London Borough of Southwark

INTERNAL AUDIT ANNUAL REPORT AND ANNUAL STATEMENT OF ASSURANCE 2022-23

For presentation to the Audit, Governance and Standards Committee

17 July 2023

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SUMMARY OF 2022-23 WORK

Internal Audit 2022-23

This report details the work undertaken by internal audit for London Borough of Southwark and provides an overview of the effectiveness of the controls in place for the full year.

All work relating to the internal audit plan for 2022-23 has been completed to at least draft report stage, and we are working with the Council to issue all final reports by the end of July 2023.

The reports that have been issued and which form the basis of the annual report for 2022-23 are listed below.

Assistant Chief Executive's Department – Governance and Assurance

- Complaints - Final
- Hospitality and Gifts - Draft
- Member / Officer Protocol – Final
- Overtime (Council wide) – Final
- Payroll and HR - Final

Children and Adults Directorate

- Adult Learning Services- Final
- Children's Quality Assurance Unit - Final
- Covid-19 Expenditure - Final
- Mental Health Services - Final
- Mosaic - Draft
- Public Health - Tobacco Control - Final
- Safeguarding – Adults - Draft
- SEND Finance - Final
- Special Educational Needs - Final

Housing Directorate

- Building Control - Draft
- Building Safety - Draft
- Buyback of Properties - Final
- New Homes Programme - Final

Environment, Neighbourhood and Growth Directorate

- Cemeteries and Crematoria - Final
- Parking Management & Estates Parking Permits - Draft Markets - Draft
- No Recourse to Public Funds - Final
- TMO – Applegarth - Final
- TMO – Brenchley Gardens - Final
- TMO - Delawyk - Final
- TMOs - Use of Reserves - Final
- Community Engagement - Final
- Climate Emergency Strategy - Draft
- Private Sector Licensing - Draft

Finance Directorate

- Accounts Payable - Final
- General Ledger - Final
- Housing Rents - Draft
- IT - Applications Review - Draft
- IT - Cloud Computing Maturity - Draft
- IT – Software Licensing – Final
- Pensions Administration – Final
- Supplier Resilience (Council wide) - Final

Where a final or draft report has been issued, the purpose of each audit, assurance opinions, number of recommendations and key findings are summarised on pages eight to 48. In the final version of the annual report, these may be subject to change. However, the overall opinion for the Council will not be affected by any changes at individual audit level.

The internal audit team has also completed the following work in 2022-23:

- Finance and Governance Service Reviews – we carried out a series of reviews on the functioning of areas within the remit of the former Strategic Director of Finance and Governance, with the objective of identifying areas working well and those where risks might be better addressed, or improvements made. An advisory report was issued to the new Strategic Director, Finance, who has confirmed that the review will be used for internal management purposes and as interviewees were informed that discussions were confidential the report cannot be issued more widely. However, we can confirm that no issues arose that would impact on the Council's annual governance statement. Any questions on this should be addressed to the Strategic Director, Finance.

- Grant audits – for which separate letters of engagement were issued:

    - Family Hubs and Start for Life
    - Protect and Vaccinate
    - Supporting Families
    - URBACT Thriving Streets EU funded project.

- Transparency Reporting – we continue to provide support and challenge to the Council in meeting its obligations for reporting expenditure under the Local Government Transparency Code 2015.

There were no restrictions placed upon the scope of our audit and our work complied with Public Sector Internal Audit Standards.

The following audits were deferred from 2022-23 to 2023-24:

- Council Delivery Plan
- Home to School Transport
- Major Regeneration
- Use of Consultants / IR35
- Pupil Registry Systems
- Sickness Absence Management
- Southwark Building Services
- Voids

The internal audit programme for schools' cyclical compliance audits was carried out. At the time of writing, the fieldwork for all 2022-23 schools' audits has been completed and we are in various stages of quality assurance and reporting. The schools audited in 2022-23 is listed below.

- Charlotte Sharman Primary
- Crawford Primary
- Dulwich Wood Primary
- Grove Children & Family Centre
- Haymerle
- Ilderton Primary
- Keyworth Primary
- Michael Faraday Primary
- Oliver Goldsmith Primary
- Peter Hills with St Mary's & St Paul's Church of England Primary
- Phoenix Primary
- Southwark Inclusive Learning Service
- St George's Church of England Primary
- St Joseph's Junior
- St Joseph's Roman Catholic Primary, George Row
- St Jude's Church of England Primary
- St Mary Magdalene Church of England Primary
- St Peter's Church of England Primary
- St Saviour's and St Olave's Church of England
- Tuke

An end of year report summarising the results and common themes arising from our school internal audit programme for 2022-23 is presented to the Committee at its meeting on 17 July 2023.

Non internal audit services provided by BDO.

The following non audit services have been provided by BDO during 2022-23:

- Risk management support
- Counter fraud support

The counter fraud work is delivered by our forensics team, which is separate to the public sector internal audit team that provides internal audit and risk management services to the Council.

We do not consider the work undertaken above to pose a threat to our independence or objectivity in delivering the internal audit services.

HEAD OF INTERNAL AUDIT OPINION 2022-23

The role of internal audit is to provide an opinion to the Council, through the Audit, Governance and Standards Committee, on the adequacy and effectiveness of the internal control system to ensure the achievement of the organisation's objectives in the areas reviewed.

The annual report from internal audit provides an overall opinion on the adequacy and effectiveness of the Council's risk management, control, and governance processes, within the scope of work undertaken by our firm as outsourced providers of the internal audit service. It also summarises the activities of internal audit for the period.

The basis for forming my opinion is:

- An assessment of the design and operation of the underpinning assurance framework and supporting processes.

- An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year – this assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

- Any reliance that is being placed upon third party assurances.

Overall, we can provide **Moderate Assurance** that there is a sound system of internal control, designed to meet the Council's objectives and that controls are being applied consistently, the same opinion as in 2020-21 and 2021-22. We continue to consider this to be a positive result given the continued increased demands on services and funding challenges faced.

Our internal audit opinions are Substantial, Moderate, Limited and No Assurance, definitions can be found in Appendix I.

Our annual report and head of internal audit opinion has been prepared based on the audit work undertaken during the year. This information will be updated in the final annual report to be presented to the Committee on 17 July 2023.

In forming my view, I have taken into account that:

- In respect of the design of the controls, an opinion of moderate assurance has been provided for 23 out of the 34 assurance audits completed, substantial assurance provided in six areas and limited assurance opinions in five areas. Overall, the Council has maintained its control environment during 2022-23. However, the relative proportion of substantial assurance opinions provided for the design of the Council's controls has decreased from 38% in 2021-22 to 18% in 2022-23.

- In respect of the operational effectiveness of the controls, an opinion of moderate assurance has been provided for 22 of the 34 assurance audits completed, substantial assurance provided in two areas, limited assurance in nine and we did not provide an opinion in one area. The relative proportion of substantial assurance opinions provided for the operational effectiveness of the Council's controls has also fallen, from 15% in 2021-22 to 6% in 2022-23.

- The relative proportion of high, medium, and low recommendations is consistent with previous years, and management has continued to respond positively to reports issued with adequate action plans to address the risks and issues identified. We have confirmed with

reference to evidence that 92% of recommendations due for implementation by the date of reporting had been completed. This represents an increase from an implementation rate of 87% in 2021-21 and is the highest that we have reported since our appointment as the Council's internal auditors.

- In respect of school audits and ongoing financial pressures, the Council is taking proactive steps to manage these, and our programme of audits has been aimed at prioritising schools with high levels of risk.

- Financial performance has been strong in the financial year 2022-23. A balanced outturn position has been achieved. There was pay, energy and inflationary pressures across all Council departments which were successfully mitigated through the drawdown on specific reserves earmarked for that purpose and the use of the planned contingency. The reserves remain stable with an unallocated general fund reserve of £22m and net earmarked reserves of £209m. Although the macroeconomic outlook continues to be uncertain, the council is in a good position to meet future challenges.

REVIEW OF 2022-23 WORK

Report issued	Number of recommendations			Internal Audit Assurance Opinions		Purpose of Audit and Key Findings
	H	M	L	Design	Operational Effectiveness	
Accounts Payable	1	2	1	Moderate	Moderate	Purpose: To provide continuing assurance on the adequacy of the design and operational effectiveness of internal controls in managing accounts payable processes via SAP, to ensure that they are promptly and effectively brought into use. We reviewed the effectiveness of the processes relating to vendor set up and amendments, raising and approval of purchase orders, payment processing and approvals. Key findings: • No assurance could be provided in relation to accounts payable system access (whether an access request form was in place, had been appropriately signed off, and access rights were appropriate to job role) as we have not received sufficient evidence. • We compared a list of SAP users (PO approvers and inputters, and invoice inputters) against a list of leavers since 1 April 2022 and found that six users continued to have access to the system after having left the Council. • We selected a sample of 20 transactions (1 April 2022 to 28 February 2023) and found that there were two incorrectly approved purchase orders (one was raised and approved by the same individual; another was approved by a staff member without the delegated authority per the scheme of management), and five purchase orders were raised after the receipt of invoices. • We found that six invoices were paid after more than 30 days, with no reason provided. As part of data analytics testing, we compared the date of invoice with the payments date to identify the compliance rate of all payments made in the period 1 April 2022 to 28 February 2023. We found that payment was made within

Report issued	Number of recommendations			Internal Audit Assurance Opinions		Purpose of Audit and Key Findings
	H	M	L	Design	Operational Effectiveness	
						30 days of the invoice date in 68% of transactions. • Data analytics highlighted that there were vendors without bank details allocated to them on the Council's AP system, and instances where vendors with different names had the same bank details.
Adult Learning Services	-	1	3	Moderate	Substantial	Purpose: To review the processes and controls in place that support effective decisions on which SALS services to offer, verifying that the right audience is being targeted and the syllabus is appropriate to ensure alignment with GLA specifications. In addition, the review determined whether the level of attendee take up is being routinely considered when undertaking decisions alongside financial viability. Key findings: • There were no Articles of Association for the SALS Governing Body, and their roles and responsibilities are unclear. • Other areas for improvement were identified including the need for a succession plan, sharing lessons learned and improved marketing of the service.
Building Control *Draft Report*	-	1	1	Substantial	Moderate	Purpose: To provide assurance over the adequacy and effectiveness of the Council's controls and approach in delivering and enforcing compliance with building control regulations. Key findings: • From our review of a sample of 20 building control applications in the period the following exceptions were identified: o In two cases (Full Plan), a decision was not made within 5-8 weeks of receiving the application. o In seven cases, evidence of inspections completed was not available. o In four cases, evidence of application payment receipt was not available.

Report issued	Number of recommendations			Internal Audit Assurance Opinions		Purpose of Audit and Key Findings
	H	M	L	Design	Operational Effectiveness	
Building Safety *Draft Report*	3	3		Limited	n/a	Purpose: to provide assurance on the Council's preparedness for the implementation of the Building Safety Act and Fire Safety Act. Our review included the engagement and performance of consultants and contractors employed on behalf of the Council. Key findings: • The fire and building safety policy and emergency response procedures have not been reviewed, ratified, and approved. • Organisational structures are not comprehensive and clearly coordinated to enable better and more collaborative working with divisions and third parties upon which the Head of Building Safety places reliance in accordance with the relevant safety regulations, including Engineering & Fire Safety. • High staff turnover and team restructures have created difficulties in continuity and efficiency for the implementation of the Fire and Building Safety Acts, and relevant safety regulations. A lack of comprehensive record keeping as well as CPD for consultants and contractors that fall under the BSA may mean the new Head of Building Safety may have difficulty demonstrating that key consultants and contractors have had appropriate skills, knowledge, experience, and the behaviours needed to manage the functions they were appointed to do. • The anticipated improvement of management information in line with the golden thread standard may be compromised if the Building Safety Management information system, including the document management control procedures are not embedded, and made readily available to the right people at the right time. • The anticipated outcomes to improve data quality in line with the golden thread may be compromised if the new building safety compliance system, True Compliance and the new housing management system, NEC Software Solutions are not implemented, optimised, and supported by skilled personnel.

Report issued	Number of recommendations			Internal Audit Assurance Opinions		Purpose of Audit and Key Findings
	H	M	L	Design	Operational Effectiveness	
						• Progress made and performance is not being reported comprehensively or reviewed to ensure there is appropriate senior management oversight and expected targets are achieved in a timely manner. Note: no opinion on control effectiveness was provided as the Council is still in preparation for the implementation of the Building Safety Act and Fire Safety Act.
Buyback of Right to Buy Properties	-	-	-	Substantial	Substantial	Purpose: To provide assurance over the adequacy of the design and operational effectiveness of the new process for the buyback 20 and 40 project. Our review also assessed how effectively the processes have been incorporated into the Council's social housing portfolio. Key findings: • No areas of concern were identified in respect of the risks audited and the control framework in MySouthwark Homeowners Service.
Cemeteries and crematoria	-	4	-	Moderate	Moderate	Purpose: To review the adequacy and effectiveness of the Council's governance arrangements and key operational and financial controls relating to burials and cremations. Key findings: • Given the nature of the activities in the crematoria, environmental legislation is of particular importance, however, the Bereavement Service does not currently have an Environmental Policy or strategy covering the cremators and cremation coffins. • Key marketing information for customers have not been updated since 2017. • 60% of the burials and 20% of the cremations sampled were not arranged within the typical industry timeframe of up to 10 business days of the funeral or cremation being booked, however, the reasons for delays were not documented clearly.

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	H	M	L	Design	Operational Effectiveness	
						• The Bereavement Service's Business Continuity Plan (BCP), dated 16 October 2019, had not been tested this year to date or been updated to incorporate the lessons learned from the events of the past two years. • New/revised monitoring arrangements and Key Performance Indicators were presented to senior management in October 2022, however, have not yet been agreed to ensure the Bereavement Service's operations have an adequate oversight, which is sufficiently comprehensive.
Children's Quality Assurance Unit	-	3	1	Moderate	Moderate	Purpose: To provide assurance over the adequacy of the design and operational effectiveness of the Council's approach to governing and monitoring the quality of the child safeguarding mechanisms, legislative compliance and the overarching framework overseen by Southwark. Key findings: • There was no specific scheme of management and delegations to cover the CQUA service or the levels of management reflected in the structure chart. • The 'Action Plan' section of the audit tool was not consistently completed. It does not contain a 'what good looks like' section, unlike the other parts of the tool. As such, the actions listed by auditors vary in detail, number, and quality. • Four of the eleven Child Protection Plans sampled did not meet the required time frames stipulated in the guidance. Two of these were that the child was not visited within 24 hours of the incident where delays were four and two working days, respectively. All four experienced delayed CPC conferences ranging from two to twenty-three days. • Broader/structural themes were not as frequently discussed in monthly Quality of Practice reports, despite auditors often raising these through comments on the audit tool. The audit tracker is not being used to capture key themes picked up

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						by the audits. • Additionally, themes shared in quality of practice reports at the monthly quality assurance (SQUARES) meetings rely on attending management to circulate with their wider teams, which does not always occur. • Individual team meetings were infrequently minuted meaning key actions or learnings are not documented. • We reviewed a sample of five reflective reviews completed following inadequate audits. There was no template frequently used and one of the sample did not include any action plan.
Climate Emergency Strategy *Draft Report*	-	4	-	Moderate	Moderate	Purpose: To provide assurance over the agreed climate emergency strategy, including adequacy of supporting plans, resourcing and identification and development of capital investment proposals. The audit included the plans relating to the corporate facilities estate. Key findings: • Whilst an action plan was in place the milestones in place had timescales listed as financial years or ongoing rather than specific quarters. Out of 109 projects, 22 of these had missed their initial milestones and had new milestones of 2023 or 2024. 24 milestones have been completed on time. This is being reviewed on a quarterly basis at Director and Officer groups to gather further information on how progress is being made. • For projects that received funding for the sustainability capital fund, a process was not in place to gather feedback on the outcomes and carbon emission reduction achieved to document and report on these. • For three reports submitted to Cabinet, climate change implications were not considered. These were based on the supply of agency workers which may have

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	H	M	L	Design	Operational Effectiveness	
						had a minor impact on the climate if sourced from outside the Borough. • The Council has neither an Accommodation Strategy nor a Corporate Facilities Estates Model to support it in measuring and controlling its own emissions to contribute to reductions across the borough.
Community Engagement	-	-	3	N/A Advisory Review	N/A Advisory Review	Purpose: To provide assurance on the adequacy of the design and operational effectiveness of internal controls in place to manage the identified risks in respect to Community Engagement. The review considered the lessons learned from the Covid-19 pandemic and how this is informing future approaches to community engagement and the impact on governance structures. It was agreed at the time of scoping that this would be an advisory review incorporating benchmarking. Areas to improve: • To steer officer engagement the Council has 2 key pieces of guidance, the consultation toolkit, and the engagement plan template. We reviewed both against the Local Government Association community engagement checklist to confirm all areas were incorporated into the guidance. We found the following was not mentioned in the Council's guidance: 1. Monitor the responses: Keep track of the number of responses you receive so action can be taken to improve response rates if necessary. Check the responses submitted to get an indication of the issues arising. 2. Analyse the results: Consider what story the data are telling and what this means in terms of the question asked. Calculated how many people gave certain answers and looked for any variations. You should also seek to identify any patterns, trends, or themes to help identify key issues. Officers also confirmed that some of the information contained within the toolkit

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	H	M	L	Design	Operational Effectiveness	
						was out of date and did not align with the new corporate approach so needed a refresh. • Our review of the information available on the Council's Consultation and Engagement website showed officers had not refreshed the following information since 2017 and therefore there is a risk it is no longer relevant: - Let's talk about ageing well. - Let's talk about new council homes for Southwark. - Become a charity trustee. - LGBT groups. - Southwark disability forum. - Southwark multi-faith forum. We also found the link for the Housing Community Involvement page no longer worked. • We confirmed officers understood the problems arising from digital engagement during the pandemic, such as bad online behaviour from the public and planning around engagement behaviour to ensure all voices are heard. We verified officers had taken action to address the issues, for example writing additional guidance. However, there was no formalised lessons learnt process documenting the actions taken, responsible officers and date of implementation. Without this there is a risk officers do not take the full action necessary to address the identified issues.
Complaints	1	1	1	Moderate	Moderate	Purpose: To provide assurance over the design and operational effectiveness of the controls relating to the Council's response to complaints, clarity of roles and responsibilities, documentation, timeliness of responses and closure of cases. Key findings:

Report issued	Number of recommendations			Internal Audit Assurance Opinions		Purpose of Audit and Key Findings
	H	M	L	Design	Operational Effectiveness	
						• From a sample of 20 complaints (15 Stage 1 and five Stage 2) we identified the following exceptions to the Council's policy: ○ In three cases, no evidence of an acknowledgement letter was available on the system. ○ In 11 cases, a decision was not made for a Stage 1 complaint and communicated to the complainant within the required timeframe per the Complaints policy, delays ranged from two to 67 working days. ○ In two cases, a decision was not made for a Stage 2 complaint and communicated to the complainant within the required timeframe per the Complaints policy, delays ranged from 19 to 97 working days as at the audit testing date (7 November 2022) ○ In nine cases, a caseworker was not assigned to the case within a reasonable timeframe (within one week) which potentially could have delayed the decision to be made within the timeframes per the policy. • Due to the introduction of recent changes such as in relation to capturing the lessons learnt, the training material needs revising. Arrangements were ad-hoc and formal training arrangements were not in place.
Covid-19 pandemic related expenditure	-	4	-	Moderate	Moderate	Purpose: To provide assurance over the accuracy and completeness of reported spend with regards to Covid-19 related expenditure incurred by the Children and Adults Services department. • Written policies and procedures were not developed in respect of the areas within the scope of this audit: passporting of money to providers for infection control equipment, staff purchasing PPE, distribution of payments to schools to compensate free school meal vouchers or allowable Uber Journey expenditure. • A framework was not developed, or a log maintained to capture lessons from issues

Report issued	Number of recommendations			Internal Audit Assurance Opinions		Purpose of Audit and Key Findings
	H	M	L	Design	Operational Effectiveness	
						encountered during the pandemic with regards to Covid-19 related expenditure, to identify improvements specific to the finance processes. • With regards to travel by Uber, we identified several exceptions to the required processes: ○ The 'Uber Medics Guide' requires that an individual staff risk assessment must be completed prior to travelling via Uber, and the outcome must show that it is appropriate for those individuals to work in the office or in the community. For a sample of ten journeys, we identified that no risk assessments had been completed. ○ There were no records to demonstrate the Uber nomination form had been completed and saved centrally. ○ The Uber for Business document during the pandemic stated that 'whilst on council business, you should avoid using public transport, including commuting to and from the office, then you may use the Uber Business Account and Southwark Council will cover the cost.' We identified Uber journeys that had not been completed for business use. ○ Monthly random sample checks had not been completed by management to verify that Uber journeys made by staff were appropriate.

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	H	M	L	Design	Operational Effectiveness	
General Ledger	-	2	1	Moderate	Moderate	Purpose: To provide assurance over the adequacy of the control framework relating to the general ledger, including cost centre management, control account reconciliations, journal transfers and budget virements. Key findings: • The Corporate Suspense and Account Reconciliation procedure and the procedures relating to reconciliation protocols were not up to date for the current period. The policies and procedures relating to cost centre creation and journal protocol were not provided during the fieldwork, therefore we could not assess the adequacy of these procedures. • We selected a sample of 20 budgets to assess whether each virement was supported by adequate documentation and was approved appropriately. We identified in six cases that these were not evidenced as approved, therefore we could not assess whether these were approved appropriately.
Hospitality and Gifts Register, Register of Interests *Draft Report*	-	4	1	Moderate	Moderate	Purpose: to provide assurance on the Council's arrangements for managing the declaration of gifts and hospitality and declarations of interest. The review will focus on staff members and other officers as categorised within the Council's policies. Key findings: • From our interviews the following concerns were raised: ○ We identified that there was a lack of awareness of training on declarations of gifts and hospitality or whether this was part of the induction process. From reviewing the Council's intranet page there is not an option in relation to training, only the available policy and procedure documentation.

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	H	M	L	Design	Operational Effectiveness	
						○ Staff were unable to review the original declaration form before signing off to ensure whether no changes meant a previous declaration had not been changed, or there was nothing to declare. ○ One manager advised that there was a new starter after the April 2022 submission date and therefore, was not captured within the annual declaration process. The manager advised there was a lack of clarity over when they were required to declare an interest. From reviewing the policy, the declaration must be declared by April the following year, however if the officer meets the definition, they must declare whether there are any interests. Best practice would be that in the event of staff changing that a declaration should be completed within 21 days to ensure there are no conflicts. ○ Not all relevant staff are completing DOIs including social workers and agency workers. From reviewing the definition of staff required to complete the declaration, these officers do not meet this definition, however they arrange placements on behalf of the Council, and this is susceptible to fraud. • The gifts and hospitality and DOI policy documents do not record details of the review date and reviewing body, therefore we could not confirm whether these were up-to-date. However, based on our testing it appeared the policies were up-to-date based on our testing and walkthroughs. • We selected a sample of gifts and hospitality records to assess whether each case has been centrally recorded and found that there is not a consistent approach to recording gifts under the policy. Only one department sampled, environment and leisure, utilised a log as a method of recording these, including those that do not breach the threshold. It was noted the policy and guidance documentation does not specify a log should be used or a template provided.

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	H	M	L	Design	Operational Effectiveness	
						• Managers advised they had issues surrounding understanding how best to dispose of unwanted gifts that had been correctly declared. • The Council does not have any monitoring in place, and no annual or interim reports are run or presented at CGP for us to review.
Housing Rents *Draft Report*	-	5	3	Moderate	Moderate	Purpose: To provide continuing assurance on the adequacy of the design and operational effectiveness of internal controls in place to accurately collect and allocate housing rental income. We also undertook a follow-up of the two medium recommendations made in our 2019-20 audit of Housing Rents. Key findings: • We tested a sample of ten former tenant arrears to assess whether adequate and timely recovery actions were taken. In three cases, action was not timely and reasons for this were not documented in the tenant's file. While all write offs reviewed were actioned per procedure, there were significant delays before former tenant arrears cases were referred for write off (gaps of two to three years between the reason for the write off and referral for write off). • We tested a sample of 15 current tenant arrears to assess whether adequate and timely recovery actions were taken. We found that in three cases, the arrears were not followed up, actioned, and monitored in a timely manner. • We tested a sample of 15 new rent accounts created between April 2022 and February 2023 and found that no tenancy agreement was retained on the system in three cases. • From our review of a sample of ten employee users with the ability to make amendments to rent accounts on Northgate, we found that three were no longer employed by the Council. One user had left in the past year (2022-23), we could not confirm when the remaining two had left (over a year ago). Access was granted

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						by a manager for one employee, as per procedure. For seven employees, manager approval emails could not be traced. Access per job role was inappropriate for two users. • The documented procedures for rent refunds, income, and arrears (both former and current tenants) and write offs were out of date and/or not regularly reviewed. • From our review of all five property deletions since 1 April 2022 we found that appropriate approval could not be evidenced for three properties. • We tested a sample of 15 actions on Rent Analytics in February 2023 and found that six actions were assigned after more than two weeks (15-32 days), and the reason for this was unclear. Of the eight cases requiring escalation, one was escalated late, and another was escalated, however this had not been recorded on the system.
IT – Applications Management *Draft Report*	-	5	3	Moderate	Moderate	Purpose: To provide assurance on the design and effectiveness of the controls in place for software applications and to highlight any areas where the controls require improvement. Key findings: • The Council has formulated a Cloud Strategy which aligns to the existing Technology & Digital Inclusion Strategy 2022-2025. However, the Cloud Strategy has yet to be finalised and approved by senior management, although we understand that the Council's overall 'cloud first' approach is endorsed. Furthermore, the Council's Cyber Security Policy is not explicit in documenting how controls over cloud infrastructure and applications will be implemented across the Council, or where responsibilities for these controls lie. • The Council has deployed the Azure Secure Score system to monitor the security configuration of its cloud infrastructure, however there was no evidence that the

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	H	M	L	Design	Operational Effectiveness	
						current score and improvement recommendations from the system are regularly monitored. We found that the OMG meetings between STS and constituent boroughs have been used to monitor the Council's cyber security posture and potential improvement work required, however this has not been present on OMG reports since the April 2023 meeting. • A spreadsheet is in place for Council services to complete when procuring applications which are deployed through Software as a Service (SaaS), assessing the security and suitability of the potential system and its supplier. However, our conversations with staff during testing identified instances where these checks have not been completed consistently by service areas and SaaS applications have been procured without reference to the ICT team during the process. • Our review of a sample of two cloud migration projects identified that the objectives of one project had not been defined at the time of testing. Furthermore, business cases and project plans for each had not yet been approved by senior or programme management. The Cloud Phase 2 / Infrastructure Improvements project was found to be progressing as a critical project, although was only supported by a high-level option analysis and recommendation document. We understand that a more comprehensive business case was being formulated at the time of testing. • The most recent OMG meeting reports highlighted that the Council's Azure VMs are not currently backed up, as these are awaiting migration to the Nutanix platform. Furthermore, a recently completed exercise identified multiple vulnerabilities with the Council's VM infrastructure, where 13 VMs and 11 SQL servers were not being backed up at the time of testing. This control weakness is compounded by the absence of planned disaster recovery testing for cloud-based infrastructure. OMG meeting reports had previously included an item to plan this testing, although we found that this had not been included in the most recent

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	H	M	L	Design	Operational Effectiveness	
						reports. • At the time of testing, we found that there was no central monitoring of cloud-migrated applications in relation to their security and performance. System administrators and service areas hold responsibility for conducting regular reviews of applications within their remit, however there was no evidence that information is collated and analysed centrally to identify potential performance issues or non-compliance with the Council's security configurations and policies.
IT - Cloud Computing *Draft Report*				Moderate	Moderate	Purpose: To provide assurance that the migration of services away from on-premise to cloud-based hosting has delivered its objectives and that there are appropriate arrangements in place for monitoring cloud service providers and the cloud service itself to ensure satisfactory data security. This review has also considered the back-up arrangements for cloud data. Key findings: • The Council has formulated a Cloud Strategy which aligns to the existing Technology & Digital Inclusion Strategy 2022-2025. However, the Cloud Strategy has yet to be finalised and approved by senior management, although we understand that the Council's overall 'cloud first' approach is endorsed. Furthermore, the Council's Cyber Security Policy is not explicit in documenting how controls over cloud infrastructure and applications will be implemented across the Council, or where responsibilities for these controls lie. • The Council has deployed the Azure Secure Score system to monitor the security configuration of its cloud infrastructure, however there was no evidence that the current score and improvement recommendations from the system are regularly monitored. We found that the OMG meetings between STS and constituent boroughs have been used to monitor the Council's cyber security posture and potential improvement work required, however this has not been

Report issued	Number of recommendations			Internal Audit Assurance Opinions		Purpose of Audit and Key Findings
	H	M	L	Design	Operational Effectiveness	
						present on OMG reports since the April 2023 meeting. • A spreadsheet is in place for Council services to complete when procuring applications which are deployed through Software as a Service (SaaS), assessing the security and suitability of the potential system and its supplier. However, our conversations with staff during testing identified instances where these checks have not been completed consistently by service areas and SaaS applications have been procured without reference to the ICT team during the process. • Our review of a sample of two cloud migration projects identified that the objectives of one project had not been defined at the time of testing. Furthermore, business cases and project plans for each had not yet been approved by senior or programme management. The Cloud Phase 2 / Infrastructure Improvements project was found to be progressing as a critical project, although was only supported by a high-level option analysis and recommendation document. We understand that a more comprehensive business case was being formulated at the time of testing. • The most recent OMG meeting reports highlighted that the Council's Azure VMs are not currently backed up, as these are awaiting migration to the Nutanix platform. Furthermore, a recently completed exercise identified multiple vulnerabilities with the Council's VM infrastructure, where 13 VMs and 11 SQL servers were not being backed up at the time of testing. This control weakness is compounded by the absence of planned disaster recovery testing for cloud-based infrastructure. OMG meeting reports had previously included an item to plan this testing, although we found that this had not been included in the most recent reports. • At the time of testing, we found that there was no central monitoring of cloud-migrated applications in relation to their security and performance. System

Report issued	Number of recommendations			Internal Audit Assurance Opinions		Purpose of Audit and Key Findings
	H	M	L	Design	Operational Effectiveness	
						administrators and service areas hold responsibility for conducting regular reviews of applications within their remit, however there was no evidence that information is collated and analysed centrally to identify potential performance issues or non-compliance with the Council's security configurations and policies.
IT - Software licence management	-	5	-	Limited	Limited	Purpose: To provide assurance on the design and effectiveness of the controls in place around software licensing and to highlight any areas where the controls might be improved. Key findings: • There was an absence of key policy documentation in place to govern software licensing management activities, both from an ICT Service and end user perspective. Attempts have been made to introduce such policies, although these remained in draft and were incomplete at the time of our testing. • Staff interviewed were knowledgeable about each of the software applications and the processes involved in managing these. However, these processes were not documented in procedural guidance for staff to follow. This results in a level of inconsistency in how different applications are managed, information is recorded, and software utilisation is monitored. Furthermore, a lack of documented processes impacts business continuity and succession planning if staff leave, move departments or are absent for prolonged periods. • Manual records are currently kept for software licence information at the Council and within STS. There were multiple gaps in key data within the Council's corporate applications register, particularly in relation to system support, licence types, system criticality, renewal dates, and licence utilisation. For example, there were no start and end dates documented for any of the licenses. The register held by STS contained some of this data, although was manually populated and updated.

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						• There was an overall lack of monitoring in place over software licence data, utilisation, and compliance with conditions. An Operational Management Group (OMG) meeting does scrutinise (in)active user accounts, which informs Microsoft 365 licence numbers, and upcoming renewals of software are kept under review. However, the reliance on manually updated information by both parties reduces monitoring capabilities. Gaps in data within the Council's corporate applications register also prevent clear oversight of software licensing activities and compliance. • The use of manually input spreadsheets has contributed to a lack of robust data on licenses and subject to improving the controls around the completeness and accuracy of date, best practice would be to move to an automated licensing tracking system.
Markets	-	3	-	Moderate	Moderate	Purpose: To review the adequacy of the design and effectiveness of the Council's governance arrangements and key operational and financial controls in place relating to markets. Key findings: • The Council's Markets Policy does not detail the application requirements for permanent and temporary traders and operators. • We reviewed a sample of 10 temporary and permanent traders and identified that in one case, a temporary permit was provided to the trader, although there was insufficient evidence of proof of address. In another instance, the permanent trader continued to trade although the trading licence was not renewed. • The Markets Team referred two out of 15 debtor accounts to the Credit Control Team for further escalation, however this was not actioned. Hence, the outstanding balances were not recovered.

Report issued	Number of recommendations			Internal Audit Assurance Opinions		Purpose of Audit and Key Findings
	H	M	L	Design	Operational Effectiveness	
Member / Officer Protocol	1	3	-	Moderate	Limited	Purpose: To provide assurance that the member/officer protocol reflects good practice and that it is being operated in practice and cases where it is not working effectively are identified and addressed. Key findings: • The Council's Member and Officer Protocol has not been reviewed since February 2020. • From a review of the Council's training records, less than 50% of Senior Officers have completed mandatory training on Safeguarding, Data Protection, Corporate Induction, Unconscious Bias, and Southwark Ways of Working. • We were informed that attendance for the Members' training programme is recorded but we were not provided with any evidence of this. • We were not provided with the procedure on how to deal with Member enquiries, such as the review process for cases, case allocation, which service departments are involved when responding to enquiries and what methods are appropriate when communicating with customers. From a survey completed by a sample of five Members and five Officers, we found that the Members were not satisfied with the quality of responses and Officers felt they did not receive sufficient training to provide accurate responses and deal with the Members requests.
Mental Health Services	2	2	-	Moderate	Limited	Purpose: To review the controls in relation to the governance, approvals, records maintained and monitoring of care packages and funding relating to the clients receiving the Council's mental health services by the Care & Support Team (CAST). Key findings: • There was no evidence of an annual finance assessment for 7 out of 11 clients required to pay for care and the reason one client did not pay for care was not

Report issued	Number of recommendations			Internal Audit Assurance Opinions		Purpose of Audit and Key Findings
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						recorded. • An annual review of the care and support plan had not been completed for two clients. • Following a change in the care and support plan personal budgets had not been updated in a timely manner for four out of ten cases tested. • In nine out of ten cases tested where personal care packages had been completed there had not been a review of expenditure to confirm whether there was a surplus of funds that needed to be repaid and that funds had been spent appropriately. A large backlog of expenditure returns dating back to 2016 have not been examined.
Mosaic *Draft Report*	-	3	1	Moderate	Moderate	Purpose: To provide assurance over the arrangements for recording, approving, and processing social care packages within Mosaic, such that only valid and accurate amounts are generated for processing and payment. Key findings: • We reviewed a sample of 10 residential nursing supported living payments and identified that in five cases, an annual review was not completed within 28 days of the referral. The timeframes for the completion of the annual reviews ranged from 52 to 125 days. • The Mosaic listing of authorisers included two users who were not located on the Children's and Adults Services (CAS) Scheme of Management. We were advised that the staff members were allocated incorrect access permissions, as they were allocated Children's Services authoriser roles (relating to Children's and Families division), however this is not appropriate to their role. • The rate for one out of 10 residential nursing supported living payments was applied incorrectly. We identified that the backdated payment rate should have

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						been £1,576.87, however this was set at £1,734.98. Consequently, we identified through this audit that this generated an overpayment of £8,489.57. • We reviewed 23 procedure documents and identified that four were not reviewed in line with the review date outlined. We found that a monitoring mechanism is not in place to ensure procedure documents are in line with current processes followed. • BUPA Overpayments Review 2020-21 - we conducted a follow up of the recommendations raised as part the BUPA Overpayments review conducted in 2020-21. We confirmed the implementation of 18 out of 31 recommendations through a review of evidence and four were closed as the Council accepted the risk for not completing the recommendation. However, we identified that the implementation of nine recommendation remained outstanding at the time of the audit fieldwork, which had passed their proposed implementation date.
New Homes Programme	-	1	1	Substantial	Moderate	Purpose: To provide assurance on the project management of the New Homes Programme including procurement, contract management and programme governance with regards to the areas of significant expenditure and priority for the Council. Key findings: • Section 9.2 of the Council's Contract Standing Orders (CSOs) states where the estimated contract value exceeds the relevant EU threshold the lead contract officer should prepare an annual monitoring report to the relevant Departmental Contract Review board (DCRB). • The EU Works threshold is £5,336,937. Wee identified three contracts from our sample of five that exceeded the threshold and our discussions with officers confirmed they had not prepared an annual monitoring report.

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						• The Delivery Programme Board terms of reference states the Board will meet as required, at least every two months. Our review of Board documentation for 2022-23 confirmed there was no meeting between 08/03/2022 to 12/06/2022, and 08/11/2022 to 09/05/2023. Officers stated this was because there were no reports for them to review due to the phasing of the projects.
No Recourse to Public Funds	-	3	-	Moderate	Limited	Purpose: To review the adequacy of the Council's key operational and financial controls in place relating to NRPF. Key findings: • Eligibility criteria: – we tested to verify that appropriate supporting documentation had been obtained to confirm eligibility criteria was met: - For one sample item there was no evidence the service user was given an appointment letter. - For five sample items there was no evidence officers completed financial background checks using a 360 Online check. - For one sample item, the background check was completed using an incorrect name because the applicant was falsely using the name of her sister. No further 360 Online check was completed. • Accommodation process: our testing found eight payments from a sample of 15 that did not match the approved amounts recorded on the Master Case List. These accommodation payments had been increased but the Council records had not been updated. • Subsistence process: – in two cases from a sample of 15 there was no evidence of manager approval, which meant we were also unable to confirm a separation of duties between the decision maker (to award subsistence) and approver. • Case reviews: – we conducted testing to confirm case reviews are completed

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						every six months: - Four case reviews were due but had not been completed. - Case reviews were completed late for a further seven ranging from one month to eight months. • Our sample testing of five care payments for 2022-23 found that none of the payments matched the amounts the Social Worker recommended be paid and were all higher. This is due to officers using a calculator which has not been updated to show the correct care rates. • We asked for the three most recent monitoring reports presented to senior management to assess whether performance was sufficiently detailed, periodically presented and contained actions to address issues. Officers advised that performance monitoring meetings did not take place in October 2022, February 2023, and March 2023. Officers provided reports for September 2022, November 2022, December 2022, and January 2023. Our analysis of the reports showed NRPF performance information was also not updated during this time (September 2022 to March 2023).
Overtime	-	3	-	N/A Advisory Review	N/A Advisory Review	Purpose: to review the adequacy of the Council's arrangements and key operational and financial controls in place relating to overtime payments. Key findings: • There are inadequate policies and procedure documents that govern the processes in relation to overtime payments therefore insufficient guidance is in place for employees and managers especially on the timeliness of inputting claims. The Remuneration policy does not have a next review date and information on who reviewed and approved the document.

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						• Whilst the year-to-date overtime data was being presented to the Strategic Director of Finance and Governance, the data is not analysed for trends. Monitoring and reporting on overtime is also not completed at a departmental level to help identify the root cause of the high overtime figures. The overtime data is not complete, with some employees not having details on their department and team input which would skew the results of any data analysis performed. • The [now] Housing Directorate has identified that their high overtime payments are an issue that needs to be tackled and are working towards this, but HR could provide additional support with this process and ensure the department are involved in future trade union discussions to ensure the Trade and Craft Terms and Conditions are revised to provide a fair policy that is beneficial to both the Council and the technicians.
Parking Management and Estates Parking Permits *Draft Report*	3	2	-	Limited	Limited	Purpose: To review the adequacy of the Council's governance arrangements and key operational and financial controls in place relating to parking management and estates parking permits. Key findings: • Organisational structure, roles, and responsibilities: Our initial enquiries identified that the Parking services' roles, responsibilities and accountabilities, the governance framework, and key financial and operational controls for on-street and estates parking were not clear, integrated or joined up. An organisational structure chart of the Parking services governance, and key financial and operational arrangements in place was created during the audit, with several noted issues requiring resolution. • Policies and procedures: Parking management and estates parking permits policies and procedures supporting the Council's Movement (Transport) Plan 2019 – 2041 were not readily available. A folder of the policies and procedures was created

Report issued	Number of recommendations			Internal Audit Assurance Opinions		Purpose of Audit and Key Findings
	H	M	L	Design	Operational Effectiveness	
						during the audit. • Fees and Charges: Not all the fees and charges approved by Cabinet for the financial year 2022-23 were updated on the Council's website in a timely manner. The fees and charges for estates parking permits 2023-24 that came into effect on 1 April 2023 were updated late on the Council's website on 12 April 2023. • Applications for new and renewed estates parking permits: Our review of a sample of estates parking permits identified two out of five resident permits did not have appropriate supporting proofs of residence and vehicle ownership. Three out of five carers' permits granted did not have appropriate supporting medical evidence. All five visitor permits sampled had no evidence of validation checks. Three of five refunds given did not state the reason the refund was given. • Payments received: There is a lack of clarity regarding income budget monitoring as part of the general Parking service management monitoring and review. • Debt management: The nature and make-up of aged, bad, and uncollectable parking debts for the financial years 2019-20, 2020-21, 2021-22 and 2022-23 could not be provided. Information regarding investigation of debt (warrants) for recovery by the Parking Service's enforcement agents and appropriate follow up of untraceable vehicles could not be provided.
Payroll and HR	-	3	2	Moderate	Moderate	Purpose: To provide continuing assurance on the adequacy of the design and operational effectiveness of internal controls in place to manage the identified risks in respect of payroll and HR. Key findings: • Due to the merger of the payroll function with HR, we identified during the walk-through of the SAP systems that the final payroll run for April 2023 was not approved by a separate reviewing officer before being posted.

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	H	M	L	Design	Operational Effectiveness	
						• From testing a sample of five overpayments since 1 April 2022, we found that recovery action was inconsistent and recovery action timeframes in three cases were insufficient. In addition, the high priority recommendations from the KFC05 Payroll and HR audit 2021/22 had not been fully implemented and have been rolled over into the 2022/23 recommendations to ensure they are addressed. • Initial data analytics we completed on the payroll standing data identified a total of 196 employees (98 pairs) with duplicate bank details, despite them being unrelated and living at different addresses. Subsequent investigation found that the report produced had overwritten bank details for employee's job sharing. This has raised the issue of a lack of review of potential duplications in the payroll data.
Pensions Administration	-	2	-	Moderate	Moderate	Purpose: to provide assurance over the management of the pension fund and controls on flow of monies around the system including the bank account. We also provided assurance over the data security and interfaces used by the new pensions admin and payroll system. Key findings: • We were provided with the UPM User List as at December 2022 which confirmed a total of 196 user accounts; we were also provided with the Citrix User list as at December 2022 which set out a total of 39 users. We reconciled the two User Lists and noted 19 users who were disabled within Citrix but were still on the UPM User List. • We performed a reconciliation between the previous system and the new system using National Insurance (NI) number. We were only able to identify 7,620 matches between both datasets following data being cleansed from the previous system, with the discrepancy of 21 staff being due to the fact they joined the Council after the implementation of UPM. We also performed data analytics on

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						the UPM data and noted: five instances where the National Insurance Number was not valid, eight employees which had duplicate entries, and nine employees who had duplicate entries with the same bank account number and sort code. This will be provided to management under separate cover for their investigation.
Private Sector Licensing *Draft Report*	1	2	1	N/A Advisory Review	N/A Advisory Review	Purpose: To assess the robustness of the key processes and controls in place for the pilot scheme around governance, projected income/saving plans, the application process, income collection and debt recovery, with a view of improving the permanent controls being in place if the scheme continues. Areas to improve: • The Licensing Team had not navigated an effective method to process the invoices with the required notices attached to the applicants This was due to a lack of administrative support within the team to process invoice requests per the Council's FC&P Team's guidance. The Licensing Team also did not have a point of contact in the FC&P Team to discuss issues they were facing with the invoice request process such as sending statutory notices with the invoices and providing all the required information to set the applicant up as a vendor on the finance system to process the invoice. Due to this, the Licensing Team had not issued any invoices to any of the applicants that wanted to pay offline, therefore in December 2022, there was a backlog of over 400 invoices and licenses not issued, which held back an income of over £500,000. The invoicing issues have also led to a backlog of refunds that have not been processed for applications that were raised through the old system. • Reconciliations between the Finance system, SAP, and the applications system, Metastreet, cannot be completed. The team are working with Metastreet and SAP to identify a common reference for both platforms. Assurance that income is as expected is obtained by matching the overall income on SAP with the total fees from applications on Metastreet, however a line-by-line reconciliation is not

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						possible. • The Licensing Process document was last updated in April 2022; however, it is not clear who prepared, reviewed, and approved the document. One of the procedure documents (Joint Licence holders) received was blank. Some of the procedures were signed off by the Head of Regulatory services. However, we noted that there is no consistency in the presentation of the procedures. The procedures have not been developed for debt management and processing write-offs. • We have confirmed that there have been no arrears since the start of the new scheme. Therefore, no write-offs have been required or an aged debtor analysis completed. However, no procedure documents have been developed to deal with future incidents. The Team still do not have clarity on their debt management responsibilities which they will work with the Council's Finance team to establish.
Public Health - Tobacco Control	-	1	2	Moderate	Moderate	Purpose: To provide assurance that the Council has adequate and effective controls in place to help mitigate the risk that Southwark will not be smoke-free by 2030. We used the Tobacco Control Plan for England, the Khan Review, NICE Guidelines, and the CLeaR self-assessment tool to guide our testing. Key findings: • Further analysis of the latest Census 2021, Annual Population Survey and Stop Smoking Service data is required to shape initiatives to engage hard-to-reach groups. • The CLeaR self-assessment tool provides Local Authorities with an evidence-based approach to measure success of local action to address smoking. At the request of the Public Health team, we evaluated how the Council is meeting sections 14.1-14.3, 15.1-15.4 and 15.6. We concluded that the Council met the requirements for three out of eight questions, and the remainder are a work in progress.

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						• Roles and responsibilities relating to tobacco control in the Public Health Division and more widely (across the Council and its partners), and how these link together, are not yet clearly defined in strategies, policies, and procedures.
Safeguarding – Adults	-	2	-	Moderate	Moderate	Purpose: To review the processes and controls in place to ensure that adults within the Council's care are properly safeguarded and statutory requirements are met. Key findings: • For our sample of 20 safeguarding referrals, we found one case where the initial assessment was signed off before the document was completed meaning it was not clear whether the approval was based on the full assessment. For a second case, the assessment was not fully detailed meaning the full nature of the safeguarding concern was not fully documented. • The Performance and Quality team carry out general audits monthly and select a sample of cases to confirm processes are being followed. However, this is not specifically targeted at Safeguarding.
SEND Finance	4	3	-	Moderate	Limited	Purpose: To provide assurance on the adequacy and effectiveness of controls in place within the SEND Finance Team with regards to the process of agreeing placement costs and making payments. Key findings: • Following approval of the EHC Plan, proposed placement and cost by the SEND Panel, a Costing Form is prepared by the SEND Team detailing the placement and cost which is authorised by a SEND Team Manager before being sent to the SEND Finance Team for inputting details onto a spreadsheet to make payments to placement providers. For a sample of 16 children with SEND, one Costing Form was not authorised by the SEND Team Manager. In another two cases, the Costing Forms were authorised after the placement start date.

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	H	M	L	Design	Operational Effectiveness	
						• For a sample of 15 payments made from April 2022 to March 2023, we were unable to confirm that the payments were accurate as we were unable to reconcile the amount recorded on the invoice to the amount due as per the authorised costing form. Seven invoices were not paid within 30 days of the invoice. Payments were made after 6 weeks to 4 months of the invoice date. • An internal deadline has been set by Corporate Finance for accruals to be raised by 17 April 2023 to meet the 21 April 2023 deadline for all revenue to be determined. As of 24 April 2023, the accruals for 2022/23 had not been raised, a Corporate Finance process commenced in the absence of the Business Manager and a total of £5,270,574 accruals had been identified as of 24 April 2023 with the process still yet to be complete. • Whilst the spreadsheet maintained by the SEND Finance Team records details of identified funding for each child, it does not record payments. Both the SEND Finance Team and the SEND Team currently maintain separate records of payments. Records of payments made are available from SAP. However, from our sample testing, it was difficult for us to reconcile the payment on SAP to the child's record on the spreadsheet. This was in the main due to the payment reference number used by the Business and Finance Manager not being the same as the student ID number generated from Capita for each child. • The Business and Finance Manager stated that a check is completed on a weekly basis between data on the spreadsheet to data maintained by SEND Team on Capita. The check is done manually, and any discrepancies are investigated/queried with the SEND Team. We were unable to confirm this weekly check being undertaken as no evidence is maintained. • We undertook a follow-up of two actions from the Education Budget Review undertaken by RSM for which a final report was issued in February 2020. Neither of the recommendations had been implemented.

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Special Educational Needs (SEN)	1	-	2	Moderate	Moderate	Purpose: To review the processes and controls in place to effectively support the quality of data used to inform decision making in relation to SEN EHC applications Key findings: • The SEN team have protocols to track each stage of the SEN process as part of the Council's monitoring and reporting process to ensure they are processed within the 20-week prescribed completion target. • From a sample of 10 EHC applications, eight applications were not completed within the 20-week timeframe. The Council's average over the five-month period January to May 2022 of meeting the target was 25%. We acknowledge that the NHS-wide cyber-attack on the care notes system has affected the ability to retrieve patient records. There has also been an increase in the volume of requests post Covid for all agencies. These factors have delayed the timely completion of multi-agency assessments nationally this year. • For the latest annual national published data set (SEND2) Southwark was in line with London and National averages. The current year data will be collected nationally in January 2023 and will be available for comparison in May 2023. The national average in the period reporting year was 60%.
Supplier Resilience	2	5	1	Limited	Limited	Purpose: To provide assurance on the controls in place to adequately monitor the financial and operational stability of its key third party suppliers and service providers. The audit was also to confirm there are adequate contingency plans in the event of supplier/service provider failure. The audit excluded care service providers as this will be included in a future commissioning audit in 2023-24 (but notes that these should still be included on the Contracts Register). Key findings: • During the audit we established there is a lack of strategic oversight of contract

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						management. The Council does not: - Have a centralised contract management function. - Keep a list of contracts it feels are the most critical, which should be scrutinised further. The Council does define contracts as either Operational or Strategic but does not maintain a list of either, although Contract Standing Orders require that Lead Contract Officers (LCOs) or their Chief Officers maintain all contracts over £5k in value on the Council's Contract Register. - Centrally perform ongoing creditor checks of key suppliers. - Provide regular training to contract managers about how to consistently monitor supplier resilience. • We tested a sample of ten contracts from the contracts register including the five highest value contracts (excluding Residential Care as this will be covered by a future audit) and a random sample of five further contracts. For four contracts we were not provided with full supporting evidence. • Our testing to ensure the contract managers had obtained operational and financial security during the procurement process found eight had conducted the appropriate checks and retained evidence. • We further tested to ensure contract managers had obtained and reviewed supplier's business continuity plans (BCP) and found inconsistent practices and in one case no BCP. • We also assessed contract monitoring / review arrangements to verify they were in line with the contract and ongoing. We found inconsistent practice and no regular monitoring in three cases. • We tested to confirm key performance indicators (KPI's) are established and

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						regularly monitored. We found inconsistent practices and in four cases no evidence that KPIs had been established was evident. • We further examined whether annual performance reporting was in line with the contract management toolkit and found one case where performance reporting was last completed 18 months ago and in another case no performance reporting had been completed. • We assessed the Council's arrangements against the five elements of the Governments supply chain framework, which is designed to be an aide for those looking to mitigate supply side risks in their supply chains and to support greater long-term resilience: Diversification, International Partnerships, Stockpiling, and surge capacity, Onshoring and Demand management. We found the Council only considers diversification as part of its toolkit. • We evaluated the risk management arrangements and our testing showed that four of the strategic contracts did not have a supplier specific risk register and none were detailed on the departmental risk register, which acts as a compensating control if there are no supplier risk registers in place. • We examined departmental business continuity arrangements and found that in four cases the contracts were not listed or no BCP was in place.
TMOs – Applegarth	-	3	1	Moderate	Moderate	Purpose: to provide assurance over the adequacy of the design of the controls and operational effectiveness relating to the TMO's operational and financial processes, such as financial management, procurement, and statutory compliance, including health and safety, fire risk assessment and asbestos. Key findings: • Invoices for purchases at the TMO were not signed by the treasurer as per the requirements of the Finance Policy.

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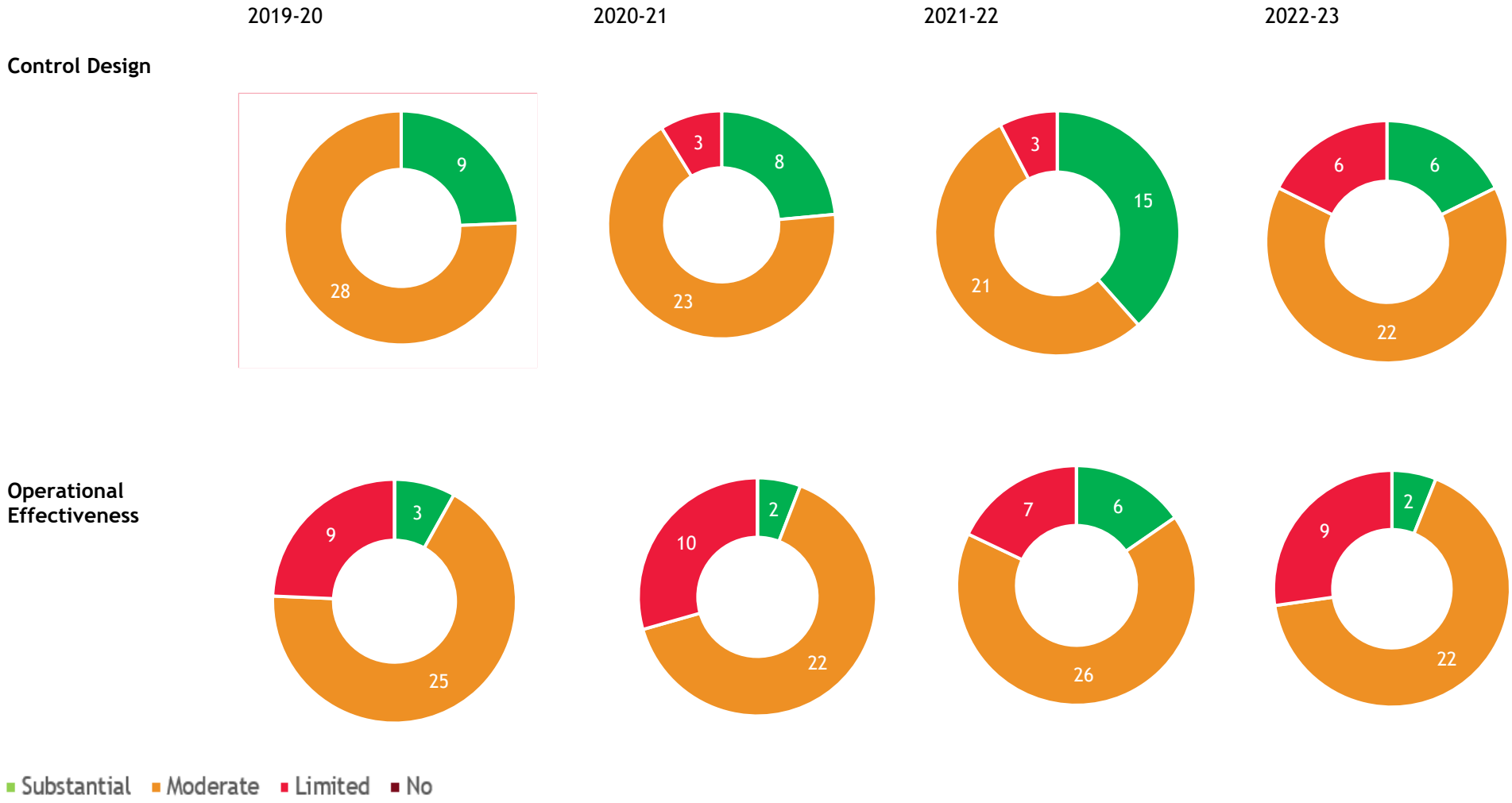
						• While the TMO review the performance figures where the budget is monitored monthly, comparing expenditure for cost centres against the agreed budget, this information is not shared with the Management Committee for review and scrutiny. • While the TMO have a complaints policy, we found it was last reviewed in February 2020. Further, we found the TMO does not currently have a recruitment policy or disciplinary procedure document in place which is a requirement set out within the MMA. • There is a not a standalone term of reference in place for the Management Committee which outlines the roles and responsibilities of members, frequency of meetings and quorum requirements in one place which is reviewed annually to ensure it includes the most up-to-date information of the committee.
TMOs – Brenchley Gardens	7	2	2	Limited	Limited	Purpose: to provide assurance over the adequacy of the design of the controls and operational effectiveness relating to the TMO's operational and financial processes, such as financial management, procurement, and statutory compliance, including health and safety, fire risk assessment and asbestos. Key findings: • Annual gas servicing and the certificates had not completed and retained by the TMO as per the Gas Safety (Installation and Use) Regulations 1998. • Budget monitoring was not being completed monthly nor was it subject to Management Committee review. • We found that works orders and invoices were not raised and authorised in line with the MMA and financial procedures.

Report issued	Number of recommendations			Internal Audit Assurance Opinions		Purpose of Audit and Key Findings
	H	M	L	Design	Operational Effectiveness	
						• Correct follow up action for properties in arrears has not been undertaken, including sending letters to residents and implementing an action plan to address the arrears. • Pre-employment documentation were not retained by the TMO to evidence the validity and clearances have been completed and authorised. • A central log of work repairs at the TMO was not being maintained and therefore we were unable to confirm if a works order was raised, completed in a timely manner, and review the quality checks completed by the TMO. • Newly let properties did not have the required checks completed and sufficient documentation retained as set out within the MMA. • The monthly Management Committee meetings were not consistently minuted to show discussions and formal actions to take forward and to be followed up at subsequent meetings. • The TMO has an equal opportunity, staff appraisal, grievance and disciplinary policies and procedures, however these were not reviewed or approved in the last 12 months. • The TMO has a finance policy, however this was last reviewed in March 2020. • There is a not a standalone terms of reference in place for the Management Committee which outlines the roles and responsibilities of members, frequency of meetings and quorum requirements in one place which is reviewed annually to ensure it includes the most up-to-date information of the committee.

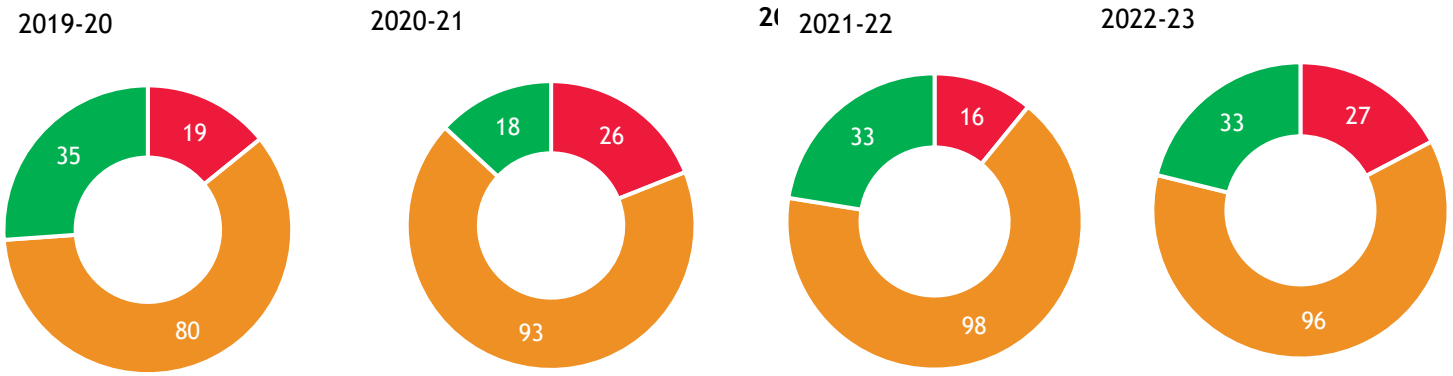
Report issued	Number of recommendations			Internal Audit Assurance Opinions		Purpose of Audit and Key Findings
	H	M	L	Design	Operational Effectiveness	
TMOs - Delawyk	-	-	1	Substantial	Substantial	Purpose: to provide assurance over the adequacy of the design of the controls and operational effectiveness relating to the TMO's operational and financial processes, such as financial management, procurement, and statutory compliance, including health and safety, fire risk assessment and asbestos. Key findings: • There is a not a standalone term of reference in place for the Management Committee which outlines the roles and responsibilities of members, frequency of meetings and quorum requirements in one place which is reviewed annually to ensure it includes the most up-to-date information of the committee.
TMOs - Use of Reserves & Surplus Funds	1	4	-	Moderate	Limited	Purpose: To provide assurance over the design and operational effectiveness of the controls relating to the cyclical maintenance allowances received for Major Works by the TMOs and the Reserve and Surplus Fund accounts being maintained and managed by the TMOs. Key findings: • Five TMOs have cyclical decoration funds (total value over £1m) presented on their financial statements (period ending 31 March 2021) and have been paid this allowance since their inception, despite these TMOs opting for Option A or B in relation to cyclical decoration responsibilities. In three of the five cases payments of the allowance have stopped. • Nine out of 16 TMOs did not have a separate Reserve and Surplus Fund reported on their balance sheet. The MMA requires the TMOs to report Reserve and Surplus Fund separately within the financial statements. • Kennington Park House Co-operative TMO does not have a minimum of 25% of the current financial year allowances maintained within the Reserve Fund. The allowance for the year 2020/21 was £64,804, meaning a minimum of £16,201

Report issued	Number of recommendations			Internal Audit Assurance Opinions		Purpose of Audit and Key Findings
	H	M	L	Design	Operational Effectiveness	
						should be held in the Reserve Fund per best practice. The TMO's Reserve Fund only had £5,691 as of 31 March 2021, which is only 8.8% of the current financial year allowance. • Applegarth TMC has an account titled 'Contractor's Fund' reported on their financial statements with a balance of £30,850. Per the accounts, the balance represents £10,000 received from Taylor Wimpey and a grant received from the Council, less clean greener expenditure. The TMO Manager explained that this account is used as the Reserves Fund, however, there is no specific Reserves Fund account on the TMO's financial statements per the requirements of the MMA. • Cooper Close Co-operative and Haddonhall Residents TMO do not present the Reserves Fund account on their financial statements, instead an accumulated surplus account is the deemed Reserves Fund on their financial statements. • Eight TMOs did not have a separate Surplus Fund presented on their financial statements per the requirement of their MMAs. • We compared the balances of Surplus Funds (for eight TMOs where a separate Surplus Fund was presented) as of 31 March 2021 with the previous year balances as of 31 March 2020. Five TMOs did not achieve the desirable efficiencies. • For Two Towers TMC, there is a deficit of £38,697 recorded as of 31 March 2021 within the Surplus Fund. We queried the negative balance on the Surplus Fund to assess if there is a strategy to address the shortfall. We noted that a documented plan is not in place and the TMO Manager advised that it is difficult to maintain balance within the Surplus Fund as payments are being made back to the Council in relation to external decoration responsibilities. • The audited financial statements for twelve out of 16 TMOs were not finalised within six months of the end of 2020/21 financial year (by 30 September 2021) per the requirement of the MMA. The delays ranged from 3 to 132 working days.

YEAR ON YEARS SUMMARY OF ASSURANCE OPINIONS AND RECOMMENDATIONS



Recommendations



Recommendation Implementation Rate

The table below shows the percentage of recommendations implemented by the year end.

2022-23	92%
2021-22	87%
2020-21	79%
2019-20	88%
2018-19	88%

ADDED VALUE

RESPONSIVENESS TO EMERGING RISKS AND COLLABORATION

We have continued to be responsive, in particular completing unplanned grant certifications at short notice to meet the Council's submissions deadlines.

We work closely with External Audit where investigations are required, e.g. the Accounts Objections review.

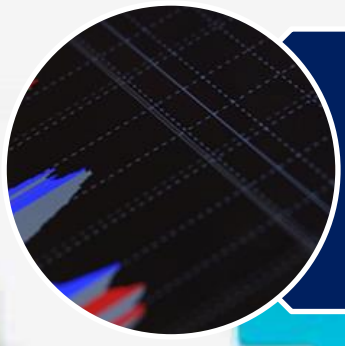
BENCHMARKING AND BEST PRACTICE

We have continued to add value in the majorty of our audits, agreeing the areas of focus as part of scoping meetings.

We undertook benchmarking to compare the Council's practices with other London boroughs.

We identified areas where the Council can improve performance and create efficiencies e.g. Children's Quality Assurance, Parking Management, SEND Finance.

Best practice comparisons were undertaken (e.g. Building Control, Supplier Resilience, Public Health - Tobacco Control.



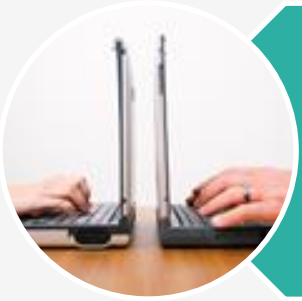
INNOVATION

We utilised data analytics in audits where appropriate (e.g. accounts payable, payroll, pensions). This has highlighted anomalies for the Council to investigate to improve its data and accuracy and completeness of transactions.

KEY RISK AND FINDINGS THEMES

PEOPLE, ROLES AND RESPONSIBILITIES

This year, we have found an absence of up to date policies and procedures in a number of areas, with roles and responsibilties not clearly defined. Training programmes have lapsed in some areas. There have been changes in senior management responsibilities and reliance on key individuals continues to be apparent as funding and resources tighten further. Succession plans are not always in place. E.g. Adult Learning Services, Children's Quality Assurance Unit, General Ledger, Markets.



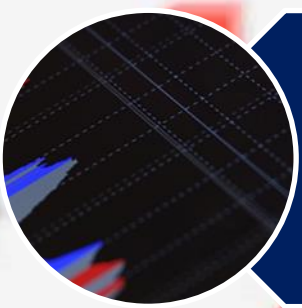
SYSTEMS & PROCESSES, TIMELINESS OF DECISIONS

We continued to identify non-compliance with policies and procedures, both corporate Council-wide and departmental or team specific. In addition, systems access is not being reviewed in key areas. Testing identified timeliness of decisons and completeness of processes to be of concern. E.g. Accounts Payable, Building Control, Cemeteries and Crematoria, Complaints, Housing Rents, Mental Health, NRPF, Parking, SEN.

DATA AND RECORDS, PUBLIC INFORMATION

Several audits identified anomalies with the data being maintained and recording of key information and evidence to support decisions. E.g. Building Control, Childrens Quality Assurance Unit, Software Management, Pensions, SEN.

In addition, the Council's web pages were found to be out of date in some areas. E.g. Community Engagement, Markets, Parking.



GOVERNANCE AND MONITORING / FOLLOW UP

Overall there are sound Governance and effective monitoring arrangements in place across the Council. However the frameworks for areas such as Contract and Supplier Management, NRPF and TMOs could be strengthened. Business Continuity Plans were not in place for key contracts.

Recommendation implementation rates have improved.

BACKGROUND TO ANNUAL OPINION

Introduction

Our role as internal auditors to London Borough of Southwark is to provide the Audit, Governance and Standards Committee, and the Directors with an opinion on the adequacy and effectiveness of the internal control system to ensure the achievement of the organisation's objectives in the areas reviewed. Our approach, as set out in the firm's Internal Audit Manual, is to help the organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

Our internal audit work for the 12-month period from 1 April 2022 to 31 March 2023 was carried out in accordance with the internal audit plan approved by management and the Audit, Governance and Standards Committee, adjusted during the year for any emerging risk issues. The plan was based upon discussions held with management and was constructed in such a way as to gain a level of assurance on the main financial and management systems reviewed. There were no restrictions placed upon the scope of our audit and our work complied with Public Sector Internal Audit Standards.

The annual report from internal audit provides an overall opinion on the adequacy and effectiveness of the organisation's risk management, control, and governance processes, within the scope of work undertaken by our firm as outsourced providers of the internal audit service. It also summarises the activities of internal audit for the period.

Scope and Approach

Audit Approach

We have reviewed the control policies and procedures employed by London Borough of Southwark to manage risks in business areas identified by management set out in the 2022-23 Internal Audit Annual Plan approved by the Audit, Governance and Standards Committee. This report is made solely in relation to those business areas and risks reviewed in the year and does not relate to any of the other operations of the organisation. Our approach complies with best professional practice, in particular, Public Sector Internal Audit Standards, the Chartered Institute of Internal Auditors' Position Statement on Risk Based Internal Auditing.

We discharge our role, as detailed within the audit planning documents agreed with London Borough of Southwark management for each review, by:

- Considering the risks that have been identified by management as being associated with the processes under review.
- Reviewing the written policies and procedures and holding discussions with management to identify process controls.
- Evaluating the risk management activities and controls established by management to address the risks it is seeking to manage.
- Performing walkthrough tests to determine whether the expected risk management activities and controls are in place.
- Performing compliance tests (where appropriate) to determine that the risk management activities and controls have operated as expected during the period.

The opinion provided on page five of this report is based on historical information and the projection of any information or conclusions contained in our opinion to any future periods is subject to the risk that changes may alter its validity.

Reporting Mechanisms and Practices

Our initial draft reports are sent to the key officer responsible for the area under review to gather management responses. In every instance there is an opportunity to discuss the draft report in detail. Therefore, any issues or concerns can be discussed with management before finalisation of the reports.

Our method of operating with the Audit, Governance and Standards Committee is to agree reports with management and then present and discuss the matters arising at the Audit, Governance and Standards Committee meetings.

Management actions on our recommendations

Management have generally been conscientious in reviewing and commenting on our reports. For the reports which have been finalised, management have responded positively. The responses indicate that appropriate steps to implement our recommendations are expected.

Recommendations follow-up

Implementation of recommendations is a key determinant of our annual opinion. If recommendations are not implemented in a timely manner, then weaknesses in control and governance frameworks will remain in place. Furthermore, an unwillingness or inability to implement recommendations reflects poorly on management's commitment to the maintenance of a robust control environment.

The implementation rate for previous recommendations is currently 91%. This rate is an improvement on the 87% in 2021-22.

Relationship with external audit

All our final reports are available to the external auditors through the Audit, Governance and Standards Committee papers and are available on request. Our files are also available to external audit should they wish to review working papers to place reliance on the work of internal audit.

Report by BDO LLP to London Borough of Southwark

As the internal auditors of London Borough of Southwark, we are required to provide the Audit, Governance and Standards Committee, and the Directors with an opinion on the adequacy and effectiveness of risk management, governance, and internal control processes, as well as arrangements to promote value for money.

In giving our opinion it should be noted that assurance can never be absolute. The internal audit service provides London Borough of Southwark with Moderate assurance that there are no major weaknesses in the internal control system for the areas reviewed in 2022-23. Therefore, the statement of assurance is not a guarantee that all aspects of the internal control system are adequate and effective. The statement of assurance should confirm that, based on the evidence of the audits conducted, there are no signs of material weaknesses in the framework of control.

In assessing the level of assurance to be given, we have taken into account:

- All internal audits undertaken by BDO LLP during 2022-23
- Any follow-up action taken in respect of audits from previous periods for these audit areas.
- Whether any significant recommendations have not been accepted by management and the consequent risks
- The effects of any significant changes in the organisation's objectives or systems
- Matters arising from previous internal audit reports to London borough of Southwark.
- Any limitations which may have been placed on the scope of internal audit – no restrictions were placed on our work.

KEY PERFORMANCE INDICATORS

Description / KPI for Internal Audit 2022-23	Actual and comment	RAG Rating
Audit Coverage		
Annual Audit Plan for 2022-23 delivered in line with timetable	All internal audit work agreed with senior management for completion during the year has been completed. Some audits as detailed in this report have been deferred to 2023-24.	
Actual days are in accordance with Annual Audit Plan - 1,030 days	We delivered 1,058 days of internal audit work the internal audit plan, the additional days related to work carried forward from 2021-22 and audits not in the original plan (e.g grant audits).	
Relationships and customer satisfaction		
Customer satisfaction reports - overall score at average of at least 3.5 / 5 for surveys issued at the end of each audit.	We have received five survey responses relating to 2022-23 audits, providing an overall rating of 5 (exceptional) in four cases and 4 out of 5 in one case.	
Annual survey to Audit, Governance and Standards Committee to achieve score of at least 70%.	A survey will be issued during the year.	-
External audit can rely on the work undertaken by internal audit (where planned)	We completed a review following an Accounts Objection, to the specification and satisfaction of the external auditors.	
Staffing		
At least 60% input from qualified staff	KPI has been met for the year.	
Audit Reporting		
Issuance of draft report within 3 weeks of fieldwork `closing' meeting	All draft reports issued to date were within 3 weeks of the closing meeting.	
Finalise internal audit report 1 week after management responses to report are received.	All final reports issued to date were within 1 week of receipt of the complete management responses.	
90% recommendations to be accepted by management	Recommendations are largely accepted by management following the closing meeting.	
Information is presented in the format requested by the customer	We have agreed the reporting format with the previous Strategic Director of Finance and Governance.	
Audit Quality		
High quality documents produced by the auditor that are clear and concise and contain all the information requested - measured within customer satisfaction surveys	We have received five survey responses as at the end of the year, four providing a rating of 5 and one providing a rating of 4 out of five with regards to the quality of our outputs.	

Positive result from any external review	In June 2021 an External Quality Assessment by the Institute of Internal Auditors reported that BDO LLP's Public Sector Internal Audit Team 'generally conforms' with the International Professional Practices Framework (IPPF) and the Public Sector Internal Audit Standards (PSIAS). This is the highest of the three ratings categories.	
Description / KPI for Council Management and Staff 2021-22	Actual and comment	RAG Rating
Response to terms of reference and reports		
Audit sponsor to respond to terms of reference within one week of receipt and to draft reports within three weeks of receipt	With minor exceptions (usually due to leave commitments), Council management have responded in a timely manner.	
Implementation of recommendations		
Audit sponsor to implement all audit recommendations within the agreed timeframe	At the end of the year 89% of recommendations due had been implemented.	
Co-operation with internal audit		
Internal audit to confirm to each meeting of the Audit, Governance and Standards Committee whether appropriate co-operation has been provided by management and staff: **a) providing unrestricted access to all the Council's records, property, and personnel relevant to the performance of engagements** **b) responding to internal audit requests and reports within the agreed timeframe and in a professional manner** **c) being open to internal audit about risks and issues within the organisation** **d) not requesting any service from internal audit that would impair its independence or objectivity.** **e) providing honest and constructive feedback on the performance of internal audit**	We can confirm that to date the Council's management and staff have overall cooperated as per the commitments a) to e).	

APPENDIX I

ANNUAL OPINION DEFINITION	
Substantial - Fully meets expectations	Our audit work provides assurance that the arrangements should deliver the objectives and risk management aims of the organisation in the areas under review. There is only a small risk of failure or non-compliance.
Moderate - Significantly meets expectations	Our audit work provides assurance that the arrangements should deliver the objectives and risk management aims of the organisation in the areas under review. There is some risk of failure or non-compliance.
Limited - Partly meets expectations	Our audit work provides assurance that the arrangements will deliver only some of the key objectives and risk management aims of the organisation in the areas under review. There is a significant risk of failure or non-compliance.
No - Does not meet expectations	Our audit work provides little assurance. The arrangements will not deliver the key objectives and risk management aims of the organisation in the areas under review. There is an almost certain risk of failure or non-compliance.

REPORT OPINION SIGNIFICANCE DEFINITION				
Level of Assurance	Design Opinion	Findings	Effectiveness Opinion	Findings
Substantial	Appropriate procedures and controls in place to mitigate the key risks.	There is a sound system of internal control designed to achieve system objectives.	No, or only minor, exceptions found in testing of the procedures and controls.	The controls that are in place are being consistently applied.
Moderate	In the main, there are appropriate procedures and controls in place to mitigate the key risks reviewed, albeit with some that are not fully effective.	Generally, a sound system of internal control designed to achieve system objectives with some exceptions.	A small number of exceptions found in testing of the procedures and controls.	Evidence of noncompliance with some controls that may put some of the system objectives at risk.
Limited	A number of significant gaps identified in the procedures and controls in key areas. Where practical, efforts should be made to address in-year.	System of internal controls is weakened with system objectives at risk of not being achieved.	A number of reoccurring exceptions found in testing of the procedures and controls. Where practical, efforts should be made to address in-year.	Non-compliance with key procedures and controls places the system objectives at risk.
No	For all risk areas there are significant gaps in the procedures and controls. Failure to address in-year affects the quality of the organisation's overall internal control framework.	Poor system of internal control.	Due to absence of effective controls and procedures, no reliance can be placed on their operation. Failure to address in-year affects the quality of the organisation's overall internal control framework.	Non-compliance and/or compliance with inadequate controls.

RECOMMENDATION SIGNIFICANCE DEFINITION	
High	A weakness where there is substantial risk of loss, fraud, impropriety, poor value for money, or failure to achieve organisational objectives. Such risk could lead to an adverse impact on the business. Remedial action must be taken urgently.
Medium	A weakness in control which, although not fundamental, relates to shortcomings which expose individual business systems to a less immediate level of threatening risk or poor value for money. Such a risk could impact on operational objectives and should be of concern to senior management and requires prompt specific action.
Low	Areas that individually have no significant impact, but where management would benefit from improved controls and/or have the opportunity to achieve greater effectiveness and/or efficiency.

FOR MORE INFORMATION:

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