NORWICH
City Council

Committee Name: Audit

Committee Date: 21/03/2023

Report title:	Internal Audit Progress Update 2022/23
Portfolio:	Cllr Paul Kendrick, Cabinet Member for Resources
Report from:	Head of Internal Audit - Norwich City Council
Wards:	All Wards

OPEN PUBLIC ITEM

Purpose

This report reviews the work performed by Internal Audit in delivering the Annual Internal Audit Plan for 2022/23.

Recommendation:

It is recommended that members review progress with delivery of the 2022/23 internal audit plan.

Policy Framework

The council has five corporate priorities, which are:

- People live independently and well in a diverse and safe city.
- Norwich is a sustainable and healthy city.
- Norwich has the infrastructure and housing it needs to be a successful city.
- The city has an inclusive economy in which residents have equal opportunity to flourish.
- Norwich City Council is in good shape to serve the city.

This report meets all the corporate priorities.

Report Details

1. The Audit Committee receive updates on progress made against the annual internal audit plan. This report forms part of the overall reporting requirements to assist the Council in discharging its responsibilities in relation to the internal audit activity.
2. The Public Sector Internal Audit Standards require the Chief Audit Executive to report to the Audit Committee the performance of internal audit relative to its agreed plan, including any significant risk exposures and control issues. To comply with the above the report identifies:
    - Any significant changes to the approved Audit Plan;
    - Progress made in delivering the agreed audits for the year;
    - And where applicable will provide any significant outcomes arising from completed audits;
    - Provides an update on outstanding internal audit recommendations.

Consultation

3. Not applicable for this report.

Implications

Financial and Resources

4. There are no specific financial implications from this report; the internal audit plan will be delivered from within the resources available.

Legal

5. There are no specific legal implications arising from this report.

Statutory Considerations

Consideration:	**Details of any implications and proposed measures to address:**
Equality and Diversity	Not applicable for this report.
Health, Social and Economic Impact	Not applicable for this report.
Crime and Disorder	Not applicable for this report.
Children and Adults Safeguarding	Not applicable for this report.
Environmental Impact	Not applicable for this report.

Risk Management

Risk	Consequence	Controls Required
Failure to undertake the Annual Internal Audit Plan could result in the Head of Internal Audit not being able to provide an annual opinion.	Reductions in Internal Audit coverage could permit on-going weaknesses in the internal control environment at the Council not being detected and reported upon.	Progress against completing the annual internal audit plan is reported to the Audit Committee in accordance with the Public Sector Internal Audit Standards. Additional resources are deployed where required to ensure adequate levels of coverage are provided for the annual opinion.

Other Options Considered

6. Not applicable for this report.

Reasons for the decision/recommendation

7. The Committee is receiving this report to conform with the Public Sector Internal Audit Standards and to assure itself on the progress being made against planned audit activity.

Background papers:

None

Appendices:

Appendix 1 Internal Audit Progress Update March 2023

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Eastern Internal Audit Services

Norwich City Council

Progress Report on Internal Audit Activity

Period Covered: 19 November 2022 to 10 March 2023

Responsible Officer: Faye Haywood – Head of Internal Audit for Norwich City Council

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1. INTRODUCTION

1.1 This report is issued to assist the Authority in discharging its responsibilities in relation to the internal audit activity.

1.2 The Public Sector Internal Audit Standards (PSIAS) requires the Chief Audit Executive to report to the Audit Committee on the performance of internal audit relative to its plan, including any significant risk exposures and control issues.

1.3 To comply with the above this report includes:

- Any significant changes to the approved Audit Plan;
- Progress made in delivering the agreed audits for the year;
- Any significant outcomes arising from audits; and
- Performance Indicator outcomes to date.

2. SIGNIFICANT CHANGES TO THE APPROVED INTERNAL AUDIT PLAN

2.1 In accordance with the PSIAS, the annual internal audit plan should be reviewed on a regular basis and adjusted, when necessary, in response to changes on the organisation's business risks, operations, programmes, systems and controls.

Since the approval of the plan in March 2022, a horizon scan of risks with the potential to impact the Council was considered by Senior Management, Internal Audit and the Audit Committee. As a result of this, the 2022/23 Internal Audit Plan was re-profiled. The changes to the Internal Audit Plan 2022/23 were outlined at the November 2022 Audit Committee meeting. No further significant changes have been made since then.

3. PROGRESS MADE IN DELIVERING THE AGREED AUDIT WORK

3.1 The current position in completing audits to date within the financial year is shown in **Appendix 1**.

3.2 In summary, audit work from quarter one and two is now finalised. Two audits assigned to quarter three have now been issued and are awaiting a management response. A large proportion of audit work was profiled into quarter four in 2022/23. All audits are scoped, booked in, and the work continues to progress with the aim of concluding testing by year end.

4. THE OUTCOMES ARISING FROM OUR WORK

4.1 On completion of each individual audit an assurance level is awarded using the following definitions:

Substantial Assurance: Based upon the issues identified there is a robust series of suitably designed internal controls in place upon which the organisation relies to manage the risks to the continuous and effective achievement of the objectives of the process, and which at the time of our review were being consistently applied.

Reasonable Assurance: Based upon the issues identified there is a series of internal controls in place, however these could be strengthened to facilitate the organisation's management of risks to the continuous and effective achievement of the objectives of the process. Improvements are required to enhance the controls to mitigate these risks.

Limited Assurance: Based upon the issues identified the controls in place are insufficient to ensure that the organisation can rely upon them to manage the risks to the continuous and

effective achievement of the objectives of the process. Significant improvements are required to improve the adequacy and effectiveness of the controls to mitigate these risks.

No Assurance: Based upon the issues identified there is a fundamental breakdown or absence of core internal controls such that the organisation cannot rely upon them to manage risk to the continuous and effective achievement of the objectives of the process. Immediate action is required to improve the controls required to mitigate these risks.

4.2 Recommendations made on completion of audit work are prioritised using the following definitions:

Urgent (priority one): Fundamental control issue on which action to implement should be taken within 1 month.

Important (priority two): Control issue on which action to implement should be taken within 3 months.

Needs attention (priority three): Control issue on which action to implement should be taken within 6 months.

4.3 In addition, on completion of audit work "Operational Effectiveness Matters" are proposed, these set out matters identified during the assignment where there may be opportunities for service enhancements to be made to increase both the operational efficiency and enhance the delivery of value for money services. These are for management to consider and are not part of the follow up process.

4.4 During the period covered by the report, Internal Audit has issued four reports in final:

Audit	Assurance	P1	P2	P3
NC2303 Anti-Fraud and Corruption	Reasonable	0	4	4
NC2323 Leasehold Management	Reasonable	0	2	4
NC2311 Leisure	Reasonable	0	3	1
NC2302 FOIs and Complaints	Reasonable	0	3	3

The Executive Summary of these reports are attached at **Appendix 2**, full copy of this report can be requested by Members.

4.5 As can be seen in the table above, as a result of these audits 24 recommendations have been raised and agreed by management.

4.6 In addition, two Operational Effectiveness Matters have been proposed to management for consideration.

4.7 A Position Statement has also been issued for NC2321 Planned Housing Maintenance. The audit concluded with six suggested actions:

- Current policies and procedures for the department are mostly inherited policies from Norse Property Services Norwich (NPSN). Each policy has been prioritised for review. Upon completion, the document control process should be followed to ensure they are regularly reviewed within agreed timeframes.
- Establish a policy for the re-visit of properties where entrance or essential work is refused.
- Ensure all property services staff are aware of the Council's policies and procedures and receive training where necessary following restructure.

- Ensure that post inspection template is developed and that the contractual pre and post inspections are completed by the Council and evidence appropriately retained.
- Develop suitable service KPIs for the service including targets and escalation processes.
- Risk Management - ensure risk actions are sufficient to further decrease the risk score toward target.

4.8 A position statement has concluded covering NC2305 Elections. The Elections Act 2022 introduces a number of changes to the administration of elections, the first of which comes into effect for the local elections in May 2023. The most significant changes for this election are new requirements for voters to provide photo identification for in-person voting and increased accessibility requirements for polling stations. A corporate level risk has been raised in relation to the management of a compliant election. This review has not resulted in any suggested actions being raised. We can confirm the following is in place.

- There is an up-to-date project plan for the delivery of the elections in May 2023, incorporating all of the new requirements of the new Act.
- Performance and progress against the project plan is monitored through monthly meetings of a project group.
- A training plan has been produced to provide necessary training on the changes to the election process to all staff who work on the election.
- A public awareness campaign is planned, to ensure that voters are aware of the changes to voting and elections, particularly the new requirements for photo identification when voting in polling stations.
- Polling station surveys have been expanded to include the new conditions around accessibility and privacy.
- Election spending is tracked and monitored.

4.9 In addition to the above work, the Head of Internal Audit is currently leading a formal investigation. Outcomes and recommendations will be shared with the committee upon conclusion of the investigation.

5. FOLLOW UP OF AGREED AUDIT RECOMMENDATIONS

5.1 In addition to providing the Committee with the performance of internal audit relative to its plan, the Public Sector Internal Audit Standards also require the Chief Audit Executive to establish a process to monitor and follow up management actions to ensure that they have been effectively implemented or that senior management have accepted the risk of not taking action.

5.2 To comply with the above this report includes the status of agreed actions.

5.3 As a result of audit recommendations, management agree action to ensure implementation within a specific timeframe and by a responsible officer. The management action subsequently taken is monitored by the Internal Audit Contractor on a regular basis and reported through to the Committee. Verification work is also undertaken for those recommendations that are reported as closed.

5.4 **Appendix 3** to this report shows the details of the progress made to date in relation to the implementation of the agreed recommendations. This appendix also reflects the year in which the audit was undertaken and identifies between outstanding recommendations that have

previously been reported to this Committee and then those which have become outstanding this time round. A total of 21 (two high, 11 medium and eight low) recommendations are currently outstanding. 26 recommendations are not yet due for completion.

5.5 In November 2022, four medium recommendations regarding Key Policies and Procedures were reported to the committee as overdue. The internal audit team have received assurance that three of these recommendations are now complete. Evidence was provided to show that a policy library has been created showing the frequency of reviews required, and this is monitored to ensure policies are periodically scheduled for review and re-approval. The remaining recommendation relates to ensuring that the new policy template and guidance information is available to staff on the intranet to assist with the development of coherent polices. This will be completed by April 2023. The Internal Audit team will continue to review the adequacy and timely review of key policies as standard during each service area audit.

Appendices 4, 5, 6 and **7** provide the committee with details of high and medium priority recommendations that are overdue by the year in which they were raised. Management responses and a new deadline have been indicated for each.

APPENDIX 1 – PROGRESS IN COMPLETING THE AGREED AUDIT WORK

Audit Area	Audit Ref	No. of days	Revised Days	Days Delivered	Status	Assurance Level	Recommendations				Date to Committee
							Urgent	Important	Needs Attention	Op	
Quarter 1											
FOIs and Complaints	NC2302	10	10	10	Final report issued on 13 February 2023.	Reasonable	0	3	3	0	Mar-23
Anti-Fraud and Corruption	NC2303	10	10	10	Final report issued on 12 December 2022.	Reasonable	0	4	4	1	Mar-23
Food Health and Safety	NC2319	10	10	10	Final report issued on 28 October 2022.	Reasonable	0	3	2	1	Nov-22
Leasehold Management	NC2323	10	10	10	Final report issued on 12 December 2022.	Reasonable	0	2	4	0	Mar-23
TOTAL		**40**	**40**	**40**							
Quarter 2											
Annual Governance Statement	NC2301	10	10	10	Final report issued 15 November 2022	Substantial	0	0	4	1	Nov-22
Leisure	NC2311	12	12	12	Final report issued on 1 December 2022.	Reasonable	0	3	1	1	Mar-23
Buildings at Risk	NC2318	10	10	10	Final report issued 4 November 2022	Reasonable	0	3	2	1	Nov-22
Planned Housing Maintenance	NC2321	15	15	15	Final position statement issued on 16 February 2023.						Mar-23
TOTAL		**47**	**47**	**47**							
Quarter 3											
Accounts Receivable	NC2307	10	0	0	Audit deferred to 2023-24.						
Payroll	NC2309	15	15	15	Draft report issued on 27 February 2023.						
Trees and Play Equipment (previously Parks and Open Spaces)	NC2314	10	12	10	Draft report in preparation, wrap up meeting booked.						
TOTAL		**35**	**27**	**25**							

Audit Area	Audit Ref	No. of days	Revised Days	Days Delivered	Status	Assurance Level	Recommendations				Date to Committee
							Urgent	Important	Needs Attention	Op	
Quarter 4											
Staff Wellbeing	NC2312	10	12	1	Scoping complete. Testing on hold due to investigation in another area.						
Procurement and Contract Management	NC2304	15	0	0	Audit deferred to 2023-24.						
Elections	NC2305	10	10	10	Draft position statement issued 3 March 2023.						
Key Controls and Assurance	NC2306	15	20	12	Fieldwork underway.						
Income	NC2308	10	0	0	Audit deferred to 2023-24.						
Housing Benefits	NC2310	15	15	1	Scoping underway.						
Garden Waste Service	NC2313	8	10	8	Fieldwork concluding.						
Markets	NC2315	10	10	1	Scoping underway.						
Towns Fund	NC2316	12	12	2	Fieldwork underway.						
Norwich Regeneration Limited	NC2317	10	12	1	Scoping complete. Testing due to start 16 March 2023						
Contaminated Land and Air Quality	NC2320	10	12	1	Scoping complete, audit testing starts 6 March 2023.						
Housing Compliance Data Validation Checks	NC2322	30	0	0	Audit deferred to 2023-24.						
Housing Services incl. Community Safety and Anti-Social Behaviour	NC2324	12	0	0	Audit deferred to 2023-24.						
Safeguarding	NC2328	0	12	10	Fieldwork concluding.						
TOTAL		**167**	**125**	**47**							
IT Audits											
ERP Project Implementation Support	Advisory	0	5	3	Addition for 2022/23 auditors to provide support to the ERP project in an advisory capacity to support project management.						
Cyber Security	NC2325	10	12	11	Draft report in review stages.						
Disaster Recovery	NC2326	10	10	7	Fieldwork concluding.						
Housing System Implementation Phase 2	NC2327	10	10	1	Scoping underway.						
Civica CRM system/master data management project	Advisory	0	5	0	Addition - specialist auditors to provide support to the project team in an advisory capacity to support project management.						
TOTAL		**30**	**42**	**22**							
Follow Up											
Follow Up	N/A	16	16	16							
TOTAL		**16**	**16**	**16**							
TOTAL		**335**	**297**	**197**			0	18	20	5	
Percentage of plan completed				**66%**							

Executive Summary – NC2303 Anti-Fraud and Corruption

OVERALL ASSESSMENT

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

This audit sought to provide assurance over the following key risk:

"Risks of financial losses as a result of fraud and corruption against the Council."

KEY STRATEGIC FINDINGS

	A detailed risk assessment covering types and categories of fraud and corruption risk to be undertaken describing the controls that are in place and any required actions for improvement.
	Once the above risk assessment is undertaken, a formal assessment of the resources required to respond to the fraud risks that the Council faces should be undertaken and revisited annually.
	An annual fraud plan to be reported to Audit Committee to reflect resources mapped to risks and arrangements for reporting outcomes.
	Assurance to be provided that the RIPA and CCTV action plan has been completed.

GOOD PRACTICE IDENTIFIED

	Policies are in place for anti-fraud and corruption, and whistleblowing, which include reporting suspected fraud, anti-money laundering and risk management.
	Codes of conduct for officers and members are included in the Council's constitution. New members receive training and conduct of members is monitored.

SCOPE

The Fighting Fraud and Corruption Strategy 2020 has highlighted an increased threat of fraud related risks for local authorities. Our review examined the Council's approach to fraud in line with the checklist provided as part of this strategy and to suggest practical recommendations for improvement where required. Our review also covered the Council's progress with the issues raised from the external inspection in June 2020 of the Council's compliance to RIPA.

ACTION POINTS

Urgent	Important	Needs attention	Operational
0	4	4	1

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	Partially in place	2,6,7,8	1
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	Partially in place	1,5	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Partially in place	4	-

Other Findings

	Governance Framework- Policies are in place for anti-fraud and corruption, whistleblowing and anti-money laundering, and these are mandatory reading for all staff and publicly available on the website. There is also a page on the website regarding reporting suspected fraud, with an online form for completion.
	Governance Framework- Codes of conduct for officers and members are included within the Council's constitution, which was revised in July 2022. This is included in training for new members and conduct of members is monitored.
	Risk Mitigation- The directorate risk register for corporate and commercial services, which is responsible corporately fraud, includes fraud risks. There is a residual score of 12 (amber), below the score (15) for escalation to the corporate risk register.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	Out of scope	-	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	Out of scope	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	Out of scope	3	-

Other Findings

Resilience - The Council does not have a counter-fraud team, so there are no professionally trained and accredited staff for counter fraud work at the Council. Fraud prevention is covered by services as part of business as usual, with reactive investigations when required. Specific specialist resources are available from Anglian Revenue Partnerships.

Executive Summary – NC2323 Leasehold Management

OVERALL ASSESSMENT

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

Assurance was provided over the following risk – "The Council failing to deliver its statutory responsibilities to leaseholders."

KEY STRATEGIC FINDINGS

A detailed review of a sample of service charge identified a potential undercharge for horticultural services. Management to review calculation methodology and implement corrective action.

Testing of service charge invoices confirmed that payment terms agreed to the lease and the statutory consultation processes had been completed as required.

Aged debt reports for sundry income are provided to all budget holders including senior management. This helps ensure continual awareness of the debt position.

A sample of ten aged debts was reviewed, and identified instances where follow-up actions after the auto-recovery stages were limited.

GOOD PRACTICE IDENTIFIED

Training is provided to all new staff outlining statutory requirements for works completed and time limitations to notify leaseholders of annual service costs.

SCOPE

An audit of this area has not been undertaken since 2016/17. At the request of senior management an audit was undertaken of billing and notification of works for Leaseholders at the Council. The audit reviewed centrally held records to verify all relevant properties are contained, and provides assurance that arrangements for billing including S20 notices are being well managed.

ACTION POINTS

Urgent	Important	Needs Attention	Operational
0	2	4	0

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	Partially in place	3 & 4	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Partially in place	1, 2, 4, & 6	-

Other Findings
Governance Framework - Staff are fully aware of the statutory limits that can be charged for works completed, including where the consultation process is not completed, and of the statutory time limitations to notify leaseholders of their annual service costs.
Risk Mitigation- The corporate and directorate risk registers were reviewed and there were no risks detailed that specifically relate to the home ownership team's processes for leasehold properties.
Risk Mitigation- Fraudulent processing risks are mitigated by segregation of duties and the access controls set on systems.

Control Compliance - Sample testing of service charges for 2020-21, which were invoiced in January 2022, was completed, and confirmed that the correct liable party was invoiced, the invoice payment terms were in line with the lease terms and the statutory consultation process had been completed for those that were invoiced for major works completed.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	In place	-	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	Out of scope	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	-

Other Findings

Performance Monitoring- Aged debt reports for all sundry income debts are provided to all budget holders including senior management.

Sustainability- The audit has reviewed the council's Corporate Plan 2022-26 and the Environmental Strategy 2020-25. There are no actions within these that relate to the scope of this audit.

The housing outcomes manager advised that there is currently a statutory requirement to inform leaseholders of their annual service charges by post, so the service are unable reduce paper produced and the postage costs by sending these by email.

Resilience - Statutory requirements for consultations are included in training provided to new staff.

Resilience- The interim Head of Housing and Community Services is aware of team restraints / backlogs and advised the service to issue statutory delay notices for the 2020-21 service charges. The detailed statements were issued before the deadline in the notices.

Executive Summary – NC2311 Leisure

OVERALL ASSESSMENT

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

This audit sought to provide assurance over the following key risk:

"The provision of leisure services has not been adapted to the impacts of the pandemic and contracts are not being managed effectively."

SCOPE

Leisure provision has not been raised as a significant risk on the CRR, however this area has not been reviewed recently. This audit provides assurance that the leisure strategy is adapting to the impacts of the pandemic and that contracts in this area are being effectively managed.

KEY STRATEGIC FINDINGS

There is no signed contract in place with the current service provider at the Riverside Leisure Centre who have managed the centre since 2013. A draft contract is in the process of being engrossed.

Some aspects of current practices of the management of the Riverside Leisure Centre do not align with the soon to be executed contract.

Neither facility has any formally agreed KPIs. The Riverside Leisure Centre provides data on their usage, without targets or escalation procedures. The Norman Centre reports KPIs to the manager but with no set targets.

The future of the Norman Centre is uncertain due to necessary improvements to the building. A future option analysis will help the Council to decide on the most beneficial way forward.

GOOD PRACTICE IDENTIFIED

Both leisure facilities have an up-to-date business continuity plan in place.

An independent options appraisal was conducted for the future of the leisure services at the Riverside Leisure Centre. The outcomes are currently being discussed internally at the Council.

ACTION POINTS/

Urgent	Important	Need Attention	Operational
0	3	1	1

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	Partly in place	1, & 4	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	In place	-	-

Other Findings

Governance Framework - As the Riverside Leisure Centre is contracted out, only internal procedures for the Norman Centre have been reviewed. All necessary procedures are in place and no procedures were identified which were in need of review.

Governance Framework - A Greater Norwich Physical Activity & Sport Strategy 2022 - 2027 has been implemented in October 2022. It has been created in partnership with other Norfolk Councils and sets out the vision for increasing levels of physical activity and sport in the Greater Norwich area. The strategy is supported by underlying strategies and an action plan and incorporates the impacts of the pandemic.

Risk Mitigation - Risk is reported and monitored at both a Corporate and Directorate level on a quarterly basis. No related risks have been raised on the corporate risk register in the past 12 months. A service risk has been raised on the directorate risk register relating to the viability of the Council's leisure facilities with a current residual risk score of 12 (as at Q2 review) which equals the target risk score.

Compliance – No complaints have been raised this year at the Norman Centre. At Riverside Leisure Centre, complaints are recorded as part of the negative feedback received through customer feedback surveys. Procedures are in place and the complaints log is brought to the quarterly contract management meetings and if necessary escalated to the Head of Service and Director.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	Partly in place	2, & 3	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	In place	-	1
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	-

Other Findings

	Sustainability - The new Greater Norwich Physical Activity & Sport Strategy has the provision of sustainable (environmentally and financially) facilities and spaces incorporated in one of their key objectives with multiple related actions on their action plan.
	Sustainability - The soon to be signed contract for the Riverside Leisure Centre contains a clause relating to Environmental Projects which states that the Contractor agrees to support and actively assist the Council in its endeavours to reduce the carbon footprint of the Centre by all reasonable methods.
	Resilience - Both leisure facilities have an up-to-date business continuity plan in place or are incorporated into the wider service area.
	Resilience - An independent options appraisal was conducted which focused on the Riverside Leisure Centre. The expiry date of the management provision is March 2024. Four options (extent, retender, insource or partnership) have been analysed and the result have been presented in a report in August 2022, together with a recommendation. Outcomes are currently being discussed by senior management.
	Resilience – The Council is aware of the rising energy prices. In addition to adding them to their directorate risk registers (see recommendation 5), they have also discussed the direct impact on the Riverside Leisure Centre in their quarterly contract management meetings and have identified that their energy budget needs adjusting.

Executive Summary – NC2302 FOI and Complaints

OVERALL ASSESSMENT

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

This audit sought to provide assurance over the following key risk:

"Reputational risks linked to non-compliance with the statutory requirements of the Freedom of Information Act 2000 (FOI) and the Environmental Information Regulations 2004 (EIR), and for unsatisfactorily responding to customer complaints, potentially resulting in referrals to the appropriate ombudsman."

SCOPE

A review of this area had not been carried out at the Council recently. A review of FOI/EIRs and Complaints was undertaken to provide assurance on the Council's response to requests for information and the handling of complaints about services provided. Response times and management information were evaluated to ensure that the Council's procedures and expectations of its customers are being met.

KEY STRATEGIC FINDINGS

Statutory and corporate response times for complaints have not been met. Improved results were noted in recent performance reports to Cabinet. However, response times varied across the service areas. The volume of outstanding late responses has been reduced from 250 in April 2022 to 81 as of 14 November 2022.

Statutory and corporate response times for FOI/EIR requests are not consistently met. Improved results were noted in recent performance reports to Cabinet. However, response times varied across the service areas. A total of 11 late FOI/EIR responses remain outstanding as of 14 November 22.

A new Transparency, Publication, and Information Access Policy, and updates to the publication scheme and associated policies are required.

The Council's management of FOI/EIR and Complaints should be enhanced further to ensure that performance continues to increase, including the recording of a risk on the directorate risk register related to the handling of complaints.

GOOD PRACTICE IDENTIFIED

FOI/EIR and complaints performance reporting is regularly provided to CLT and Cabinet. Additionally, FOI/EIR and complaints officers provide weekly reporting to managers of responses requiring action.

A new Customer Experience Lead post was created in April 2022, with a focus on managing and improving the complaints processes.

ACTION POINTS

Urgent	Important	Needs Attention	Operational
0	3	3	0

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	Partially in place	1, 5 & 6	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	Partially in place	3	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Partially in place	2, 4	-

Other Findings
Governance Framework - FOI/EIR: Information for submitting FOI/EIR requests is readily available to the public on the Council's website – "how to make an FOI request". This includes an online form to complete as an option for submitting a FOI/EIR request, and the note "we aim to reply to your request as soon as possible but within 20 working days", which is the statutory response time. Exemptions under FOI/EIR are also separately detailed on the website.
Governance Framework - Complaints: The revised complaints policy was approved by CLT in July 2022, the update being in line with the housing ombudsman complaints handling code, which came into effect 1 October 2022. The policy, and the self-assessment to the ombudsman complaints handling code, are published on the council's website. Additionally, Information on how to make a complaint via an online form or other methods is readily available to the public on the website, which includes details of response times. This includes details of what will not be dealt with under the complaints process.
Governance Framework – Complaints: 83 members of staff completed the ombudsman complaints training at the end of 2021, and a further 60 staff have been identified to complete this during the next year commencing in February 2023. This has now been embedded as a rolling training programme.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	In place	-	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	Out of scope	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	Partially in place	-	-

Other Findings

Performance Monitoring - FOI/EIR: formal KPIs have been in place from 2022-23 for timely responses to FOI/EIR requests, and other internal performance measures are monitored. This includes analysis by service and directorate, and a summary of outstanding late responses.

Regular reporting of results is in place:

- Quarterly reports are provided to CLT, and the KPI results included in the quarterly corporate performance report presented to Cabinet.

- 6 weekly reporting to CLT has commenced from December 2022.

- Weekly reports are provided to service managers to provide performance information and details of cases where responses are outstanding.

- A summary of the year-to-date performance was presented to the managers forum in November 2022.

Over the current year performance has fluctuated each month, with the KPI not being met corporately until August 2022. The statutory response time is 20 working days, with the KPI set at 90% compliance. The results have ranged from 72.9% in June 2022 to 97.9% in September 2022, with three consecutive months of continuous improvement since June 2022, and both August and September 2022 within the corporate target.

As of 30th November 2022, the volume of outstanding late responses has reduced, with 11 now outstanding, the oldest being 7 months.

Performance Monitoring - Complaints: A formal KPI for timely responses to complaint requests is in place for 2022-23 and is monitored. This includes analysis by service and directorate, and a summary of outstanding late responses.

Regular reporting of results is in place:

- Quarterly reports are provided to CLT, and the KPI results included in the quarterly corporate performance report presented to Cabinet.

- 6 weekly reporting to CLT has commenced from December 2022

- Weekly reports are provided to service managers to provide performance information and details of cases where responses are outstanding. The reports were updated in May 2022 separately report Stage 1 and Stage 2 complaints.

- A summary of the year-to-date performance was presented to the managers forum in November 2022.

A number of improvements have been made to the process and monitoring by management of the outstanding responses to complaints. The customer experience lead has regular meetings with heads of service and senior managers to discuss specific cases, so that many of the old cases could be closed on the system. This has yielded positive results with clearance of outstanding responses, reducing from 250 in April 2022 to 81 on 14 November.

Resilience - FOI/EIR: Resourcing shortages were identified for supporting and monitoring FOI/EIR responses, and management are aware of the backlogs of work. As part of the restructure agreed by CLT in September 2021, a new information governance team has now been established, with the Data Protection Officer being recently appointed as the Information Governance Manager, and an officer will be in place from 6 February 2023.

Resilience - Complaints: A new role of Customer Experience Lead was introduced from April 2022. Part of this role is to manage the processes for complaints, although managers are responsible for completing the responses. As noted elsewhere, recent changes implemented have positively impacted performance.

APPENDIX 3 – STATUS OF AGREED INTERNAL AUDIT RECOMMENDATIONS

		Completed between 19 November 2022 to 1 March 2023			Previously reported to Committee as outstanding			(New) Outstanding			Total Outstanding	Not Yet Due for implementation		
		High	Medium	Low	High	Medium	Low	High	Medium	Low		High	Medium	Low
Audit Area	**Assurance Level**													
2019/20 Audits														
Payroll	Control: Satisfactory Compliance: Substantial					1					1			
2020/21 Audits														
Equality Duties	Limited						1				1			
Key Policies & Procedures	Limited		3	2		1					1			
2021/22 Audits														
Risk Maturity Assessment	Reasonable					2					2			
Off-payroll working (IR35) compliance	Reasonable						3				3			
Accounts Payable	Reasonable					2	1				3			
Council Tax	Reasonable		1	4							0			
NNDR	Reasonable			1		1	1				2			
Environmental Services	Limited		2	3							0		2	
Capital Accounting & Management	Limited		2		2						2			
Treasury Management	Reasonable		1								0			
2022/23 Audits														
Food Health and Safety	Reasonable		2	1			1				1		1	
Annual Governance Statement	Substantial			1						1	1			2
Anti-Fraud and Corruption	Reasonable										0		4	4
Leasehold Management	Reasonable		1	1							0		1	3
Leisure	Reasonable		1						1		1		1	1
FOIs and Complaints	Reasonable								1		1		2	3
Buildings at Risk	Reasonable			1		2					2		1	1
		0	**13**	**14**	**2**	**9**	**7**	**0**	**2**	**1**	**21**	**0**	**12**	**14**

APPENDIX 4 – OUTSTANDING INTERNAL AUDIT RECOMMENDATIONS – 2019/20

Job	Recommendation	Priority	Responsible Officer	Due Date	Revised Due Date	Status	Latest Response
Payroll	Complete the signing of the co-operation agreement with Sefton.	Medium	Dawn Bradshaw, Head of HR and OD	31/12/2021	31/03/2023	Outstanding	Agreement has been redrafted and signed off by NCC, including an extension to the terms of the agreement. Nplaw have provided the agreement to the 3rd party payroll provider, and there have been ongoing discussions on a small number of points. Meeting scheduled with payroll provider and respective legal advisers for 10 March 2023, with a view to finalising the agreement. The service continues to operate to the service standards agreed. It is anticipated that formal signing of the co-operation agreement will be concluded by the end of March 2023.

APPENDIX 5 – OUTSTANDING INTERNAL AUDIT RECOMMENDATIONS – 2020/21

Audit	Recommendation	Priority	Responsible Officer	Due Date	Revised Due Date	Status	Latest Response
Key Policies and Procedures	Develop a framework that gives guidance for developing a coherent and relevant policy and ensure the new framework is communicated to staff. The content could include multiple elements.	Medium	Helen Chamberlin, Head of Strategy, Engagement and Culture	31/01/2022	31/05/2023	Outstanding	A template and guidance have been developed and will be communicated to colleagues from April 23.

APPENDIX 6 – OUTSTANDING INTERNAL AUDIT RECOMMENDATIONS – 2021/22

Audit	Recommendation	Priority	Responsible Officer	Due Date	Revised Due Date	Status	Latest Response
Risk Maturity Assessment	4.1 A risk management training programme to be developed for relevant Council staff, highlighting roles and responsibilities and give practical tips for the identification and articulation of risk.	Medium	Neville Murton, Interim Head of Finance, Audit and Risk	30/09/2022	30/06/2023	Outstanding	This is currently being developed for delivery.
Risk Maturity Assessment	4.5 Please see recommendation at 4.2 regarding the update of Corporate and Directorate registers. The Risk Management Policy and Strategy to be reviewed to clarify the following points: 4.5.1 Review the wording of the updated Risk Management Policy & Strategy and ensure that it includes details about when risks should be de-escalated.4.5.2 The council should specify responsibilities for risk control action owners.	Medium	Neville Murton, Interim Head of Finance, Audit and Risk	30/09/2022	30/06/2023	Outstanding	This will be incorporated into the policy update planned for June 2023.
Accounts Payable	4.2 The council's 'No PO, no Pay' policy to be formally documented and re-launched with staff and suppliers.	Medium	Neville Murton, Interim Head of Finance, Audit and Risk	31/10/2022	30/04/2023	Outstanding	The no PO no pay is not yet a formalised policy and is something that will be picked up as part of the implementation of the new ERP system on 1st April. All user PO email sent 12/10/22 to underline current E5 arrangements and remind them of the importance of raising a PO. Revised implementation date in line with the implementation of the new system.
Accounts Payable	4.3 As part of formalising the 'No Purchase Order No Pay' policy, an Exceptions' List be created, listing the instances in which a PO is not required prior to purchasing.	Medium	Neville Murton, Interim Head of Finance, Audit and Risk	31/10/2022	30/04/2023	Outstanding	As above.
NNDR	Review, agree and document how the process for discretionary charity top up relief is awarded covering the applicable financial delegations for the responsible officers. Regular reports on discretionary charity top ups to be provided to the Head of Revenues and Benefits quarterly.	Medium	Tanya Bandekar, Head of Revenue and Benefits	31/12/2022	30/06/2023	Outstanding	Head of Revenues and Benefits has received an updated policy but it needs more work and will need to be approved by Cabinet, and possibly Full Council.
Capital Accounting and Management	Minutes of meetings to discuss capital project progress are taken and include agreed actions, with a link to any supporting reports from Property Services. Reports to	High	Resources, Performance and Delivery Board	30/11/2022	31/07/2023	Outstanding	New Capital Programme Board to be set up that would bring together all capital projects for monitoring purposes and all board reports that

Audit	Recommendation	Priority	Responsible Officer	Due Date	Revised Due Date	Status	Latest Response
	include highlights, risks and issues as appropriate.						pick up capital elements would feed through into this Board. New reference terms to be created and responsibilities noted in the Constitution. Governance is being reviewed across the piece to identify gaps and ensure there is no unnecessary duplication. Existing reporting will be reviewed to see where standardisation can be utilised to reduce workflows. However, central board would need to have certain key requirements, includes one tied to FM Code. Therefore, a standardised template will be created, as well as monitoring documents. It will need to include lifetime spend, in-yr spend, variances as well as traffic light review with three key variables (spend to budget, timeliness and quality of delivery/benefit realisation). Decisions regarding the capital programme, wider risk management and reviews of financing options would also be reviewed here so that the Board was explicitly strategic in nature. Equally, all business cases would get internal sign off, even if concepts would only be agreed by CLT. The goal is that the Capital Programme Board would have a clear remit covering: 1) Corporate Monitoring of Capital 2) Internal review of capital business cases, even if lower level ones were de facto approved at sub-Boards (Concepts are approved at CLT) 3) Strategic recommendations regarding the capital programme allied to quarterly updates on financing and borrowing projections, so that the Capital Strategy,
Capital Accounting and Management	All capital projects for the year are monitored for delays in works, to ensure the expenditure to date is reasonable for the works that have been completed, records are retained as to reasons with agreed actions to be taken, and that for each capital project, on the schedule included in the performance reports to Cabinet, there is a brief comment relating to progress and budget as appropriate.	High	Neville Murton, Interim Head of Audit, Finance and Risk	30/11/2022	31/07/2023	Outstanding	

Audit	Recommendation	Priority	Responsible Officer	Due Date	Revised Due Date	Status	Latest Response
							Treasury Management Strategy and Asset Management Strategy feed directly and consistently into the MTFP and 30-Year HRA Business Plan Meetings would be set up and aligned to external requirements (4 quarterly monitors, budget setting requirements and the need to report on Capital Strategy, Asset Management Strategy and July Finance Review/MTFP Strategy and Budget Setting).

APPENDIX 7 – OUTSTANDING INTERNAL AUDIT RECOMMENDATIONS – 2022/23

Job	Recommendation	Priority	Responsible Officer	Due Date	Revised Due Date	Status	Latest Response
Buildings at Risk	Set up Heritage at Risk meeting timetable with all relevant stakeholders	Medium	Sarah Ashurst, Head of Planning and Regulatory Services	30/11/2022	30/04/2023	Outstanding	Initial meeting has taken place and a further meeting has been scheduled for April, but a programme of meetings has not yet been put in place. This is a task likely to fall to a new C&D Team Leader which we are in the process of recruiting to through a restructure.
Buildings at Risk	A process to be implemented which monitors progress on agreed actions assigned to Officers arising from HAR meetings. In addition, it is suggested that a mechanism should be developed for monitoring when properties have last been inspected/contacted.	Medium	Sarah Ashurst, Head of Planning and Regulatory Services	30/11/2022	30/04/2023	Outstanding	Action 1 – This is linked to the first recommendation. Internal Audi are awaiting receipt of evidence to close this part of the recommendation. Action 2 - This is a task likely to fall to a new C&D Team Leader which we are in the process of recruiting to through a restructure.
Leisure	Finalise and sign the contract for Riverside Leisure Centre.	Medium	Helen Chamberlin, Head of Strategy, Engagement and Culture	31/01/2023	31/03/2023	Outstanding	We are intending to extend the Riverside contract, which ends in 2024; a deed of variation has been prepared and is going through its final sign off stages. The intention is then to sign both the DoV and the original contract at the same time.
FOIs and Complaints	Management to update the Directorate Risk Register to include a risk related to the complaints handling process. Management should ensure that the risk includes mitigations for any increases to complaints arising from the repairs and maintenance services, as outlined within the Corporate Risk Register.	Medium	Brian Burton, Interim Head of Asset Management	30/01/2023	31/03/2023	Outstanding	The complaints handling process is already a specific repairs and maintenance trigger that has been added to the Corp Risk Register under CORP 22 - Failure to meet performance and service improvement requirements (repairs and maintenance). The control and mitigation detail will be added for Qtr 4.