AUDIT PROGRESS REPORT 2020/21

1 PURPOSE OF REPORT

1.1 This report provides Members with an update on the work of the Internal Audit team, in terms of progress made against the annual audit plan, and action taken by Service departments in implementing audit recommendations.

1.2 Detail of the progress made in delivery of the annual audit plan is provided for at **Enclosure No.1.**

2 INTRODUCTION

2.1 Internal Audit is a statutory requirement under the Accounts and Audit Regulations. Internal Audit's work is monitored through regular reports presented to this Committee.

3 RISK IMPLICATIONS

3.1 Failure to operate a robust assurance process (which includes delivering the Internal Audit Annual Plan) increases the risk that inadequacies in the Council's risk management, governance and control arrangements are not identified and effective remedial action agreed and implemented.

3.2 If the Internal Audit Plan is not substantially completed by June 2022, the Chief Audit Executive (CAE) may not be able to give a sufficiently informed opinion on the Council's control environment. The CAE's opinion is a source of assurance for the Annual Governance Statement (AGS), which is also considered by the Audit Committee and is of interest to the external auditor for their assessment of the Council's arrangements to use its resources economically, efficiently, and effectively. The lack of CAE opinion could negatively impact on the AGS and Value for Money assessment.

3.3 The main risk to delivering the audit plan is the risk of insufficient resources, this is considered below

4 RESOURCE IMPLICATIONS

4.1 Excluding the CAE (provided by Basildon Borough Council) the audit resource at the commencement of 2021/22 was 1 Full Time Equivalent (FTE) staff. From May 2021 onwards this increased to 1.6 FTE as a member of the team returned from maternity leave.

5 LEGAL IMPLICATIONS

5.1 Under the Local Government Act 1972 (s151) and the Accounts and Audit Regulations, the Council has a responsibility to maintain an adequate and effective Internal Audit function.

5.2 The Internal Audit Section works to the statutory Public Sector Internal Audit Standards. This includes the requirement to prepare and present regular reports to the Audit Committee on the performance of the Internal Audit service.

6 PARISH IMPLICATIONS

6.1 None.

7 EQUALITY AND DIVERSITY IMPLICATIONS

8 An Equality Impact Assessment has been completed and found there to be no impacts (either positive or negative) on protected groups, as defined under the Equality Act 2010

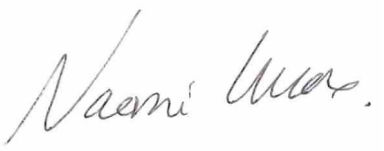
9 RECOMMENDATION

9.1 It is proposed that the Committee **RESOLVES**

(1) That the update on delivering the 2021/22 Audit Plan be noted.

(2) That the conclusions and results from completed audit engagements in Appendices 2 and 3 be noted.

(3) That the updated status of audit recommendations in Appendix 4 be noted.



Naomi Lucas
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Background Papers: -

None. For further information please contact Jim Kevany on: -

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If you would like this report in large print, Braille or another language please contact 01702 318111.

Enclosure No.1

1 DELIVERY OF THE ANNUAL AUDIT PLAN 2021/22

1.1 A table detailing the audit engagements completed to date is provided for at **Appendix 1**.

1.2 A total of five audit engagements from the 2021/22 Annual Audit Plan have been completed; Two engagements were rated as 'Good' and two as "Adequate". These assessments include light touch engagements where specific elements of operations are reviewed and do not reflect the entire operation. One engagement has no rating because it was the completion of a questionnaire from Essex County Council and did not require an audit opinion.

1.3 At this time of the year a significant amount of time is expended on the initial testing for the Housing Benefit Subsidy Audit, on behalf of the external auditor, BDO.

1.4 The opinion given and main points arising from the completed audit engagements is summarised at **Appendix 2** or in respect of light touch reviews at **Appendix 3**. An explanation of the meaning of and reason for each assessment (opinion) is provided in **Appendix 5**. This appendix should be read in conjunction with **Appendix 6** setting out the recommendation categories.

2 COUNTER FRAUD ACTIVITY

2.1 The Revenues & Benefits service has continued to be heavily involved in 2021/22 in processing business grants and dealing with an increased LCTS and housing benefits workload as a result of the Covid-19 pandemic response.

2.2 Responsibility for investigating fraud, excluding housing benefits, or error relating to Local Council Tax Support (LCTS), Council Tax & Business Rates discounts and exemptions rests with the local authority and for Rochford District Council such work is undertaken by the Compliance Officer, Revenues and Benefits, and officers in Business Rates. Both the National Fraud Initiative (NFI) and Pan Essex Data Hub provide the means for the Council to identify potential fraud through data matching, followed by subsequent investigation by the Compliance Officer.

2.3 Data was submitted in October 2020 as part of the National Fraud Initiative biennial exercise across a wide body of public organisations. Data matches produced by this exercise are being worked upon. Some of the outcomes are included in the following paragraphs

2.4 As at 20/8/21 the value of Council Tax identified as recoverable, as a result of Revenues & Benefits compliance work, from all sources including LCTS, was £86k, of which £74k related to identifying unbilled properties and withdrawal of discounts or exemption that no longer apply.

2.5 Housing Benefit fraud continues to be investigated by the Department for Work & Pensions, but the Revenues & Benefits Team continues to identify and collect overpayments of Housing Benefit. Amounts identified for recovery by compliance work in respect of Housing Benefits was £10.5k as at 20/8/2021.

2.6 From April, to 20/8/21, the value of identifiable gains in respect of business rates was £131.5k of which £60k related to unbilled properties. The rest related to undeclared changes or ineligible discounts. The total gain, net of discounts or reliefs, is £120K.

3 MONITORING OF INTERNAL AUDIT RECOMMENDATIONS

3.1 Recommendations arising from completed audit engagements are shown **in Appendix 4**.

This includes the current status of all recommendations that were live as at the date of the prior Audit Committee in July 2021 and all recommendations raised since that date. 7 recommendations were brought forward from 2020/21. There are 13 live recommendations. One recommendation, ICT Security 2019/20, has had the end date changed, since the last Audit Committee, due to an update in progress as shown in the appendix.

3.2 A total of 6 new recommendations have been raised since the last Audit Committee.

COMPLETED AUDIT ENGAGEMENTS SUMMARY - APPENDIX 1

AUDIT ENGAGEMENT	CORE ELEMENT OF PLAN	ASSURANCE RATING	REPORTED TO AUDIT COMMITTEE	RECOMMENDATION CATEGORY			
				C	S	M	L
Complaints Report 2 – 2021/22	Failure to engage with stakeholders to understand and communicate what the Council should be trying to achieve.	Adequate	28/9/21	-	-	1	-
Treasury Management Report 3 – 2021/22	Failure to ensure good governance of the Councils activities and delivery of its priorities Failure to provide consistent value for money (VFM) across all services or obtain VFM in its procurement	Good	28/9/21	-	-	-	1
Cemetery Management Report 4 – 2021/22	Failure to ensure good governance of the Council's activities and delivery of its priority outcomes	Adequate	28/9/21	-	-	1	3
Restart Grant Certification Audit 5- 2021/22	Failure to ensure good governance of the Council's activities and delivery of priority outcomes	Good	28/9/21	-	-	-	-

OTHER WORK UNDERTAKEN		
AUDIT AREA	**NATURE OF WORK**	**REPORTED TO AUDIT COMMITTEE**
Disabled Facility Grants 2020/21 Certification Audit 1 – 2021/22	Completion of testing a sample of DFG, awarded in 2020/21, for compliance with regulations on behalf of Essex County Council. There were no matters arising.	28/9/2021

APPENDIX 2

COMPLETED AUDIT ENGAGEMENTS

COMPLAINT HANDLING
Report 2 2021/22

Audit objective

To assess whether the controls and procedures around the handling of complaints received by the Council are effective from the perspective of the residents and the Council.

Corporate links

This audit contributes to the assurance available in regard to the following Business Plan objectives and risks identified on the corporate risk register:

Business Plan objective	Enable Communities
Corporate risk	Failure to engage with stakeholders to understand and communicate what the Council should be trying to achieve.

Reason for inclusion in the annual audit plan

This audit is a planned, standard assurance review identified through the annual assessment of all Council's activities.

Audit opinion

Our opinion is expressed on the scale of assurance as set out below:

Good	Adequate	Limited	None
	✓		

We have formed our audit opinion based on how well controls have been designed and effectively operated to mitigate the following risks:

Risk area	Assurance Level	No. of Recommendations
Not all complaints are identified and recorded	**Adequate**	None
Complaints are not dealt with in line with Council Policy or documented procedures	**Adequate**	None

Risk area	Assurance Level	No. of Recommendations
Staff are not trained in effective complaint handling	**Adequate**	None
Complaints are not treated confidentially or are handled sensitively	**Adequate**	None
Areas for improvement are not effectively identified and acted upon	**Adequate**	1 Moderate
There is inaccurate or ineffective reporting of complaints and outcomes	**Adequate**	None
Data is not effectively controlled	**Adequate**	None
Risk Assessments are not in place, not relevant or are not up to date	**Adequate**	None

Executive Summary

The Council has an established Comments, Compliments and Complaints Procedure published on the Website that provides guidance for staff and customers on submitting a complaint and the four key escalation stages. The existing Customer Charter, which sets out the standard of service that residents can expect from the Council including complaint handling, is currently under review for publication in 2021/22.

Customer Services (CS) assumed corporate responsibility for complaint handling in September 2020. Internal Audit (IA) acknowledge that work is underway to improve the process for customer feedback. There are plans to introduce a Customer Records Management System as part of the Connect Cultural and Transformation Programme, that will facilitate and improve many aspects of customer services, including the process for raising comments, compliments, and complaints. Until then, CS officers maintain a Customer Feedback Spreadsheet that provides detail and records progress of resident feedback of all types, including the service it relates to and target dates for resolution, if appropriate. Council systems are also used to assign complaint reference numbers and record correspondence. These are reported to the Quarterly Business Review meeting of the Leadership Team (LT). The spreadsheet used to make the initial revised report to LT was not formatted correctly resulting in inaccurate interpretations being provided. This will be adjusted going forward.

Between August 2020 and June 2021, 195 official complaints were received into the Council. IA tested a sample of 20 complaints and concluded that the underlying process is known, but testing and subsequent discussions have identified there is an inconsistent approach across the Council in respect to:

- Timescales to respond to complaints
- The definition of an '*official*' complaint
- Responsibility for dealing with and responding to complaints

- The need to notify CS of complaints that are received directly into service areas
- The content and quality of letters to customers
- Reporting to CS on lessons learnt and how processes have been improved as a result of a complaint, where appropriate.

A recommendation has been raised to address these areas.

Complaints are handled confidentially and once received into CS, are promptly acknowledged (usually within one working day), assigned to a responsible officer and timescales are established with the customer. Unless advised otherwise, the stated resolution timescale is five working days and has been for some time. CS have identified that this may not be achievable in the majority of cases and this is supported from the sample testing where 12 out of 20 cases did not meet this expected timescale. No enquiry was made during this review as to why this took so long but it was apparent from records that customer services were chasing responses from service areas. Resolution timescales will be reviewed to align with the Customer Charter response time. There is a process to escalate complaints up to and including the Ombudsman.

Approximately 51% of complaints (99 in total), received into the Council related to the Street Scene service and were primarily regarding missed bin collections or crew behaviour. This is a considerably low number given that green waste, residual, and recycling amount to over 60,000 collections each week. The Street Scene service also received the greatest number of compliments across the Council (41%), for the same period. Approximately 25% of complaints related to the Planning Service and were primarily regarding a delay or dissatisfaction in decision making. The performance of the team is being reviewed in order to make service improvements.

Reporting to the Leadership Team (LT) QBR meeting is in its infancy and the CS Manager has acknowledged that it is a work in progress to improve the accuracy and focus of the reports, and so a recommendation is not being raised at this stage. CS report on complaint trends and although a small number of service areas appear to address areas for improvement, there is currently no formal process in place to track and measure mitigations put in place to address them. This work is being addressed in the review of the CS standards.

The Privacy Notice for CS is currently being updated for publication on the Council's website. The Service Area Risk Register is due for review imminently and requires updating to include complaint management.

This is a relatively new process, under new ownership. Steps have been taken to identify issues and the service is moving in the right direction.

TREASURY MANAGEMENT
Report 3- 2021/22

Audit objective

To ensure that the Council has approved clear treasury management objectives, strategies, and policies and that these are supported by sound operational practices, including authorisation and recording of transactions and reporting of performance to relevant stakeholders.

Corporate links

This audit contributes to the assurance available regarding the following Business Plan objectives and risks identified on the corporate risk register:

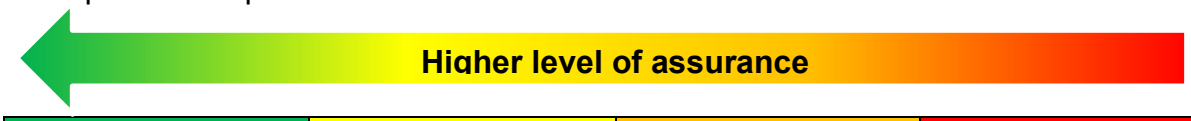
Business Plan objective	Maximise our assets Become financially self-sufficient
Corporate risk	Failure to ensure good governance of the Councils activities and delivery of its priorities. Failure to provide consistent value for money (VFM) across all services or obtain VFM in its procurement. Data is lost, disclosed or misused to the detriment of individuals or organisations.

Reason for inclusion in the annual audit plan

This audit is a planned, standard assurance review identified through the annual assessment of all Council's activities.

Audit opinion

Our opinion is expressed on the scale of assurance as set out below:



Good	Adequate	Limited	None
✓			

We have formed our audit opinion based on how well controls have been designed and effectively operated to mitigate the following risks:

Risk area	Assurance Level	No. of Recommendations
Treasury Management practices are not defined or not defined in line with required CIPFA Code of Practice and therefore does not meet statutory requirements.	**Adequate**	None
There is not regular reporting on Treasury Management activity and performance in	**Good**	None

Risk area	Assurance Level	No. of Recommendations
line with required CIPFA Code of Practice and therefore does not meet statutory requirements.		
Investments are made which do not comply with the approved strategy increasing the risk of loss.	**Good**	None
Cash flows are not accurately forecast resulting in a failure to meet liabilities as they become due or incurring avoidable borrowing costs or missed investment income.	**Good**	None
CHAPS or direct payments are made inappropriately, in error or fraudulently.	**Good**	None
Investment or borrowing transactions are not correctly recorded or reconciled to relevant financial systems.	**Adequate**	1 Low
Maturing investments and their associated interest payments are not received promptly and in full.	**Good**	None
Borrowing does not comply with Treasury Management policies which may result in the Council acting outside of its powers or borrowing with excessive costs.	**N/A**	No borrowing undertaken in 2021-22 at time of audit.
The maturity profile of borrowing is unaffordable or could require re-financing at unfavourable rates. Opportunities to re-finance are not regularly considered to manage future interest rate risk or reduce current costs of borrowings.	**N/A**	No borrowing undertaken in 2021-22 at time of audit.
Borrowing is not repaid on time or in full.	**N/A**	No borrowing undertaken in 2021-22 at time of audit.
Data is not effectively controlled	**Good**	None
Risk Assessments are not in place, not relevant or are not up to date	**Adequate**	None

Executive Summary

The Council's Treasury Management Procedures are satisfactory and in line with proper practice issued by the Chartered Institute of Public Finance and Accountancy (CIPFA). The Investment Strategy Statement and required Mid and End Year reviews have been approved by the Member Body.

The Treasury Management Practices were last reviewed in 2018. The service is aware and going forward reviews will be updated as part of the annual Treasury Strategy Review.

The controls in place for authorising, placing, and returning investments are managed effectively. Investments are evidenced within cash flow forecasting, dealing summaries and bank statements. Associated interest is also received in line with institute arrangements. Measures are in place to ensure segregation between initiating and approving an investment.

Regular monitoring of Council systems is undertaken, and an annual reconciliation provides assurance that investments and interest are correctly coded against the general ledger. To enhance this control, monthly reconciliations as part of the existing monitoring process should be adopted.

The Service Area Risk Register has not been updated since March 2019 and is currently under review.

CEMETERY MANAGEMENT
REPORT 4 – 2021/22

Audit objective

To assess whether controls and procedures in place in respect of cemetery management are effective.

Corporate links

This audit contributes to the assurance available regarding the following Business Plan objectives and risks identified on the corporate risk register:

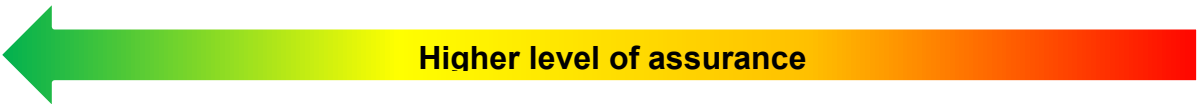
Business Plan objective	Maximise Our Assets Being Financially Sustainable
Corporate risk	Failure to ensure good governance of the Council's activities and delivery of its priority outcomes. Council held data is lost, disclosed, or misused to detriment of individuals or organisations as result of inadequate protection

Reason for inclusion in the annual audit plan

This audit is a planned, standard assurance review identified through the annual assessment of all Council's activities.

Audit opinion

Our opinion is expressed on the scale of assurance as set out below:



Good	Adequate	Limited	None
	✓		

We have formed our audit opinion based on how well controls have been designed and effectively operated to mitigate the following risks:

Risk area	Assurance Level	No. of Recommendations
Cemetery record keeping does not comply with legislation	**Adequate**	None
Cemeteries are not maintained in line with government guidance	**Adequate**	1 Moderate (No. 1)
Correct control is not maintained over fees and charges relating to cemetery management	**Good**	None
Data is not effectively controlled	**Adequate**	2 Low Priority (Nos. 2 & 3)

Risk area	Assurance Level	No. of Recommendations
Risk Assessments are not in place, not relevant or are not up to date	**Adequate**	1 Low Priority (No. 4)

Executive Summary

The cemetery management function is well established with the administration under the control of a dedicated officer within Customer Services, with the Woodlands / Open Spaces Team responsible for interments and ongoing maintenance of the cemeteries. The Council operates two cemeteries; Hall Road (and extension) and Rayleigh, which is, apart from limited circumstances, closed to new burials. There is, at Rayleigh, a Columbarium for interment of ashes and Memorial Wall with scope for scattering of ashes. Information about the cemeteries and the terms and conditions applying is available on the Council's website.

Figures provided by the Administrator advise that there were 172 interments in 2020/21 (132 in prior year) and 68 to date in 2021/22. Many of these were carried out under Covid-19 restrictions and at a time when resources were stretched.

Documentation examined shows the process to be both timely and respectful. The Epilog cemetery software provides a complete administrative tool and serves as the various records and registers required under the Local Authorities Cemetery Order 1977 (LACO) and its amendment in 1986. These include grave numbering and registration and records of ownership of burial plots. All relevant aspects of the LACO appear to be complied with apart from the requirement to acknowledge burials by returning part of a registrars' authority to bury form within four days of the interment. Whilst all those tested (16 cases) were returned within fourteen days only five were within the required timescale. These delays resulted from Covid-19 related issues and the relevant officer provides assurance that the standard is now being met. Accordingly, no recommendation has been raised. There are maps / plans for the cemeteries, in line with the LACO, but that for the extension in Hall Road is very much a rough draft, with plans to produce a formal version in the future.

One of the requirements under a government guide for burial grounds is that they should be kept in a good state of order and repairs. As part of the audit work the cemeteries were visited and areas between burial plots were considered to be in good condition visually. On the brief visit there was no obvious signs of anything needing significant repair.

There are a wide range of risk assessments and method statements for safe operations in the cemeteries. All operatives in the cemeteries have completed specialist training relating to burials. In discussion the officer with cemetery responsibility advised that whilst there are inspections there is no formal "force testing" to identify headstones or memorials that are at risk of falling and which could be a danger to visitors and staff. There should be, in accordance with the Institute of Cemeteries & Crematorium Management policy of 2019, a five-year programme to carry out such testing to address this risk. There are many headstones and memorials in Rayleigh Cemetery of a significant age on an undulating site, which could increase the risk. A recommendation has been made accordingly.

The complaints record for the second half of 2020/21 and first quarter of 2021/22 were examined. There were no complaints recorded against the cemeteries function but there were four compliments for the operatives relating to customer services and respectfulness.

There are published fees for the different types of interments and placing of monuments in the Council's cemeteries. Testing confirmed that all the required fees had been collected and posted to the relevant finance codes.

Minor recommendations have been made concerning data privacy notices, entries on the information asset register and cemetery-specific risk register entries within the service area risk register for Customer Services. These recommendations are to enhance controls rather than address service failings.

APPENDIX 3

COMPLETED LIGHT TOUCH AUDIT ENGAGEMENTS

RESTART GRANT CERTIFICATION
REPORT 5 – 2021/22

Assessed as Good

In March 2021, the government introduced grant support in the form of a one-off payment of up to £6000 for non-essential retail and up to £18,000 for hospitality, accommodation, leisure, personal care, and gym businesses in England.

Guidance was received from the Department for Business, Energy, and Industrial Strategy (BEIS) and there was an expectation that grants would be delivered quickly to help eligible businesses reopen safely following the easing of coronavirus restrictions across the Country.

BEIS produced risk assessment templates that supported internal controls and minimised risks for previous Covid-19 related grants. These were reviewed by Internal Audit (IA) and deemed appropriate for the purposes of the Restart Grant.

An online application form was created and incorporated the necessary guidance. The form had several declarations, and it was not possible for applicants to submit an application unless they answered ‘yes’ to each one. The declarations included a warning about fraudulent applications, confirmation that the business was trading as at 01/04/21, and that state aid limits were not exceeded.

A running total and record of all grants awarded were held centrally on Council systems. Weekly returns of grants paid were submitted directly to Central Government.

As part of an assurance review, a sample of 24 payments covering both strands of the grant were assessed to confirm the necessary checks had been completed, that the applicants were entitled to the grant and that payments were correctly made. Any queries were satisfactorily answered by the Business Rates Officer and there were no matters arising. It was also evident that officers involved in processing the grants were aware of and active in fraud prevention, and the relevant checks were undertaken.

Restart Grants were paid to a total of 444 applicants at a value of £3.370m

APPENDIX 4

PROGRESS OF AUDIT RECOMMENDATIONS

Report No	Report Title	Rec No	Risk	Recommendation	Implementation progress
17 2017/18	Procurement	3a	M	Contract Procedure Rules and Procurement Guidance will be updated (a)	Agreed Implementation Date 31/3/19 CPR review ongoing. Revised end date 31/12/19. Work in progress with many elements progressed but unable to complete, partially in respect of EU arrangements. Revised end date 31/03/20 Revised end date to bring in line with Constitution review and Financial Regulations review, 31/3/21 Constitution update to be reviewed and rescoped. Revised implementation date 31/3/22
2 2018/19	Street Cleaning Contract	1	M	For consistency and future planning, the work of the Street Scene Officers involved in monitoring the contract will be documented in a set of operational procedures.	Agreed Implementation date 1/4/19. Outcomes are being negotiated with Contractor. Revised end date 30/06/19. Monitoring sheets are being implemented. Written procedures still to be developed. Revised implementation 31/10/19. Procedures still to be developed. Revised end date 31/12/19. **Current Position (15/6/21)** This is now being actioned. A system is expected to be in place within 3 months Revised End Date 30/9/21

Report No	Report Title	Rec No	Risk	Recommendation	Implementation progress
6 2018/19	Insurance Arrangements	1	M	A project team will be established to consider an approach to produce, ideally, to produce a single asset register and to work on a solution. Matter raised during the audit will be reviewed and reflected in the 2018/19 balance sheet	Original End Date 31/12/19 The recommendation to establish an internal project team to create a master list of assets has been completed using Land Registry information to produce a single document that all internal teams will refer to and keep updated. Due to the different requirements of the finance, legal and assets teams, each service area also retains supporting documentation to supplement this for their own records. The supporting documentation is currently being worked through by the legal and assets teams to verify it is fully up to date. Some additional resource may be required to complete this work and determine whether a more integrated digital database solution can be utilised going forward – this will be investigated as part of the Connect Programme which is due to report back in summer 2021. End date 31/07/2021. . Report date is now Autumn 2021. Revised end date 31/3/2021

Report No	Report Title	Rec No	Risk	Recommendation	Implementation progress
11 2018/19	Budget Setting and Monitoring	2	M	RDC Financial Regulations will be reviewed to include appropriate controls of transfers to and from Reserves as stated in the Medium-Term Financial Strategy. To be considered as part of overall review of Financial Regs during 2019/20.	Agreed implementation date 31/03/20. Financial regulations to be reviewed as part of overall constitution. Revised end date 31/03/21. Constitution update to be reviewed and rescoped. Revised implementation date 31/3/22
14 2018/19	Contracts Procurement and Purchasing	2	M	Finance resilience checks will form part of the competitive process for fully tendered purchases for high value, high risk contracts, in order for the Council to be aware of the financial health of a supplier before entering into business with them. Contract Procedure Rules will be amended to include this detail.	Agreed implementation date 31/12/19 Revised end date to bring in line with other CPR recommendations 31/3/20 Revised end date to bring in line with Constitution review and Financial Regulations review. 31/3/21 Constitution update to be reviewed and rescoped. Revised implementation date 31/3/22
14 2018/19	Contracts Procurement and Purchasing	3	L	CPR will be amended to include safeguarding requirements and whether copies of contractor's policy statements should be included in all appropriate contracts.	Agreed implementation date 31/12/19. Unable to progress CPR until EU arrangements are known. Revised end date 31/03/20 Revised end date to bring in line with Constitution review and Financial Regulations review. 31/3/21 Constitution update to be reviewed and rescoped.

Report No	Report Title	Rec No	Risk	Recommendation	Implementation progress
					Revised implementation date 31/3/22
24 2019/20	ICT Security	2	S	The Council will commission a penetration test of the ICT environment as soon as practicable after completion of the migration of all operational systems to a cloud or managed service to determine its integrity	The internal infrastructure work was completed in March 2021 This now enables a penetration test to take place, and this has been commissioned to take place in early September 2021. Work started on the penetration test in the week commencing 6-9-21. It is expected that the report arising will be received by the end of September. Revised end date 30/9/21
4 2021/22	Cemetery Management	1	M	An inspection regime that will carry out “force testing” of potentially dangerous headstones or memorials, will be initiated in line with the Institute of Cemeteries & Crematorium Management policy of 2019.	Agreed Implementation date 28/2/22
4 2021/22	Cemetery Management	2	L	The Cemetery service will seek guidance from the Data Protection Officer to determine if a cemetery specific privacy notice is required.	Agreed implementation date 30/9/21

Report No	Report Title	Rec No	Risk	Recommendation	Implementation progress
4 2021/22	Cemetery Management	3	L	The cemetery management process will be included in the Information Asset Register	Agreed implementation date 30/9/21
4 2021/22	Cemetery Management	4	L	The Customer Services Risk Register will be updated to document the potential risks and the range of mitigating controls that are in place in respect of cemetery administration.	Agreed implementation date 30/9/21
2 2021/22	Complaint Handling	1	M	Internal and External Complaints Procedures will be updated to include the following areas: - What constitutes a complaint - How to deal with and report incoming complaints to Customer Services - The importance of formally responding, and communicating in a standard format, informing the customer of the escalation process should they remain unsatisfied. - Reporting to Customer Services on lessons learnt and how processes have been improved as a result of a complaint, where appropriate Out of date procedures on the intranet will be removed.	Agreed implementation date 31/10/21

Report No	Report Title	Rec No	Risk	Recommendation	Implementation progress
3 2021/22	Treasury Management	1	L	To enhance existing controls, monthly reconciliations will be adopted as part of the existing monitoring process.	Immediate Implementation

APPENDIX 5

BASIS FOR AUDIT OPINION		
Assurance level	***Internal Audit's opinion is based on <u>one or more</u> of the following conclusions applying: -***	***Basis for choosing assurance level***
Good	• The activity's key controls are comprehensive, well designed and applied consistently and effectively manage the significant risks. • Management can demonstrate they understand their significant risks and they are proactively managed to an acceptable level. • Past performance information shows required outcomes are clearly defined and consistently met.	Recommendations are 'low' rating. Any 'moderate' recommendations will need to be mitigated by consistently strong controls in other areas of the activity.
Adequate	• Most of the activity's key controls are in place, well designed and applied consistently and effectively manage the significant risks. • Management can demonstrate they understand their significant risks and they are generally and proactively managed to an acceptable level. • Past performance information shows required outcomes are clearly defined and generally met.	Recommendations are 'moderate' or "Low" rating. Any 'significant' rated recommendations will need to be mitigated by consistently strong controls in other areas of the activity. A 'critical' rated recommendation will prevent this level of assurance.
Limited	• The activity's key controls are absent or not well designed or inconsistently applied meaning significant risks. • Management cannot demonstrate they understand and manage their significant risks to acceptable levels. • Past performance information shows required outcomes are not clearly defined and or consistently not met.	Recommendations are 'significant' or a large number of 'moderate' recommendations. Any 'critical' recommendations need to be mitigated by consistently strong controls in other areas of the activity.
None	• The activity's key controls are absent or not well designed or inconsistently applied in all key areas. • Management cannot demonstrate they have identified or manage their significant risks.	Recommendations are 'critical' without any mitigating strong controls in other areas of the activity.

	• Required outcomes are not clearly defined and or consistently not met.	

APPENDIX 6

RECOMMENDATION CATEGORIES		
C	**CRITICAL**	The identified control weakness could lead to a **critical impact** on the activity's ability to manage the risks to achieving its key objectives. The control weakness means the associated risk **highly likely** to occur or have occurred. There are **no compensating controls** to possibly mitigate the level of risk.
S	**SIGNIFICANT**	The identified control weakness could have a **significant impact** on the activity's ability to manage the risks to achieve its key objectives. The control weakness means the associated risk is **likely to occur** or have occurred. There are **few effective compensating controls**. Where there are compensating controls, these are more likely to be detective (after the event) controls which may be insufficient to manage the impact. The difference between 'critical' and 'significant' is a lower impact and or lower probability of occurrence and or that there are some compensating controls in place.
M	**MODERATE**	The identified control weakness could have a **moderate impact** on the activity's ability to manage the risk to achieving its key objectives. The control weakness **does not undermine the activity's overall ability** to manage the associated risk (as there may be compensating controls) but could reduce the quality or effectiveness of some processes and or outcomes.
L	**LOW**	The identified control weakness is **not significant,** and recommendations are made in general to improve current arrangements. Note – these recommendations will not be followed up.