2013 and were introduced with the intention of promoting further improvement in the professionalism, quality, consistency and effectiveness of IA across the public sector. They stress the importance of robust, independent and objective IA arrangements to provide senior management with the key assurances they need to support them both in managing the organisation and in producing the Annual Governance Statement (AGS).

2.3 The effectiveness of IA is a key cornerstone of corporate governance. The Accounts and Audit (England) Regulations 2011 require relevant bodies 'to conduct an annual review of the effectiveness of its IA' and that IA should conform to 'proper practices'. If the effectiveness of IA is not measured then the IA service will not know where to improve or how efficient and effective the service is.

2.4 In 2015/16, the effectiveness of IA was assessed against the UK PSIAS internally by the Council's Internal Audit team. This review provided reasonable assurance raising three medium and six low priority recommendations. The 2016/17 IA assurance review has been conducted externally by Mazars Public Sector Internal Audit to provide additional independence to the assurance provided to CMT and the Audit Committee.

3. Executive Summary

3.1 Overall, the IA opinion is that we are able to give **REASONABLE** assurance over the key risks to the achievement of objectives for the IA function. Definitions of the IA assurance levels and IA risk ratings are included at **Appendix C**.

3.2 The IA Service's purpose, authority, responsibility and position within the Council is documented in the London Borough of Hillingdon's Internal Audit Charter. Policies and

procedures are available to staff detailing the IA Assurance and Consultancy Review Process, as well as providing guidance in order to fulfil their role within the IA Team. We reviewed these documents and found these to be adequately detailed.

3.3 Planning meetings are held with key stakeholders across the Council, which together with a variety of other information sources enables IA to undertake an audit needs analysis to determine the high level plan, and IA priorities and assignments for the year. Further meetings are held throughout the year to determine quarterly audit plans, which helps the function to have the flexibility to respond to the changing environment in which the Council operates. From examination of the meeting notes on the IA Shared Drive, we confirmed that meetings had been held as described above. Formal updates of the IA Plan are reported to the CMT and the Audit Committee through quarterly progress reports which help to ensure IA remains aligned with the Council's objectives and the risks identified by management.

3.4 Prior to each audit engagement, planning meetings are held with the Key Sponsor or their representatives to identify the key risks prior to the Terms of Reference being drafted. Once approved by the Senior IA Manager and then the Key Sponsor, the Terms of Reference is formally issued. From three audit engagements tested, we confirmed that this process had been followed in each case.

3.5 Audit documentation is all held electronically on the Council's Internal Audit software 'Teammate'. This includes meeting notes and research; the documenting of controls in place against risks; audit findings together with supporting evidence, and the completed audit reports. From our review of three audit engagements examined on Teammate, we confirmed that the audit had been carried out in accordance with the Terms of Reference agreed with the Key Sponsor. However, we also found that:

- In one case it was not clear which evidence document attached on Teammate related to the issue identified during testing;

- In two cases documents relating to the findings were not attached on Teammate, however these were available on the IA shared drive; and

- In two audits examination of the risk and control evaluations identified that individual controls had not been mapped against risks.

3.6 Once the audit working papers are prepared, the auditor will sign off their electronic working papers, and their work will then be subject to a quality review by their line manager. As part of the management review, the line manager will raise review points for the auditor to address prior to the issue of the draft audit report. However, in two cases we identified that documented review points were not provided in advance of the draft audit report being issued. We were informed that given the close proximity between staff within the IA team, review points would have been given and cleared verbally prior to the draft being issued rather than being documented.

3.7 Once all review points have been cleared, an exit meeting is held with the auditee where audit findings are discussed, although exit meeting notes are not documented. Following this, the auditor forwards a copy of the draft audit report to the Head of Internal Audit (HoIA) for his review. Once the management response to the draft report is received from the auditee, this will be taken into consideration before the issue of the final report, which also requires review from the HoIA prior to issue. From our sample of three audit reviews tested, we found that the review from the HoIA was not always documented, although we were informed that approval is often given verbally.

3.8 The process of following up recommendations to confirm they have been implemented is managed through Teammate, which gives the recommendation owner the ability to access, update the implementation status, and monitor their recommendations. Any updates to the implementation status are sent to the IA Management Team so that this can be monitored.

3.9   High and Medium priority recommendations are monitored through to implementation. Discussions established that High priority recommendations are verified by reviewing supporting evidence, with Medium priority recommendations verified either through evidence or confirmation from the responsible officer depending on resource constraints. We tested a sample of ten recommendations as well as reviewing Teammate for high priority recommendations that had been marked as implemented but not verified. We found that supporting evidence had been uploaded onto Teammate and verified by IA (where applicable) in all but one of the recommendations tested. In the remaining one instance, we were informed this was a recommendation from 2014 that had been uploaded onto Teammate for training purposes.

3.10   IA staff are required to complete individual timesheets on TeamTec which is an application within Teammate on a weekly basis. Management will review the days charged to each audit and input this in their monitoring spreadsheet once the audit is complete. Any areas of concern will be queried with the auditor and discussed with management, with reasons for budget disparities also recorded in the monitoring spreadsheet. Staff Capacity Plans are completed for each member of staff detailing their target utilisation rate for the quarter (i.e. what percentage of their time should be spent on completing audit engagements) and these targets are reviewed by management on a monthly basis.

3.11   We confirmed that the HoIA delivers an Annual IA Report and Opinion Statement that summarises the main findings arising from IA's assurance and consultancy work from the previous year, as well being used by the Council to support its Annual Governance Statement. Quarterly progress reports were also presented to the Corporate Management Team and Audit Committee with summary information on all current year assurance, consultancy and grant claim verification work covering the prior quarter.

3.12   As part of this review we have verified the implementation of the **3 MEDIUM** risk recommendations raised as part of the 2015/16 Effectiveness of IA review, confirming that one recommendation has been fully implemented with the remaining two partly implemented (refer to key findings 2 and 3 at **Appendix B**).

3.13   The detailed findings and conclusions of our testing which underpin the above IA opinion have been discussed at the exit meeting with the Head of Business Assurance and the Senior Internal Audit Manager and are available to management upon specific request. The key findings and IA recommendations raised in respect of the risk and control issues identified are set out in the Management Action Plan included at **Appendix A**. Good practice suggestions and notable practices are set out in **Appendix B** of the report.

4. Acknowledgement

4.1   We would like to formally thank all of the officers contacted during the course of this review for their co-operation and assistance. In particular the Head of Business Assurance, Senior Internal Audit Manager, Assistant Internal Audit Manager, and Principal Auditor, whose advice and help were gratefully appreciated.

5. Internal Audit Contact Details

This audit was led by:	Miyako Graham ACCA **Audit Manager (Mazars)**
Audit support was provided by:	Daniel Ah Qune ACCA **Assistant Audit Manager (Mazars)**
This audit was reviewed by:	James Graham CMIIA **Senior Audit Manager (Mazars)**

Management Action Plan

No.	Key Finding
1	From three internal audit engagements tested, we identified two cases where we could not confirm that the audit file on Teammate had been reviewed prior to the issue of the Draft/Final Audit Report: • Disabled Facilities Grants and Adaptations – Documented feedback provided to the Auditor and signed off by the Reviewer on Teammate 07/09/15; Draft Report issued 31/07/15; and Final Report issued 04/09/15. • Corporate Procurement – Documented feedback provided to the Auditor and signed off by the Reviewer on Teammate on 29/10/15, Draft Report issued 21/10/15 and Final Report issued 13/11/15. We were informed that given the close proximity between staff within the IA team, review points would have been given and cleared verbally prior to the draft being issued rather than being documented. Additionally in two cases, working papers were signed off on Teammate by the auditor following the issue of the Draft/Final Audit Report: • Disabled Facilities Grants and Adaptations – Signed off by the Auditor as complete 01/09/15; Draft Report issued 31/07/15; and Final Report issued 04/09/15. • Housing Needs – Allocations and Assessments – Signed off by the Auditor 29/04/16, Draft Report issued 09/02/16, Final Report issued 02/03/16.

Risk	Recommendation	Management Action Proposed	Risk Owner & Implementation date
Where audit files are not evidenced as reviewed, or signed off as completed prior to the issue of the Draft/Final Audit Reports, there is an increased risk that audit findings in the report may not be accurate and control weaknesses may not be identified.	A formal sign off document should be put in place for each Audit review. This will help to ensure that all necessary checks have been completed prior to the issue of the audit reports. This should include, but is not limited to: • Confirmation that the audit working papers have been signed off as complete by the Auditor; • Confirmation that the audit file has been reviewed on Teammate; • Confirmation that review points have been addressed; and • Approval from the HoIA prior to the issue of the audit reports.	We have significantly enhanced our usage of TeamMate throughout the year, including implementing a TeamMate checklist in April 2016 to help ensure the full completion. The Quality Assurance and Improvement Programme (QAIP) will capture this aspect which will be taken forward through our TeamMate User Group (TMUG).	Senior Internal Audit Manager (Martyn White) 30th September 2016
Risk Rating		**Risk Response***	
MEDIUM 🟡		**TREAT**	

Management Action Plan

No.	Key Finding
2	As identified in the 2014/15 Effectiveness of IA review, a formal assurance mapping exercise has not been undertaken across the Council.

Risk	Recommendation	Management Action Proposed	Risk Owner & Implementation date
There is an increased likelihood that sources of assurance are not identified resulting in gaps in assurance arising with increased potential risks materialising. Further, there is an increased likelihood that a duplication of effort where alternative sources of assurance are not considered when formulating the audit plan.	A formal assurance mapping exercise should be undertaken across the Council to enable reliance to be placed on other forms of assurance and focus IA resource on assurance gaps across the Council. Until this exercise takes place, alternative sources of assurance should be included as part of the planning meeting agenda template to be discussed with management when setting the annual and quarterly audit plans.	We will look to undertake assurance mapping against the Corporate Risks to identify sources of assurance to focus IA resources. Wider assurance mapping will be undertake once enhancements to the Council's risk management processes, in particular the identification and assessment of risks, have been embedded throughout the Council.	Head of Business Assurance (Muir Laurie) 30th April 2017

Risk Rating		Risk Response*	
MEDIUM ●		**TREAT**	

Good Practice Suggestions & Notable Practices Identified

No.	Key Finding	Observation / Suggestion	Risk / Rationale	Risk Rating
3	From three audit engagements examined, we identified the following: • In one case (Recommendation 10 – Disabled Facilities Grants and Adaptations) it was not clear which evidence document related to the issue identified. • In two cases (Recommendations 2 and 10 – Disabled Facilities Grants and Adaptations) documents relating to the findings were not attached on Teammate, however these were available on the IA shared drive. • In two cases (Disabled Facilities Grants and Adaptations and Corporate Procurement), examination of the risk and control evaluations for the audit identified that individual controls had not been mapped against risks. Discussions with management established that improving the use of Teammate has been subject to much discussion amongst management, with a Teammate working group set up, and training sessions held to fully utilise the functionality of the system. A similar issue was raised as part of the 2014/15 Effectiveness of IA review.	The use of Teammate should continue to be monitored to help ensure that staff are fully documenting their work on Teammate, and utilising the full benefits of the software.	Where audit working papers are not clearly documented and referenced, there is a risk that evidence may not be in place to support audit findings or may not be located should the issue be challenged. Where individual controls are not mapped against risks, gaps in controls and control weaknesses and risk exposures may not being identified, with and recommendations not raised to address these.	**LOW**

Good Practice Suggestions & Notable Practices Identified

No.	Key Finding	Observation / Suggestion	Risk / Rationale	Risk Rating
4	Exit meetings are held with the auditee to discuss the main findings and conclusions from the audit; however, we were informed that meeting minutes are not taken.	IA should consider documenting the key discussions and responses from the auditee during the exit meeting debriefing.	Where exit meeting minutes are not taken, there is a risk that IA cannot demonstrate that the auditee has been adequately debriefed, and that the auditee's comments (if relevant) are not taken into account prior to the draft report being issued.	**LOW** ●
5	The 'Internal Audit Assurance Review Process' document states that for follow ups 'Action owners have the ability to change implementation dates and 'sign off' recommendations which they believe have been implemented but these will all be verified by IA before any changes are accepted. We were informed that where follow up extension deadlines have been amended, these are emailed to management but do not require approval.	IA should consider a periodic review of all extensions, and their extension dates to confirm these are justified and reasonable.	Where extension deadlines are not reviewed, there is a risk that implementation of recommendations can unnecessarily delayed without them showing as outstanding.	**LOW** ●
6	Planning meetings are held with key stakeholders across the Council, which together with a variety of other information sources enable IA to undertake an audit needs analysis to determine the high level plan, and IA priorities and assignments for the year. Further meetings are held throughout the year to determine quarterly audit plans.	Quarterly Audit plans are agreed by the CMT and AC.	This approach represents good practice by enabling IA to have the flexibility to respond to the changing environment in which the Council operates.	**NOTABLE PRACTICE** ●

Good Practice Suggestions & Notable Practices Identified

No.	Key Finding	Observation / Suggestion	Risk / Rationale	Risk Rating
7	Staff Capacity Plans are agreed following one to one meetings between staff and their line manager detailing their target utilisation rate for the quarter (i.e. what percentage of their time should be spent on completing audit engagements as well as other tasks such as training). Progress against these targets is reviewed by management on a regular basis.	Staff Capacity Plans are developed for the IA Team.	This approach represents good practice. By setting targets based on individual needs, to help ensure time spent on audit work is maximised.	**NOTABLE PRACTICE** ●

INTERNAL AUDIT ASSURANCE LEVELS AND DEFINITIONS

ASSURANCE LEVEL	DEFINITION
SUBSTANTIAL	There is a **good level of assurance** over the management of the key risks to the Council objectives. The control environment is robust with no major weaknesses in design or operation. There is **positive assurance** that objectives will be achieved.
REASONABLE	There is a **reasonable level of assurance** over the management of the key risks to the Council objectives. The control environment is in need of some improvement in either design or operation. There is a misalignment of the level of residual risk to the objectives and the designated risk appetite. There remains **some risk** that objectives will not be achieved.
LIMITED	There is a **limited level of assurance** over the management of the key risks to the Council objectives. The control environment has significant weaknesses in either design and/or operation. The level of residual risk to the objectives is not aligned to the relevant risk appetite. There is a **significant risk** that objectives will not be achieved.
NO	There is **no assurance** to be derived from the management of key risks to the Council objectives. There is an absence of several key elements of the control environment in design and/or operation. There are extensive improvements to be made. There is a substantial variance between the risk appetite and the residual risk to objectives. There is a **high risk** that objectives will not be achieved.

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

   - establishing and monitoring the achievement of the authority's objectives;

   - the facilitation of policy and decision-making;

   - ensuring compliance with established policies, procedures, laws and regulations – including how risk management is embedded in the activity of the authority, how leadership is given to the risk management process, and how staff are trained or equipped to manage risk in a way appropriate to their authority and duties;

   - ensuring the economical, effective and efficient use of resources, and for securing continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness;

   - the financial management of the authority and the reporting of financial management; and

   - the performance management of the authority and the reporting of performance management.

2. **Risk Appetite:** The amount of risk that the Council is prepared to accept, tolerate, or be exposed to at any point in time.

3. **Residual Risk:** The risk remaining after management takes action to reduce the impact and likelihood of an adverse event, including control activities in responding to a risk.

RISK RESPONSE DEFINITIONS

RISK RESPONSE	DEFINITION
TREAT	The probability and / or impact of the risk are reduced to an acceptable level through the proposal of positive management action.
TOLERATE	The risk is accepted by management and no further action is proposed.
TRANSFER	Moving the impact and responsibility (but not the accountability) of the risk to a third party.
TERMINATE	The activity / project from which the risk originates from are no longer undertaken.

INTERNAL AUDIT RECOMMENDATION RISK RATINGS AND DEFINITIONS

RISK	DEFINITION
HIGH ●	The recommendation relates to **a significant threat** or opportunity that impacts the Council's corporate objectives. The action required is to mitigate a substantial risk to the Council. In particular it has an impact on the Council's reputation, statutory compliance, finances or key corporate objectives. **The risk requires senior management attention**.
MEDIUM ●	The recommendation relates to **a potentially significant threat** or opportunity that impacts on either corporate or operational objectives. The action required is to mitigate a moderate level of risk to the Council. In particular an adverse impact on the Department's reputation, adherence to Council policy, the departmental budget or service plan objectives. **The risk requires management attention**.
LOW ●	The recommendation relates to **a minor threat or opportunity** that impacts on operational objectives. The action required is to mitigate a minor risk to the Council as a whole. This may be compliance with best practice or minimal impacts on the Service's reputation, adherence to local procedures, local budget or Section objectives. **The risk may be tolerable in the medium term**.
NOTABLE PRACTICE ●	The activity **reflects current best management practice** or is an innovative response to the management of risk within the Council. **The practice should be shared with others**.