Southern Internal Audit Partnership

Assurance through excellence and innovation

WEST SUSSEX COUNTY COUNCIL
INTERNAL AUDIT PROGRESS REPORT JUNE 2022

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June 2022

Contents:

1. Role of Internal Audit

The requirement for an internal audit function in local government is detailed within the Accounts and Audit (England) Regulations 2015, which states that a relevant body must:

> ***'Undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance.'***

The standards for 'proper practices' are laid down in the Public Sector Internal Audit Standards [the Standards – updated 2017].

The role of internal audit is best summarised through its definition within the Standards, as an:

> ***'Independent, objective assurance and consulting activity designed to add value and improve an organisations' operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes'.***

The County Council is responsible for establishing and maintaining appropriate risk management processes, control systems, accounting records and governance arrangements. Internal audit plays a vital role in advising the County Council that these arrangements are in place and operating effectively.

The County Council's response to internal audit activity should lead to the strengthening of the control environment and, therefore, contribute to the achievement of the organisations' objectives.

2. Purpose of report

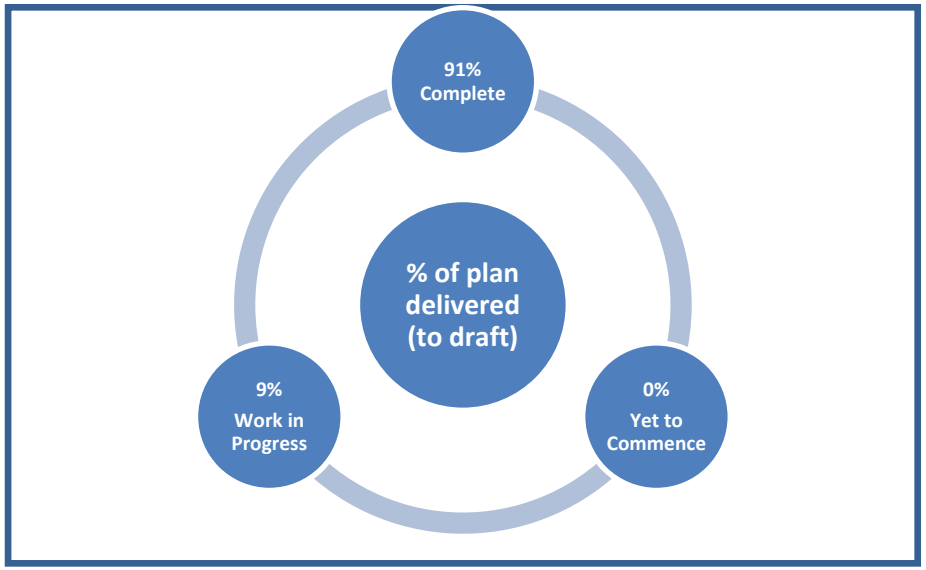
In accordance with proper internal audit practices (Public Sector Internal Audit Standards), and the Internal Audit Charter the Chief Internal Auditor is required to provide a written status report to 'Senior Management' and 'the Board', summarising:

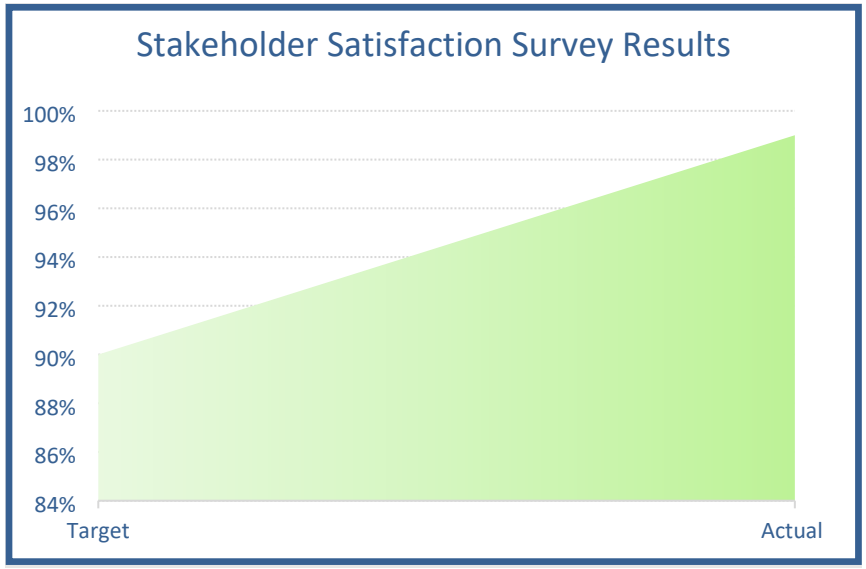
- The status of 'live' internal audit reports;
- an update on progress against the annual audit plan;
- a summary of internal audit performance, planning and resourcing issues; and
- a summary of significant issues that impact on the Chief Internal Auditor's annual opinion.

Internal audit reviews culminate in an opinion on the assurance that can be placed on the effectiveness of the framework of risk management, control and governance designed to support the achievement of management objectives of the service area under review. Assurance opinions are categorised as follows:

Substantial	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.
Reasonable	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.
Limited	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.
No	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.

3. Performance dashboard





Compliance with Public Sector Internal Audit Standards

An 'External Quality Assessment' of the Southern Internal Audit Partnership was undertaken by the Institute of Internal Auditors (IIA) in September 2020. The report concluded:

'The mandatory elements of the IPPF include the Definition of Internal Auditing, Code of Ethics, Core Principles and International Standards. There are 64 fundamental principles to achieve with 118 points of recommended practice. We assess against the principles. It is our view that the Southern Internal Audit Partnership conforms to all 64 of these principles.

We have also reviewed SIAP conformance with the Public Sector Internal Audit Standards (PSIAS) and Local Government Application Note (LGAN). We are pleased to report that SIAP conform with all relevant, associated elements.'

4. Analysis of 'Live' audit reviews

Audit Review	Report Date	Audit Sponsor	Assurance Opinion	Total Management Action(s)	Not Accepted	Not Yet Due	Complete	Overdue		
								L	M	H
Special Educational Needs	Oct 2020	DCYP&L	Limited	7	0	0	6		1	
School Traded Services	Mar 2021	DCYP&L	Reasonable	7	0	0	3		1	3
S75 Governance	Apr 2021	JSDC	Limited	12	0	0	10		2	
Children's Services P-Cards	Jun 2021	DCYP&L	Limited	17	0	0	16			1
Cyber Security (Risk Treatment)	Jul 2021	DFSS	Reasonable	3	0	1	1		1	
Cloud Service Provisioning	Jun 2021	DFSS	Reasonable	5	0	0	3		2	
Hammonds (Residential Care Home)	Nov 21	DA&H	No	17	0	0	16		1	
Home to School Transport	Nov 21	DPS	Reasonable	7	0	0	6		1	
Annual Governance Statement	Nov 21	DL&A	Reasonable	9	0	1	8			
WSFRS Fleet Management	Nov 21	CFO	Reasonable	3	0	0	2		1	
Special Schools Funding Thematic	Nov 21	DCYP&L	Reasonable	4	0	0	0	2	2	
WSFRS Operational Training Delivery	Jan 22	CFO	Limited	14	0	0	8		3	3
Firewatch	Jan 22	CFO	Limited	4	0	0	2		1	1
IR35	Feb 22	DHR&OD	Limited	11	0	0	9		2	
WSFRS Risk and Business Continuity	Mar 22	CFO	Reasonable	15	0	5	5		5	
AMHPs	Mar 22	DA&H	Reasonable	5	0	1	2			2
School Thematic – Governors' Pay Decisions (Governance)	Mar22	DCYP&L	Reasonable	5	0	2	3			
IT Assurance Mapping	Apr 22	DFSS	Reasonable	6	0	3	1			2
Information Governance - GDPR	May 22	DL&A	Limited	19	0	16	3			
ITIL Process Transition	May 22	DFSS	Reasonable	6	0	5	1			
Equality Impact Assessments	May 22	DPS	Limited	12	0	12	0			

Audit Review	Report Date	Audit Sponsor	Assurance Opinion	Total Management Action(s)	Not Accepted	Not Yet Due	Complete	Overdue		
								L	M	H
WSFRS Working Time Regulations	May 22	CFO	No	7	0	7	0			
School Thematic-Summer School Funding	June 22	DCYP&L	Reasonable	1	0	1	0			
WSFRS Safe & Well Visits	June 22	CFO	Limited	13	0	11	2			
Total								**2**	**23**	**12**
Overdue Management Actions - Direction of travel since March 2022 progress report								**-6**	**+1**	**-5**

Audit Sponsor

Chief Executive
Becky Shaw

Chief Fire Officer (CFO) Sabrina Cohen- Hatton	Director of Adults & Health (DA&H) Alan Sinclair	Director of Children, Young People & Learning (DCYP&L) Lucy Butler	Director of Place Services (DPS) Lee Harris	Assistant Chief Executive (ACE) Sarah Sturrock	Director of Finance & Support Services (DF&SS) Katharine Eberhart	Director of HR/OD (DHR/OD) Gavin Wright	Director of Law & Assurance (DL&A) Tony Kershaw

5. Executive Summaries of reports published concluding a 'Limited' or 'No' assurance opinion

Information Governance - GDPR		
Audit Sponsor	**Assurance opinion**	**Management Actions**
Director of Law & Assurance	Limited	Low 1 / Medium 15 / High 3

Summary of key observations:

This audit sought to review compliance with the operational controls and processes to provide assurance effective information governance was in place. The report refers to The Information Commissioner's Office (ICO) guidance and Codes of Practice which are not mandatory but should be considered in the monitoring and control of personal data.

Whilst the review and its objectives were focussed on GDPR in relation to employees, similar such risks can apply to members and therefore reference has been made where such risks were apparent. As elected members are not employees and are not contracted to the Council different measures to address risks associated with data processing must be established using different methods of enforcement to minimise risks.

The Data Protection Officer for WSCC is the Director of Law & Assurance and via onward delegation, operationally the responsibilities are discharged by the Data Protection Team, who keeps up to date on legislative changes and has been established to provide support to the Authority on all aspects of data protection.

Comprehensive policies and procedures/guidance were found to be available and accessible to staff, however, a number did not contain sufficient version control, ownership or review dates. The remote working policy is for employees and therefore does not specifically include or refer to members and there is no equivalent guidance for members.

A log is maintained of all data breaches and used to record personal data incidents and breaches. Lessons learned from data breaches are shared to prevent future re-occurrences.

There is mandatory data protection training on induction and attendance/completion is monitored. Any outstanding induction training is escalated until completed and the Data Protection and Cyber Security induction modules have a 95.6% or above completion rate. However, there is also mandatory annual refresher training for staff on Data Protection and Cyber Security. Although attendance/completion is monitored, and outstanding training is escalated to Line Managers and subsequently Directors, the Data Protection and Cyber Security & GDPR refresher training only has a completion rate of 78.7% and 77.1% respectively.

As of May 2022, approximately 11% of members have not undertaken IT Security and Data Protection Training which is mandatory for employees and deemed important for members by the Governance Committee as it strengthens data protection awareness. The Governance Committee deliberately adopted the term 'mandatory' to give it more importance even though members cannot be mandated to comply. The Member's Training Plan shows that regular reminders are issued to encourage them to complete refresher training via e-learning. This is to be raised at the Governance Committee on 09/05/22, where the importance of training will be re-enforced.

A requirement of the ICO is for an Information Asset Register (IAR) to be in place to record details of personal information held by WSCC. Information Asset Owners (IAOs) are responsible for the accuracy and completeness of information held in the IAR. From examining the IAR there are significant gaps in the information recorded. The ICO sets expectations on their website to help public bodies fulfil and comply with their data protection obligations. The template currently being used does not record the expected information to comply with ICO expectations.

The Information Governance Group (IGG) have a compliance plan which covers the risks and actions associated with data security, training & awareness, data sharing, data subject rights, accountability and data protection principles. However, it does not record anything relating to monitoring departments retention and deletion/disposal of documents or any reference to the IAR, which would provide the IGG with information on the sources of information held, including how sensitive it is and the volumes involved to enable them to assess the associated risk, thereby providing greater assurance on information governance to the Authority.

The ICO expect Authorities to have a range of data protection KPIs to help provide assurance on information governance activities/processes e.g. completion of data protection and information governance training, security breaches, incidents & near misses and records management. Although the IGG contribute to the compliance programme, identify and share areas of good practice, report areas of concern/risk and agree actions with relevant directorates, the IGG do not maintain any KPIs or make reference to any held, monitored or maintained by other sources.

Equality Impact Assessments

Audit Sponsor	Assurance opinion	Management Actions		
Director of Place Services	Limited	Low 1	Medium 5	High 6

Summary of key observations:

The scope of this review focused on the processes in place within the Highways, Transport and Planning Directorate for the management of the Equality Impact Assessment process to ensure that obligations under the Equality Act 2010 are met.

Whilst there is an awareness within the Directorate of the Equality Act 2010 and the requirement that an EIA is needed to support decision reports for executive decisions, there is a lack of understanding of the needs and issues of some groups with protected characteristics. Although corporate guidance is available detailing the processes for the completion and sign off of Equality Impact Assessments and some voluntary on-line training in respect of some of the protected characteristics, there is no comprehensive corporate training in respect of the Equality Act 2010 and the needs of all protected characteristics.

Although corporate guidance and information is available to all staff through the intranet, this is not easily located. The guidance available is not dated to confirm it is up to date and the latest available. In addition, EIA processes for non-executive decisions are not addressed.

Decision reports for executive decisions should be supported by a completed EIA with reference to the outcome of the EIA process detailed in Section 7 - Policy Alignment and Compliance of the decision report. Ten decision reports were tested with only four EIAs available to confirm the EIA process had been followed.

EIAs are not completed in respect of highways works that do not require an executive decision. These operational works are subject to National Standards relating to the specific type of work being carried out with National Standard GG101 (Design Manual for Roads and Bridges) confirming “an initial EIA screening should be carried out to determine if a full EIA process should be undertaken”. However, these are not being undertaken either.

WSFRS – Safe and Well Visits

Audit Sponsor	Assurance opinion	Management Actions		
Chief Fire Officer	Limited	Low 0	Medium 7	High 6

Summary of key observations:

The audit focused on the recommendations within the 2018/19 HMICRFS inspection report aimed at ensuring WSFRS prioritise home fire safety check activity to target those most at risk, with visits being carried out in a timely manner. We reviewed documented procedures and carried out testing on a sample of completed safe and well visits to ensure procedures are being followed. We also reviewed safeguarding training and performance monitoring.

Testing found a good overarching governance framework in place regarding the Community Risk Management Plan and Prevention Service Plan (both of which replace the Prevention Strategy 2018-22). There was an up-to-date Standard Operating Procedure in place which outlined the process to be followed for completing visits.

We also can report that an initial risk rating is assigned to each referral received based on various risk factors, and timescales are in place for the completion of a visit depending upon the risk rating. Following the completion of the Safe and Well Visit, a final risk rating is assigned to the individual on the system which provides the Service with valuable management information about their most vulnerable residents.

Testing found however, that overall performance targets for completion of Safe and Well visits were not being met. We acknowledge that COVID-19 has had a significant impact on referrals received, and therefore, visits undertaken, however there remains a significant gap between the target and actual figures. The recording system, Farynor, enables monitoring of referral numbers over a five-year period to identify trends and gaps in referrals. As a result of the monitoring that has been taking place since January 2022, the Service has met with a number of key partners to increase awareness of safe and well visits with the aim of increasing referrals and, as a result, visits undertaken. This work is ongoing and will play a vital role in aiding the Service to meet targets moving forward.

We also identified some issues around completion of the visit records on the system and a number of historic cases where it was unclear whether the visit had taken place.

Review of training records found that the two mandatory safeguarding training modules (Adults and Children) were overdue for a number of staff. We understand that there are some discrepancies with training records which has resulted in some training that has been completed not showing on the system.

Management information is produced and reviewed by key staff on a weekly basis and performance against core measures, which includes the number of safe and well visits delivered against targets, is reported to Strategic Performance Board on a quarterly basis.

Home Office and HMICFRS returns, which include data on safe and well visits, are submitted in line with requirements.

Given the priority placed on SWVs by the service an immediate and robust action plan has been initiated with many of the issues already addressed. A follow up internal audit has also been booked for Q3 to reassure on the progress of this action plan.

WSFRS – Working Time Regulations

Audit Sponsor	Assurance opinion	Management Actions		
Chief Fire Officer	No	Low 0	Medium 5	High 2

Summary of key observations:

Following the HMICFRS report published in June 2019, which highlighted the monitoring of working hours as an area for improvement there is a draft project mandate which is going through the WSFRS governance process to develop a system in line with the appropriate organisational policies/procedures for monitoring the working hours of employees to ensure compliance with the Working Time Regulations, Grey Book, WSCC constitution and associated FR Service SOPs. This will include monitoring of employees' total working hours for WSFRS/WSCC (multiple contracts and additional hours/overtime); RDS employee declarations of primary employment, monitoring and any subsequent changes; wholetime and support staff requests for permission for secondary employment, monitoring and any subsequent changes. This audit was requested to help inform this project through identifying current issues and gaps in the control framework.

The Working Time Regulations require that a worker's working time, including overtime, in any reference period which is applicable in each case shall not exceed an average of 48 hours for each seven days. With some exceptions, workers can choose to work more than 48 hours a week on average ('opt out'); employers should keep up to date records of all workers who have opted out.

Our testing identified that the WSFRS Working Hours Policy details how WSFRS ensure compliance with Working Time Regulations, however, there have been numerous amendments to the legislation referenced in the policy since the last review date in 2010. The Working Hours SOP was also found to be out of date as it does not refer to FireWatch, the main system used to record working hours and has not been updated since 2015.

Testing of a sample of records found that signed opt out forms were not consistently held on employee files or, where held, forms were out of date, with inconsistencies to what was recorded in FireWatch.

There is no overall record of the number of hours an employee has worked for WSFRS including all regular shifts, full shift overtime and compulsory overtime. Information from different systems used for recording overall working hours is not readily available to allow active monitoring. In addition, records of other employment for Wholetime, Retained and Support Staff are not up to date.

There are currently no formal monitoring arrangements in place to provide assurance over compliance with the Working Time Regulations.

We understand that the completion, review and audit of flexi duty working time record sheets were included in recommendations made in a report following a Health and Safety incident in 2016. The Flexible Duty System SOP states that People Support will monitor flexible duty working hours and will conduct an audit of the Flexible Duty System Working Time Record Sheets on a quarterly basis; we were advised that an audit spreadsheet was completed up to December 2018 but is no longer used as it did not provide meaningful outcomes.

According to the Working Hours SOP, quarterly reports should be available to group and/or line management on request from Pay & Employment Services, to monitor hours worked and any potential risks; Payroll were unaware of the quarterly reports referred to.

The Group Crewing SOP states that Station Managers will audit records, including the accuracy of FireWatch, for their station and send quarterly audit reports to Operational Group Managers however, we were advised that no reports are received. We were also advised that the IT Infrastructure does not support overall monitoring of hours across multiple contracts or report accurately on shifts worked or owed.

6. Planning & Resourcing

To ensure internal audit focus remains timely and relevant to the changing needs and requirements of the organisation that SIAP have adopted an approach of quarterly planning. The quarter 1 plan was approved by the County Council's Executive Leadership Team and the Regulation, Audit & Accounts Committee in March 2022.

SIAP will continue to liaise with key stakeholders over the remainder of the year to develop ongoing quarterly plans.

The rolling work programme (section7 below) outlines audit activity during 2021/22 and 2022/23 (Q1).

7. Rolling Work Programme

Audit Review	Sponsor	Scoping	ToR	Fieldwork	Draft Report	Final Report	Assurance Opinion	Comment
2020/21								
Dual Use Agreements	P&A	✓	✓	✓	Dec 21	Dec 21	Position Statement	
Central Government Grants (allocation)	Corporate	✓	✓	✓	Oct 21	Nov 21	Reasonable	
Cyber Security (Risk Treatment)	DFSS	✓	✓	✓	Jun 21	Jul 21	Reasonable	
Cloud Service Provisioning	DFSS	✓	✓	✓	Jun 21	Jun 21	Reasonable	
School Thematic Review(s)	DCYP&L	✓	✓	✓	Jun 21	Nov 21	Reasonable	
2021/22								
Ash Dieback	DHT&P	✓	✓	✓	Jan 22	Jan 22	Reasonable	
Our Council Plan - Performance	CE/DF&SS	✓	✓	✓	Sep 21	Oct 21	Reasonable	
Think Family claims	DCYP&L	✓	n/a	n/a	n/a	n/a	n/a	Two claims completed
Firewatch	CFO	✓	✓	✓	Aug 21	Jan 22	Limited	
Home to School Transport	DPS	✓	✓	✓	Sep 21	Nov 21	Reasonable	
Highways Maintenance	DPS	✓	✓	✓	Jul 21	Aug 21	Reasonable	
School Thematic – HT Pay	DCYP&L	✓	✓	✓	Feb 22	Mar 22	Reasonable	
SFVS (20/21 analysis)	DCYP&L	✓	n/a	n/a	May 22	Jun 22	n/a	
Hammonds-Residential Care Home	DA&H	✓	✓	✓	Sep 21	Nov 21	No	

Audit Review	Sponsor	Scoping	ToR	Fieldwork	Draft Report	Final Report	Assurance Opinion	Comment
People Framework	DHR&OD	✓	✓	✓	Aug 21	Nov 21	Reasonable	
Annual Governance Statement	DL&A	✓	✓	✓	Nov 21	Nov 21	Reasonable	
Payroll	DF&SS	✓	✓	✓	Jul 21	Sep 21	Reasonable	
Mortuary Services Contract Management	DPS	✓	✓	✓	Oct 21	Nov 21	Reasonable	
IT Transition Programme	DF&SS	✓	✓	✓	Jul 21	Aug 21	Position Statement	
IT Assurance Mapping	DF&SS	✓	✓	✓	Mar 22	Apr 22	Reasonable	
ITIL Process Transition	DF&SS	✓	✓	✓	April 22	May 22	Reasonable	
Adults Income	DA&H	✓	✓	✓	May 22			
AMHPS	DA&H	✓	✓	✓	Feb 22	Mar 22	Reasonable	
WSFRS Risk & Business Continuity	CFO	✓	✓	✓	Feb 22	Mar 22	Reasonable	
Health & Safety	DHR&OD	✓	✓	✓	May 22	Jun 22	Reasonable	
Capital Project Delivery (Education)	DCYP&L / DPS	✓	✓	✓	Jun 22			
Accounts Receivable	DF&SS	✓	✓	✓				
Budgetary Control	DF&SS	✓	✓	✓	Sep 21	Nov 21	Reasonable	
WSFRS Operational Training Delivery	CFO	✓	✓	✓	Nov 21	Jan 22	Limited	
WSFRS Fleet Management	CFO	✓	✓	✓	Oct 21	Nov 21	Reasonable	
WSFRS Working Time Directive	CFO	✓	✓	✓	Apr 22	May 22	No	
IR35	DHR&OD	✓	✓	✓	Aug 21	Feb 22	Limited	
Parkside Service Charge Review	DPS	✓	✓	✓	n/a	Sep 21	n/a	
Information Governance - GDPR	DL&A	✓	✓	✓	Apr 22	May 22	Limited	
Assurance Mapping (Children's)	DCYP&L	✓	✓	✓	n/a	May 22	Position Statement	
Equality Impact Assessments	DHT&P	✓	✓	✓	Apr 22	May 22	Limited	
Climate Change Strategy	DE&PP	✓	✓	✓	Apr 22	Jun 22	Reasonable	
Payments to Providers (Hospital Discharge Pathway)	DA&H	✓	✓	✓				
Assurance Mapping (Adults)	DA&H	✓	✓	✓	May 22			
Savings Realisation Framework	DF&SS	✓	✓	✓	Jun 22	Jun 22	Reasonable	

Audit Review	Sponsor	Scoping	ToR	Fieldwork	Draft Report	Final Report	Assurance Opinion	Comment
Financial Resilience	DF&SS	✓	✓	✓	Jun 22	Jun 22	Reasonable	
Vaccination (Preparedness)	DHR&OD / EDAH	✓	✓	✓	n/a	Nov 21	Position Statement	
Business Continuity (WSCC)	CFO	✓	✓	✓	Apr 22	Apr 22	Reasonable	
School Thematic – Summer School Funding	DCYP&L	✓	✓	✓	Apr 22	Jun 22	Reasonable	
HR Policy Decision Making	DHR&OD	✓	✓	✓				
Treasury Management	DF&SS	✓	✓	✓	Jun 22	Jun 22	Substantial	
SEND (Follow Up)	DCYP&L	✓	✓	✓				
WSFRS Communication and Equipment	CFO	✓	✓	✓	May 22	Jun 22	Position Statement	
WSFRS Safe and Well Visits	CFO	✓	✓	✓	May 22	Jun 22	Limited	
SFVS Returns Q4 21-22	DCYP&L	✓	n/a	n/a	n/a	n/a	n/a	
Contract Management-Advocacy	DA&H	✓	✓	✓				
Local Energy Communities 2 Seas Region	DPS	✓	✓	✓	May 22			
Grants 2021/22								
Highways Maintenance Block Grant	DHTP	n/a	n/a	n/a	n/a	n/a	n/a	Complete
HIV PrEP	DPH	n/a	n/a	n/a	n/a	n/a	n/a	Complete
Additional Home to school transport	DHTP	n/a	n/a	n/a	n/a	n/a	n/a	Complete
Bus Services Operator Grant	DHTP	n/a	n/a	n/a	n/a	n/a	n/a	Complete
Travel Demand Management Grant	DHTP	n/a	n/a	n/a	n/a	n/a	n/a	Complete
2022/23 (Q1)								
Company Governance Framework	DL&A	✓	✓	✓				
Capita Contract	DF&SS	✓	✓					
Children's Care Placements	DCYP&L	✓						
Grenfell Tower – Action Plan	CFO	✓	✓	✓	Jun 22	Jun 22	Reasonable	
School Thematic – School buildings upkeep / maintenance	DCYP&L	✓	✓					
SFVS Q1	ADE&S	n/a	n/a	n/a	n/a	n/a	n/a	Complete
Shaw Homes – Contract Management	DA&H							

Audit Review	Sponsor	Scoping	ToR	Fieldwork	Draft Report	Final Report	Assurance Opinion	Comment
Adults Assurance (Safeguarding / SAB /Provider Failure)	DA&H	✓	✓					
Direct Payments	DA&H / DFS&S	✓	✓					
Workforce Planning	DHR/OD	✓						
Fraud (Proactive / Reactive)	DF&SS	✓	✓	✓				
Procurement	DF&SS	✓	✓					
Contract Management	Corporate							
Use of Agency Staff	DHROD	✓	✓					
XMA Contract Delivery	DF&SS							
IT Contingency	DF&SS							
Grants 2022/23								
Contracted Public Bus Services	ADHTP	n/a	n/a	n/a	n/a	n/a	n/a	Complete
Supporting Families Q1 claim	DCYP&L	n/a	n/a	n/a	n/a	n/a	n/a	Complete

Annexe 1

Overdue 'High Priority' Management Actions

School Traded Services - Reasonable

Observation: Strategy
There is no agreed strategy in place on how to grow School Traded Services income and reach the £500,000 income target within 3 years.

Risk: School traded services income will not meet the assigned income targets

Management Action	Original Due Date	Revised Due Date	Latest Service Update
Project timeline to be established identifying tasks /steps required to prepare for the withdrawal of DSG funding from April 2022	31.10.21	30.09.22	The Government is in consultation with all LA's regarding the brokerage grant which funds school effectiveness. The consultation is looking at changing statutory responsibilities of LA's. It is not yet clear from Government whether all the grant will be withdrawn or a proportion. Until the consultation is complete, and the amounts involved known the project timeline cannot be developed.
Strategy to be formed & communicated	30.07.21	30.09.22	A questionnaire is due to be issued to all stakeholders to help understand their requirements which have changed in part due to the pandemic. The results alongside clarification of funding will help inform the development of the new strategy.

Observation: Pipeline Report
We observed that there is a pipeline report in place which plans when products / school services will go through the scrutiny process via the QA Board. Whilst plans include all Education & Skills school services, it does not include all school services delivered throughout the wider Council.

Risk: Missed opportunity for scrutiny and improvement if some school services are not directed towards the QA Board.

Management Action	Original Due Date	Revised Due Date	Latest Service Update
Consider next steps following the LGA review outcomes.	31.05.21	30.09.22	The LGA review is being considered as part of the restructure and will influence the strategic direction of the service. The service is concentrating on the educational offers first but will continue to offer other services from the wider council which can be included via the QA board process. The intention is to communicate to the wider council the position regarding traded services and to encourage their buy in to it.

Children's Services - P-Cards - Limited

Observation: Review of active P-cards
An exercise was undertaken where managers within Children's Services were sent a list of P-card holders and asked to identify any which were no longer required. This resulted in a list of 203 P-cards being identified for cancellation. However, the exercise to close these P-cards has not yet been completed. Further to this, other control options such as cancelling P-cards where value and volume of spend has been minimal over a prolonged period have not been explored.

Risk: P-cards with no business need are approved or remain in circulation, risking unnecessary spend.

Management Action	Original Due Date	Revised Due Date	Latest Service Update
All to be reviewed again (project should be owned by one individual and overseen by a member of DLT).	30.07.21	30.06.22	This remains partly completed. Due to the substantial restructuring of the Childrens' Social Care teams in February there were a significant number of managers and staff moving hierarchy which took longer than anticipated to confirm on SAP. This meant a delay to confirming new approvers and cardholders, this is now nearing completion. Following this an assurance exercise will take place to ensure that no other members of staff other than those approved hold P cards. Managers have been reminded to ensure that those on maternity leave, leavers etc are removed as P card holders as part of their exit.

WSFRS Operational Training Delivery- Limited

Observation: Training Database
WSCC's training database is Learning Pool, and WSFRS also maintain their own database, FireWatch. Training is recorded in Learning Pool on completion of training and then the FireWatch record should be updated; and therefore, staff training records should align. However, testing found that Learning Pool records for mandatory training around Maintenance of Knowledge (MOK) and Maintenance of Competence (MOC) training courses are not accurately reflected in FireWatch.

Risk: Risk to staff and public creating potential for reputational damage, should operational staff be ordered to incidents for which they have not completed adequate training.

Management Action	Original Due Date	Revised Due Date	Latest Service Update
Complete API (automated link) between Learning Pool and FireWatch	31.03.22	30.06.22	The API installation is now paid for and being tested with a view to it being introduced in the next 2 months

Observation: Policy Update
Audit testing found that the latest version, (V2), of the Training Policy was dated 2nd December 2011. This means that it has been approx. 10 years since the last recorded revision which, at that point in time, was noted as "Course Changes". During our review we confirmed that courses change with greater frequency than every 10 years, and the availability of facilities to provide certain training have also changed.

While the Policy reflects key elements of training required, and demonstrates future focus, a more frequent review would enable greater assurance to be taken around it being in date; and therefore, a current and active source of control.

Risk: Policy if out of date and does not reflect current requirements.

Management Action	Original Due Date	Revised Due Date	Latest Service Update
Review and update of Learning & Development (Training) policy. Include a regular review process	28.02.22	31.07.22	L&D review and update nearing completion and will then be passed over to RMG for final scrutiny and publication
As part of the above – update the Assessment Frequency model (in line with up-to-date best practice)	31.03.22	30.06.22	MOC scheme has now been reviewed and updated with a view to introducing a 3-year scheme (was 2 year). This has included a review of the assessment frequencies through the most up to date risk-rated model

Firewatch - Limited

Observation: Monitoring of competencies against training records in Firewatch
Our review found a lack of assigned responsibility and formalised procedures around the monitoring of training records within Firewatch to ensure the correct competencies have been assigned both initially and following contract changes, which could result in different competencies being required. This element of administration was previously carried out by the Training Administrator who is no longer in post, and it has not been consistently carried out since their departure. Whilst these tasks have been carried out by the Learning and Development Instructor since their appointment in March 2021, monitoring of records is an administratively heavy task and is limited to the time available by the Learning and Development Instructor

Risk: Inaccurate data is held in Firewatch, increasing the risk of the mobilisation of staff who do not meet competency requirements for the role.

Management Action	Original Due Date	Revised Due Date	Latest Service Update
Firewatch API installation	31.03.22	30.06.22	The API installation is now paid for and being tested with a view to it being introduced in the next 2 months

AMHPs - Reasonable

Observation: SAMHP Register

The AMHP Service works within various legislative requirements including 'The Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008'. The regulations require that a record is kept of each AMHP it approves and specify eight key areas including the completion of training.

The information is retained in a local spreadsheet. Comparison of the spreadsheet to the 2008 regulations found that the register did not include confirmation of the 18 hours training required per year. Whilst this is mitigated to some extent through the re-approval process undertaken via the Approval Panel which requires confirmation of the training completed by the AMHP, and some records are retained in alternative systems the local spreadsheet does not hold all required information as one source.

Risk: Non-Compliance with legislative requirements.

Management Action	Original Due Date	Revised Due Date	Latest Service Update
The AMHP register, maintained within the AMHP Service on behalf of the Council, has now been redesigned to clearly account for these specific requirements of the AMHP Regulations 2008. This includes adding information that each AMHP's CPD record has been checked at six-monthly and 12-monthly intervals.	31.03.22	31.08.22	The register has been amended so we can capture CPD, but we have yet to commence the 6 monthly checks as we need a template, which is nearing completion.
All AMHPs will be instructed to discuss and show their CPD records to their named AMHP professional supervisor, and those records will be documented on an agreed CPD template which will be circulated.	31.03.22	31.08.22	The register has been amended so we can capture CPD, but we have yet to commence the 6 monthly checks as we need a template, which is nearing completion.

IT Assurance Mapping - Reasonable

Observation: Microsoft Azure Security Configuration Assessment

The results of the Microsoft Azure Security Configuration assessment are documented in the "WSCC Review PowerON CA MFA" report. To address some of the issues in this report we were provided with an email discussion on the results and evidence of the implementation of geographic conditional access and enforcement of the use of multi factor authentication.

However, there is no evidence of governance over the management of all the results of this assessment such as a risk or strategic fit assessment, the assignment of resources and time bounding of actions.

Interview with the Head of IT established that this piece of work contributed to the forward planning for cloud services and plans for future direction of travel but has not required formal governance of specific actions pending further strategic implementations.

Risk: Security configuration weaknesses are not addressed. Value is not obtained from the commissioned work.

Management Action	Original Due Date	Revised Due Date	Latest Service Update
Immediate implementation of an Azure Tenant Development Working group to comprise Council officers and technologists from Version 1. Scope: Technical review and documentation of proposed configuration options and applicable considerations or risks	29.04.22	30.06.22	This delay is on the basis that Version 1 Datacentre Migration due diligence started later than anticipated and therefore we are still awaiting their analysis and recommendations.
Modification of TDA (Technical Design Authority) ToR to reflect widened formal governance scope as the decision making body within IT Services.	29.04.22	30.06.22	This delay is on the basis that Version 1 Datacentre Migration due diligence started later than anticipated and therefore we are still awaiting their analysis and recommendations.

Annexe 2

Overdue 'Low & Medium Priority' Management Actions (June 2022)

Audit Review	Report Date	Opinion	Priority		Due Date	Revised Due Date
			Low	Medium		
Special Educational Needs	Oct 2020	Limited		1	31.12.20	31.01.22
School Traded Services	Mar 2021	Reasonable		1	30.06.21	30.09.22
S75 Governance	Apr 2021	Limited		1	30.06.21	31.03.23
				1	31.03.22	31.03.23
Cyber Security (Risk Treatment)	Jul 2021	Reasonable		1	31.12.21	30.09.22
Cloud Service Provisioning	Jun 2021	Reasonable		1	31.03.22	30.06.22
				1	31.03.22	30.06.22
Home to School Transport	Nov 2021	Reasonable		1	31.12.21	30.09.22
Hammonds	Nov 2021	No		1	28.02.22	31.08.22
WSFRS Fleet Management	Nov 2021	Reasonable		1	31.03.22	30.06.22
Special Schools Funding Thematic	Nov 2021	Reasonable		1	31.03.22	31.03.23
				1	31.03.22	31.03.23
			1		31.03.22	31.03.23
			1		31.03.22	31.03.23
WSFRS Operational Training Delivery	Jan 2022	Limited		1	28.02.22	31.07.22
				1	28.02.22	31.07.22
				1	30.01.22	30.06.22
Firewatch	Jan 2022	Limited		1	31.03.22	30.06.22
IR35	Feb 2022	Limited		1	28.02.22	30.09.22
				1	28.02.22	30.09.22
WSFRS Risk and Business Continuity	Mar 2022	Reasonable		1	01.06.22	TBC
				1	01.06.22	TBC
				1	01.06.22	TBC
				1	01.06.22	TBC
				1	01.06.22	TBC
Total			**2**	**23**		