**Appendix Two: Audit Report Executive Summaries (Opinion Audits)**
The following Executive Summaries have been issued for audit opinion reviews finalised in the quarter and are attached below.

| Reference in Appendix | Audit Area |
|---|---|
| ES 1 | Assurance Review – MLCO Governance |
| ES 2 | DSAS Quality Assurance Framework Follow up |
| ES 3 | St Luke's C of E Primary School |
| ES 4 | St Peter's Catholic Primary School |
| ES 5 | ICT Software Licensing Follow Up |
| ES 6 | Treasury Management Compliance |
| ES 7 | Neighbourhood Investment Fund (NIF) |
| ES 8 | Highways – Greater Manchester Road Activity Permit Scheme (GMRAPS) |
| ES 9 | Contractor Whistleblowing Arrangements Follow Up |
| ES 10 | Taxi Framework TC067 Follow Up |
| ES 11 | Compliance with Public Contract Regulations 2015 |

**ES1 Manchester City Council Internal Audit Assurance Review Report 2019/20**

**Adult Social Care**

**Assurance Review – MLCO Governance**

| **Distribution** | |
|---|---|
| James Binks | Director of Policy, Performance and Reform, Responsible Officer |
| Bernadette Enright | Executive Director of Commissioning & DASS, Accountable Officer |
| Tim Griffiths | Assistant Director – Corporate Affairs (MLCO) |
| Peter Ball | Head of System Transformation (MHCC) |
| Carol Culley | Deputy Chief Executive and City Treasurer |
| Nick Gomm | Director of Corporate Affairs (MHCC) |
| Claire Yarwood | Chief Finance Officer (MHCC) |
| Laura Foster | Director of Finance (MLCO) |
| Councillor Craig | Executive Member |
| Joanne Roney | Chief Executive |
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| Lead Auditor | Emma Maddocks | 0161 234 5269 |
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| | |
|---|---|
| Draft Report Issued | 9 August 2019 |
| Final Report Issued | 11 September 2019 |

**Executive Summary**

| **Assurance Objective** | **Assurance Opinion** | **Business Impact** |
|---|---|---|
| To provide assurance that the governance arrangements between Manchester City Council and the | Limited | High |

| | | |
|---|---|---|
| Manchester Local Care Organisation are operating effectively and in line with the partnering agreement and supporting delivery of key objectives. | | |

| Sub objectives that contribute to overall opinion | Assurance |
|---|---|
| Committee structures and membership | Reasonable |
| Clarity and discharge of roles and responsibilities | Limited |
| Decision making and discharge of statutory duties | Limited |
| Performance and other reporting | Limited |

| Key Actions | Risk | Priority | Planned Action Date |
|---|---|---|---|
| Partners should work together to clarify accountabilities, responsibilities, delegations, and reporting lines, seeking to ensure clear and consistent governance arrangements for adults' social care. Two working groups of key individuals from the Council, MLCO and MHCC will be established to assess the current accountability structures in place across the three organisations and to make a proposal for simplifying these. | Critical | 3 months | 30/11/19 |

| Assurance Impact on Key Systems of Governance, Risk and Control | | |
|---|---|---|
| Finance | Strategy and Planning | Resources |
| Information | Performance | Risk |
| People | Procurement | Statutory Duty |

## 1. Introduction and Background

1.1. The Manchester Local Care Organisation (MLCO) was established on 1 April 2018 via the signing of a Partnering Agreement, bringing together five partner organisations to deliver integrated community health and social care services: Manchester City Council, Manchester Health and Care Commissioning (MHCC), Manchester University NHS Foundation Trust (MFT), Greater Manchester Mental Health NHS Foundation Trust (GMMH), and the Manchester Primary Care Partnership (MPCP). The MLCO is not a statutory body or legal entity but a "virtual organisation". The MLCO is hosted by and has reporting assurance accountabilities for the delivery of health services through to MFT. The majority of adult social care services will be delivered

virtually through the MLCO, but statutory responsibility will remain with the Council.

1.2. Our work aimed to provide assurance that the governance arrangements between the Council and the MLCO are operating effectively in line with the partnering agreement and are supporting delivery of key objectives.

## 2. Findings

2.1. Our audit work considered: committee structures and membership; clarity and discharge of roles and responsibilities; decision making and discharge of statutory duties; and performance and other reporting.

2.2. The governance arrangements defined within the Partnering Agreement are minimal and include a Partnership Board for strategic oversight and accountability, and an MLCO Executive for management and oversight of delivery of services. The Partnership Board is made up of two representatives from each of the five partner organisations, but the Council has had only one representative on the Board for much of the past year. The Deputy Chief Executive and City Treasurer has recently been appointed to fill the Council's second position. MLCO Executive is comprised of the 9 members of the MLCO Executive Team, which includes the Executive Director of Commissioning & DASS.

2.3. The governance structure beneath Partnership Board and LCO Executive has evolved over time. The key governance groups in place at the time of our review were: the Quality & Safety Committee (QSC); the Finance, Contracting & Performance Group (FCPG); the Operational Management Group (OMG); and the Programme Board. Terms of Reference for these groups were out of date, though this had already been picked up by an internal MLCO governance review and was being actioned. We struggled to reconcile actual versus expected attendance as the minutes listed only names or initials whereas members were defined in the Terms of Reference by job title, and it was rarely evident which attendees were there as delegates. However, it was concerning that attendance at many of these governance groups was both large (e.g. 16 to 22 individuals at each meeting of the QSC) and varied from one meeting to the next. Such groups risk being ineffective and inefficient due to a lack of focus and clarity of purpose for each of the members / attendees – i.e. who is responsible and accountable, and who is there to be consulted, and who is there to provide or receive information.

2.4. We considered the extent to which Council staff attended and contributed to governance groups. Although there was some Council representation at each of the meetings we examined, this tended to vary and did not always seem appropriate in terms of role and seniority. This was largely attributed to a simple lack of capacity for senior managers to attend all of the meetings at which they are expected, not only in the MLCO, but across the Council and MHCC as well. Since the Partnering Agreement was signed, there have been significant changes in the Adults Management Team, including a new

Executive Director of Commissioning & DASS and the appointment of three new Assistant Directors.

2.5. To help alleviate the pressure on senior managers' time, the Adults Management Team recently undertook a review of membership at each of the MLCO governance groups and made decisions regarding who would attend each group and who would be copied in for information. These decisions will need to be incorporated into the revised terms of reference.

2.6. We also considered the nature of the reports and discussions regarding adult social care that took place at MLCO governance groups. For the most part, it was evident that papers were being presented regarding decisions that had already been made or updates on plans already in progress – i.e. for information. Staff with whom we spoke from both the Council and the MLCO agreed that decision-making regarding adult social care was still largely happening within the existing Council management and governance structures.

2.7. The Service Level Agreement (Schedule 9 of the Partnering Agreement) is meant to be the main vehicle to describe the arrangements between the Council and the MLCO in regards to delivering adult social care services, but it was widely agreed that the SLA is out of date and incomplete, and does not reflect the current management structure in ASC. The MLCO plans to update the SLA as part of Phase 2. While the MLCO is attempting to increase integration with ASC, there is not a clear understanding about which bodies at which organisation are ultimately responsible or accountable, and which are to be consulted or informed. MHCC also wants oversight of key decisions, and the Council's governance bodies (Executive and Scrutiny Committees) likewise consider ownership, as the statutory responsibility remains with the Council. This lack of clarity has resulted in both gaps and overlap in accountability, and in duplication of effort.

2.8. These issues around capacity and multiple reporting lines will not be easily resolved and will require compromise from all partner organisations. However, in order to achieve the integration agenda, it will be key that roles, responsibilities, resources and risks are clarified to the satisfaction of all partners. A proposal to form a working group with representation from the Council, MLCO and MHCC has been agreed in principle and is the main recommendation arising from our work.

2.9. Finally, we considered the adequacy of the performance reporting information to MLCO governance groups in regards to Adult Social Care. The ASC 'Balanced Scorecard', which has been in place for a number of years for internal Council use, has been brought to the Finance, Contracting & Performance Group (FCPG). This scorecard contains a huge amount of data but it is difficult to extract meaningful information from it. The ASC Performance Board has recently been re-established, and this group aims to develop a set of focused KPIs for use by both the MLCO and the Council. Work was also underway on an MLCO-wide 'Quality Dashboard', which will

include some ASC performance metrics, though these were yet to be defined and finalised.

## 3. Conclusions and opinion

3.1. Successful integration of health and social care services is key to achieving the aims of the Manchester Locality Plan. Integration efforts have been and will continue to be hampered by unclear and inefficient reporting lines and clashes over ownership. For this reason, we can offer only **limited assurance** at this time that the governance arrangements between the Council and the MLCO are operating effectively in line with the partnering agreement and are supporting delivery of key objectives.

3.2. A number of actions are already underway to address some of the issues we have raised here, such as revising committee terms of reference and membership, updating the SLA, and simplifying performance metrics. Following discussion with the Director of Policy, Performance and Reform, the Executive Director of Commissioning & DASS, and representatives from the MLCO and MHCC, we have raised just one recommendation regarding the need to jointly work together to simplify governance and accountability arrangements with the aim of developing a more effective and efficient approach that eliminates gaps and overlap, reduces duplication of effort, and streamlines reporting requirements. However we do consider this recommendation to be a critical risk and addressing the issues raised within it being absolutely fundamental to continued work towards integration.

**ES 2 Internal Audit Report 2019/20**

**Adults Services: Disability Supported Accommodation Services**

**Follow Up Audit: DSAS Quality Assurance Framework**

| **Distribution** | |
|---|---|
| Karen Crier | Programme Lead, Health and Social Care Integration, Responsible Officer |
| Bernadette Enright | Executive Director of Commissioning & DASS, Accountable Officer |
| Nicola Thompson | Service Manager Independent Living |
| Sally Gill | Interim Service Manager Disability Supported Accommodation Services |
| Councillor Craig | Executive Member |
| Joanne Roney | Chief Executive |
| Carol Culley | Deputy Chief Executive and City Treasurer |
| Fiona Ledden | City Solicitor |
| Karen Murray | External Audit (Mazars) |

| **Report Authors** | | |
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| Auditor<br>Lead Auditor<br>Audit Manager | Phoebe Scheel<br>Emma Maddocks<br>Kathryn Fyfe | 36845<br>35269<br>35271 |

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|---|---|
| Draft Report Issued | 9 August 2019 |
| Final Report Issued | 11 September 2019 |

| **Audit Objective** | **Overall Implementation Status** |
|---|---|
| To provide assurance over the implementation of audit recommendations agreed in response to the audit of the DSAS QA Framework issued in February 2018. | Outstanding |

## 1 Audit Summary

1.1 In November 2017 to January 2018, Internal Audit undertook an audit seeking to provide assurance that the Quality Assurance Framework for the Disability Supported Accommodation Service (DSAS) was operating effectively and in accordance with expectations to support delivery in line with legislation.

1.2 We provided a limited assurance opinion in February 2018 and made two recommendations. The first was to be undertaken in the short term to address current risks, and the second was to be developed in the longer term. Both were considered major risks to effective service delivery. A component of the second recommendation, to consider integrating oversight of the DSAS QA Framework into the Adults QA team, was not agreed by management. However, a number of actions were agreed with a target date for implementation of 31 August 2018.

1.3 In order to provide assurance to the Accountable Officer (Executive Director of Commissioning & DASS), SMT, and Audit Committee that progress had been made to address risk, we undertook a follow up audit in 2018/19 in line with policy where a limited opinion has been provided. The scope was to assess whether agreed actions had been completed to address the recommendations.

## 2 Conclusion and Opinion

2.1 There has been insufficient progress made to implement and embed recommendations to address the risks identified and at this time, we conclude there is a no reduction in the overall exposure to risk.

2.2 Our attempts to follow up on progress against the recommendations were initially hampered by a lack of information from the service. Following receipt of some evidence in July 2019 and discussions with management in August 2019 about progress we have concluded that while management have taken some initial action the recommendations remain incomplete. We are satisfied that service managers understand that further action is required, and a series of specific actions have been agreed for completion.

2.3 The original recommendations and current confirmed status are attached at Appendix 1.

2.4 The explanation of recommendation prioritisation and follow up assurance is attached at Appendix 2.

2.5 Based on the results of this follow up audit, the next step will be to include the outstanding status of these actions in our next quarterly update reports to DMT and Audit Committee. The Executive Director of Commissioning & DASS will be invited to attend the Audit Committee to update on progress, which can be linked to the planned update on the Adults Service Improvement Programme. This is scheduled for Audit Committee in November 2019.

## Appendix 1: Implementation Status Update

**Recommendation 1 (Major risk):**
Management should consider which key areas of the Care Act registered managers and support coordinators should provide assurance over for all citizens in their properties. To support this, there will need to be:

- A register of each citizen, staff member and property which should be monitored centrally to ensure full, timely coverage.
- Each Centre's own registered manager and support coordinators should complete these checks as soon as possible to support the CQC inspections and provide results to the Interim Service Manager (DSAS) and Programme Lead.
- Accountability for registered managers and support coordinators to implement any actions that are identified. Results can then be assessed and addressed at a strategic level if further support or resources are needed.
- Clarity as to how registered managers assure themselves that quality control checks are built into day to day service provision. This should help inform the QA Framework, allowing auditors to provide an opinion on these arrangements rather than lower level, task specific compliance.

**Internal Audit Assessment:**

We were initially told by the Interim Service Manager that a register of all citizens, staff and properties was in place, but a copy was not provided to enable Internal Audit to verify this. The Service Manager Independent Living later told Internal Audit that creation of the register was assigned to PRI, that all information had been provided to them (other than staff details, which was only recently sent), and that it remained with PRI for action. No date was given for completion.
The register was meant to be a mechanism for centrally monitoring QA activity to ensure full and timely coverage. Local actions had been taken to provide for some oversight function but this was insufficient. For example, the North area had created their own google sheet listing the properties (rather than people) and the planned audit dates but this did not include details of citizens or staff, or when each had last been audited.
We were not provided with any evidence that registered managers or support coordinators had completed or were completing basic checks and/or reporting back on these.
In August 2019 management shared a 'House File Tracker' google sheet for the South Locality which was intended to serve as both the register to track QA activity, and also enable monitoring of other key activity, such as DIDS applications, SW reviews, PEEPs etc. On here an 'audit' tab to record activity had recently been added, but was not yet populated. We were told that populating this tracker for each locality would be a priority action, to be completed by the end of September. Once fully populated, we agreed that this would satisfy the first, second, and fourth bullet points of this recommendation.
There remained no system in place to ensure accountability for actions arising from the audits. Actions were left with Support Coordinators and Registered Managers to complete and monitor locally which was unchanged from the time of the original audit. After further discussions with service managers it was agreed that a tracker to monitor the status of actions will be introduced and we have confirmed that this tracker has been set up. Registered Managers were asked to populate it with all outstanding audit actions by the first week of September. We have been told that the tracker will be reviewed and discussed every four weeks at the Senior Leadership

meeting. Once in place, this process will satisfy the third bullet point of the recommendation.
At this time, until the further agreed changes described above have been actioned and embedded, we consider this recommendation is **outstanding**.

**Recommendation 2 (Major risk):**
Management should consider integrating oversight of the Supported Living QA process into the role of Adults QA team and revise the content of the Framework. This could include:

- A workshop including key partners, support coordinators and registered managers used to inform a revised framework.
- Supporting an effective QA audit process and clarifying whether inquiry or inspection of evidence is required for each question/section and QA auditors recording where this has been done.
- Where assurance is being, or should be, sought from more specialist input such as HR, Health and Safety, Risk and Resilience, Corporate Property, Contract Monitoring and Learning and Events teams.

Internal Audit propose to support development action by assisting management in the development and delivery of a redesign workshop.

**Internal Audit Assessment:**
Management did not agree that it would be appropriate to integrate the DSAS QA function with the Adults QA team, however it was agreed to hold a workshop to review and propose changes to the QA Framework, audit tool and guidance documents. We can confirm that these workshops took place in March 2018 as planned.
From our review of the revised audit tool and guidance documents, it is apparent that some changes had been made, but it was not evident that the risks previously identified have been satisfactorily addressed. In particular:

- The audit tool for citizens was still broad and generically worded and it was clear from reviewing a sample of completed audits that questions were being answered inconsistently and not in line with the guidance, and that actions were not always being raised where standards were not met.
- There is still no moderation process in place. From our review of a sample of completed audits, there was still inconsistency and incompleteness in how questions were answered and the depth to which outcomes were recorded.

To drive service improvement forward management have now arranged to hold a workshop with all Support Coordinators in October 2019 to develop and agree an audit moderation process. This workshop will also consider the content and wording of the audit tool following our feedback to determine where further improvements can be made.
At this time, pending the planned October workshop and development of an audit moderation process and changes to the audit tool arising from it, we consider this recommendation is **outstanding**.

**ES 3 Internal Audit Report 2019/20**
**Schools Financial Health Checks**
**St Luke's C of E Primary School**

| Distribution | |
|---|---|
| Saeeda Ishaq | Head Teacher, Responsible Officer |
| Tanveer Ahmed | Chair of Governors, Accountable Officer |
| Joanne Darlington | School Business Manager |
| Councillor Bridges | Executive Member for Children and Schools |
| Joanne Roney | Chief Executive |
| Carol Culley | Deputy Chief Executive and City Treasurer |
| Fiona Ledden | City Solicitor |
| Paul Marshall | Strategic Director, Children's and Education Services |
| Amanda Corcoran | Director of Education & Skills |
| Reena Kohli | Directorate Finance Lead, Children's Finance |
| Isobel Booler | Strategic Head of Schools QA & SEND |
| Karen Murray | External Audit (Mazars) |

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| | |
|---|---|
| Draft Report Issued | 7 October 2019 |
| Final Report Issued | 11 October 2019 |

**Executive Summary**

| Audit Objective | Assurance Opinion | Business Impact |
|---|---|---|
| To provide assurance to the Governing Body and the Local Authority over the adequacy, application and effectiveness of financial control systems operating at your school. | Substantial | Medium |
| **Objectives** | | **Assurance** |
| Allocation of financial roles and responsibilities | | Substantial |
| Long term financial planning, budget approval and monitoring | | Reasonable |
| Key financial reconciliations | | Substantial |
| Expenditure, specifically purchasing and payroll | | Substantial |

| | | | |
|---|---|---|---|
| Income collection and recording | | | Substantial |
| **Key Actions (Appendix 1)** | **Risk** | **Priority** | **Planned Action Date** |
| The School Development Plan should cover three academic years as required in the School's financial regulations and should link to the longer term budget projections. | Significant | 6 months | 31 January 2020 |

| **Assurance Impact on Key Systems of Governance, Risk and Control** | | |
|---|---|---|
| Finance | Strategy and Planning | Resources |
| Information | Performance | Risk |
| People | Procurement | Statutory Duty |

## 1. Audit Summary

1.1. The 2019/20 Internal Audit plan includes an allocation of time to complete financial health checks at a sample of Local Authority maintained schools. We agreed to include St Luke's C of E Primary School in our audit programme due to the length of time elapsed since the previous audit.

## 2. Conclusion and Opinion

2.1. We are able to provide **substantial** assurance over the adequacy, application and effectiveness of financial control systems operating at St Luke's.

2.2. Overall the school operates strong financial control systems, particularly the allocation of financial roles and responsibilities, performing key financial reconciliations and accurate recording of expenditure. There is a comprehensive Scheme of Financial Delegation and an Operational Financial Procedures Manual in place and we found these were in the main complied in the areas tested.

2.3. We identified one significant or higher risk recommendation and this relates to the school development plan and the need to develop this into a three year plan. Whilst we understand the reason for not having a long term plan, given the uncertainty of future years, this is however a requirement of the School's Financial Regulations. Schools are required to have three year budget forecasts and it is important that these forecasts align to the school's priorities to demonstrate their affordability.

## 3. Summary of Findings

### Key Areas of Strength and Positive Compliance

3.1. The key financial controls and delegations are documented in the Scheme of Financial Delegation and Operational Financial Procedure Manual. These clearly define roles and responsibilities and are consistent with actual controls in operation.

3.2. Arrangements for budget setting and monitoring are clearly defined and monthly processes for reviewing and managing the budget are evident. Key financial reconciliations were completed on a timely basis and reviewed by management.

3.3. Our testing of expenditure controls, including reviewing a sample of lower value and higher value purchases and payroll changes confirmed compliance with Operational Financial Procedures and the Scheme of Financial Delegation, with a couple of minor exceptions.

3.4. The Business Manager has completed a self-assessment of the school's cash management financial controls using a template provided by Internal Audit following the cash in schools audit. The assessment identified some minor control issues that resulted in the School Business Manager (SBM) commissioning two neighbouring Business Managers to complete a review of the schools cash handling arrangements.

3.5. A number of changes to improve cash handling controls were introduced; two people are now present when cash is processed. The Business Manager confirmed the school has moved to the use of Parent Pay wherever possible, to reduce the value of cash on premise. Fieldwork confirmed that for cash that was received there were effective controls over cash receipting, counting, recording and banking, including appropriate separation of duties.

**Key Areas for Development**

3.6. We make one significant or higher risk recommendation relating to the need to develop the School Development Plan into a three year document and ensure that the budget implications of each priority is clearly articulated. If there is no budget implication this should also be noted.

3.7. We make a number of moderate and minor risk recommendations to address individual instances of non-compliance and to help strengthen existing controls.

**ES4 Internal Audit Report 2019/20**

**Children's Services - St Peter's Catholic Primary School**

**Financial Health Check**

| **Distribution** | |
|---|---|
| **Name** | **Title** |
| Cathy Quinn | Head Teacher Responsible Officer |
| Nicola Eaton-Barnes | School Business Manager |
| Ellen Bowes | Chair of Governors Accountable Officer |
| Councillor Bridges | Executive Member for Children and Schools |
| Joanne Roney | Chief Executive |
| Carol Culley | Deputy Chief Executive and City Treasurer |
| Fiona Ledden | City Solicitor |
| Paul Marshall | Strategic Director, Children's and Education Services |
| Amanda Corcoran | Director of Education & Skills |
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| | |
|---|---|
| Draft Report Issued | 19 August 2019 |
| Final Report Issued | 5 September 2019 |

**Executive Summary**

| **Audit Objective** | **Assurance Opinion** | **Business Impact** |
|---|---|---|
| To provide assurance over the adequacy, application and effectiveness of financial control systems operating at the school | Substantial | Medium |

| System / Risk Objectives | Assurance |
|---|---|
| Confirm that the financial management framework, including budget setting and monitoring arrangements, support effective and efficient use of resources. | Substantial |
| Confirm expenditure controls support the achievement of value for money; open and transparent decision making and minimise the risk of inappropriate use of funds. | Substantial |
| Ensure income collection and recording is complete and accurate, with appropriate allocation of roles and responsibilities. | Substantial |

| Key Actions (Appendix 1) | Risk | Priority | Planned Action Date |
|---|---|---|---|
| The Head Teacher should ensure that in developing a new School Development Plan, it makes clear reference to the budgetary implications of the agreed priorities and which budget the necessary funding will be allocated to. | Moderate | 12 months | Dec 2019 |
| School Financial Procedures should specify the frequency of budget monitoring as well as recipients, for example monthly to school management and termly for governors. | Moderate | 12 months | Dec 2019 |
| An Anti-fraud and Corruption policy should be developed and then approved by Governors. | Moderate | 12 months | Dec 2019 |
| The Head Teacher should consider the introduction of a formal Gifts and Hospitality Register for items above an agreed minimum value. | Moderate | 12 months | Already in place |
| A summary of expenditure by individual supplier and analysis to be presented regularly to Governors as part of the budget monitoring process. | Moderate | 12 months | April 2019 |
| The Head Teacher should ensure that a formal arrears policy is developed and implemented and ensure parents and governors are fully aware of the requirements in advance of enforcing any debt recovery actions. | Moderate | 12 months | Dec 2019 |

| Assurance Impact on Key Systems of Governance, Risk and Control | | |
|---|---|---|
| Finance | Strategy and Planning | Resources |
| Information | Performance | Risk |
| People | Procurement | Statutory Duty |

## 1. Audit Summary

1.1. The 2019/20 Internal Audit plan includes an allocation of time to complete financial health checks at a number of Local Authority maintained Schools. We agreed to include St Peter's Catholic Primary School in our audit programme as the Head Teacher and School Business Manager (SBM) had only recently been appointed and sought an independent assurance over the financial control environment at the School.

## 2. Conclusion and Opinion

2.1 We are able to provide **substantial** assurance over the adequacy, application and effectiveness of financial control systems operating at the school. Overall we considered that controls across financial management, income and expenditure controls that had been developed were strong. Whilst there was a projection of budget pressures in future financial years we were satisfied with the effectiveness of the arrangements, for managing, monitoring and challenging the school's financial position, introduced by the Head Teacher and School Business Manager. These arrangements will be crucial in managing the School through a potentially difficult financial period. Consideration should be given to seeking input from the City Council if these pressures cannot be addressed internally and if a deficit budget becomes more certain.

2.2 The school is currently planning for a deficit position of £117,000 by 2020/21 Schools Finance team have confirmed that these figures are based on 'worse case' scenario projections and that the School should receive a pension grant, based on number of staff in pension fund, which has not yet been formally confirmed. This funding will provide resources to significantly reduce the current forecast deficit. This is a similar situation for the majority of schools who have not included the pension grant in their figures until it is confirmed formally. In addition this is the first time schools have been asked to produce a three year budget plan.

## 3. Summary of Findings

### Key Areas of Strength and Positive Compliance

3.1. The School had recently appointed a new Headteacher and School Business Manager (SBM) who had been tasked with review and implementation of revised financial and operational procedures and this was actively underway. The School also purchased budget support through a service level agreement

providing assistance with both budget setting and budget monitoring information up to, and including, the budget monitoring reports to governors.

3.2. Appropriate revised financial processes had been developed should ensure effective financial control and efficient use of resources if implemented as designed.

3.3. Expenditure controls had been revised and implemented and the SBM confirmed these will be subject to annual review to ensure they continue to be appropriate and effective.

3.4. The School operated a 'cashless' system and had introduced Parent Pay for the collection of dinner monies; school trips and breakfast club. This by design enables more secure control over income.

**Key Areas for Development**

3.5. Further work to strength controls is still needed particularly around ensuring documents and required policies are up to date and subject to annual revision. There is a plan in place to enable this to happen with resources to be prioritised accordingly.

3.6. It is essential that all governors are provided with key financial information to enable them to make effective decisions on the school's resources particularly in terms of budget setting and monitoring. Governors do not currently receive a cumulative spending report by supplier which can be produced directly from the School's financial management system (FMS) and is often used by Schools to assure governors over levels of spend with individual suppliers. If this is introduced as recommended it will ensure Governors have the necessary information to support and challenge spend.

3.7. The School was trying to introduce a 'cashless' income system but there was still relatively small amounts of cash paid in which were mainly for the School Fund. It is still necessary to monitor income and ensure it is collected in a timely and consistent manner. At the time of the review the School was developing an Arrears Policy should the situation ever arise.

**ES 5 Manchester City Council Internal Audit 2019/20**

**Corporate Core Directorate**

**ICT Software Licensing Follow Up Report**

| **Distribution** | |
|---|---|
| **Name** | **Title** |
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| Carol Culley | Deputy Chief Executive & City Treasurer, Accountable Officer |
| Steve Terence | Head of PMO and Governance |
| Councillor Ollerhead | Executive Member |
| Mary Lynch | Service Delivery Manager |
| Chris Daniels | Licence Manager |
| Joanne Roney | Chief Executive |
| Fiona Ledden | City Solicitor |
| Karen Murray | External Audit (Mazars) |

| **Report Authors** | | |
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| Audit Manager | Kathryn Fyfe | 35271 |

| | |
|---|---|
| Draft Report Issued | Not applicable |
| Final Report Issued | 11 October 2019 |

| **Audit Objective** | **Overall Implementation Status** |
|---|---|
| To provide assurance over the implementation of audit recommendations agreed in response to the audit of ICT Software Licensing issued in July 2018. | Partially Implemented |

## 1. Audit Summary

1.1 In July 2018 we undertook a review of the effectiveness of controls in relation to software licensing governance, inventory and discovery, validation, and operational management.

1.2 Based on the work undertaken we provided a limited assurance opinion and made five recommendations for improvement, with agreed target dates for implementation of August 2018, December 2018 and April 2019.

| Priority | Accepted | Rejected |
|---|---|---|
| Critical/Major | 2 | 0 |
| Significant | 3 | 0 |
| Moderate | 0 | 0 |
| Minor | 0 | 0 |

1.3 As part of our routine follow up work we were able to determine that the recommendation agreed for implementation in August 2018 had been fully implemented. In order to provide assurance to the Accountable Officer (Deputy Chief Executive and City Treasurer), SMT and Audit Committee, we undertook a follow up audit to determine the implementation status of the remaining four recommendations and confirm whether the exposure to risk had reduced.

1.4 This was not a repeat of the previous testing carried out to provide assurance over ICT software licensing arrangements but rather an assessment of progress made with the implementation of the agreed audit recommendations.

## 2. Conclusion and Opinion

2.1 Our review of progress against the recommendations shows that two recommendations are now fully implemented, with a further two being partially implemented. We therefore conclude there is a partial reduction in the overall exposure to risk associated with this area.

2.2 The partially implemented and outstanding actions will fall six months overdue at the end of October 2019. At this point, in line with the process agreed with Audit Committee, we would ordinarily escalate these for the attention of the relevant Accountable Officer and Executive Member. However, given the timing of this report, we do not plan to issue a separate escalation letter in this instance.

2.3 Should recommendations remain partially implemented or outstanding at the end of January 2020, Audit Committee will request that the Accountable Officer and Executive Member attend in person, to explain the delays and proposed steps to mitigate or accept reported risks.

2.4 The original recommendations and current confirmed status are attached at Appendix 1. An explanation of recommendation prioritisation and follow up assurance is attached at Appendix 2.

2.5 Based on the work completed and assurance obtained we will include the reported status of these actions in our quarterly update reports to SMT and Audit Committee.

**Appendix 1: Status Update**

**Recommendation 1 (Significant)**
The Council should review the need for a business case for dedicated full-time resource and software licensing tools in order to drive a centralised and consistent approach to software licensing management.

**Internal Audit Assessment:**
An ICT Business Concept Document has been completed outlining the requirements in this area and the potential solutions identified. An outline of the potential cost of the work has been identified, which is forecast to be met from the wider capital allocation for ICT improvement, and the project is included in the Corporate Core project portfolio. However, a full business case is yet to be produced and a formal decision on whether to proceed has not yet been taken. As such we consider this recommendation to be partially implemented.

**Recommendation 2 (Major)**
In accordance with industry good practice (ISO 19770-1), the Council should implement a SAM policy and ensure that it provides an overarching approach to the acquisition, implementation and disposal of software as well as key compliance requirements.

The policy should reference key software licensing processes, such as software acquisition, monitoring, disposal and ongoing compliance. Where processes do not follow a centralised approach they should be formally documented for each application.

Furthermore it should state the process for reviewing, approving, issuing, and controlling relevant process and procedural documentation.

**Internal Audit Assessment:**
We were supplied with a copy of this policy, and confirmed that the recommended areas were included in it. We were also able to confirm that the policy had been formally approved by the Interim Director of ICT, and published on the intranet alongside other relevant and related ICT policies. As such we consider this recommendation is now implemented.

**Recommendation 3 (Major)**
Software licensing management roles, responsibilities and capability gaps need to be defined, implemented and communicated to ICT and the Directorates.

Additionally, both the end users of licenced applications and IT staff who install and maintain the applications should have a clear understanding of the appropriate processes and procedures that limit risk to and ensure compliance. This recommendation should be considered in the wider context of the potential requirement to define roles relating to application ownership across the Council, with a specific focus the specific responsibilities that the role entails.

**Internal Audit Assessment:**
As noted above, the software licensing policy has been approved and

published. However, no formal communication of this policy to relevant staff has been undertaken.
The policy includes an appendix detailing the roles and responsibilities of relevant stakeholders in respect of the approval, communication, distribution and enforcement of the policy itself. However, a wider assessment of roles across licence management had not been completed, and capability gaps had not been assessed.
As such we consider this recommendation remains outstanding.

**Recommendation 4 (Significant)**
The current systems used by ICT to support software asset management should be reassessed to ensure that they are fit for purpose and possess the capability to process, create and maintain all stores and records for software and related assets.

Furthermore, the Council should look to move away from the manually intensive process currently in operation and explore the automation of tasks required to maintain compliance with software licenses and control software spending.
The tools available to the Council should provide the functionality to detect and manage all exceptions to SAM policies, processes, and procedures; including license user rights and necessary infrastructure and processes for the effective management, control and protection of the software assets, at all stages of the software license lifecycle.
Once reporting is established, regular validation audits should be completed by the SAM team to ensure that the reported position is accurate.
**Internal Audit Assessment:**
The formal commissioning of a licence management tool was being explored as part of the preparation of the business case identified in recommendation 1 above.
However, given that this business case had yet to be formally considered, the Licence Manager was exploring how better use could be made of existing data sets. He had built a basic spreadsheet-based tool to support the identification of significant discrepancies in licence management. However, this tool required further work to confirm the reliability of associated information and to develop expectations around its use.
As such we consider this recommendation is partially implemented.

**Recommendation 5 (Significant)**
The Council should ensure that the remediation actions to address the SAP non-compliance are implemented as a matter of priority.
**Internal Audit Assessment:**
The recommendation related to a historical issue highlighted by SAP in relation to evidence supporting the extent of compliance. ICT have made efforts to improve the depth of information available to them, and taken steps to address factors that could affect compliance levels on an individual basis.
In addition, an external expert was commissioned to advise the Council on its position with respect to SAP licensing compliance. The conclusion of this review was that the Council could usefully take steps to reduce the level of licenses held.

The detail of this review is being taken forward by ICT but sufficient actions have been taken to actively manage the risk of challenge by the supplier. As such we consider this recommendation is now implemented.

**ES 6 Internal Audit Report: 2019 / 20**

**Corporate Core: Core Financial Systems**

**Treasury Management: Compliance**

| **Distribution** | |
|---|---|
| **Name** | **Title** |
| Karen Gilfoy | Chief Accountant, Financial Management Responsible Officer |
| Carol Culley | Deputy Chief Executive and City Treasurer Accountable Officer |
| Tim Seagrave | Group Finance Lead |
| David Williams | Treasury Manager |
| Matus Majer | Deputy Treasury Manager |
| Joanne Roney | Chief Executive |
| Fiona Ledden | City Solicitor |
| Janice Gotts | Deputy City Treasurer |
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| Councillor Ollerhead | Executive Member |

| **Report Authors** | | |
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|---|---|
| Draft Report Issued | 5 July 2019 |
| Final Report Issued | 30 July 2019 |

**Executive Summary**

| **Audit Objective** | **Assurance Opinion** | **Business Impact** |
|---|---|---|
| To give assurance over the extent of compliance with established procedures for Treasury Management. | Substantial | Medium |

| **System / Risk Objectives** | **Assurance** |
|---|---|

| | |
|---|---|
| Cash-flow forecasting | Substantial |
| Investments | Substantial |
| Borrowing | Substantial |
| Call Account Deposits | Substantial |

| **Key Actions – See Appendix 1 Summary of any critical, significant or reasonable risk issues reported** | **Risk** | **Priority** | **Planned Action Date** |
|---|---|---|---|
| None | N/A | N/A | N/A |

| **Assurance Assessment on Key Systems of Governance, Risk and Control** | | |
|---|---|---|
| Finance | Strategy and Planning | Resources |
| Information | Performance | Risk |
| People | Procurement | Statutory Duty |

## 1. Audit Summary

1.1 The Council's Internal Audit Strategy includes the provision of assurance over a range of core financial systems. This provides proportionate, independent, ongoing assurance to officers, Members and key stakeholders that controls in these core systems are appropriately designed and are operating as intended. The Treasury Management service is responsible for the financial management of funding and debt of over £1 billion pounds and we therefore agreed with managers to carry out a review of compliance with existing controls in this area. Based on our testing of a sample of transactions in key areas of the business, we concluded that that there are proportionate controls in place surrounding the Treasury Management service and they are applied consistently.

## 2. Conclusion and Opinion

2.1. Our work included sample testing of the following processes: the cash-flow which is used to inform daily investment decisions; the investments made being in accordance with the approved strategy; as well as call back borrowing and deposits from specified bank accounts. Our sample testing did not identify any areas of non-compliance with established procedure and we were satisfied that controls were operating effectively.

2.2. On the basis of our review, we are able to provide a **substantial** assurance opinion on the administration of the Treasury Management system. It should be noted that as of April 2019 the Internal Audit assurance rating framework has been amended and now substantial assurance is the highest level of rating that can be achieved.

## 3. Summary of Findings

### Key Areas of Strength and Positive Compliance

3.1. Our review of the Treasury Management cash-flow records confirmed that the live document was assessed twice a day (morning and afternoon) and that action was taken when necessary to ensure that the main bank account was maintained within the parameters of a pre-arranged balance. To test this we selected 20 days from the 2018 / 2019 cash-flow records. For each of the 20 days we confirmed that there was a morning and afternoon assessment of funds, with a record of the subsequent decisions taken being retained. These decisions ranged from investing funds, depositing funds or calling back funds to balance the account, or deciding to take no action.

3.2. When the cash-flow identified a surplus amount of funds, this amount was invested for a period until it is required. Our testing of ten 2018 / 2019 investments confirmed that evidence was retained demonstrating that each transaction was prepared, approved and authorised by appropriate officers. We also confirmed that investments were made with institutions that complied with the approved Strategy.

3.3. The Treasury Management Team had access to several other accounts which are utilised in the management of the main bank account. These call accounts provided the facility to borrow or invest (deposit) funds at short notice to maintain the pre-agreed balance on the main account. We tested ten investments (deposits) and ten borrowing transactions between the main account and the call accounts. Our testing confirmed that all of the necessary documents were appropriately prepared, approved and authorised for each transaction.

### Key Areas for Development

3.4. We did not identify any areas for development, however, we were advised by the Deputy Treasury Manager that there was no guidance material available for the four major functions that comprise the team's service. The Group Finance Lead advised that he intended to produce documents following the novation of the Greater Manchester Housing Investment Fund to the Greater Manchester Combined Authority by the end of 2019. Given that the team complies with MIFID II legislation relating to having suitably qualified and experienced officers in key roles, we agree that this timeframe should not present any significant risks to service delivery.

**ES 7 Internal Audit Report 2019 / 20**

**Neighbourhoods**

**Neighbourhood Investment Fund (NIF)**

| **Distribution** | |
|---|---|
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| Fiona Worrall | Strategic Director Neighbourhoods, Accountable Officer |
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|---|---|
| Draft Report Issued | 5 August 2019 |
| Final Report Issued | 2 September 2019 |

| **Audit Objective** | **Assurance Opinion** | **Business Impact** |
|---|---|---|
| To provide assurance that there is a robust process in place to process applications and ensure money awarded is spent as intended and delivers the outcomes anticipated | Reasonable | Low |

| **System / Risk Objectives** | **Assurance** |
|---|---|
| Defined Process | Reasonable |
| Record Keeping and Communication | Reasonable |

| | |
|---|---|
| Payment Process | Substantial |
| Monitoring Process | Limited |
| Management Information | Reasonable |

| Key Actions | Risk | Priority | Planned Action Date |
|---|---|---|---|
| NIF funding should only be spent where there has been an application from a community group. Team leaders should not approve payment at the request of Members where there is no community group application in support of the payment. | Significant | 6 months | 30/09/2019 |
| Guidance should be updated to include agreed timescales for monitoring NIF grants and details of checks to be undertaken; management should ensure this is completed. | Significant | 6 months | 31/12/2019 |

| Assurance Impact on Key Systems of Governance, Risk and Control | | |
|---|---|---|
| Finance | Strategy and Planning | Resources |
| Information | Performance | Risk |
| People | Procurement | Statutory Duty |

## 1 Audit Summary

1.1 The Neighbourhood Investment Fund (NIF) makes £640,000 available for all of the 32 wards (£20,000 per ward) each year. The wards fall into either the North, South or Central area of the City. There is a maximum of £10,000 per application to fund Community Groups to carry out activities that benefit people in their local neighbourhood. To be successful, planned activity must be in line with the defined eligibility criteria.

1.2 We selected a sample of 45 applications in 2018/19 (six of which were refusals) from across each of the three areas (North, South and Central) to ensure the following key requirements were met:-

- Ward Councillors had been consulted on the application.
- Payment was made into a community bank account.
- The application was in line with NIF eligibility and ward priorities.
- Timely monitoring had been carried out.
- Receipts to support expenditure had been submitted

- Any unspent grant money had been reclaimed.

## 2 Conclusion and Opinion

2.1 Overall we provided reasonable assurance over the Neighbourhood Investment Fund scheme for assessing and awarding grants. The basis for our opinion is that there is a well-defined approach to the award of grants, applications examined were mainly in line with the guidance and approval/rejection had been sought from Members. Where applications had been rejected the rationale was considered to be reasonable.

2.2 There were some areas where governance and control could be strengthened and we found a few anomalies within our sample where the process had not been applied as intended; due to differences in local ward approach. In particular there were some gaps in the audit trail supporting the decision to award grants and there were some inconsistencies in the timeliness of monitoring We found a number of NIF grants were awarded to community groups who had previously had funding. This limits the funding available to new Community Groups, and in those cases there was limited evidence that alternative funding streams to encourage sustainability were being sought.

2.3 We made two significant recommendations. The first was to ensure that a NIF grant should only be approved following an application from a community group. The second was around updating the guidance in support of NIF and needing to define timescales for monitoring grants and checks to be completed. Management agreed to address both of these recommendations with acceptable timescales.

**ES 8 Internal Audit Report 2019 / 20**

**Neighbourhoods and Growth and Development**

**Highways - Greater Manchester Road Activity Permit Scheme (GMRAPS)**

| **Distribution** | |
|---|---|
| **Name** | **Title** |
| Steve Robinson | Director of Highways, Accountable Officer |
| Kevin Gilham | Head of Citywide Highways, Responsible Officer |
| Clare Lunn | Highways Manager (Inspection) |
| Joanne Roney | Chief Executive |
| Carol Culley | Deputy Chief Executive and City Treasurer |
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| Janice Gotts | Deputy City Treasurer |
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| **Report Authors** | | |
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|---|---|
| Draft Report Issued | 3 October 2019 |
| Final Report Issued | 15 October 2019 |

| **Audit Objective** | **Assurance Opinion** | **Business Impact** |
|---|---|---|
| To provide assurance over processing of GMRAP's for the Council. | Reasonable | Medium |

| **System /Risk Objectives** | **Assurance** |
|---|---|
| Permits are issued for all work completed. | Reasonable |
| Penalties are levied and enforced for failure to apply or breaches of permit conditions. | Reasonable |

| | |
|---|---|
| Reinstatement work is undertaken to an expected standards. | Reasonable |
| Appropriate action is taken when works are assessed as inadequate. | Reasonable |
| Highways works are coordinated to minimise avoidable costs and disruption. | Limited |

| Key Actions | Risk | Priority | Planned Action Date |
|---|---|---|---|
| Ensure permits are in place and updated timely for all in house works. | Significant | Within 6 months | 31 January 2020. |

| Assurance Impact on Key Systems of Governance, Risk and Control | | |
|---|---|---|
| Finance | Strategy and Planning | Resources |
| Information | Performance | Risk |
| People | Procurement | Statutory Duty |

## 1. Audit Summary

1.1. The Traffic Management Permit Schemes (England) Regulations 2007 and Part 3 of the Traffic Management Act 2004 provide Highway Authorities with the powers to introduce permit schemes to manage road works on the public highway. Transport for Greater Manchester (TfGM) have set up a joint permit system for the ten Councils within Greater Manchester. They administer the scheme and validate applications on behalf of each authority before forwarding the application to the relevant authority for approval.

1.2. The Council and TfGM each receive a proportion of the income from permit application fees to offset the costs of delivering the service. In 2018/19 Manchester City Council issued 11,995 permits to utilities companies and 2,736 permits for in house works. In house works are undertaken by or on behalf of Manchester Contracts.

1.3. The Council received £601K from permits issued in 2018/19 (after a decution of £146K had been made by TfGM for the adminstration of the scheme).

1.4. We selected a sample of permits issued tested these to ensure that:

- Conditions applied to permits had been adhered too.
- Fines were issued for non-adherence to permit conditions.
- Reinstatement works were as per the permit conditions.
- Appropriate action had been undertaken when works were assessed as inadequate.

- Works across utilities and the in house team had been co-ordinated to ensure minimum disruption to road users.

## 2. Conclusion and Opinion

2.1. Overall we can provide reasonable assurance over the GMRAPS permitting process. There is a robust process in place to identify any breach of permit conditions and there is clear guidance in place for the issuance of fines including values and timescales.

2.2. The permit process for in house works needs to be improved as currently only about 60% have a permit applied and this should be 100%. We note that management have been focusing on improving permitting levels in recent years and the number of permits issued has increased from 2,466 in 2015/16 to 5,649 in 2018/19.

2.3. We suggest clarity is sought and guidance amended accordingly on charging for permits and any subsequent fines relating to Network Rail and TfGM for breaches of permit conditions and failed reinstatenments.

2.4. There is a robust inspection process for works undertaken by utility companies and we found that circa 3,000 inspections had been carried out on works with an average pass rate in excess of 92.4%. We consider the risk that highway work is undertaken without the necessary permit being issued is low for utility companies.

2.5. Clarification around collection of fines and debt recovery procedures should be sought to ensure that all fines are collected and or pursued.

**ES 9 Manchester City Council Internal Audit 2019/20**

**Corporate Core: Corporate Services Directorate**

**Contractor Whistleblowing Arrangements Follow Up Report**

| **Distribution** | |
|---|---|
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| Janice Gotts | Deputy City Treasurer, Accountable Officer |
| Councillor Ollerhead | Executive Member |
| Jacqui Dennis | Deputy City Solicitor |
| Mark Leaver | Strategic Lead, Integrated Commissioning |
| Paul Murphy | Group Manager, Procurement |
| Karen Lock | Procurement Manager Level II |
| Joanne Roney | Chief Executive |
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| Karen Murray | External Audit (Mazars) |

| **Report Authors** | | |
|---|---|---|
| Senior Auditor<br>Interim Lead Auditor<br>Audit Manager | Jess Jordan<br>Clare Roper<br>Kathryn Fyfe | 36842<br>35264<br>35271 |

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|---|---|
| Draft Report Issued | Not applicable |
| Final Report Issued | 18 July 2019 |

| **Audit Objective** | **Overall Implementation Status** |
|---|---|
| To provide assurance over the implementation of audit recommendations agreed in response to the audit of Contractor Whistleblowing Arrangements issued in September 2018. | Implemented |

## 1. Audit Summary

1.1 In September 2018 we undertook a review of the whistleblowing arrangements in contracts to provide assurance over the processes in place for ensuring the Council's contractual suppliers had whistleblowing arrangements in place.

1.2 Based on the work undertaken we provided a limited assurance opinion and made two recommendations for improvement with agreed target dates for implementation of December 2018.

| Priority | Accepted | Rejected |
|---|---|---|
| Critical | 0 | 0 |
| Significant | 2 | 0 |
| Moderate | 0 | 0 |
| Minor | 0 | 0 |

1.3 In order to provide assurance to the Accountable Officer (SMT Chief Officer), SMT and Audit Committee we undertook a follow up audit to confirm whether the exposure to risk had reduced.

1.4 This was not a full re-review of contractor whistleblowing arrangements but rather an assessment of progress made with the implementation of the agreed audit recommendation.

## 2. Conclusion and Opinion

2.1 Our review of progress against the recommendations shows that both recommendations have now been implemented we therefore conclude there is a reduction in the overall exposure to risk associated with this area.

2.2 The original recommendations and current confirmed status are attached at appendix 1.

2.3 The explanation of recommendation prioritisation and follow up assurance is attached at appendix 2.

2.4 Based on the work completed and assurance obtained we will include the reported status of these actions in our quarterly update reports to SMT and Audit Committee.

**ES 10 Manchester City Council Internal Audit Report 2019/20**

**Corporate Core – Integrated Commissioning and Procurement**

**Follow Up Audit: Taxi Framework TC067**

| **Distribution** | |
|---|---|
| **Name** | **Title** |
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| Janice Gotts | Deputy City Treasurer, Accountable Officer |
| Councillor Ollerhead | Executive Member |
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| | |
|---|---|
| Draft Report Issued | Not Applicable |
| Final Report Issued | 26 September 2019 |

| **Audit Objective** | **Overall Implementation Status** |
|---|---|
| To provide assurance over the implementation of audit recommendations agreed in response to the audit of Taxi Framework TC067 issued December 2018. | Implemented |

## 1. Audit Summary

1.1 In December 2018 Internal Audit undertook an audit/assurance review of Taxi Framework TC067 to provide assurance over the governance arrangements in place for this framework agreement.

1.2 Based on the work undertaken we provided a limited assurance opinion and made the following number of recommendations for improvement with agreed target dates for implementation between January 2019 and June 2019.

| Priority | Accepted | Rejected |
|---|---|---|
| Critical | 0 | 0 |
| Significant | 3 | 0 |
| Moderate | 2 | 0 |
| Minor | 0 | 0 |

1.3 In order to provide assurance to the Accountable Officer (SMT Chief Officer), SMT and Audit Committee we undertook a follow up audit to confirm whether the exposure to risk had reduced.

1.4 This was not a full re-review of the operation of the taxi framework but rather an assessment of progress made with the implementation of the agreed audit recommendations.

## 2. Conclusion and Opinion

2.1 Our review of progress against these recommendations shows that all recommendations have now been implemented. As a result we therefore conclude there is a reduction in the overall exposure to risk in this area.

2.2 The original recommendations and current confirmed status are attached at appendix 1.

2.3 The explanation of recommendation prioritisation and follow up assurance is attached at appendix 2.

2.4 Based on the work completed and assurance obtained we will include the reported status of these actions in our quarterly update reports to SMT and Audit Committee.

**ES 11 Internal Audit Report 2019/20**

**Corporate Services – Integrated Commissioning and Procurement**

**Compliance with Public Contract Regulations 2015**

| **Distribution** | |
|---|---|
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|---|---|
| Draft Report Issued | 23 July 2019 |
| Final Report Issued | 02 September 2019 |

**Executive Summary**

| **Audit Objective** | **Assurance Opinion** | **Business Impact** |
|---|---|---|
| To provide assurance over the arrangements in place to ensure the Council complies with the Public Contracts Regulations (PCR) 2015. | Reasonable | Medium |

| **System /Risk Objectives** | **Assurance** |
|---|---|
| Tender processes are compliant with PCR 2015 | Reasonable |

| | |
|---|---|
| Reporting and publication requirements within PCR 2015 are complied with. | Limited |
| Contract Terms are in line with PCR 2015 | Reasonable |

| Key Actions (Appendix 1) | Risk | Priority | Planned Action Date |
|---|---|---|---|
| Ensure that the Chest is updated to reflect the current status of all procurements and includes the contract report. | Significant | 6 months | 31 January 2020 |
| Ensure compliance with the notification timelines stated within the regulations. | Significant | 6 months | 31 January 2020 |

| Assurance Impact on Key Systems of Governance, Risk and Control | | |
|---|---|---|
| Finance | Strategy and Planning | Resources |
| Information | Performance | Risk |
| People | Procurement | Statutory Duty |

## 1. Audit Summary

1.1. The Public Contract Regulations 2015 came into force in February 2015 with full implementation of the regulations by October 2018. Where Regulations are breached the contracting authority may be subject to fines and the courts can deem the contract “ineffective”, resulting in the procurement needing to be rerun causing financial losses, delays and reputational damage to the Council. Given these risks we agreed to provide assurance over the Council’s arrangements for ensuring compliance with the Regulations.

## 2. Conclusion and Opinion

2.1. We can provide a **reasonable** level of assurance over the arrangements in place to ensure compliance with the Public Contract Regulations 2015. From our testing we were able to confirm that the majority of procurements tested complied with the Regulations. We did however identify a small number of activities where reporting timelines had not been met and one occasion where an award letter had been sent before the end of the standstill period, which is set at 10 days following contract award.

2.2. The key issue we noted was limited compliance with prescribed timelines and ensuring that steps were completed without unnecessary delay once an award decision had been made. We acknowledge that this is only a small part of the regulations and that there can be bottlenecks of activity for the Procurement Team which places pressure on resources however improvements are needed

to ensure that steps required by the Regulations are completed within the required timelines to minimise risk of challenge.

## 3. Summary of Findings

3.1. We reviewed 44 procurement activities that had been completed through the Chest (made up of 56 lots) and found that the majority of procurement activities reviewed were in line with the Public Contract Regulations 2015, there were however some areas where the Council was not fully compliant with the regulations which are explained in further detail below.

3.2. We reviewed directorate contract registers and spend data from SAP to identify any procurements which had not gone through the Chest system. From this we did not identify any procurements that were above the threshold to which the Public Contract Regulations 2015 would apply. Our testing therefore focused only on procurements which had gone through the Chest.

### Key Areas of Strength and Positive Compliance

3.3. Timelines for the submission of tender documents were generally in line with the Regulations for all but one case when the submission deadline fell just short of the required period (27 days as opposed to the required 30). This was due to human error. These periods are set to ensure that suppliers have time to review the opportunity presented, ask any questions that they may have and prepare.

3.4. Where a standstill period was instigated this was found to be set for the correct length of time in the majority of cases, although we identified one activity consisting of four lots, where the award letters had been sent before the end of the standstill period set (letters sent 7 days into the standstill period, again due to human error). Standstill periods are imposed by the Regulations in order to allow those who have been unsuccessful in the tender to raise any objections that they may have over the process and have these resolved prior to the contract being formally awarded.

### Key Areas for Development

3.5. The Chest was not being updated consistently for the final stages of the procurement activities which resulted in gaps in the detail available on the system in relation to particular procurement exercises. This was most evident where an activity had been suspended or discontinued and recording the reasons for this.

3.6. We identified three activities where further information was needed from the Procurement Team to identify the current status, including one activity where the Procurement Team were unclear if the procurement had been formally discontinued or taken forward by the service area. In addition there were a further three instances where contract reports had not been uploaded to the system. We confirmed that this should be undertaken by officers within Corporate Procurement though issues with workload bottlenecks mean that these actions are not always undertaken promptly.

3.7. It should be noted that as long as the contract report/ document detailing the discontinuation of activity is in existence uploading these to the system is not necessary to ensure compliance with the regulations. However, uploading of the reports is good practice and helps to ensure that evidence of compliance can be easily located if needed in the future. Of the three contract reports that were not uploaded we were able to see copies of two, the third related to activity for the NHS Clinical Commissioning Group and as such they would hold the report in compliance with their procurement processes (though we would still recommend that a copy be uploaded to the Chest as we had carried out the procurement), as such we were not concerned that this presented a lack of compliance with the regulations.

3.8. A number of activities were identified where the OJEU Award Notices had not been published within 30 days of the award as required by the Regulations. In six cases notification took between 79 and 262 days and a further two had not yet been processed despite contracts having been awarded more than 180 days earlier. We were informed that resource issues at the time of award had been a factor in this.

2.6 One procurement activity was identified which had been undertaken as a non OJEU procurement as the indicative tender value was initially considered to fall under the threshold. However following the tender we confirmed that the cost of the contract was above the procurement thresholds. This activity had not been carried out in compliance with the Regulations due to the increase in value of the contract, however it was carried out in compliance with Council rules which follow the principles of the EU procurement.