Agenda

Meeting: **Audit Committee**

Venue: **Brierley Room, County Hall, Northallerton** (Location plan at page 5)

Date: **Wednesday 10 October 2018 at 3.00pm**

Note: **Members are invited to attend a seminar concerning Treasury Management and Commercial Investments at 2.30 pm in the Brierley Room**

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Business

1. **Minutes of the meeting held on 26 July 2018**

(Pages 6 to 11)

Enquiries relating to this agenda please contact Ruth Gladstone **Tel: 01609 532555**
or e-mail ruth.gladstone@northyorks.gov.uk
www.northyorks.gov.uk

2. Declarations of Interest

3. Public Questions or Statements

Members of the public may ask questions or make statements at this meeting if they have given notice to Ruth Gladstone of Democratic Services and supplied the text *(contact details at the foot of the first page of agenda)* by midday on Friday 5 October 2018. Each speaker should limit themselves to 3 minutes on any item. Members of the public who have given notice will be invited to speak:-

- at this point in the meeting if their questions/statements relate to matters which are not otherwise on the Agenda (subject to an overall time limit of 30 minutes);
- when the relevant Agenda item is being considered if they wish to speak on a matter which is on the Agenda for this meeting.

If you are exercising your right to speak at this meeting, but do not wish to be recorded, please inform the Chairman who will instruct those taking a recording to cease while you speak.

4. Progress on Issues Raised by the Committee – Joint report of the Corporate Director – Strategic Resources and the Assistant Chief Executive (Legal and Democratic Services)
(Pages 12 to 14)

5. Health and Adult Services Directorate:-

(a) **Internal Audit Work** - Report of the Head of Internal Audit
(Pages 15 to 27)

(b) **Internal Control Matters** - Report of the Corporate Director – Health and Adult Services
(Pages 28 to 49)

6. Internal Audit Report on Information Technology, Corporate Themes and Contracts - Report of the Head of Internal Audit
(Pages 50 to 64)

7. Business Continuity – Update Report - Report of the Head of Resilience and Emergencies
(Pages 65 to 68)

8. Annual Audit Letter 2017/18 – Letter from KPMG
(Pages 69 to 77)

9. Progress on 2018/19 Internal Audit Plan - Report of the Head of Internal Audit
(Pages 78 to 82)

10. Annual Report of the Audit Committee - Report of the Chair of the Audit Committee
(Pages 83 to 91)

11. Audit Committee Terms of Reference / Review of Effectiveness – Report of the Corporate Director – Strategic Resources
(Pages 92 to 99)

12. Audit Committee Programme of Work 2018/19
(Page 100)

13. Other business which the Chairman agrees should be considered as a matter of urgency because of special circumstances

Barry Khan
Assistant Chief Executive (Legal and Democratic Services)

County Hall
Northallerton

Notes:

Emergency Procedures for Meetings

Fire

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Persons should not re-enter the building until authorised to do so by the Fire and Rescue Service or the Emergency Co-ordinator.

An intermittent alarm indicates an emergency in nearby building. It is not necessary to evacuate the building but you should be ready for instructions from the Fire Warden.

Accident or Illness

First Aid treatment can be obtained by telephoning Extension 7575.

AUDIT COMMITTEE

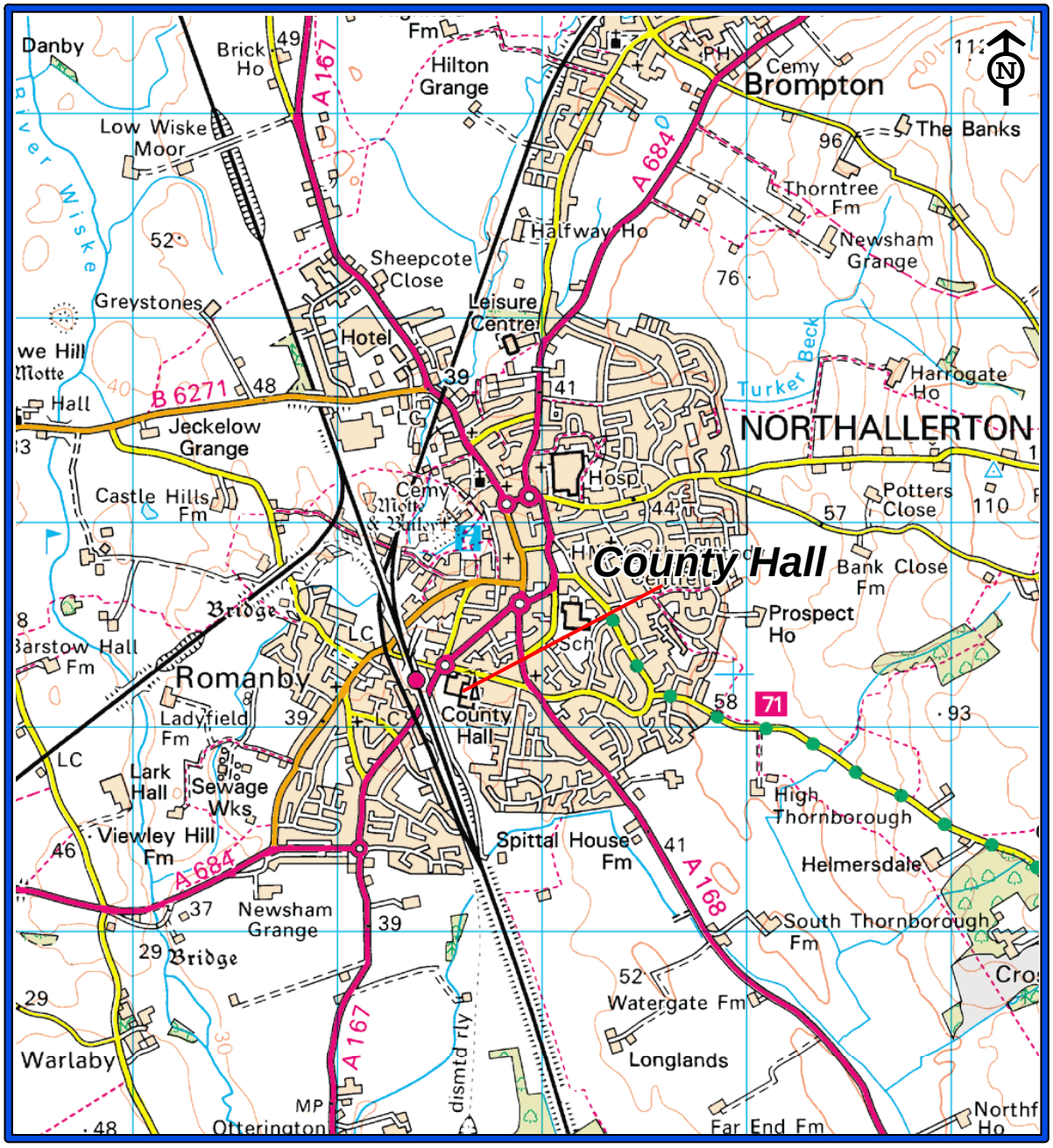
1. Membership

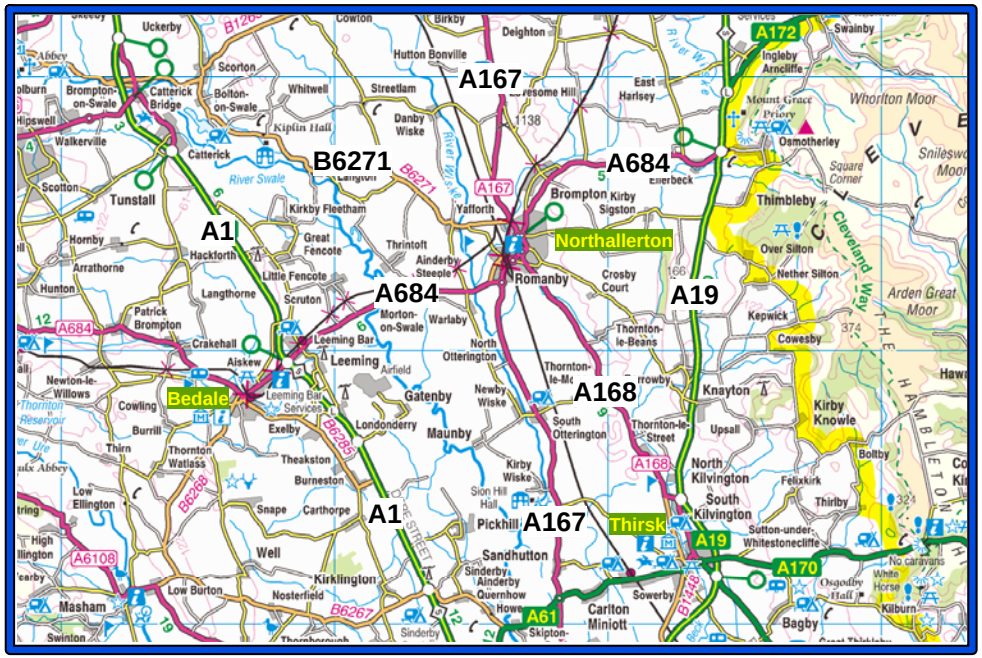
County Councillors (8)			
	Councillors Names		*Political Group*
1	ARTHUR, Karl		Conservative
2	ATKINSON, Margaret	Vice-Chairman	Conservative
3	BAKER, Robert		Conservative
4	CLARK, Jim		Conservative
5	HUGILL, David		Conservative
6	LUNN, Cliff	Chairman	Conservative
7	MACKAY, Don		NY Independents
8	WEBBER, Geoff		Liberal Democrat
Members other than County Councillors (Non-voting) (3)			
1	PORTLOCK, David		
2	MARSH, David		
3	GRUBB, Nick		
Total Membership – (11)		**Quorum – (3) County Councillors**	

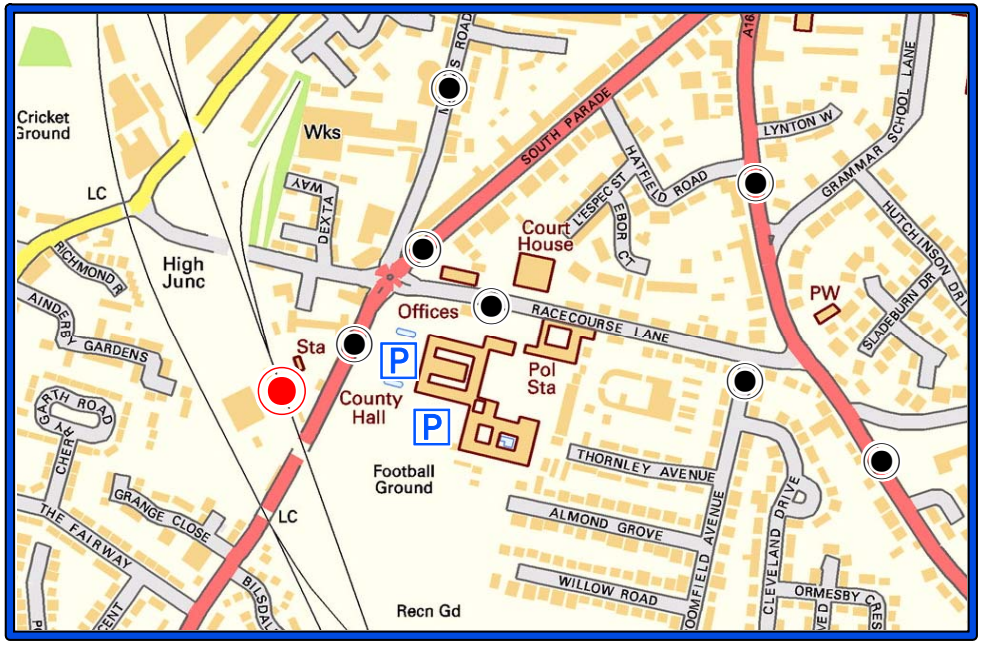
Con	**Lib Dem**	**NY Ind**	**Labour**	**Ind**	**Total**
6	1	1	0	0	8

2. Substitute Members

Conservative		**Liberal Democrat**	
	Councillors Names		*Councillors Names*
1	BACKHOUSE, Andrew	**1**	BROADBANK, Philip
2	COOPER, Richard	**2**	
3	THOMPSON, Angus	**3**	
4	PARASKOS, Andy	**4**	
5	PATMORE, Caroline	**5**	
NY Independent			
	Councillors Names		
1			
2			
3			
4			
5			







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North Yorkshire County Council

North Yorkshire County Council

Audit Committee

Minutes of the meeting held on Thursday 26 July 2018 at 1.30 pm at County Hall, Northallerton

Present:-

County Councillor Members of the Committee:-

County Councillor Cliff Lunn (in the Chair); County Councillors Karl Arthur, Margaret Atkinson, Robert Baker, Jim Clark, David Hugill and Geoff Webber

Independent Members of the Committee:-

Mr David Marsh and Mr David Portlock

In Attendance:-

County Councillor Carl Les (Leader of the County Council)

KPMG Officer: Rashpal Khangura

Deloitte Officers observing this meeting: Paul Thomson and Nick Rayner

Veritau Ltd Officer: Max Thomas (Head of Internal Audit)

County Council Officers: Amanda Alderson (Senior Accountant, Strategic Resources), Gary Fielding (Corporate Director – Strategic Resources), Ruth Gladstone (Democratic Services) and John Raine (Head of Technical Finance, Strategic Resources)

Apology for Absence:-

An apology for absence was received from County Councillor Don Mackay

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Copies of all documents considered are in the Minute Book

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74. Minutes

Mr David Marsh (Independent Member) advised that Kevin Draisey (Head of Procurement and Contract Management) had undertaken to provide data concerning contracts with smaller companies but that had not been done. Mr David Marsh also advised that he wished such data to be circulated to all Members of the Audit Committee. Gary Fielding advised that he understood that Kevin Draisey had already supplied the data requested but that the situation would be checked.

Resolved -

That the Minutes of the meeting held on 21 June 2018, having been printed and circulated, be taken as read and be confirmed and signed by the Chairman as a correct record, subject to correction of the following typographical errors which each appear in the preamble to Minute 68 regarding Corporate Governance:- ‘DGPR’ to be replaced with ‘GDPR’; and ‘26 July 2017’ to be replaced with ’26 July 2018’.

75. Declarations of Interest

There were no declarations of interest.

76. Public Questions or Statements

There were no questions or statements from members of the public.

77. External Audit Report 2017/18 on North Yorkshire County Council and North Yorkshire Pension Fund

Considered -

The report of KPMG which summarised the key findings in relation to the 2017/18 external audit of the County Council and the Pension Fund, the key issues of which were as follows:-

- Subject to all outstanding queries being resolved to KPMG's satisfaction, KPMG anticipated issuing unqualified audit opinions on the financial statements of the County Council and the Pension Fund by the deadline of 31 July 2018.

- KPMG had concluded that the County Council had made proper arrangements to secure economy, efficiency and effectiveness in its use of resources. Therefore KPMG anticipated issuing an unqualified value for money opinion.

Rashpal Khangura of KPMG presented the report and thanked officers and Members, highlighting that this was the final year when KPMG would be providing the external audit to the County Council and the Pension Fund.

Rashpal Khangura responded to Members' questions. Mr David Portlock referred to the use of the word 'errors' by Rashpal Khangura during his presentation in connection with the audit adjustments which had been agreed with Officers. Mr Portlock suggested that this gave a misleading impression and that, rather than 'errors', these were complex technical issues regarding interpretation and presentation in respect of which different opinions were possible. There was discussion about the adjustments which had been made to the financial statements in the context of recent changes made to accounting guidance. Rashpal Khangura agreed that 'errors' was probably a strong word. Mr Portlock commented that, in his view, 'errors' was an incorrect word. The Corporate Director – Strategic Resources commented that there were presentation and interpretation issues and Officers had no incentive to overstate the value of assets.

Resolved -

That the report be noted.

78. Annual Report of the Head of Internal Audit

Considered -

The report of Max Thomas (Head of Internal Audit) which advised of:-

- the internal audit work performed during the year ended 31 March 2018, together with the opinion of the Head of Internal Audit in respect of the overall framework of governance, risk management and control in place within the County Council;

- breaches of Finance, Contract and Property Procedure Rules identified during 2017/18 audit work;

- Internal Audit performance outturn for 2017/18 and 2018/19 performance targets for Veritau; and

- Veritau's conformance to professional standards and the conclusions arising from the Quality Assurance and Improvement Programme.

The report was introduced by Max Thomas who also responded to Members' questions. Max Thomas described engagement between Veritau and the County Council's Management as excellent. Max Thomas provided confirmation that Management were taking appropriate action to address Information Security and Transparency issues.

County Councillor Jim Clark asked about any arrangements in place to mitigate against risk where the County Council was involved in arrangements with Health organisations such as CCGs. Gary Fielding provided an assurance that proper controls were in place over pooling arrangements and that the County Council was aware of such issues and was not in a vulnerable position in that regard.

Resolved -

(a) That the overall 'Substantial Assurance' opinion of the Head of Internal Audit regarding the overall framework of governance, risk management and control operating within the County Council be noted.

(b) That the significant control issues identified through internal audit work in 2017/18 be noted.

(c) That the outcome of the Quality Assurance and Improvement Programme and the confirmation that the Internal Audit Service conforms with the Public Sector Internal Audit Standards be noted.

(d) That the performance outturn for 2017/18 in respect of internal audit and the corresponding performance targets for 2018/19 be noted.

79. Report following the Detailed Review of the Draft Statement of Final Accounts (incorporating Annual Governance Statement) for 2017/18

Considered -

The report of the Members' Working Group, comprising the Committee's Chairman and Vice-Chairman and Mr David Portlock (Independent Member of the Committee), concerning the outcome of their detailed consideration of the draft Statement of Final Accounts and the Annual Governance Statement for 2017/18. The conclusions of the Members' Working Group were as follows:-

- The Group was satisfied that all appropriate actions had been taken and satisfactory explanations had been provided where required.

- No further issues had been identified up to the date of the Group's report. However, it was highlighted that the Members' Working Group had not been made aware of the finalised position on the findings of the County Council's External Auditors.

- Subject to the above, the Members' Working Group recommended the Audit Committee to approve the Statements of Final Accounts and the Annual Governance Statement for 2017/18.

The report was introduced by Mr David Portlock who also advised that the officers had been totally engaged in the review process. Mr Portlock asked for the Minutes of this meeting to record his appreciation and thanks to the officers.

The Chairman and Vice-Chairman each expressed their thanks to Mr Portlock for the time he had taken in participating in this review and for producing the report submitted to this meeting.

Resolved -

That the report be noted.

80. Statement of Final Accounts for 2017/18, including Letter of Representation

Considered -

The report of Gary Fielding (Corporate Director – Strategic Resources) which invited the Committee to approve a Letter of Representation required to be submitted to the External Auditor, and to approve a Statement of Final Accounts for 2017/18 following completion of the external audit of those accounts and to approve the Annual Governance Statement for 2017/18.

The report was introduced by Gary Fielding who expressed his thanks:- to Mr David Portlock for the amount of work he had undertaken, and for the way in which he had done that work; to Rashpal Khangura and his staff at KPMG for their courtesy and the good constructive relationship which they had with the County Council's officers; and to the Finance Team which he described as "brilliant". Gary Fielding also highlighted that preparation of the County Council's annual Statement of Final Accounts became more difficult each year due to changes in guidance and that the team had done a great job. The Chairman, on behalf of Members, echoed those thanks.

Gary Fielding provided confirmation that he was happy to sign the Letter of Representation.

Mr David Portlock highlighted that the conclusions of the Members' Working Group included a recommendation which was subject to any issues arising from the External Auditor's close-off work. Mr Portlock advised that no such issues had arisen and he was therefore happy for the Committee to approve the recommendations before it.

Resolved -

(a) That the Chairman be authorised, on behalf of the Audit Committee, to sign the Letter of Representation as set out at Appendix A to the report.

(b) That, in relation to the Statement of Final Accounts 2017/18:-

(i) the changes to the Final Statement of Final Accounts, as set out in paragraph 4 of the report and at Appendix B to the report, be noted;

(ii) the Final Statement of Final Accounts for 2017/18, as described at paragraph 5.2 of the report, be approved; and

(iii) the Chairman be recommended to sign the Statement of Responsibilities for the Statement of Accounts, as set out at Appendix C to the report.

(c) That the Annual Governance Statement 2017/18 be approved and the Chairman be authorised to sign the Annual Governance Statement on the Committee's behalf, as described at paragraph 6.5 of the report.

81. Audit Committee Work Programme

Considered -

The report of Gary Fielding (Corporate Director - Strategic Resources) which set out the Committee's Work Programme and advised of the outcome of a review of the County Council's approach to commercial investment and the subsequent selection of three Property Funds for potential inclusion on the County Council's Investment List.

The report was introduced by Gary Fielding who highlighted the proposals that:- Treasury Management and Commercial Investments should be the theme for the Committee's Seminar to be held in October 2018; private discussions between Committee Members and the External and Internal Auditors would be scheduled at some point; and that lessons learned from Northamptonshire County Council should be reported, possibly as a substantive item of business at a future meeting of the Committee.

During questions, Gary Fielding provided confirmation that Governance and Treasury Management strategy and policy issues had been considered before the decision had been made to move some of the County Council's investments into property funds, and also that due diligence had been carried out.

It was reported that the meeting of the Committee, currently scheduled for Thursday 18 October 2018, needed to be re-arranged to another date. The afternoon of Wednesday 10 October 2018 was suggested as the date to which the meeting should be moved. Members expressed support for that suggestion.

It was suggested that the Committee should meet during March 2019, instead of during April 2019, in order to reduce the gap between the December 2018 meeting and the April 2019 meeting. However, an additional meeting of the Committee could be convened if necessary.

Members asked for the dates of the Committee's meetings to be held between now and January 2020 to be circulated. Officers undertook to arrange the necessary action.

Resolved -

(a) That the Work Programme be approved.

(b) That the Committee's meeting currently scheduled for Thursday 18 October 2018 be moved to the afternoon of 10 October 2018.

(c) That the dates of all meetings of the Committee to be held between now and January 2020 be emailed to Committee Members and Independent Members.

82. Appointment of Independent Members

Note: Mr David Marsh and Mr David Portlock (Independent Members) left the meeting before this item of business was considered.

Considered -

The report of County Councillor Cliff Lunn (Committee Chairman) which advised of the outcome of the recruitment process, and interviews where necessary, for the appointment of up to three Independent Members of the County Council's Audit Committee to serve for four years up to and including 31 July 2022.

It was reported orally that Mr David Marsh and Mr David Portlock were recommended for appointment for a further term and that Mr Nicholas Grubb who, at interview, had demonstrated the necessary skills and ambition, together with a fresh perspective, should be offered appointment as an Independent Member of the Committee.

Resolved -

(a) That the persons listed below (in alphabetical order by surname) be offered appointment as Independent Members of the Audit Committee, to serve for the four years up to and including 31 July 2022:-

- Mr Nicholas Grubb
- Mr David Marsh
- Mr David Portlock

(b) That the Constitution Members' Working Group be recommended to agree that the term of appointment of Independent Members of the Audit Committee shall be four years from the 31st July during the year which follows a County Council election in order to provide consistency during the period for production, and subsequent approval of, the Statement of Final Accounts.

In closing the meeting, the Chairman, on behalf of the Committee, expressed Members' thanks to KPMG for all the work they had undertaken during recent years as the County Council's External Auditor.

The meeting concluded at 2.40pm.

RAG/JR

NORTH YORKSHIRE COUNTY COUNCIL

AUDIT COMMITTEE

10 October 2018

PROGRESS ON ISSUES RAISED BY THE COMMITTEE

Joint Report of the Corporate Director – Strategic Resources and the Assistant Chief Executive (Legal and Democratic Services)

1.0 PURPOSE OF THE REPORT

1.1 To advise Members of

(i) progress on issues which the Committee has raised at previous meetings

(ii) other matters that have arisen since the last meeting and that relate to the work of the Committee

2.0 BACKGROUND

2.1 This report is submitted to each meeting listing the Committee's previous Resolutions and / or when it requested further information be submitted to future meetings. The table below represents the list of issues which were identified at previous Audit Committee meetings and which have not yet been resolved. The table also indicates where the issues are regarded as completed and will therefore not be carried forward to this agenda item at the next Audit Committee meeting.

Date	Minute number and subject	Audit Committee Resolution	Comment	Complete?
	41 – Audit Committee Terms of Reference / Review of Effectiveness	That a review of the Committee's effectiveness be undertaken after November 2018 and in the meantime, the Chairman take informal soundings from individual Members on a 1 to 1 basis and the CD Strategic Resources speak with relevant officers on a 1 to 1 basis to seek any comments they may have regarding the effectiveness of the Committee	On agenda for this meeting	x
21.06.18	66 – Draft Statement of Accounts 2017/18	That a Corporate Governance Working Group be created to provide further overview of the Statement of Final Accounts for 2017/18 and the supporting documentation and that		✓

Date	Minute number and subject	Audit Committee Resolution	Comment	Complete?
		the Chairman and Vice-Chairman of Audit Committee and Mr David Portlock be appointed to that Working Group.		
	69 – 2018/19 Internal Audit Plan	That the CD – SR report to a future meeting on the knowledge acquired following financial and management failures at Northamptonshire CC	Possible additional item to be raised in pre-training event for 10 October	?
26.07.18	81 – Audit Committee Work Programme	That the Committee's meeting currently scheduled for Thursday 18 October 2018 be moved to the afternoon of 10 October 2018	This meeting has now been moved.	✓
	81 – Audit Committee Work Programme	That the dates of all meetings of the Committee to be held between now and January 2020 be emailed to Committee Members and Independent Members	The email has been circulated to all.	✓

3.0 TREASURY MANAGEMENT

Property Funds

3.1 Property Funds, pooled investment vehicles investing in diversified UK commercial property, were added to the schedule of Non Specified Investments as part of the 2018/19 Annual Treasury Management Strategy. The Investment strategy provides for up to £20m to be invested for a period of up to 5 years in Property Funds.

3.2 Following consultation with the Audit Committee and subsequent approval by the Commercial Investment Board, a procurement process, supported by the County Councils Treasury Management advisers was undertaken and two Property Funds, BlackRock UK Property Fund and Threadneedle Property Unit Trust were selected for an initial £6m investment.

3.3 Accounts with both funds are now operational and units for these funds are currently being sourced. The first investment in each of the funds (£3m) will be placed at the next transaction date at the end of October.

Pension Fund Support

3.4 The North Yorkshire Pension Fund is currently rebalancing investment in certain asset classes following a review its investment strategy. The Pension Fund will utilise the current treasury management arrangements with the County Council to manage the £160m disinvestment and reinvestment process over the 3 year period.

3.5 The Pension Fund due diligence process was concluded in September and the disinvestment process is scheduled to commence in early October, which will result in the

initial £160m additional funds being managed under the treasury management function from mid-October. The £160m additional funds are forecast to reduce to nil over the 3 year period.

Treasury Management Support

3.6 Arrangements are currently being made to provide Treasury Management support to Ryedale District Council and for the District Council's cash funds to be invested as part of the County Council's total investment pool. This is part of the wider partnership working with Ryedale District Council. North Yorkshire County Council already has similar arrangements in place with Selby District Council.

3.7 In addition, the Treasury Management team has also agreed to provide Treasury Management support to Align Property Partners – one of the County Councils subsidiary companies. In a similar arrangement to other users of the service, the Align cash funds will be invested as part of the County Council's total investment pool.

4.0 RECOMMENDATION

4.1 That the Committee considers whether any further follow-up action is required on any of the matters referred to in this report.

GARY FIELDING
Corporate Director – Strategic Resources

BARRY KHAN
Assistant Chief Executive
(Legal and Democratic Services)

County Hall
NORTHALLERTON

10 October 2018

Background Documents: Report to, and Minutes of, Audit Committee meeting held on 21 June 2018 and 26 July 2018

NORTH YORKSHIRE COUNTY COUNCIL

AUDIT COMMITTEE

10 OCTOBER 2018

INTERNAL AUDIT WORK FOR THE HEALTH AND ADULT SERVICES DIRECTORATE

Report of the Head of Internal Audit

1.0 PURPOSE OF THE REPORT

1.1 To inform Members of the **internal audit work** performed during the year ended 31 August 2018 for the Health and Adult Services (HAS) directorate and to give an opinion on the systems of internal control in respect of this area.

2.0 BACKGROUND

2.1 The Audit Committee is required to assess the quality and effectiveness of the corporate governance arrangements operating within the County Council. In relation to HAS, the Committee receives assurance through the work of internal audit (as provided by Veritau), as well as receiving a copy of the latest directorate risk register.

2.2 This agenda item is considered in two parts. This first report considers the work carried out by Veritau and is presented by the Head of Internal Audit. The second part is presented by the Corporate Director – Health and Adult Services and considers the risks relevant to the directorate and the actions being taken to manage those risks.

3.0 WORK DONE DURING THE YEAR ENDED 31 AUGUST 2018

3.1 Details of the internal audit work undertaken for the directorate and the outcomes of these audits are provided in **Appendix 1.**

3.2 Veritau has also been involved in carrying out a number of assignments which have not resulted in the completion of an audit report. This work has included special investigations that have either been communicated via the Whistleblowers' hotline or have arisen from issues and concerns referred to Veritau by HAS management. We have also led on work involving data matches received from the National Fraud Initiative (NFI). Finally, we have provided support to directorate management in respect of a number of safeguarding alerts and other matters.

3.3 As with previous audit reports, an overall opinion has been given for each of the specific systems or areas under review. The opinion given has been based on an assessment of the risks associated with any weaknesses in control identified. Where weaknesses are identified then remedial actions will be agreed with

management. Each agreed action has been given a priority ranking. The opinions and priority rankings used by Veritau are detailed in **Appendix 2**. Some of the audits undertaken in the period focused on value for money or the review of specific risks so did not have an audit opinion assigned to them.

3.4 It is important agreed actions are formally followed up to ensure that they have been implemented. Veritau follow up all agreed actions on a regular basis, taking account of the timescales previously agreed with management for implementation. **On the basis of the follow up work undertaken during the year, the Head of Internal Audit is satisfied with the progress that has been made by management to implement previously agreed actions necessary to address identified control weaknesses.**

3.5 The programme of audit work is risk based. Areas that are assessed as well controlled or low risk are reviewed less often with audit work instead focused on the areas of highest risk. Veritau's auditors work closely with directorate senior managers to address any areas of concern.

4.0 AUDIT OPINION

4.1 Veritau performs its work in accordance with the Public Sector Internal Audit Standards (PSIAS). In connection with reporting, the relevant standard (2450) states that the Chief Audit Executive (CAE)[1] should provide an annual report to the board[2]. The report should include:

(a) details of the scope of the work undertaken and the time period to which the opinion refers (together with disclosure of any restrictions in the scope of that work)

(b) a summary of the audit work from which the opinion is derived (including details of the reliance placed on the work of other assurance bodies)

(c) an opinion on the overall adequacy and effectiveness of the organisation's governance, risk and control framework (i.e. the control environment)

(d) disclosure of any qualifications to that opinion, together with the reasons for that qualification

(e) details of any issues which the CAE judges are of particular relevance to the preparation of the Annual Governance Statement

(f) a statement on conformance with the PSIAS and the results of the internal audit Quality Assurance and Improvement Programme.

4.2 The overall opinion of the Head of Internal Audit on the framework of governance, risk management and control operating in the Health and Adult Services directorate is that it provides **Substantial Assurance.** There are no qualifications to this opinion and no reliance was placed on the work of other assurance bodies in reaching that opinion.

[1] The PSIAS refers to the Chief Audit Executive. This is taken to be the Head of Internal Audit.
[2] The PSIAS refers to the board. This is taken to be the Audit Committee.

5.0 **RECOMMENDATION**

5.1 That Members consider the information provided in this report and determine whether they are satisfied that the internal control environment operating in the Health and Adult Services Directorate is both adequate and effective.

Max Thomas
Head of Internal Audit

Veritau Ltd
County Hall
Northallerton

26 September 2018

BACKGROUND DOCUMENTS

Relevant audit reports kept by Veritau Ltd at 50 South Parade, Northallerton.

Report prepared by Stuart Cutts, Audit Manager, Veritau and presented by Max Thomas, Head of Internal Audit.

Appendix 1

FINAL AUDIT REPORTS ISSUED IN THE YEAR ENDED 31 AUGUST 2018

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
A	Visits to care provider establishments: • The Lodge, (Scarborough) • Mencap (Scarborough) • Moorview (Whitby) • UBU Roche Avenue (Harrogate) • Avalon (Scarborough) • Eldercare • Foresight • Avalon Shared Lives • Financial Management review - Botton Village	Various: 1 x High Assurance 4 x Substantial Assurance 1x Reasonable Assurance 1 x Limited Assurance 2 x No opinion	We completed a programme of audit visits to care providers to ensure: • Financial transactions relating to service users are recorded correctly and in accordance with the care provider's policies and procedures; • All expenditure relating to service users is appropriate and properly evidenced; • Financial arrangements ensure that the property of service users is protected.	Various	Some providers did not have financial risk assessments on file for residents. There were no instructions available to staff on how to handle each resident's money. We also found several examples where providers were not fully complying with their own policies. This included instances where they were failing to carry out sufficient checks of the cash held by residents and were either not completing reconciliations of accounts or signing them off. For those establishments given high and substantial assurance the arrangements were found to be generally working as expected with a small number of improvement points. The 'no opinion' audits were targeted 'follow up' reviews of specific issues. As such we did not evaluate the wider systems, processes and controls within theses establishments. Areas for improvement were however highlighted.	**Six P2 and twenty P3 actions were agreed** **Responsible Officer: Assistant Director – Quality and Engagement** The Quality and Engagement Team discussed the issues identified with the providers in question and worked as necessary to ensure any required improvements were made.

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
B	Direct Payments (2016/17)	Substantial Assurance	We reviewed the Direct Payment system to ensure: • The application process and initial assessment provided sufficient control and choice to the individual • There was effective monitoring of Direct Payment customers to ensure adequate care was provided and any misuse of Direct Payments was identified. • Performance management of Direct Payments (including management arrangements, policy, procedure, interaction with other areas of HAS and analysis of data) was effective.	October 2017	The control framework in place ensures Direct Payments are set up and used correctly in the majority of cases. The applications process and initial assessment of Direct Payment customers provided sufficient control and choice. There was potential for improving the integration and knowledge between some Direct Payment advisors and social care workers. The monitoring of Direct Payment accounts requires some improvement. Whilst effective monitoring was seen widely from the sample of cases we reviewed, some cases required more frequent monitoring than was taking place. Direct Payment clients were unable to employ personal assistants when they were the most appropriate and flexible option of care.	**One P2 and five P3 actions were agreed** **Responsible Officer: Direct Payment Team Leader** The DP procedure requires all reviews to be conducted jointly by DP Advisors and Social Care workers. Successful work has been completed in the Selby area focusing on realigning reviews to ensure they are conducted jointly. DPSS Team Leaders plan to ensure this practice is embedded countywide. Workshops were undertaken in September 2017 to review the monitoring process. A new process and plan was to be implemented. The level of frequency was also to be reviewed. The 'Make Care Matter' proposal aimed to raise awareness about adult social care, including a platform to advertise for personal assistants. We have also introduced a new Approaches - Pilot underway
C	Controls for Residential Care	Reasonable Assurance	The County Council pays towards the residential or nursing care of over 2,000 people at an annual cost of approximately £63 million. It is important that information about deaths is communicated to	October 2017	Providers were not routinely notifying the council of deaths within the 48 hour contractual period. Of the 51 deaths reviewed, only 16 had been notified within 48 hours. There was no consistency to how	**Five P2 and two P3 actions were agreed** **Responsible Officer: Benefits, Assessment and Charging Manager and Quality Assurance Manager**

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			the Council and between departments, and that systems are updated accordingly. The audit reviewed the procedures and controls in place that ensure: • Information on residential care deaths was being promptly provided to the Council and effectively processed and updated through all relevant Council systems • Scrutiny of bed returns information was up to date, robust and issues of incomplete/out of date returns were being appropriately managed and escalated.		deaths are reported to the council. The wording of the contract means any contact with the council will mean the home has complied with its contractual obligations. Once the 'Tell Us Once' death notification is received by the council, the relevant details are not being processed onto Liquid Logic in a timely manner. Entering a date of death into Liquid Logic also does not stop payments being made. Providers were not always submitting the Bed Returns to the council. In addition, the council was not always processing the information contained within the Bed Returns submitted by the providers. The checking process before sending out the following four weekly Bed Returns was not always being completed effectively. One example was found where the council had failed to end payments to a home for a service user, despite being notified of the death on five Bed Returns.	The audit has raised awareness of the terms and conditions of the contract. A bulletin has been sent to providers to reinforce the message that providers must comply with the terms and conditions of the contract. The BACS Manager has reinforced the need for BACS staff to be notified of deaths so appropriate action can be taken. Work is ongoing with the General Manager, Registrars, Archives and Coroners to develop a process whereby registrars will notify NYCC of all deaths on regular basis. There is awareness of the weaknesses in the bed returns process. Some procedures have changed over the last year with a view to improving the situation. A lack of resources has contributed to some of the issues. The BACS manager is to work with other officers in the Council to help make further improvements in the sending of letters to providers.
D	HAS Debt Management	No opinion given	Senior HAS management requested a review in order to better understand the factors which have contributed to debts being written off or taking a	November 2017	A number of control weaknesses were identified. Financial assessments were not always being completed in a timely	**Six P2 actions were agreed** **Responsible Officer: Assistant Director Strategic Resources**

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			significant amount of time to collect. The review considered whether: • The processes in place for debt recovery were efficient • Invoices were being written off when appropriate and following the correct procedures • Credit Notes were being correctly raised. The review tested a sample of debts being dealt with in Credit Control and three specific cases requested by management. No opinion was given due to the targeted nature of the audit work.		manner resulting in clients accumulating a high value of backdated debt. Invoices were also not being issued in a timely manner from the date of the financial assessment. There are a number of cases where debt has been incurred through financial abuse. In one case a social care worker put the client's account on hold for a four month period so debt accumulated. This was due to some poor internal communication. One of the debts in the sample tested had numerous time delays between each part of the process until resolution. For the sample tested, debts had been written off at an appropriate level and credit notes had been used appropriately to correct errors in the issuing of invoices.	The findings helped support internal work on the corporate review of income and debt management which HAS Leadership Team were considering. Heads of Service have reminded staff of the need for timely referrals for financial assessments to be made. A reminder has been issued by Head of Quality and Monitoring to providers regarding their obligation to report changes including non-payment of contributions by the client. Credit Control now have 'read only' access to LLA and ContrOCC All staff have been reminded of the need to report suspected financial abuse, whether through Safeguarding or direct to the relevant manager.
E	Public Health	Substantial Assurance	The Public Health team have produced a new strategy to help reduce the rate of obesity in North Yorkshire. The Council also re-commissioned the smoking prevention service to help support	December 2017	We found the Public Health Team has plans were in place to respond to public health incidents. These have been co-ordinated with Emergency Planning and Public Health England.	**Three P3 actions were agreed** **Responsible Officer: Health Improvement Manager** Public Health and the Contracting

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			delivery of the Tobacco Control Strategy. The audit reviewed the procedures and controls in place to ensure: • The council has appropriate plans to prepare for and prevent public health incidents, which are co-ordinated with other agencies • Plans were in place to deliver and monitor the strategy for Healthy Weight, Healthy Lives: Tackling overweight and obesity in the North Yorkshire 2016-2026. • The new model for reducing the levels of smoking was effectively monitored and has appropriate performance mechanisms.		Progress has been made in delivering projects that contribute to the overall identified priority areas for the Healthy Weight, Healthy Lives Strategy. The strategy has a plan for clear governance arrangements. Solutions4Health (S4H) was awarded the contract for the new smoking prevention service. However, S4H had not been fully meeting the performance requirements set out in the contract. There was no control in place to validate S4H clients that receive remote support, to ensure the client and their details are genuine. The council has taken action to support and challenge S4H to address the poor performance. We also completed some additional audit checks which found errors with the payments by results claim form.	Team were working with S4H to identify additional controls to improve validation checking of performance data to help prevent a similar incident from occurring again. All S4H clients are now required to take a Carbon Monoxide meter reading. This test will help to support claims that the client has stopped smoking. Management were also considering carrying out spot checks to provide additional insight and/or assurance on the contract as/when required. Improvements to the claim form and process have been made.
F	Care Market Failure	Substantial Assurance	The Care Act requires a local authority to promote the efficient and effective operation of a market in services for meeting care and support needs. Failure of the care market is also on both the HAS and corporate risk register. The audit reviewed procedures	April 2018	Officers demonstrated a good understanding of the Care Act. Risk reduction actions appeared appropriate and were consistent with what the council must do to ensure compliance with the Act. The Quality and Monitoring team have developed an approach and system to react to any Market Failure.	**One P2 action was agreed** **Responsible Officer: Head of Quality Monitoring** The Market Position Statement will be updated.

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			and controls in place to ensure: • The council is complying with the statutory obligations of the Care Act 2014 in relation to the social care market • The authority has mitigating actions to effectively reduce the risk of market failures and these actions are being monitored sufficiently. • The risk management processes are then used to influence future planning.		The 2020 programme has implemented measures with a view to supporting people to remain within their own home and thereby staying out of care. There are initiatives in place to develop the resilience of the workforce and encourage recruitment in required areas; for example the developing of a 'heat map' and organised roadshows. The council is also developing methods of making recruitment easier and streamlined for providers. The Care Act 2014 requires local authorities to develop a Market Position Statement. Whilst the council had a written statement, it had not been updated since 2013.	
G	Learning Disability Accommodation	Substantial Assurance	NYCC are carrying out a full review of Learning Disability Accommodation and Care and Support with a view to ensuring the services provided are both compliant with the Care Act and meet the requirements of other legislation. The audit reviewed procedures and controls in place to ensure: • A robust plan was in place to	May 2018	Good progress has been made creating the Supported Living Pathway document and establishing appropriate governance arrangements. The Transformation Plan maps out the six work streams and logs the actions to be completed at each stage. Risks had been considered and an awareness of key risks has been demonstrated. However, at the time of audit the outcomes from this work had not been completely documented.	**Three P3 actions were agreed** **Responsible Officer: AD Commissioning and Quality & Head of Commissioning** A Risk log will be developed including mitigations. Risk and issue management is to be incorporated into formal project governance through the 2020 programme. Information requirements will be

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			achieve the new procurement arrangements for accommodation • The council was identifying and managing the key risks to the future ways of working for Learning Disability Accommodation and Care and Support		Data to help support decisions on the Learning Disability project has been a difficult to obtain. Further work will be required to analyse the data and to create meaningful information. The Council may require some additional skills and/or support to help progress the scheme.	prioritised. We will work on the basis of known current needs initially based on collated understanding of individual needs. We will work with Public Health to use the planned JSNA on Learning Disability to identify and analyse information. We will agree the scope of the next phase of Strength Based Assessments and establish appropriate project governance. We will consider if additional project resource is needed.
H	Financial Assessments	Substantial Assurance	The completion of a timely financial assessment is an important part of the care process. We reviewed the procedures and controls for financial assessments to assess whether: • Sufficient evidence was provided by the client to justify the outcome of the assessment • Assessments were being completed in a timely and efficient manner (subject to external influences) • Performance was monitored	June 2018	Charging policies cover all areas of social care. Detailed guidance is available for staff to assist with the completion of financial assessments. Assessments were up to date and there was no backlog An Assessment and Appointment module went live from February 2018. Appointment letters are now auto-generated by ContrOCC and additional information will be able to be extracted for reporting purposes. The annual uplift procedure has continued to improve over the last 5 years. Although the client uplift was applied in May 2018 this was earlier than in previous years.	**Three P2 actions were agreed** **Responsible Officer: BACs Manager** Those annual uplift proformas that have not been returned for 2 or more consecutive years will be chased up. We will then update the capital information. We will look at devising a performance measure which is produced directly from ContrOCC and which can record time taken for a financial assessment to be completed (whilst excluding any of the outside influences which are outside our control and which might skew the data). Declarations are already being reviewed as part of the GDPR

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
					The capital elements of some financial assessments are not being updated regularly. A significant number of clients (20%) do not return their completed pro-forma and the council does not challenge these clients any further. Generally there was no undue delay to the completion of the assessments. Delays are sometimes inevitable depending on the availability of relatives and advocates. However, target times have not been set for the completion of financial assessments. Signed declarations are not always obtained from clients or their representatives.	compliance work. We will issue a reminder to staff to obtain a signed declaration and to enter a diary date to chase this up where a declaration has not been obtained.
I	Direct Payments (2017/18)	Reasonable Assurance	We reviewed the Direct Payment system to ensure: • The monitoring process for Direct Payments is consistent and sufficient for Direct Payment clients. • Support Plans are consistent and effective for Direct Payments clients. • The Direct Payment Support Service (DPSS) monitors and processes payments effectively	July 2018	The control framework helps to ensure Direct Payments are set up and used correctly, in the majority of instances. The majority of the issues found in the audit were linked to the one case referred by Veritau's Fraud team. We noted some cases did not have an immediate handover between Direct Payment Advisors (DPAs) Some DPAs are unable to effectively escalate their concerns with the administration or management of the Direct Payment.	**Three P2 actions and seven P3 actions were agreed** **Responsible Officer: Assistant Director, Inclusion (CYPS) and DPSS Manager** Improvements will be made to address the specific issues identified with the case in question. A change in process for managed accounts was implemented in October 2017. A formal transition process will be

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			The audit reviewed a sample of both Children's and Adults Direct Payments. One case was referred to the Veritau Fraud Team for further investigation.		There were inconsistent levels of documentation saved on Liquid Logic.	written and agreed between HAS & CYPS. Payments for all DPs to be made via ContrOCC. CYPS assessment staff will complete the HAS DP training package, with a focus on support plan completion.

Appendix 2

Audit Opinions and Priorities for Actions

Audit Opinions	
Audit work is based on sampling transactions to test the operation of systems. It cannot guarantee the elimination of fraud or error. Our opinion is based on the risks we identify at the time of the audit. Our overall audit opinion is based on 5 grades of opinion, as set out below.	
Opinion	**Assessment of internal control**
High Assurance	Overall, very good management of risk. An effective control environment appears to be in operation.
Substantial Assurance	Overall, good management of risk with few weaknesses identified. An effective control environment is in operation but there is scope for further improvement in the areas identified.
Reasonable assurance	Overall, satisfactory management of risk with a number of weaknesses identified. An acceptable control environment is in operation but there are a number of improvements that could be made.
Limited Assurance	Overall, poor management of risk with significant control weaknesses in key areas and major improvements required before an effective control environment will be in operation.
No Assurance	Overall, there is a fundamental failure in control and risks are not being effectively managed. A number of key areas require substantial improvement to protect the system from error and abuse.

Priorities for Actions	
Priority 1	A fundamental system weakness, which presents unacceptable risk to the system objectives and requires urgent attention by management.
Priority 2	A significant system weakness, whose impact or frequency presents risks to the system objectives, which needs to be addressed by management.
Priority 3	The system objectives are not exposed to significant risk, but the issue merits attention by management.

NORTH YORKSHIRE COUNTY COUNCIL
AUDIT COMMITTEE

10 OCTOBER 2018

INTERNAL CONTROL MATTERS FOR THE HEALTH & ADULT SERVICES DIRECTORATE

Report of the
Corporate Director – Health & Adult Services

1.0 **PURPOSE OF THE REPORT**

1.1 To outline some of the key service risks and governance developments within the Directorate

1.2 To provide details of the **Risk Register** for the HAS Directorate.

2.0 BACKGROUND

2.1 The Audit Committee is required to assess the quality and effectiveness of the corporate governance arrangements operating within the County Council. In relation to the HAS Directorate the Committee receives assurance through the work of internal audit (detailed in a separate report to the Committee), details of the Statement of Assurance provided by the Corporate Director, together with the Directorate Risk Register.

3.0 KEY GOVERNANCE DEVELOPMENT AND RISK ISSUES

3.1 There are a number of key governance developments in the forthcoming year which may impact on the Directorate. A summary of these are set out in more detail below:

3.2 MTFS: 2020, Beyond 2020 Savings and Budget Pressures

As part of the Council's 2020 programme, HAS has a current savings programme adding up to £17m over the period 2017-2020. The current financial year has a target of £4m. While overall this programme remains on target, the Directorate continues to face budget pressures relating to increasing demand, issues within the care market and the need to play a part in reducing Delayed Transfers of Care. Temporary (and reducing) funding has been allocated through the Improved Better Care Fund (IBCF) to assist with some of these pressures but there is currently no guarantee of it continuing beyond 2020 and this limits the step changes we would wish to make on care worker

pay and structural reform of the market. The added conditions around DTOC also provide uncertainty.

A significant issue for the council is the ongoing overspend within Care and Support. This was £4m in 2017-18, and despite growth of £2m and inflation, is estimated at this stage to be £4m in 2018-19. In both years this was funded by IBCF – but this is temporary money and is not guaranteed to continue after 2020.

3.3 Reducing Budget Pressures

A major focus in this year and the immediate future is tackling that overspend. A draft Action Plan had been drawn up which builds on a comprehensive review of all cost centres and a redistribution of existing resources and growth to better march need. The Plan will also take account of an assessment of the reasons for the overspend, and focuses on the following areas:

3.4 Practice

Although our emphasis on prevention has helped us to mitigate against the increasing demand and cost pressures, we will ensure that our decision-making is consistent across the Council. We will also ensure that our practice continues to have a "strength-based approach." This is where we understand what a person's needs are but also what support they themselves and others can give. It is a more collaborative way of working which concentrates on what people can – rather than cannot – do.

3.5 Productivity

We will ensure that standards of productivity are high right across the entire Council. We will make best use of technology. To minimise the number of assessments which end before completion (one in four), we will strengthen our so-called "front door" arrangements. This is where we can quickly make decisions about which route to take with different social care contacts and referrals and therefore reduce unproductive effort.

3.6 Market

Increasing demands (such as the ageing population profile and increased care needs) place more pressure on local care systems and help to drive up costs. The proportion of placements for older people (65+) above NYCC rates (42%) is rising. It is a key driver of budget pressures, particularly in Harrogate & Craven where the levels rises to 70%. We will continue our exploration of options to create more (and less expensive) market capacity. We will also work with Procurement and Brokerage colleagues to get the best out of contract management.

In addressing each of these areas, we will bring forward actions to reduce costs, including consideration of policy in some cases, as well as practice and commercial possibilities.

4.0 DIRECTORATE RISK REGISTER

4.1 The **Directorate Risk Register** (DRR) is the end product of a systematic process that initially identifies risks at Service Unit level and then aggregates these via a sieving process to Directorate level. A similar process sieves Directorate level risks into the Corporate Risk Register.

4.2 The Risk Prioritisation System used to derive all Risk Registers across the County Council categorises risks as follows:

Category 1 and 2 are high risk (RED)
Category 3 and 4 are medium risk (AMBER)
Category 5 is low risk (GREEN)

These categories are of course relative not absolute assessments - equally the Risk Register at Directorate level is designed to identify the dozen or so principal risks that may impact on the achievement of performance targets etc. for the Directorate as a whole in the year – it is not a full Register of all the risks that are managed in the Directorate.

4.3 The detailed DRR is shown at **Appendix A.** This shows a range of key risks and the risk reduction actions designed to minimise them together with a ranking of the risks both at the present time and after mitigating action.

4.4 A summary of the DRR is also attached at **Appendix B**. As well as providing a quick overview of the risks and their ranking, it also provides details of the change or movement in the ranking of the risk since the last review in the left hand column.

4.5 A six month update review of the register will take place in February 2019

4.6 There have been no new risks added to the risk register since November 2017 (date of last progress report to the Committee) are as follows:

4.7 One risk has been deleted from the Directorate risk register since November 2017. This was around Cultural Change, as this is now less of an issue and the service has embedded new approaches such as the Strength-based approach into its transformational model. Any risks relating to this are now picked up elsewhere in the register (such as in Transformation or Workforce Planning and Development).

4.8 The significant actions that were achieved include the following:

- Financial Pressures/Transformation – 2020 Benefits Deep Dive carried out and regular budget deep dive with Chief Executive and Corporate Director – Strategic Resources. Fundamental and ongoing review of HAS budgets

- Major Failure due to Quality and/or Economic Issues in the Care Market – Market analysis and mapping and information analysis (shared with Locality Provider group). QI team now in place
- Workforce Planning and Development – training academy and a recruitment excellence centre to support the independent and voluntary sector in place; monthly performance reports to HASLT including service delivery reports, complaints and commendations and workforce metrics; Strength based approach in place; Living Well Service in place; management arrangements for Mental Health services in place.
- Deprivation of Liberty (DoLs) Supreme Court Ruling – LEAN review carried out; regular briefings to HASLT, staff and providers; continue to monitor and manage capacity and resource issues
- Partnership and Integration with the NHS – Integration and Better Care Fund Plan 2017/19 developed with CCGs and agreed at Health and Wellbeing Board; 2020 Health Programme focussing on integration established
- Transformation – formal nine month New Ways of Work review carried out
- Information Governance and Health & Safety – wheelchair guidance in place; further IOSH and risk assessment training carried out to raise competency;
- Extra Care Housing – extension to the framework to allow partners to propose schemes ahead of a tender bid

4.10 Any ranking changes of the risks are shown on the left hand side of the Summary report **Appendix B.**

5.0	**RECOMMENDATION**
5.1	That the Committee note the Risk Register for the Health and Adult Services Directorate and provide feedback or comments thereon.

RICHARD WEBB
Corporate Director – Health & Adult Services
October 2018

Health and Adult Services Directorate

Risk Register: **Month 0 (August 2018) – detailed**
Next Review Due: **February 2018**
Report Date: **17th August 2018 (*cat*)**

Phase 1 - Identification							
Risk Number	3/229	**Risk Title**	3/229 - Financial Pressures	**Risk Owner**	CD HAS	**Manager**	CSD AD SR (AH)
Description	Financial pressures arising from difficulties in delivering MTFS Savings requirements, managing in year financial overspends, Better Care Fund contributions, market pressure and complexity of client needs leading to service impact or additional savings needing to be identified within HAS or corporately.			**Risk Group**	Financial	**Risk Type**	C&S 1/252

Phase 2 - Current Assessment											
Current Control Measures	Fortnightly performance and governance HAS LT meetings; Corp PMO resources applied to projects and programme management; regular monitoring of in year financial performance and reporting to portfolio Members; corp provision for financial pressures in HAS available for drawdown; reviewed HAS 2020 including completion of benefits profiles for all savings lines; heat map action plan completed; recommendations from the actual cost of care exercise implemented; tracking of paper records in place for performance; 2020 Benefits deep dive carried out and regular budget deep dives with Chief Exec and CD SR; review of 4% savings business cases; fundamental review and ongoing review									
Probability	H	**Objectives**	H	**Financial**	H	**Services**	M	**Reputation**	M	**Category**	1

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	1/501 - Carry out review of revised practice within the care pathway including the SBR and PIR activity; 15mth review taking place and embedding practice	HAS AD C&S	Sun-30-Jun-19	
Reduction	1/545 - Formulate and agree a plan to reduce the overspend and target the £4M reduction by 2020	CSD AD SR (AH) HAS AD C&S	Sun-30-Sep-18	
Reduction	3/247 - Continue to revise and update a market position statement - ongoing	HAS AD C&Q	Sun-30-Jun-19	
Reduction	3/379 - Ongoing budget review which models cost drivers, demand and complexity of cases and implement revised budgets across the Directorate	CSD AD SR (AH)	Sun-31-Mar-19	
Reduction	3/421 - Complete separate review of complexity of client needs; will be addressed as part of the 24mth strength based review	HAS AD C&S	Fri-31-Aug-18	
Reduction	3/423 - Complete the Financial assessments, billing and contracts (ABC) project to improve market and cost information, service standards and information security	CSD AD SR (AH) HAS AD H&I	Tue-31-Mar-20	
Reduction	3/460 - Ensure that we account for the BCF funding as per the Regulations on a quarterly basis	CSD AD SR (AH)	Sat-31-Aug-19	
Reduction	3/472 - Implement action plan following outcome of state of the market exercise and ensure inclusion of NHS and Partners - ongoing (Make Care Matter joint recruitment in Scarborough and IBCF monies used for recruitment)	HAS HoHR	Sun-30-Jun-19	
Reduction	3/551 - Carry out more focussed and timely budget monitoring for areas of concern	CSD AD SR (AH)	Sun-31-Mar-19	

Phase 4 - Post Risk Reduction Assessment											
Probability	M	**Objectives**	H	**Financial**	H	**Services**	M	**Reputation**	M	**Category**	2

Phase 5 - Fallback Plan		
		Action Manager
Fallback Plan	3/567 - Further fundamental review in order to further prioritise services	CSD AD SR (AH)

Health and Adult Services Directorate

Risk Register: **Month 0 (August 2018) – detailed**
Next Review Due: **February 2018**
Report Date: **17th August 2018 (*cat*)**

Phase 1 - Identification							
Risk Number	3/162	**Risk Title**	3/162 - Major Failure due to Quality and/or Economic Issues in the Care Market	**Risk Owner**	CD HAS	**Manager**	HAS AD C&Q
Description	Major failure of provider/key providers results in the Directorate being unable to meet service user needs. This could be caused by economic performance or resource capabilities including recruitment and retention. The impact could include loss of trust in the Care Market, increased budgetary implications and issues of service user safety.			**Risk Group**	Legislative	**Risk Type**	Corp 20/194

Phase 2 - Current Assessment											
Current Control Measures	Regular review and monitoring contracts; standard contract terms; approvals process; regular meetings to share best practice; experienced staff; regular communication with providers; bulletins; customer feedback; Engagement Group; legal services; CQC; Financial Services & insurance consultation; Independent Sector Partnership B (ISPB); market analysis and mapping and information analysis (Locality Provider group); capacity planning; alerts system including brokerage; Service Unit & provider BCPs; QA Framework developed; guidance and ongoing training for purchasing staff; engage with AD ASS; reg meetings with Q&M, Health Commissioner and police; robust comms with CCGs; quality monitoring embedded in Dir perf monitoring; market position statement; heat map action plan; recommendations from the actual cost of care exercise implemented; QI team in place; funding for market improvement team agreed through BCF;										
Probability	H	**Objectives**	M	**Financial**	M	**Services**	M	**Reputation**	H	**Category**	1

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	3/23 - Carry out recruitment for quality and improvement team; recruitment to complete and then structure to embed	HAS AD C&Q	Mon-31-Dec-18	
Reduction	3/247 - Continue to revise and update a market position statement - ongoing	HAS AD C&Q	Sun-30-Jun-19	
Reduction	3/254 - Jointly with Health continue to monitor baseline assessments QA framework and risk profiles of providers; targets are reviewed at quarterly officer meetings and info fed into engagement group; ongoing pursuit of opportunities for joint working between HAS and NHS with plans in place for health brokerage	HAS AD C&Q	Sun-30-Jun-19	
Reduction	3/371 - Continue with regular engagement meetings with CQC locally and engage with CQCs national programme of identifying providers where there is significant risk of failure;	HAS C&Q Ho Q&M	Sun-30-Jun-19	
Reduction	3/472 - Implement action plan following outcome of state of the market and ensure inclusion of NHS and Partners - ongoing (Make Care Matter joint recruitment in Scarborough and IBCF monies used for recruitment)	HAS HoHR	Sun-30-Jun-19	
Reduction	3/519 - Review any opportunities to stabilise the market through additional Govt funding given to social care for this purpose (review position each year for next 3 years of funding);IBCF being used for piloting an approach to rural dom care, supporting recruitment and training	CSD AD SR (AH) HAS AD C&Q	Tue-30-Apr-19	
Reduction	3/1963 - Continue to engage in ADASS work to manage major problems occurring, such as financial issues in the care provider market and ensure robust contingency planning and to learn lessons from serious case reviews at a national level; more work being done to enhance regional ways of working; this continues, awaiting legal views on info sharing	HAS AD C&Q	Sun-30-Jun-19	
Reduction	47/221 - Work with Veritau on audits of individual suppliers (ongoing)	HAS C&Q Ho Q&M	Sun-30-Jun-19	
Reduction	47/434 - 2020 Market shaping/development project work – completed the first piece of work and areas of work identified to commence priority projects	HAS AD C&Q	Sun-30-Jun-19	
Reduction	47/435 - Workforce group to develop and support workforce across the sector; regular item on the agenda on ISPB,	HAS HoHR	Sun-30-Jun-19	

Reduction	47/486 - Monitor issues caused by the complex partner relationships, meetings and structures and raise at HASLT where appropriate - ongoing						HAS AD C&Q		Sun-30-Jun-19			
Reduction	47/533 - Begin the preparation for next Actual Cost of Care exercise; connected to green paper coming in autumn 18						HAS AD C&Q		Sun-30-Jun-19			
Phase 4 - Post Risk Reduction Assessment												
Probability	H	**Objectives**	M	**Financial**	M	**Services**	M	**Reputation**	M	**Category**	2	
Phase 5 - Fallback Plan												
										Action Manager		
Fallback Plan	3/523 - Make client safe, crisis meeting, implement relevant steps, consultation with senior staff and relevant organisations (e.g. Police CQC). Effective communication to relevant parties, utilise established failure plan.									HAS AD C&Q		

Health and Adult Services Directorate

Risk Register: **Month 0 (August 2018) – detailed**
Next Review Due: **February 2018**
Report Date: **17th August 2018 (*cat*)**

Phase 1 - Identification							
Risk Number	3/184	**Risk Title**	3/184 - Workforce Planning and Development	**Risk Owner**	CD HAS	**Manager**	HAS HoHR
Description	Failure to appropriately plan and fulfil workforce requirements and / or develop managers and staff in line with transformation agenda resulting in reduction in quality of service and transformation objectives not achieved, staff unclear about their roles and an inability to implement new ways of working			**Risk Group**	Personnel	**Risk Type**	Dir Only

Phase 2 - Current Assessment											
Current Control Measures	Workforce Strategy and OD Plan refreshed and agreed by HAS LT; HR representation on each 2020 programme board; Directorate restructure complete; Directorate Vision in place; HAS Transformation Board; regular DJCC meetings with Unison; training plan in place; ASYE implemented; assessment pathway programme and specifically the Care and Support restructure completed; Practice team established; Practice development sessions for practitioners rolled out; training academy and a recruitment excellence centre to support the independent and voluntary sector in place; monthly performance reports to HASLT including service delivery reports, complaints and commendations and workforce metrics; Strength based approach in place; Living Well Service in place; management arrangements for Mental Health services in place									
Probability	H	**Objectives**	M	**Financial**	H	**Services**	H	**Reputation**	M	**Category**	1

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	3/189 - Continue to implement a training academy to support the independent and voluntary sector with the ICG and providers	HAS HoHR	Thu-31-Jan-19	
Reduction	3/207 - Continue to implement a recruitment excellence centre to support the independent and voluntary sector with the ICG and providers	HAS HoHR	Thu-31-Jan-19	
Reduction	3/218 - Continue to implement the Directorate Training Plan which encompasses all the key changes facing Operational Staff and equips Heads of Service and CSMs to ensure delivery (ongoing)	HAS AD C&S HAS HoHR	Sat-31-Aug-19	
Reduction	3/231 - Ensure Directorate Managers are provided with training in people management processes, reorganisation and redundancy processes, change management, 'common sense' performance management and forecasting needs (ongoing)	HAS HoHR	Sat-31-Aug-19	
Reduction	3/263 - Ensure use of Insight is embedded with Directorate managers and exceptions and performance issues are identified through quarterly reports to HAS LT and HRBPs input to Assistant Directors and ensure appropriate action is taken	HAS LT	Mon-31-Dec-18	
Reduction	3/324 - Implement and embed recruitment standards and report on vacancy positions on a monthly basis	HAS AD C&S HAS HoHR	Mon-31-Dec-18	
Reduction	3/340 - Provide HR and WD advice and support to Managers leading Transformation Projects (ongoing)	HAS HoHR	Sat-31-Aug-19	
Reduction	3/372 - Ensure leadership and management continue to evolve methods of effective communication to enable involvement and feedback from staff and co-production with service users and partners (ongoing)	HAS LT	Sat-31-Aug-19	
Reduction	3/463 - Continue to develop and implement the Make Care Matter campaign to ensure recruitment across the Sector (ongoing)	HAS AD C&S HAS HoHR	Sat-31-Aug-19	
Reduction	3/476 - Support staff to operate into integrated teams and arrangements (ongoing)	HAS AD C&S HAS HoHR	Sat-31-Aug-19	
Reduction	3/547 - Develop and implement programme to enable managers to take ownership of and prioritise their responsibilities, and hold them to account, so that roles are carried out efficiently (see action 3/321 above)	HAS HoHR	Sun-31-Mar-19	
Reduction	3/548 - Develop and implement a Directorate induction and development plan for new managers	HAS HoHR	Sun-31-Mar-19	

Reduction	3/549 - Implement wider Mental Health team structures							HAS AD C&S HAS HoHR	Fri-31-May-19		
Reduction	3/1952 - Develop proposals and implement Directorate management structure phase 2							CD HAS	Sat-31-Mar-18	Sat-30-Jun-18	
Reduction	3/1953 - Carry out the post implementation review of the Care and Support restructure							HAS AD C&S	Sat-31-Mar-18	Thu-31-May-18	
Reduction	3/1964 - Continue to engage with and contribute to all 2020 North Yorkshire workstreams (ongoing)							HAS LT	Sat-31-Aug-19		
Phase 4 - Post Risk Reduction Assessment											
Probability	M	**Objectives**	M	**Financial**	M	**Services**	H	**Reputation**	L	**Category**	2
Phase 5 - Fallback Plan											
										Action Manager	
Fallback Plan	3/531 - Review and revise workforce arrangements including managers' responsibilities									CD HAS	

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Risk Register: **Month 0 (August 2018) – detailed**
Next Review Due: **February 2018**
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Phase 1 - Identification							
Risk Number	3/217	**Risk Title**	3/217 - Deprivation of Liberty (DoLs) Supreme Court Ruling	**Risk Owner**	CD HAS	**Manager**	HAS AD C&S
Description	Failure to manage increase in workload (and manage the existing backlog) as a result of the DoLs Supreme Court judgment resulting in financial and reputational issues including potential legal action			**Risk Group**	Legislative	**Risk Type**	C&S 1/219

Phase 2 - Current Assessment											
Current Control Measures	Resources and capacity have been increased; action plan in place in line with ADASS recommendations; regular report on activity, performance and finance provided to Leadership Team; statutory process implemented; action plan reviewed following external review; Corporate funding draw down; briefing report to CMB with ongoing quarterly reports; training reviewed; review of backlog and risks carried out; LEAN review carried out; regular briefings to HASLT, staff and providers; continue to monitor and manage capacity and resource issues										
Probability	M	**Objectives**	H	**Financial**	H	**Services**	H	**Reputation**	H	**Category**	2

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	1/100 - Ensure the In-House registered providers adhere to the DoLS supreme court judgement	HAS AD C&S	Sun-30-Jun-19	
Reduction	1/502 - Work through backlog management plan for the lower risk (as defined by ADASS) people including proposal for extra resource to assist in this area; identified additional post at Best Interest Assessor level to ensure appropriateness of rating of those on the outstanding list	HAS AD C&S	Sun-30-Jun-19	
Reduction	1/522 - Implementing actions following the findings of the LEAN review	HAS AD C&S	Sun-30-Jun-19	
Reduction	3/255 - Prepare for implementation of Liberty Protection Safeguards	HAS AD C&S	Sun-30-Jun-19	
Reduction	3/320 - Maintain communication with key partners	HAS AD C&S	Sun-30-Jun-19	

Phase 4 - Post Risk Reduction Assessment											
Probability	M	**Objectives**	H	**Financial**	H	**Services**	H	**Reputation**	H	**Category**	2

Phase 5 - Fallback Plan		
		Action Manager
Fallback Plan	3/556 - A further review of the action plan, with external support may be sought. Escalation to senior management with potential options for mitigation.	HAS AD C&S

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Risk Register: **Month 0 (August 2018) – detailed**
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Phase 1 - Identification							
Risk Number	3/180	**Risk Title**	3/180 - Partnership and Integration with the NHS	**Risk Owner**	CD HAS	**Manager**	HAS AD H&I HAS AD C&S Dir Public Health HAS AD C&Q
Description	Failure to shape and drive the configuration of the NHS from both a Commissioner and Provider perspective resulting in suboptimal maximisation of integration across the NYCC footprint, a negative impact on the customer experience and the possibility of fragmented care and poor outcomes.			**Risk Group**	Partnerships	**Risk Type**	Corp 20/47

Phase 2 - Current Assessment											
Current Control Measures	Effective HWB partnership with clear governance providing strategic leadership regarding H&W across the County; chief Officer representation influencing the development of STP/ICSs; HASLT locality delivery model in place actively shaping local integration plans; Joint leadership in Harrogate developing a new model of care building on the work of Vanguard; joint commissioning boards in Hamb/Rich and Scarborough/Ryedale CCGs underpinned by s75 agreements; investment of IBCF and BCF to protect social care; Health and Well-being Strategy in place; corporate task and finish group for DToC in place; HWB development sessions; Integration and Better Care Fund Plan 2017/19 developed with CCGs and agreed at Health and Wellbeing Board; 2020 Health Programme focussing on integration established										
Probability	M	**Objectives**	M	**Financial**	H	**Services**	M	**Reputation**	H	**Category**	2

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	3/208 - Ensure NHS partners are fully aware of the democratic and political environment they are operating within and liaise with Scrutiny colleagues to ensure a positive outcome (ongoing)	CD HAS	Fri-31-May-19	
Reduction	3/209 - Actively monitor relationships, priorities and communications and ensure that HAS managers are fully engaged at appropriate level and review at HAS WLT on a regular basis (ongoing)	CD HAS	Fri-31-May-19	
Reduction	3/384 - Agree and implement new models of care in all CCG localities building on primary care footprints of c30-50k of population	CD HAS	Sun-31-Mar-19	
Reduction	3/385 - Engage wider HASLT in testing the implications of different integration models (ongoing)	HAS AD C&Q HAS AD H&I	Fri-31-May-19	
Reduction	3/420 - Develop and implement joint commissioning plans with the CCGs and shape and influence models of primary community health and social care in each locality	HAS AD H&I	Tue-30-Apr-19	
Reduction	3/428 - Improve the DToC (Delayed Transfer of Care) performance to avoid financial penalties and reputational issues. Implement the work programme of the Transfers of Care Board. – H&I overview with C&S delivery	HAS AD C&S HAS AD H&I	Sun-30-Sep-18	
Reduction	3/429 - Consider MoUs for STP / ICS across the County that explicitly define the Council's involvement and engagement in these arrangements	CSD AD SR (AH) HAS AD C&Q HAS AD H&I	Sun-30-Jun-19	
Reduction	3/430 - Review governance arrangements for the Health and Wellbeing Board to ensure delivery of the joint H & W Strategy	HAS AD H&I	Sun-30-Sep-18	
Reduction	3/460 - Ensure that we account for the BCF funding as per the Regulations on a quarterly basis	CSD AD SR (AH)	Sat-31-Aug-19	

Reduction	3/466 - Continue to monitor the impact of the challenge of having 3 STPs / ICSs including through health scrutiny,	CD HAS	Fri-31-May-19	
Reduction	3/467 - Actively work with Partners on a new way for the health system to work in North Yorkshire	HAS AD H&I	Sun-30-Sep-18	
Reduction	324/491 - Ensure that additional social care funding is used in a sustainable way (ie non recurrent). Further lobbying required with Govt to establish how this dovetails with improved BCF and additional funding post green paper. This will continue until 2019/20	CD HAS CD SR	Sun-31-Mar-19	
Reduction	324/492 - Carry out preparations for potential CQC area review regarding integration; NYCC are not in the first group of reviews so earliest date this would be needed is now Sep 2018	HAS LT	Sun-30-Sep-18	

Phase 4 - Post Risk Reduction Assessment											
Probability	M	**Objectives**	M	**Financial**	H	**Services**	M	**Reputation**	H	**Category**	2

Phase 5 - Fallback Plan		
		Action Manager
Fallback Plan	3/532 - Escalation to CMB and Executive Members, further engagement with senior tiers in NHS locally, regionally and nationally.	CD HAS

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Phase 1 - Identification							
Risk Number	3/218	**Risk Title**	3/218 - Managing effective outcomes for individuals	**Risk Owner**	CD HAS	**Manager**	HAS AD C&S
Description	Failure to meet targets in line with the Care Act resulting in poor outcomes for individuals and internal and external criticism, reputational issues.			**Risk Group**	Performance	**Risk Type**	C&S 1/17

Phase 2 - Current Assessment											
Current Control Measures	HASLT; C&SLT; embedded performance management; budgetary management; needs assessment questionnaire; individual targets for workers; more direct intervention planned on testing out assessment pathway plan targets and savings; care and support pathway developed and implemented; demand modelled using census information; bi-monthly CSM forums; management of delivery of social care mental health services implemented (phase 1);										
Probability	M	**Objectives**	H	**Financial**	H	**Services**	H	**Reputation**	H	**Category**	2

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	1/78 - Continue to set targets through robust service planning aligned to Directorate Vision	HAS AD C&S	Sun-30-Jun-19	
Reduction	1/107 - Continue to embed the Dignity and Respect agenda	HAS AD C&S	Sun-30-Jun-19	
Reduction	1/317 - Ensure effective assessment and review processes are maintained throughout the transformation programme; BAU has been impacted by need to address other areas eg. DToCs	HAS AD C&S	Sun-30-Jun-19	
Reduction	1/331 - Continue with awareness raising of care act responsibilities and engagement with NHS and other partners, emphasising strength based approach, including sign posting to National training; plan needed to make sure we are embedding the change in culture	HAS AD C&S	Sun-30-Jun-19	
Reduction	1/333 - Maintain strong links to 2020 projects to ensure duties and requirements are taken into account; strategic review by CASLT ensuring links to to frontline procedures	HAS AD C&S	Sun-30-Jun-19	
Reduction	3/206 - Maintain robust DToC approach with a view to minimising numbers and impact	HAS AD C&S	Sun-30-Jun-19	
Reduction	3/457 - Embed the care and support pathway service redesign and ensure NHS are working to our model in integration matters	HAS AD C&S	Sun-30-Jun-19	
Reduction	3/475 - Develop a business case for and implement the operational delivery of social care mental health services (phase 2)	HAS AD C&S	Thu-28-Feb-19	
Reduction	3/542 - Review approach to equality and diversity issues within service provision	HAS AD C&S HAS Ho E&G	Sun-30-Jun-19	

Phase 4 - Post Risk Reduction Assessment											
Probability	L	**Objectives**	H	**Financial**	M	**Services**	M	**Reputation**	H	**Category**	3

Phase 5 - Fallback Plan		
		Action Manager
Fallback Plan	1/15 - Review performance and capacity including access to additional funding	HAS AD C&S

Health and Adult Services Directorate

Risk Register: **Month 0 (August 2018) – detailed**
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Phase 1 - Identification							
Risk Number	3/27	**Risk Title**	3/27 - Safeguarding Arrangements	**Risk Owner**	CD HAS	**Manager**	HAS AD C&S HAS AD H&I
Description	Failure to have an effectively monitored, robust, Safeguarding regime and partnership arrangements in place and ensure that we fulfil our wider lead authority role (under the Care Act) results in risk to service users, inability to reach required standard on CQC and adverse effect on Directorate reputation.			**Risk Group**	Partnerships	**Risk Type**	C&S 1/14

Phase 2 - Current Assessment											
Current Control Measures	Detailed action plan; Safeguarding general manager and team; strengthening of Safeguarding policy team; case file audit and review; independent chair to Safeguarding Board in place; risk enablement panel in place and being reviewed; countywide safeguarding general manager in place; testing of initial performance metrics for Safeguarding Board has taken place further developing performance activity; initial safeguarding procedures reviewed linked to consultation in light of the Care Act and are being reviewed again; safeguarding board performance framework; Q&E [protocol for the relationship between Adults Social Care (and Children's Trust) and the Health and Wellbeing Board agreed and implemented;] information framework for serious incident data, eg drug death etc in place									
Probability	M	**Objectives**	H	**Financial**	H	**Services**	M	**Reputation**	H	**Category**	2

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	1/357 - Continue to bring in further staff whenever possible to address significant vacancies in the structure	HAS AD C&S	Fri-31-Aug-18	
Reduction	1/514 - Ensure in house provider workforce have appropriate training and development in this area	HAS C&S Ho PS	Sun-30-Jun-19	
Reduction	1/515 - Continue to strengthen Governance arrangements in HAS following consideration of North Yorkshire and national safeguarding adult reviews (ongoing)	HAS AD C&S	Fri-31-May-19	
Reduction	1/516 - Consider recommendations from commissioned independent review of safeguarding practice as part of the preparations for the implementation of the latest policy and procedures	HAS AD C&S	Tue-30-Apr-19	
Reduction	3/145 - Continue to ensure Partners are fully engaged with Safeguarding Boards centrally and locally, particularly new health partners (CCGs). Carry out review of local arrangements with Children's Safeguarding Board and Community Safety Partnerships	HAS AD C&S HAS AD H&I	Fri-31-May-19	
Reduction	3/187 - Continue to work with Quality and Engagement team to improve quality assurance (development of new approaches and tools around working with providers on quality assurance issues); including work and regular meetings with CQC, Health and Healthwatch	HAS AD C&S HAS AD H&I	Tue-30-Apr-19	
Reduction	3/217 - Ensure training in respect of latest policies and procedures for elected Members, staff and Partners is reviewed and delivered	HAS AD C&S	Sun-31-Mar-19	
Reduction	3/321 - Continue joint work with CYPS and the Community Safety Partnership (together with formal quarterly meetings of the InterBoard Network to be set up by Jun 2018)	HAS AD H&I	Tue-30-Apr-19	
Reduction	3/1961 - Continue to embed safeguarding work to deliver the Transforming Care programme incl. embedding the care act role of Principal Social Worker and Safeguarding Board Manager with closer scrutiny of Transforming Care work	HAS AD C&S	Sun-30-Jun-19	
Reduction	324/161 - Continue to report regularly to HASLT, Care and Independence O&S Committee and Health and Wellbeing Board particularly in light of preparation for the latest policy and procedures.	HAS AD H&I	Sun-31-Mar-19	
Reduction	324/336 - Carry out the supervisory body role for DoLS to ensure the system is as effective as possible within existing resources (reliant of Law Commission proposals that have been delayed – linked to action 20/615)	HAS AD H&I	Mon-31-Dec-18	

Reduction	324/343 - Continue with scoping work in preparation of implementing the Law Commission proposals (linked to action 324/336)						HAS AD C&S HAS AD H&I		Mon-31-Dec-18		
Reduction	324/546 - Implement the new safeguarding policies and procedures (internal SG board is leading to ensure operational guidance is in place)						HAS AD H&I		Tue-30-Apr-19		
Phase 4 - Post Risk Reduction Assessment											
Probability	L	**Objectives**	H	**Financial**	H	**Services**	M	**Reputation**	H	**Category**	3
Phase 5 - Fallback Plan											
										Action Manager	
Fallback Plan	3/33 - Escalate to Safeguarding Board / Mgt Board and carry out necessary review and action improvement plans, lessons learned from any serious case reviews									HAS AD C&S	

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Phase 1 - Identification							
Risk Number	3/226	**Risk Title**	3/226 - Transformation	**Risk Owner**	CD HAS	**Manager**	HAS AD C&S
Description	Failure to continue the transformation of care and support in a timely way such that savings are made, significant change and improvement is implemented and personal independence is maximised			**Risk Group**	Change Mgt	**Risk Type**	C&S 1/222

Phase 2 - Current Assessment											
Current Control Measures	Corporate and HAS 2020 Governance arrangements including reporting to & monitoring by Directorate & Corp Programme Board; dedicated programme staff; Transformation Board; HAS Programme Briefs Produced; EIAs being developed; Exec members involved in programme development; HAS LT members assigned to specific programme activity; HAS Vision; engagement with NHS commissioners and providers; workforce development plan in place; detailed review of 2020 transformation savings; a formal nine month review of new ways of working carried out;										
Probability	M	**Objectives**	H	**Financial**	H	**Services**	H	**Reputation**	H	**Category**	2

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	1/360 - Continue to deliver the customer service centre (CSC) aspects of new ways of working; additional resource added to CSC to support mental health work	HAS AD C&S	Sun-30-Jun-19	
Reduction	1/444 - Continue to engage with customers and staff around new practice and ways of working and respond to issues raised	HAS AD C&S	Sun-30-Jun-19	
Reduction	1/446 - Develop a performance and trend dashboard to monitor activity and savings; revisit performance reports with strategic support service; progress made but still needs link to savings	HAS AD C&S	Sun-31-Mar-19	
Reduction	1/511 - Embed the new pathways and ensure that a strength based approach applies across the piece including with health to ensure this becomes business as usual approach	HAS AD C&S	Sun-30-Jun-19	
Reduction	1/524 - Carry out 15 month analysis of PIR of new ways of working and report outcome to Leadership team	HAS AD C&S	Wed-31-Jan-18	Sat-31-Mar-18
Reduction	3/475 - Develop a business case for and implement the operational delivery of social care mental health services (phase 2)	HAS AD C&S	Thu-28-Feb-19	
Reduction	3/552 - Carry out 18 month analysis of PIR of new ways of working and report outcome to Leadership team	HAS AD C&S	Wed-31-Oct-18	

Phase 4 - Post Risk Reduction Assessment											
Probability	L	**Objectives**	M	**Financial**	H	**Services**	M	**Reputation**	M	**Category**	3

Phase 5 - Fallback Plan		
		Action Manager
Fallback Plan	1/15 - Review performance and capacity including access to additional funding	HAS AD C&S

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Risk Register: **Month 0 (August 2018) – detailed**
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Phase 1 - Identification							
Risk Number	3/164	**Risk Title**	3/164 - Information Governance and Health and Safety	**Risk Owner**	CD HAS	**Manager**	CSD AD SR (AH)
Description	Failure to ensure that good and safe governance arrangements in respect of data security and health and safety are in place throughout the Directorate			**Risk Group**	Legislative	**Risk Type**	Dir Only

Phase 2 - Current Assessment											
Current Control Measures	Info Gov - Monitoring of mandatory eLearning for all staff; information management through key messages and intranet; application of Caldicott principles; information governance procedures; Corporate laptop and security encryption; continued use of information asset register; implementation of process if/when data breaches occur including cascading lessons learnt; implementation of secure data transfer methods; developing robust information sharing protocols; Corporate Information Governance Group and Directorate Group (HAS IG group); Periodic update at HASLT performance board; regular security sweeps, asset owner training completed H & S - Corporate H & S policy, and action plan; wider HAS leadership team H&S training completed; wheelchair guidance in place; further IOSH and risk assessment training carried out to raise competency;										
Probability	M	**Objectives**	L	**Financial**	M	**Services**	L	**Reputation**	H	**Category**	2

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	3/147 - Continue to implement Caldicott when required	HAS AD H&I	Sun-30-Jun-19	
Reduction	3/148 - Continue to implement awareness raising campaign for information governance	HAS AD H&I	Sun-30-Jun-19	
Reduction	3/227 - Continue to ensure and promote use of secure methods of data transfer	HAS AD H&I	Sun-30-Jun-19	
Reduction	3/364 - Review disposal arrangements of documents following issue of refreshed corporate policy and guidance	HAS AD H&I	Sun-30-Jun-19	
Reduction	3/365 - Ensure 'lessons learned' reports are reviewed following any breach	HAS AD H&I	Sun-30-Jun-19	
Reduction	3/366 - Review H&S management and inaugurate refreshed Directorate RMG	CSD AD SR (AH)	Wed-31-Jan-18	Mon-30-Apr-18
Reduction	3/373 - Work closely with the new Data Governance team in Strategic Support (and carry out review of local Info gov arrangements)	HAS AD H&I	Sun-30-Jun-19	
Reduction	3/423 - Complete the Financial assessments, billing and contracts (ABC) project to improve market and cost information, service standards and information security	CSD AD SR (AH) HAS AD H&I	Tue-31-Mar-20	
Reduction	3/431 - Review and revise current arrangements regarding statutory inspections to ensure compliance for example Medequip	CSD AD SR (AH)	Mon-31-Dec-18	
Reduction	3/543 - Develop and implement a work programme for the DIGG with monthly meeting covering eg. IAR, adhereance to a single document retention policy, priorities around info sharing agreements	HAS AD H&I	Sun-30-Jun-19	
Reduction	3/544 - Regular updates to leadership team / forum to look at Info Gov data trends	HAS AD H&I	Sun-30-Jun-19	
Reduction	3/550 - Continue to carry out IOSH and risk assessment training to raise competency within the Directorate	CSD AD SR (AH)	Tue-30-Apr-19	

Reduction	6/124 - Progress data sharing issues with Health colleagues to ensure the benefits of this are realised					HAS AD H&I		Sun-30-Jun-19			
Phase 4 - Post Risk Reduction Assessment											
Probability	L	**Objectives**	L	**Financial**	M	**Services**	L	**Reputation**	H	**Category**	3
Phase 5 - Fallback Plan											
										Action Manager	
Fallback Plan	3/36 - Media management, staff disciplinary, work with Information Commissioner's Office and HSE when necessary									CSD AD SR (AH)	

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Phase 1 - Identification							
Risk Number	3/167	**Risk Title**	3/167 - Public Health	**Risk Owner**	CD HAS	**Manager**	Dir Public Health
Description	Failure to deliver a distinctive public health agenda for North Yorkshire and carry out the statutory public health functions resulting in failure to maximise health gain in the County, inability to effectively commission public health services, develop and implement strategies and manage the Public Health grant			**Risk Group**	Partnerships	**Risk Type**	PH 5/196

Phase 2 - Current Assessment											
Current Control Measures	Regular Public Health business and team meetings; Consultant link roles with NYCC Directorates, CCGs and Districts; Public Health service plan in place; Consultation on public health commissioning intentions; MOU for Advice Service with CCGs in place; Joint Contracts group with CYC; Health and Wellbeing Board; H & W Strategy; Link to relevant Em Planning/Health Protection structures in place; Leading work on the Prevention Framework; PH team performance monitoring mechanism in place; updated JSNA in place; development of financial framework; Major contracts and service are procured; dealing with letting new contracts; quarterly reports to HASLT and PH Business team; new financial framework for PH budget finalised;										
Probability	L	**Objectives**	M	**Financial**	H	**Services**	M	**Reputation**	M	**Category**	3

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	5/246 - Continue to ensure Public Health statutory functions are met	Dir Public Health	Sun-30-Jun-19	
Reduction	5/247 - Continue development of the Public Health Advisory Service for CCGs	Dir Public Health	Sun-30-Jun-19	
Reduction	5/248 - Ensure 2020 Finance continues to consider Public Health needs and that Public Health team are aware of impact on resource and finance risk (development of 5 year indicative framework)	Int Fin Acc	Sun-30-Jun-19	
Reduction	5/249 - Explicitly embed Public Health in the Councils mainstream strategies and policies eg. trading standards, education, children social care, LEP (ongoing) and embed within the HAS locality model	Dir Public Health	Sun-30-Jun-19	
Reduction	5/251 - Continue to ensure sufficient capacity and skills in the Public Health team and in the interim, explore alternative solutions to release more time for consultant level work	Dir Public Health	Sun-30-Jun-19	
Reduction	5/313 - Continue to ensure good systems are in place for monitoring our performance against the PHOF by reporting as part of the Council's performance framework	Dir Public Health	Sun-30-Jun-19	
Reduction	5/532 - Work with Exec and others to agree PH spending once the ring-fence is removed, in the context of the BEST program including both what the budget will be and on what it will be spent	Dir Public Health	Sun-31-Mar-19	

Phase 4 - Post Risk Reduction Assessment											
Probability	L	**Objectives**	M	**Financial**	M	**Services**	M	**Reputation**	M	**Category**	5

Phase 5 - Fallback Plan		
		Action Manager
Fallback Plan	3/526 - Further develop and implement alternative delivery models taking into account good practice elsewhere	Dir Public Health

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Risk Register: **Month 0 (August 2018) – detailed**
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Report Date: **17th August 2018 (*cat*)**

Phase 1 - Identification							
Risk Number	3/228	**Risk Title**	3/228 - Extra Care Housing	**Risk Owner**	CD HAS	**Manager**	HAS AD C&Q
Description	Failure to effectively deliver the Extra Care Programme and EPH reprovision resulting in suboptimal financial savings, potential challenge to EPH reprovision proposals, poor project management of Extra Care Scheme Development			**Risk Group**	Strategic	**Risk Type**	Comm 47/248

Phase 2 - Current Assessment											
Current Control Measures	Robust needs assessment (independently tested), Programme management structure, use of experienced external advisors in respect of legal, finance and procurement services, governance arrangements, member support, programme manager recruited, procurement of Framework partners outcome completed; call off contract timetable developed and aligned with necessary consultations; reviewed process for EPH reprovision to ensure fit for purpose; process for mini procurements agreed; financial investment and VfM for existing developments reviewed; impact of benefit (housing) changes reviewed; extension to the framework to allow partners to propose schemes ahead of a tender bid										
Probability	M	**Objectives**	M	**Financial**	L	**Services**	M	**Reputation**	L	**Category**	4

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	3/377 - Identify specific issues and requirements for each Scheme	HAS AD C&Q	Tue-31-Mar-20	
Reduction	3/378 - Develop bespoke programme for each Scheme	HAS AD C&Q	Tue-31-Mar-20	
Reduction	3/380 - Finance - ongoing close monitoring of financial model to ensure savings are achieved; savings profile reviewed and will deliver but behind schedule	HAS AD C&Q	Mon-30-Sep-19	
Reduction	3/426 - Carry out implementation reviews and consider lessons learned for future schemes	HAS AD C&Q	Mon-30-Sep-19	
Reduction	3/459 - Regular review of Schemes within the timetable for the delivery of Extra Care and adjust where necessary to deliver savings	HAS AD C&Q	Tue-31-Mar-20	
Reduction	47/81 - Look at new and innovative approaches for smaller schemes	HAS AD C&Q	Tue-31-Mar-20	
Reduction	47/82 - Ensure effective utilisation of an agreed consultation process for procurement in respect of EPHs (ongoing)	HAS AD C&Q	Tue-31-Mar-20	

Phase 4 - Post Risk Reduction Assessment											
Probability	L	**Objectives**	L	**Financial**	L	**Services**	L	**Reputation**	L	**Category**	5

Phase 5 - Fallback Plan		
		Action Manager
Fallback Plan	3/566 - Continually review progress and changes in market conditions and Partner circumstances and make appropriate adjustments to the Programme	HAS AD C&Q

Health and Adult Services Directorate

Appendix B

Risk Register: **Month 0 (August 2018) – summary**
Next Review Due: **February 2018**
Report Date: **17th August 2018 (*cat*)**

Identity			Person		Classification								Fallback Plan	
					Pre						RR		Post							
Change	Risk Title	Risk Description	Risk Owner	Risk Manager	Prob	Obj	Fin	Serv	Rep	Cat	RRs	Next Action	Prob	Obj	Fin	Serv	Rep	Cat	FBPlan	Action Manager
◀▶	**3/229 - Financial Pressures**	Financial pressures arising from difficulties in delivering MTFS Savings requirements, managing in year financial overspends, Better Care Fund contributions, market pressure and complexity of client needs leading to service impact or additional savings needing to be identified within HAS or corporately.	CD HAS	CSD AD SR (AH)	H	H	H	M	M	**1**	9	31/08/2018	M	H	H	M	M	**2**	Y	CSD AD SR (AH)
◀▶	**3/162 - Major Failure due to Quality and/or Economic Issues in the Care Market**	Major failure of provider/key providers results in the Directorate being unable to meet service user needs. This could be caused by economic performance or resource capabilities including recruitment and retention. The impact could include loss of trust in the Care Market, increased budgetary implications and issues of service user safety.	CD HAS	HAS AD C&Q	H	M	M	M	H	**1**	12	31/12/2018	H	M	M	M	M	**2**	Y	HAS AD C&Q
◀▶	**3/184 - Workforce Planning and Development**	Failure to appropriately plan and fulfil workforce requirements and / or develop managers and staff in line with transformation agenda resulting in reduction in quality of service and transformation objectives not achieved, staff unclear about their roles and an inability to implement new ways of working	CD HAS	HAS HoHR	H	M	H	H	M	**1**	16	31/12/2018	M	M	M	H	L	**2**	Y	CD HAS
◀▶	**3/217 - Deprivation of Liberty (DoLs) Supreme Court Ruling**	Failure to manage increase in workload (and manage the existing backlog) as a result of the DoLs Supreme Court judgment resulting in financial and reputational issues including potential legal action	CD HAS	HAS AD C&S	M	H	H	H	H	**2**	5	30/06/2019	M	H	H	H	H	**2**	Y	HAS AD C&S
◀▶	**3/180 - Partnership and Integration with the NHS**	Failure to shape and drive the configuration of the NHS from both a Commissioner and Provider perspective resulting in suboptimal maximisation of integration across the NYCC footprint, a negative impact on the customer experience and the possibility of fragmented care and poor outcomes.	CD HAS	HAS AD H&I HAS AD C&S Dir Public Health HAS AD C&Q	M	M	H	M	H	**2**	13	30/09/2018	M	M	H	M	H	**2**	Y	CD HAS
◀▶	**3/218 - Managing effective outcomes for individuals**	Failure to meet targets in line with the Care Act resulting in poor outcomes for individuals and internal and external criticism, reputational issues.	CD HAS	HAS AD C&S	M	H	H	H	H	**2**	9	28/02/2019	L	H	M	M	H	**3**	Y	HAS AD C&S

Health and Adult Services Directorate

Risk Register: **Month 0 (August 2018) – summary**
Next Review Due: **February 2018**
Report Date: **17th August 2018 (*cat*)**

Identity			Person		Classification								Fallback Plan	
					Pre						RR		Post							
Change	Risk Title	Risk Description	Risk Owner	Risk Manager	Prob	Obj	Fin	Serv	Rep	Cat	RRs	Next Action	Prob	Obj	Fin	Serv	Rep	Cat	FBPlan	Action Manager
◀▶	**3/27 - Safeguarding Arrangements**	Failure to have an effectively monitored, robust, Safeguarding regime and partnership arrangements in place and ensure that we fulfil our wider lead authority role (under the Care Act) results in risk to service users, inability to reach required standard on CQC and adverse effect on Directorate reputation.	CD HAS	HAS AD C&S HAS AD H&I	M	H	H	M	H	**2**	13	31/08/2018	L	H	H	M	H	**3**	Y	HAS AD C&S
◀▶	**3/226 - Transformation**	Failure to continue the transformation of care and support in a timely way such that savings are made, significant change and improvement is implemented and personal independence is maximised	CD HAS	HAS AD C&S	M	H	H	H	H	**2**	7	31/10/2018	L	M	H	M	M	**3**	Y	HAS AD C&S
▼	**3/164 - Information Governance and Health and Safety**	Failure to ensure that good and safe governance arrangements in respect of data security and health and safety are in place throughout the Directorate	CD HAS	CSD AD SR (AH)	M	L	M	L	H	**2**	13	31/12/2018	L	L	M	L	H	**3**	Y	CSD AD SR (AH)
◀▶	**3/167 - Public Health**	Failure to deliver a distinctive public health agenda for North Yorkshire and carry out the statutory public health functions resulting in failure to maximise health gain in the County, inability to effectively commission public health services, develop and implement strategies and manage the Public Health grant	CD HAS	Dir Public Health	L	M	H	M	M	**3**	7	31/03/2019	L	M	M	M	M	**5**	Y	Dir Public Health
▼	**3/228 - Extra Care Housing**	Failure to effectively deliver the Extra Care Programme and EPH reprovision resulting in suboptimal financial savings, potential challenge to EPH reprovision proposals, poor project management of Extra Care Scheme Development	CD HAS	HAS AD C&Q	M	M	L	M	L	**4**	7	30/09/2019	L	L	M	L	M	**5**	Y	HAS AD C&Q

Key	
▲	Risk Ranking has worsened since last review.
▼	Risk Ranking has improved since last review
◀▶	Risk Ranking is same as last review
- new -	New or significantly altered risk

NORTH YORKSHIRE COUNTY COUNCIL

AUDIT COMMITTEE

10 OCTOBER 2018

INTERNAL AUDIT REPORT ON INFORMATION TECHNOLOGY, CORPORATE THEMES AND CONTRACTS

Report of the Head of Internal Audit

1.0 PURPOSE OF THE REPORT

1.1 To inform Members of the **internal audit work** completed during the year to 31 August 2018 in respect of information technology (IT), corporate themes and contracts and to give an opinion on the systems of internal control in respect of these areas.

2.0 BACKGROUND

2.1 The Audit Committee is required to assess the quality and effectiveness of the corporate governance arrangements operating within the County Council. In relation to IT, corporate themes and contracts, the Committee receives assurance through the work of internal audit (provided by Veritau) as well as receiving copies of relevant corporate and directorate risk registers.

2.2 This report considers the work carried out by Veritau during the period to 31 August 2018. It should be noted the internal audit work referred to in this report tends to be cross cutting in nature and therefore there are no corresponding directorate risk registers to consider.

2.3 The Corporate Risk Register (CRR) is fully reviewed every year and updated by the Chief Executive and Management Board in September / October. A six monthly review is then carried out in April / May. The latest updated Corporate Risk Register was presented to the Committee in June 2018. There have been no significant changes in the County Council's risk profile since that date.

3.0 WORK CARRIED OUT DURING THE YEAR TO 31 AUGUST 2018

3.1 Summaries of the internal audit work undertaken and the reports issued in the period are attached as follows:

IT audit assurance and related work	**Appendix 1**
Corporate assurance	**Appendix 2**
Contracts and procurement	**Appendix 3**

3.2 Internal Audit has also been involved in a number of related areas, including:

- providing advice on corporate governance arrangements and IT related controls;
- providing advice and support to assist various project groups;
- providing advice and guidance to directorates and schools on ad hoc contract queries and on matters of compliance with the County Council's Contract and LMS Procedure Rules;
- attending meetings of the Corporate Information Governance Group (CIGG);
- contributing to the development and roll-out of the procurement strategic action plan, including participation in a number of delivery areas;
- carrying out a number of investigations into data security incidents and corporate or contract related matters that have either been communicated via the whistleblowers' hotline or have arisen from issues and concerns reported to Veritau by management.

3.3 This is the first year that IT audit coverage has been provided directly by Veritau. In addition to the specific IT audits detailed in Appendix 1, there has been an increased coverage of IT related controls and activities as part of general audits where key IT systems are in operation.

3.4 As with previous audit reports an overall opinion has been given for each of the specific systems or areas under review. The opinion given has been based on an assessment of the risks associated with any weaknesses in control identified. Where weaknesses are identified then remedial actions will be agreed with management. Each agreed action has been given a priority ranking. The opinions and priority rankings used by Veritau are detailed in **appendix 4**.

3.5 It is important that agreed actions are formally followed up to ensure that they have been implemented. Veritau formally follow up all agreed actions on a quarterly basis, taking account of the timescales previously agreed with management for implementation. **On the basis of the follow up work undertaken during the year, the Head of Internal Audit is satisfied with the progress that has been made by management to implement previously agreed actions necessary to address identified control weaknesses.**

3.6 The programme of audit work is risk based. Areas that are assessed as well controlled or low risk tend to be reviewed less often with audit work instead focused on the areas of highest risk. Veritau's auditors work closely with directorate senior managers to address any areas of concern.

4.0 AUDIT OPINION

4.1 Veritau performs its work in accordance with the Public Sector Internal Audit Standards (PSIAS). In connection with reporting, the relevant standard (2450) states that the chief audit executive (CAE)[1] should provide an annual report to the board[2]. The report should include:

[1] For the County Council this is the Head of Internal Audit.
[2] For the County Council this is the Audit Committee.

(a) details of the scope of the work undertaken and the time period to which the opinion refers (together with disclosure of any restrictions in the scope of that work)

(b) a summary of the audit work from which the opinion is derived (including details of the reliance placed on the work of other assurance bodies)

(c) an opinion on the overall adequacy and effectiveness of the organisation's governance, risk and control framework (i.e. the control environment)

(d) disclosure of any qualifications to that opinion, together with the reasons for that qualification

(e) details of any issues which the CAE judges are of particular relevance to the preparation of the Annual Governance Statement

(f) a statement on conformance with the PSIAS and the results of the internal audit Quality Assurance and Improvement Programme.

4.2 The overall opinion of the Head of Internal Audit on the framework of governance, risk management and control operating across the three functional areas is that it provides **Substantial Assurance**. There are no qualifications to this opinion. No reliance has been placed on the work of other assurance bodies in reaching this opinion.

5.0 **RECOMMENDATION**

5.1 That Members consider the information provided in this report and determine whether they are satisfied that the overall control environment operating in respect of information technology, corporate and contract arrangements is both adequate and effective.

Max Thomas
Head of Internal Audit

Veritau Ltd
County Hall
Northallerton

26 September 2018

BACKGROUND DOCUMENTS

Relevant audit reports kept by Veritau Ltd at 50 South Parade, Northallerton.

Report prepared and presented by Max Thomas, Head of Internal Audit (Veritau).

Appendix 1

INFORMATION TECHNOLOGY - FINAL AUDIT REPORTS ISSUED IN THE YEAR TO 31 AUGUST 2018

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
A	Cyber Security	Substantial Assurance	We reviewed the ICT procedures and controls to determine whether they were compliant with the following ISO 27001 clauses: • Information Security Policies (A5) • Physical Security (A11) • Operations Security (A12) • Information Security Incident Management (A16) Comparisons were also drawn between the Council's cyber arrangements and the requirements of the National Cyber Security Centre's 10 Steps to Cyber Security.	June 2018	The Council has a comprehensive Information Security Management System (ISMS) with a suite of policies that underpin security practices. On the whole, the suite of policies and procedure notes are comprehensive and relevant. Several policies were found to have passed their review date. There was also no formal Back Up Policy in place. Good back up practices were in place but these should be outlined in a formal policy. The Technical Incident Management Procedure does not include information on how to identify a potential security incident (DDoS/ransomware/phishing etc). There are strict change management procedures in place which appear to be working effectively. The Council is also proactively seeking ways to educate users about cyber incidents.	**One P3 action was agreed.** **Responsible Officer: Head of Technology Solutions** All policies in the ISMS have been reviewed and updated. A backup policy will be created which will detail objectives and requirements. The Technical Incident Management Procedure will be reviewed and altered accordingly.
B	Asset Management	Reasonable Assurance	The council has a large number of ICT assets. We reviewed the procedures and controls in place to determine	August 2018	Comprehensive policies and procedures are in place for the management of assets. The policies are in line with the control objectives	**One P2 action and one P3 action agreed.** **Responsible Officers: Service**

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			whether: • Asset management processes are in line with relevant requirements of ISO 27001 & 20000. • The asset register shows a true representation of the location of assets.		set out within ISO 27001 & 20000. In general, the council is following these policies and procedures. However, we did find a number of policies were out of date. The council has utilised asset management software to record details of its IT assets, including the name of the user. However, there are a small number of assets which are not allocated or in use. There is no formal procedure for recovering these assets.	**Centre Manager and Head of Technology Services.** **Service Centre Manager:** We will address the issue of unused devices including improved reporting. We will also introduce a monthly dip sample of 20 "live" mobile assets. **Head of Technology Services:** We will assess the list of legacy equipment and make a recommendation to CIGG to either write-off or commit more resources to further recover the assets.

Appendix 2

CORPORATE THEMES - FINAL AUDIT REPORTS ISSUED IN THE YEAR TO 31 AUGUST 2018

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
A	Transparency Code	Limited Assurance	In 2015 the Department for Communities and Local Government published the 'Local Government Transparency Code' to allow greater and easier access to data. The purpose of this audit was to assess the extent to which: • The data requirements specified by the Transparency Code were being complied with; • Data was published on a timely basis as per the timeframes specified in the Transparency Code. The scope of the audit did not include any review of the accuracy or completeness of the data being published.	November 2017	The Council was not complying with the publication and statutory requirements of the Transparency Code. All relevant data was not being published. Some of the published data was not published according to the required timescales. Only 3 of the 12 relevant sections of the Code had related information published correctly and per the required timescales. The remaining data sets were either incomplete, difficult to locate, out of date or not published at all. There was a lack of clarity on individual responsibilities. No retrospective checks were being made to ensure the information had been correctly published on the Data North Yorkshire website. There was a lack of management oversight and guidance for the whole process. A follow audit on Transparency is in progress at the time of this report.	**Three P2 actions agreed.** **Responsible Officers: Data Governance Manager and Data and Intelligence Manager** The Data Governance Team will develop and implement an effective and efficient process to ensure accurate information is published within the required timescales. The Data and Intelligence Team will develop and roll out relevant and regular training for information asset owners and operational employees
B	IR35	Substantial	From April 2017, local	January	The process to assess cases referred	**One P2 action and one P3 action**

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
		Assurance	authorities and other public sector bodies are responsible for collecting Income tax and National Insurance for contractors and interim staff, who work through limited companies (IR35). The Resourcing Solutions Team within Human Resources is responsible for assessing and determining whether the IR35 legislation applies. We reviewed the procedures and controls to ensure that: • Sufficient checks have taken place when determining whether IR35 applies or not • Relevant team(s) have received appropriate training in order to carry out their duties correctly; • Where IR35 support and guidance has been provided externally, this has been sufficient.	2018	to the Resourcing Solutions Team was found to be operating effectively. The Resourcing Solutions Team is reliant on cases potentially within the scope of IR35 to be referred from other departments and service areas. Awareness and details of the changes has been raised across the Council by the Assistant Chief Executive (Business Support), HR and OD. However, a check on the NYCC Intranet failed to find any easily accessible guidance on IR35 for employees. The Resourcing Solutions Team has received adequate and suitable training in order to fulfil their responsibilities and appropriate support and advice was provided externally. However, there was no centrally held record of courses attended by members of staff. Currently there is no process in place to check expenditure for potential IR35 cases. There is therefore a risk some cases have not been referred to the Resourcing Solutions Team to determine.	**agreed.** **Responsible Officer: Principal Advisor Resourcing Solutions.** Resourcing Solutions Team to undertake a periodic check of a financial subjective related report on a quarterly basis for the next 12 months (from January 2018). This will be reviewed in 12 months' time and if no evidence is found of non compliance with IR35, the check will be completed less frequently e.g. every 6-12 months. The Resourcing Solutions Team members responsible for IR35 will log all future training completed in relation to IR35 legislation on the Learning Zone. This will appear on their Learning Zone records within 6 weeks of being submitted. This will include the name and nature of the training and the date that it was attended.
C	Capital Programme Management	Substantial Assurance	Business and Environmental Services (BES) is responsible for the largest element of	January 2018	There is sufficient and adequate monitoring of the capital programmes for BES and CYPS.	**One P2 action agreed.** **Responsible Officer: Network**

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			expenditure within the NYCC Capital projects budget. The majority of the expenditure relates to the Highways Capital Programme. We reviewed the procedures and controls to ensure that: • The capital programme is monitored consistently and effectively. • Changes to capital projects are made in line with the Council's policy. The audit focussed predominantly on capital project management within BES and CYPS.		The CYPS capital programme reflects the greater flexibility permitted by some of the grants used to fund projects. However, for BES some budget monitoring of project expenditure was found to be inaccurate. Some significant scheme variations forms had not been submitted to the Capital Programme Coordinator in a timely manner. In other cases the scheme variation forms contained insufficient information.	**Strategy Manager.** Team performance is now the subject of regular scrutiny through the 'Highways North Yorkshire' governance structure. The inclusion of significant scheme variation form compliance into this framework has resulted in an improvement. It is acknowledged that any continued individual instances of failure to comply could be considered a performance issue and dealt with accordingly.
D	Attendance Management	Reasonable Assurance	'Sickness' is one of the key performance indicators reported on a quarterly basis to the Executive. We reviewed the procedures and controls to ensure: • Absence is correctly reported by employees and recorded by managers consistently and in line with the Attendance Management policy.	February 2018	We reviewed the Attendance Management policy and found it to be complete and up to date. Training has been provided to all managers to support compliance with the policy. A 'workflow' is also in place for managers to follow when selecting the correct course of action to take for an employee's absence. Further manual controls are also in place including regular reminder emails. Our testing found that relevant	**Two P2 actions and one P3 actions were agreed** **Responsible Officer: Assistant Chief Executive (Business Support)** Updated training has been introduced in late 2017 on the attendance management procedure. This is mandatory for all managers to complete. Consideration will be given to see if there is the capability to mandate

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			• Managers monitor the absences and take appropriate and effective action where necessary. • The data used to calculate the sickness Key Performance Indicator is complete and accurate.		documentation relating to employee absence is not recorded on Wisdom. Managers were also not documenting Return to Work interviews (as required by the Attendance management policy). There was also insufficient evidence of the management of recurring absences.	the workflow and include auto-fill forms from the workflow into Wisdom. Auto-fill forms would ensure that completed Return to Work Interviews and Self-Certificates were stored in the correct place on Wisdom.
E	Revenue Budget Management	Substantial Assurance	We reviewed procedures and controls to ensure: • Budgets were set in an consistent manner and recorded correctly • Budget Managers had the necessary tools to forecast and manage their budgets effectively • Effective budget monitoring was assisting managers to operate within their set budget	May 2018	A number of issues have been identified around the "user friendliness" of the system. These issues are causing some frustration in the use of e-forecasting. Officers are in some cases reverting to other processes, for example spreadsheets to provide assurance and feel confident in undertaking their budget responsibilities. There is also some confusion about the respective responsibilities of budget managers and Finance staff.	**Two P3 actions were agreed.** **Responsible Officers: Head of Strategic Finance & Head of Internal Clients.** The Issue Log will be reviewed and proposed actions will be reported to Finance Leadership Team (FLT). Visits will be arranged to other organisations where there is evidence the system is being used more effectively. A briefing paper on functionality and the applicability of Smartview will be taken to FLT. There will also be further promotion of the online training courses for budget managers. A 'classroom' training resource has also now been developed. Support to forecasting is, or will be, diarised, for example monthly sessions with HAS managers within

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
						the forecasting period.
F	Transition from Children to Adults	Reasonable Assurance	Between the ages of 18 and 25, support for young people may transfer from CYPS to HAS. We reviewed the procedures and controls for the transition of children to adults to ensure: • The arrangements were robust and compliant with legislation • The directorates efficiently managed the quality and flow of data and information leading to quality outcomes	August 2018	The Council is undertaking a joint CYPS and HAS review of the transition process as part of the 2020 programme. The review is in the early stages of development. The audit highlighted that improvements could be made to the practical application of the 'Preparing for Adulthood' model. Issues were raised with the quality of Education, Health and Care Plans (EHCPs) and the quality and flow of information between CYPS and HAS. Cases were not always being transferred to HAS in a timely manner. There is also a need for further support and targeted transitions training for staff in both CYPS and HAS.	**One P2 and four P3 actions were agreed** **Responsible Officers: Assistant Director Commissioning and Assistant Director Inclusion** A joint review of the current transitions model has been undertaken and a newly agreed model is currently under development with the support of the 2020 programme. Development of the new Transitions model which will involve members of staff in CYPS and HAS Adult jointly working on cases from the age of 16 years. AD Inclusion to discuss with Head of SEND to ensure the final copy of the EHCP and subsequent reviews are sent to the relevant HAS social worker. Quality issues are already being addressed as part of the work being undertaken by the Head of SEND.
G	Information Security compliance audits	Various compliance visits:	• ESS • Racecourse Lane • The Lodge	Various	Following each visit, a detailed report is sent to the Senior Information Risk Owner (SIRO), as well as to relevant	**Six P2 actions were agreed** **Responsible Officer:**

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
		2 x High Assurance 1x Reasonable Assurance 2 x Limited Assurance 1 x No Assurance	• Hipswell House • Morton on Swale, SW Team • Legal		directorate managers. Data security practices and compliance with council policies was found to be poor in a number of instances.	**Corporate Director - Strategic Resources (and others)** Responses have been obtained from relevant directorate managers following each audit. Management have viewed the findings seriously and have taken immediate action where issues have been discovered. Follow up visits have been arranged where significant information risks have been identified.

Appendix 3

CONTRACTS - FINAL AUDIT REPORTS ISSUED IN THE YEAR TO 31 AUGUST 2018

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
A	Foundation Housing	No Opinion Given	In June 2017, concerns were raised about the Offenders Housing Related Support service being delivered by Foundation Housing. The annual contract cost is £486k. The purpose of the audit was to review the issues which had been raised. We also sought to review the extent to which contract performance was being effectively managed.	September 2017	We found no significant weaknesses with the service. Quarterly contract management meetings have taken place in accordance with the contract. No concerns were raised at those meetings about staffing levels or the service provided by Foundation Housing. Quarterly performance monitoring information has also been submitted in line with the contract. Performance information was currently based on quantitative measures only. However, there is scope to include more qualitative measures to help evaluate the delivery of outcomes.	Quality Assessment Framework (QAF) visits were carried out at the Foundation Housing offices in Harrogate and Scarborough in October 2017. An action plan is to be developed from the evidence gathered from the QAF visits. Targets and timescales will be agreed with Foundation Housing by the end of the calendar year.
B	Revenue Contracts – Dalewood Follow Up	No Opinion Given	In 2016, an audit visit to Dalewood Trust was carried out with the Quality and Contracting team. A number of significant weaknesses were identified. This follow up audit was to provide assurance that the actions agreed in the last audit report had been completed and there was a strategy in place for the future delivery of the Day Service	December 2017	A number of significant changes have been made which has improved the data and effectiveness of contract management A revised attendance spreadsheet has been introduced which improves the quality of data, ensures the correct payments are made and enables issues with service use to be more easily identified.	-

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			Contract.		No new findings were raised as a result of this follow up review. All the agreed actions from the previous audit have been implemented or will be accommodated as part of the future strategy.	
C	Framework Contract Complaint	No Opinion Given	In 2017, NYCC created a supplier framework for schools and academies to purchase Management Information Systems and Financial Accounting Systems. After being accepted onto the framework and after the stand still period one supplier raised a complaint regarding the framework's adherence to the 'Public Contracts Regulations 2015' legislation. The purpose of this audit was to provide assurance that: • The processes for developing and implementing the framework agreement were appropriate. • Any lessons to be learnt from this procurement exercise had been identified.	May 2018	The procurement process was completed to the necessary standard for this type of framework agreement. The framework had been appropriately investigated, assessed and approved. Due to the specific nature of the framework, conclusions drawn from this case may not be applicable in future procurement exercises. All procurement officers however need to be made aware of the key learning points of this case. A further review of existing frameworks should also be considered. Comprehensive notes should be made at any pre procurement events held with potential suppliers.	The recommendations from this review will be raised within the weekly Leadership Team meetings and cascaded to the procurement officers for future awareness.

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
D	Organised Crime – Procurement Risks	Substantial Assurance	In December 2016, the Home office published a report which identified the procurement related risks to local authorities from organised criminals. The purpose of this audit was to review the Home office report and to assess the arrangements currently in place at the council.	August 2018	We found the council already has procedures in place to deter and identify fraud as recommended in the Home Office report. The council has recently embarked on a procurement strategy which aims to obtain the best value for the authorities spend, through the efficient use of resources and technology. However, procedures for disclosing potential conflicts of interest in procurement have not been revisited since the procurement function returned 'in-house' in 2017. The Home Office report also recommends two additional contract clauses.	**Two P3 actions were agreed.** **Responsible Officer: Head of Procurement.** We will review and update the declaration of interest process for procurements as part of the Policy and Process procurement strategy work stream. We will consider the recommended wording for our template procurement documents as part of the Policy and Process procurement strategy work stream.

Appendix 4

AUDIT OPINIONS AND PRIORITIES FOR ACTIONS

Audit Opinions	
Audit work is based on sampling transactions to test the operation of systems. It cannot guarantee the elimination of fraud or error. Our opinion is based on the risks we identify at the time of the audit. Our overall audit opinion is based on 5 grades of opinion, as set out below.	
Opinion	**Assessment of internal control**
High Assurance	Overall, very good management of risk. An effective control environment appears to be in operation.
Substantial Assurance	Overall, good management of risk with few weaknesses identified. An effective control environment is in operation but there is scope for further improvement in the areas identified.
Reasonable Assurance	Overall, satisfactory management of risk with a number of weaknesses identified. An acceptable control environment is in operation but there are a number of improvements that could be made.
Limited Assurance	Overall, poor management of risk with significant control weaknesses in key areas and major improvements required before an effective control environment will be in operation.
No Assurance	Overall, there is a fundamental failure in control and risks are not being effectively managed. A number of key areas require substantial improvement to protect the system from error and abuse.

Priorities for Actions	
Priority 1	A fundamental system weakness, which presents unacceptable risk to the system objectives and requires urgent attention by management.
Priority 2	A significant system weakness, whose impact or frequency presents risks to the system objectives, which needs to be addressed by management.
Priority 3	The system objectives are not exposed to significant risk, but the issue merits attention by management.

NORTH YORKSHIRE COUNTY COUNCIL

AUDIT COMMITTEE

10 October 2018

BUSINESS CONTINUITY – UPDATE REPORT

1 Purpose of Report

1.1 To provide an overview of the current resilience and business continuity (BC) arrangements for North Yorkshire County Council and to provide continued assurance for the management of risk within directorates and service areas.

2 Background

2.1 NYCC resilience and business continuity (BC) arrangements are reviewed on an ongoing basis by the NYCC Resilience & Emergencies Team (RET) over recent years to ensure plans continue to be fit for purpose. In 2016 an updated methodology was introduced in order to prioritise the business continuity needs of each individual service area. This has evolved to ensure a consistent and corporate approach to BC planning across the organisation and a robust system to manage any disruption to the provision of priority NYCC services.

The RET has continued to respond to internal audit reviews and service area manager feedback to focus on reducing bureaucracy, improving engagement and transparency and ensuring a consistent corporate document format for NYCC resilience and business continuity.

2.2 The NYCC BC documentation consists of:

Business Impact Analysis (BIA) - The Business Impact Analysis looks at priority business functions and quantifies the impact a loss of those functions may have.

Incident Management Plan (IMP) - The Incident Management Plan helps a service area to plan a process to respond to and work around a range of possible impacts on their provision of priority services during any incident.

2.3 These documents are held centrally on the NYCC BC share-point site. This allows for ease of access, allowing service area practitioners and management to make informed business continuity decisions. This also provides a framework for assurance during any disruption of service and signposts a course of to mitigate any loss of priority services.

3 Corporate Business Continuity Policy

3.1 BC and potential disruption to NYCC services are corporately addressed through a consistent assessment considering loss of staff, equipment and technology, buildings and key suppliers. These considerations are addressed through pre-planning and mitigation measures identified in service area BC plans.

3.2 Each directorate has continued to work with the RET to utilise planning training and exercising to focus on any possible disruption and to ensure staff know what to do and when to do it during any relevant incident.

3.3 To ensure conformity, specific officers have been designated to review service area BC arrangements and a reporting regime put in place. Every directorate has a designated BC champion to oversee their business continuity and to represent their directorate at the Corporate Risk Management Group (CRMG) in support of managers producing BC plans for directorate priority services. Three out of the four Champions received core training on their role in July 2018. The fourth champion (HAS) was unavailable and is scheduled to receive training by end of October 2018. Further training will be scheduled in early 2019 to develop the role

3.4 The Corporate Director (Strategic Resources) continues to have overall responsibility for BC within NYCC, with the BC function co-ordinated and supported by the RET. The Leader of the Council, Cllr.Carl Les, continues to hold the executive portfolio for resilience, emergency planning and business continuity.

3.5 Directorates are required to provide a BC RAG (Red, Amber, Green) status update to the CRMG every quarter. This process allows directorate BC champions to monitor and inform their directors on the current status of their directorate BC plans and provide the key information required to confirm their satisfaction in annual statements of assurance. This is a rolling program of improvement and over a three year period will identify any areas that may require further investment in BC resilience, particularly those traded services that NYCC has a commitment to provide during a period of severe disruption.

4 Corporate Business Continuity Plan

4.1 A Corporate NYCC Business Continuity Plan is in place, agreed by NYCC Management Board and introduced to ensure a consistent and co-ordinated response across the organisation during any disruptive incidents.

The Business Continuity Plan has been tried and tested in-house by all directorates during a number of recent incidents that have required service areas to put their plans into action to mitigate the impacts of various disruptions.

- **"Beast from the East - Severe Weather - February 2018 -** This required a corporate NYCC consideration for potential impacts on staffing, resources and priority service provision. The corporate BC plan was used to plan for

expected resourcing problems, staff getting to their normal place of work, the increased demand placed on certain areas of service provision including the Customer Service Centre, Highways and Social Care and corporate management of staff, facilitating them in working from home or from alternative locations. This incident involved “managing-out” less urgent tasks and service provision and the use of BC plans to work around impacts and a focus of resources available for the provision of NYCC priority services.

- **Wide area gas supply issues Ryedale - December 2017 -** Management of NYCC BC and multi-agency response dealing with outage and implications for vulnerability, social care and resourcing Health and Adult Services.

- **Cyber-attacks** - After the 2017 NHS cyber-attack and a number of lower level recent attacks on NYCC systems, a NYCC cyber security workshop and exercise will be held in November 2018. This will focus on ensuring NYCC has a robust corporate approach and that we are maximising the opportunities to ensure we are as resilient as possible to cyber-attack.

- **Northallerton School incidents** - These incidents tested the resilience of NYCC on a number of fronts including media management and communications and service provision from Children and Young Peoples Services. Lessons from these incidents are being embedded to improve our capabilities in the management of significant incidents.

NYCC has also continued to respond to a number of regular incidents across the county including sink-holes, landslips and severe weather - all of which have tested our NYCC BC and response and recovery plans.

The provision of a structured BC framework across NYCC directorates, including links with the multi-agency Response to Major and Critical Incidents (RMCI) plan has enhanced management of information and supported a communication strategy that informs NYCC senior management, enabling them to identify priorities in the restoration of priority services.

4.2 The Corporate BC Plan has continued to evolve and organisational learning has been identified with multi-agency LRF partners from recent national events such as Grenfell and the Manchester Arena attack. Significant incidents impacting on NYCC are subject to a de-brief process with lessons identified then tasked for embedding to ensure future resilience. Lessons from the Tour de France and Tour de Yorkshire races are also being embedded in the planning for the 2019 World Cycle Championships.

4.3 Some service areas such as Technology & Change and the Customer Service Centre have very specific recovery requirements during any incidents. As such they have additional plans to ensure they can support response to wider disruption across NYCC. These service areas continue to provide corporate Incident Management Plans to allow informed strategic and corporate BC decision making during service disruption. Analysis by Technology & Change

of the information technology requirements identified in the service BIAs assists in their disaster recovery strategies.

4.4 Designated officers within the RET continue to provide on-going support for directorate BC champions and their staff within each directorate. The RET officers work with the directorate BC Champions to ensure that service areas have the knowledge and support to meet their BC responsibilities and that Incident response, training and exercising is part of their an annual work-plan.

4.5 Resilience and BC planning will continue to be an evolving process with the RET and directorate BC Champions working together to ensure robust, consistent, planned and exercised BC arrangements are in place to provide the required assurance across the organisation.

5 Recommendation

5.1 Audit Committee to note the resilience and business continuity arrangements within North Yorkshire County Council and the continued work of the directorate business continuity Champions, supported by the Resilience & Emergencies Team, to embed resilient practice across the organisation.

Author: Tom Knox, Head of Resilience & Emergencies - NYCC

KPMG

Annual Audit Letter 2017/18

North Yorkshire County Council

August 2018

Section one

Summary for Audit Committee

Section one:

Summary for Audit Committee

This Annual Audit Letter summarises the outcome from our audit work at North Yorkshire County Council ("the Authority") in relation to the 2017-18 audit year.

Although it is addressed to Members of the Authority, it is also intended to communicate these key messages to key external stakeholders, including members of the public, and will be placed on the Authority's website.

Audit opinion

We issued an unqualified opinion on the Authority's financial statements on 30 July 2018. This means that we believe the financial statements give a true and fair view of the financial position of the Authority and of its expenditure and income for the year. The financial statements also include those of the pension fund.

Financial statements audit

Our audit procedures are designed to identify misstatements which are material to our opinion on the financial statements as a whole . Materiality for the Authority's accounts was set at £15 million which equates to around 1.4% percent of gross expenditure. We design our procedures to detect errors in specific accounts at a lower level of precision. Materiality for the Pension Fund was set at £25 million which is approximately 0.7% percent of gross assets.

We report to the Audit Committee any misstatements of lesser amounts, other than those that are "clearly trivial", to the extent that these are identified by our audit work. In the context of the Authority, an individual difference is considered to be clearly trivial if it is less than £0.75 million for the Authority (£1.25 million for the Pension Fund).

We identified two significant audit adjustments. One related to the accounting entries of the Authority's Pension Deficit Contributions payment made in 2017/18. This adjustment impacted on the General Fund but with a nil net effect, and decreased net assets by £16.8m. The other related to the valuation of the Council's share of the Allerton Waste Recovery Plant asset and as a result of technical accounting adjustments the value of the asset was reduced by £49m. This adjustment had no impact on the General Fund.

Additionally we identified some non significant and presentational adjustments required to ensure that the accounts were complaint with the Code of Practice on Local Authority Accounting in the United Kingdom 2017-18.

Our audit work was designed to specifically address the following significant risks:

— **Management Override of Controls** – Professional standards require us to communicate the fraud risk from management override of controls as significant because management is typically in a unique position to perpetrate fraud. We had no matters arising from this work;

— **Valuation of PPE** – There was a risk that the carrying values of assets not revalued in year would differ materially from year-end fair value, and inappropriate valuation methods and assumptions could be used. We did not identify any issues;

— **Accounting treatment of the Allerton Waste Recovery asset** – As this was the first year this asset became operational there was a risk that the value of the asset recognised by the Council would not be materially correct;

— **Pensions Liabilities** – There was a risk that the assumptions and methodology used in the valuation of the Council's pension obligation were not reasonable. As a result of our work we determined that the Pension Asset, Obligation and Net Pension Liability are materially correctly stated; and

— **Faster Close of Financial Statements** – For 2017/18 draft financial statements were required by 31 May 2018.

Summary for Audit Committee (cont.)

Other information accompanying the financial statements

Whilst not explicitly covered by our audit opinion, we review other information that accompanies the financial statements to consider its material consistency with the audited accounts. This year we reviewed the Annual Governance Statement and Narrative Report. We concluded that they were consistent with our understanding and did not identify any issues.

Pension fund audit

From our planning work we did not identify any significant risks relating to the Pension Fund.

Our audit identified one audit adjustment which resulted in deficit contributions being increased by £25m with a corresponding decrease in current liabilities. As a result the Net Assets of the Fund increased by the £25m.

Whole of Government Accounts

We reviewed the consolidation pack which the Authority prepared to support the production of Whole of Government Accounts by HM Treasury. We reported that the Authority's pack was materially consistent with the audited financial statements.

Value for Money conclusion

We issued an unqualified conclusion on the Authority's arrangements to secure value for money (VFM conclusion) for 2017/18 on 30th July 2018. This means we are satisfied that during the year the Authority had appropriate arrangements for securing economy, efficiency and effectiveness in the use of its resources.

To arrive at our conclusion we looked at the Authority's arrangements to make informed decision making, sustainable resource deployment and working with partners and third parties.

Value for Money risk areas

We undertook a risk assessment as part of our VFM audit work to identify the key areas impacting on our VFM conclusion and considered the arrangements you have put in place to mitigate these risks.

Our work identified no significant matters.

High priority recommendations

We raised no high priority recommendations as a result of our 2017/18 work.

Summary for Audit Committee (cont.)

Certificate

We are not yet able to issue our certificate. We are required to give an opinion on the consistency of the financial statements of the pension fund included in the Pension Fund Annual Report with the pension fund accounts included in the statements of North Yorkshire County Council.

Until we do so, we are unable to certify that we have concluded the audit for 2017/18 in accordance with the requirements of the Local Audit & Accountability Act 2014 and the Code of Audit Practice.

Audit fee

Our fee for 2017/18 was £94,490, excluding VAT (2017: £94,490). Our fee for the audit of the Pension Fund was £24,943 excluding VAT (2017: £24,943). Consistent with previous years we have requested approval from PSAA Ltd to raise an additional fee of £4,996 relating to the audit of the Pension Fund, reflecting the work we are required to carry out at the Pension Fund on behalf of the auditors of Pension Fund Scheduled Bodies. Further detail is contained in Appendix 2, including fees for additional work.

Exercising of audit powers

We have a duty to consider whether to issue a report in the public interest about something we believe the Authority should consider, or if the public should know about.

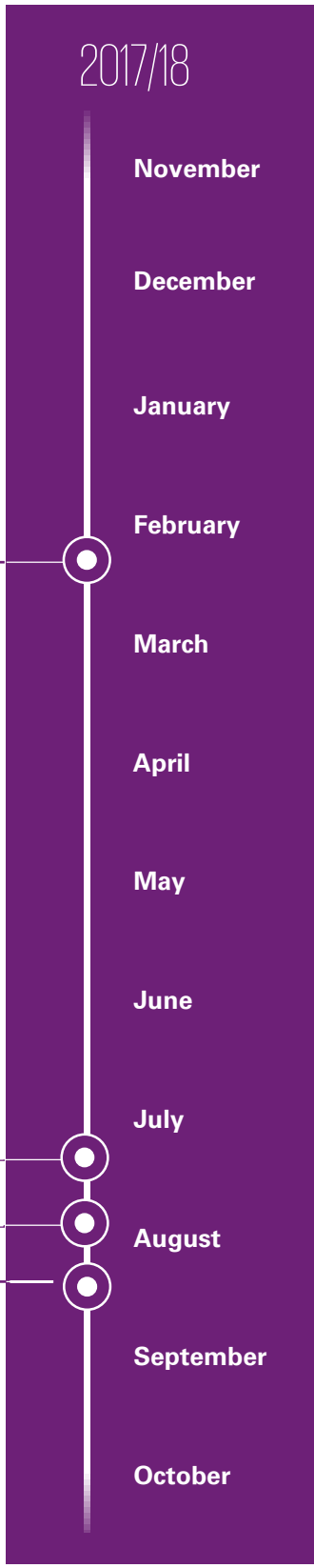
We have not identified any matters that would require us to issue a public interest report.

Appendices

Appendix 1:

Summary of reports issued

This appendix summarises the reports we issued since our last Annual Audit Letter. These reports can be accessed via the Audit Committee pages on the Authority's website.



External Audit Plan

The External Audit Plan set out our approach to the audit of the Authority's financial statements, including those of the Pension Fund, and to support the VFM conclusion.

Report to Those Charged with Governance

The Report to Those Charged with Governance summarised the results of our audit work for 2017-18 including key issues and recommendations raised as a result of our observations.

We also provided the mandatory declarations required under auditing standards as part of this report.

Auditor's Report

The Auditor's Report included our audit opinion on the financial statements (including the pension fund accounts) along with our VFM conclusion.

Annual Audit Letter

This Annual Audit Letter provides a summary of the results of our audit for 2017-18.

Appendix 2:

Audit fees

This appendix provides information on our final fees for the 2017-18 audit.

External audit

Our final fee for the 2017/18 audit of the Authority was £94,490, which is in line with the planned fee (2016/17 £94,490).

Our fee for the 2017/18 audit of the Pension Fund is estimated to be £29,939 (2016/17 £29,939). This includes £4,996 for which approval from PSAA has been requested relating to work we carried out following requests from the auditors of other Scheduled Bodies for assurance over IAS19 accounting entries.

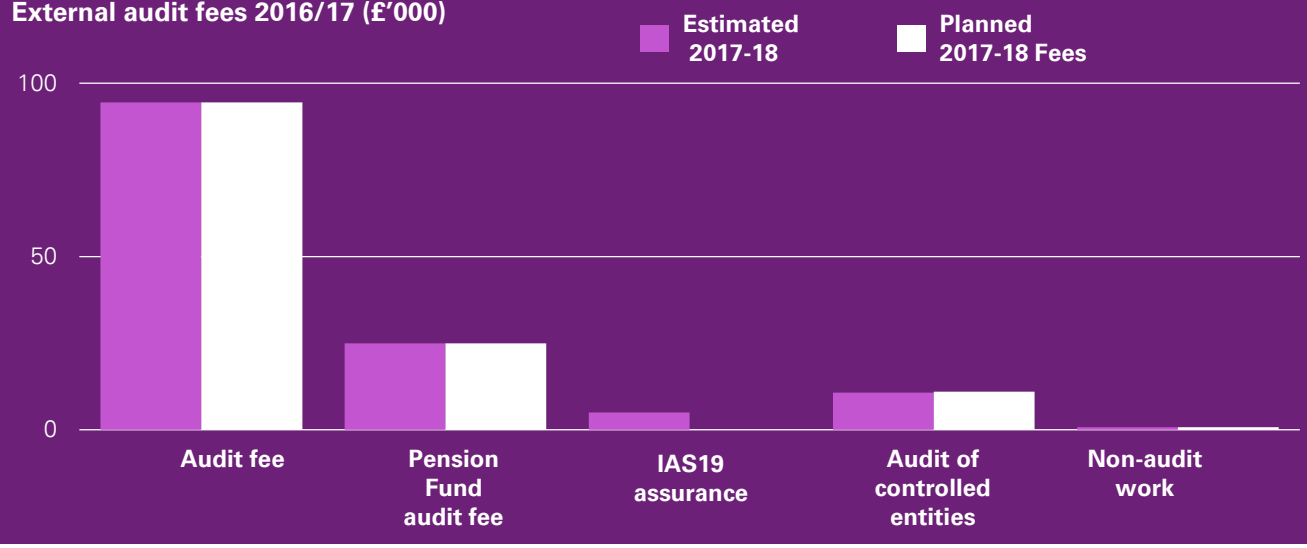
Audit of controlled entities

We charged £7,250 for the audit of the 2017/18 accounts of the Authority's controlled company Align Property Partners Ltd, and £3,500 for the audit of the 2017/18 accounts of the Authority's controlled company Brierley Homes Ltd.

Other services

We charged £750 for Pension Fund tax withholding work. This work was not related to our responsibilities under the Code of Audit Practice.

External audit fees 2016/17 (£'000)



The key contacts in relation to our audit are:

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NORTH YORKSHIRE COUNTY COUNCIL

AUDIT COMMITTEE

10 OCTOBER 2018

PROGRESS ON 2018/19 INTERNAL AUDIT PLAN

Report of the Head of Internal Audit

1.0 PURPOSE OF THE REPORT

1.1 To inform Members of the progress made to date in delivering the 2018/19 Internal Audit Plan and any developments likely to impact on the Plan throughout the remainder of the financial year.

2.0 BACKGROUND

2.1 Members approved the 2018/19 Audit Plan on the 21 June 2018. The total number of planned audit days for 2018/19 is 1,100 (plus 956 days for other work including counter fraud and information governance). The performance target for Veritau is to deliver 93% of the agreed Audit Plan.

2.2 This report provides details of how work on the 2018/19 Audit Plan is progressing.

3.0 INTERNAL AUDIT PLAN PROGRESS BY 31 AUGUST 2018

3.1 The internal audit performance targets for 2018/19 were set by the County Council's client officer. Progress against these performance targets, as at 31 August 2018, is detailed in **Appendix 1**.

3.2 Work is ongoing to complete the agreed programme of work. It is anticipated that the 93% target for the year will be exceeded by the end of April 2019 (the cut off point for 2018/19 audits). **Appendix 2** provides details of the final reports issued in the period. A further 7 audit reports have been issued but remain in draft. Fieldwork is currently underway with a number of other scheduled audits.

Contingency and Counter Fraud Work

3.3 Veritau continues to handle cases of suspected fraud or malpractice. Such assignments are carried out in response to issues raised by staff or members of the public via the Whistleblower Hotline, or as a result of management raising concerns. Since the start of the current financial year, 18 cases of suspected fraud or malpractice have been referred to Veritau for investigation. 6 of these are internal fraud cases, 8 relate to social care and 3 are external fraud. A further case related to an application for a school place. A number of these investigations are still ongoing. Two adult social care cases were recently prosecuted by the CPS. The Veritau Fraud Team supported the Police with both investigations.

Information Governance

3.4 Veritau's Information Governance Team (IGT) continues to handle a significant number of information requests submitted under the Freedom of Information and Data Protection Acts. The number of FOI requests received between 1 April 2018 and 31 August 2018 is 585 compared with 534 requests received during the corresponding period in 2017. The IGT is currently below the performance response target of 95% for 2018/19 with approximately 90% of requests so far being answered within the statutory 20 day deadline. The IGT also coordinates the County Council's subject access requests (SARs) and has received 100 such requests between 1 April 2018 and 31 August 2018 compared to 88 requests received during the corresponding period in 2017.

3.5 Veritau has been appointed as the County Council's Data Protection Officer following the implementation of the General Data Protection Regulation (GDPR) on 25 May 2018. The IGT has been assisting the County Council to update the information governance policy framework in line with the requirements of GDPR and the new Data Protection Act 2018. Other work has included preparing data sharing agreements, recording data security incidents, investigating serious data security incidents, and providing advice and support to service departments. Veritau auditors have also continued to undertake a programme of unannounced compliance visits to County Council premises in order to assess staff awareness of the need to secure personal and sensitive information.

Variations to the 2018/19 Audit Plan

3.6 All proposed variations to the agreed Audit Plan arising as the result of emerging issues and/or requests from directorates are subject to a Change Control process. Where the variation exceeds 5 days then the change must be authorised by the client officer. Any significant variations will then be communicated to the Audit Committee for information. The following variations have been authorised since the last progress report. The variations follow discussions with management and reflect changes in current priorities:

Financial safeguarding procedures (HAS)	+10 days
Direct Payments (HAS)	-10 days
Net change to plan	**nil**

Follow Up of Agreed Actions

3.7 Veritau follows up all agreed actions on a regular basis, taking account of the timescales previously agreed with management for implementation. An escalation process is in place for when agreed actions are not implemented or where management fail to provide adequate information to enable an assessment to be made. At this stage in the year, there are no actions which have needed to be escalated. On the basis of the follow up work undertaken during the year to date, the Head of Internal Audit is satisfied with the progress that has been made by management to implement previously agreed actions necessary to address identified control weaknesses.

External Assessment

3.8 In order to comply with the Public Sector Internal Audit Standards (PSIAS), internal auditors working in local government are required to maintain a quality assurance and improvement programme (QAIP). As part of this programme, providers are required to have an external assessment of their working practices at least once every five years. The last external assessment of Veritau was undertaken in April 2014 by the South West Audit Partnership (SWAP).

3.9 A further external assessment of Veritau will be undertaken by SWAP in November 2018. SWAP is a not for profit public services company operating primarily in the South West of England. As a large shared service internal audit provider it has the relevant knowledge and expertise to undertake external inspections of other shared services and is independent of Veritau. The assessment will include a review of documentary evidence, including self-assessments completed by Veritau, and face to face interviews with a number of senior officers at each of the Veritau clients and Veritau auditors. The assessors may also wish to speak to the chair of the audit committee as part of the assessment process. The results of the assessment will be included in future internal audit progress reports to the committee, once a report has been received from the assessor. Any specific areas identified as requiring further development and/or improvement will also be included in the QAIP.

4.0 **RECOMMENDATION**

Members are asked to note:

4.1 the progress made in delivering the 2018/19 Internal Audit programme of work and the variations agreed by the client officer.

4.2 the planned external quality assessment of audit working practices by the South West Audit Partnership.

Report prepared and presented by Max Thomas, Head of Internal Audit

Max Thomas
Head of Internal Audit
Veritau Limited
County Hall
Northallerton

19 September 2018

Background Documents: Relevant audit reports kept by Veritau at 50 South Parade, Northallerton.

Appendix 1

PROGRESS AGAINST 2018/19 PERFORMANCE TARGETS (AS AT 31/8/2018)

Indicator	Milestone	Position at 31/8/2018
To deliver 93% of the agreed Internal Audit Plan	93% by 30/4/19	18.29%
To achieve a positive customer satisfaction rating of 95%	95% by 31/3/19	100%
To ensure 95% of Priority 1 recommendations made are agreed	95% by 31/3/19	100%
To ensure at least 30% of investigations completed result in a positive outcome (management action, sanction or prosecution)	30% by 31/3/19	54.55%
To identify actual fraud savings of £50k (quantifiable savings)	£50k by 31/3/19	£23,905
To ensure 95% of FOI requests are answered within the Statutory deadline of 20 working days	95% by 31/3/19	89.91%

Appendix 2

FINAL 2018/19 AUDIT REPORTS ISSUED TO DATE

Audit Area	Directorate	Overall Opinion
Visits to Care Providers - Avalon (Scarborough)	HAS	Substantial assurance
Visits to Care Providers – Eldercare	HAS	Substantial assurance
Visits to Care Providers – Foresight	HAS	Reasonable assurance
Visits to Care Providers - Botton Village - Avalon Shared Lives	HAS	Substantial assurance
Developing Stronger Families April/May claim	CYPS	No opinion

NORTH YORKSHIRE COUNTY COUNCIL

AUDIT COMMITTEE

10 OCTOBER 2018

ANNUAL REPORT OF THE AUDIT COMMITTEE

Report of the Chair of the Audit Committee

1.0 PURPOSE OF THE REPORT

1.1 To enable Members to consider the draft annual report of the Audit Committee for the year ended 30 September 2018, prior to its submission to County Council.

2.0 ANNUAL REPORT

2.1 The Chartered Institute of Public Finance and Accountancy (CIPFA) has issued guidance to local authorities to help ensure that audit committees operate effectively. The guidance recommends that audit committees should report annually on how they have discharged their responsibilities. A copy of the draft annual report of this Audit Committee is attached at **Appendix 1**. A copy of the Audit Committee's Terms of Reference is attached to the report as **Appendix A**, for information.

3.0 RECOMMENDATIONS

3.1 It is recommended that Members:

(i) note this report; and

(ii) consider and approve the draft annual report of the Audit Committee prior to its submission to the County Council.

CHAIRMAN OF THE AUDIT COMMITTEE

BACKGROUND DOCUMENTS
Relevant public reports presented to the Audit Committee and minutes of the meetings of the Audit Committee

Report prepared by Max Thomas, Head of Internal Audit and presented by Cllr Clifford Lunn, Chair of the Audit Committee

County Hall
Northallerton

11 September 2018

PURPOSE OF THE REPORT

To provide Members of the County Council with details of the work carried out by the Audit Committee during the year ended 30 September 2018. The report also details how the Audit Committee has fulfilled its Terms of Reference during this period.

BACKGROUND

The Audit Committee is responsible for overseeing the County Council's corporate governance, audit and risk management arrangements. The Committee is also responsible for approving the Statement of Accounts and the Annual Governance Statement. The Committee's specific powers and duties are set out in Schedule 1 of the Constitution under the Terms of Reference of the Audit Committee. A copy of the Terms of Reference is attached at **Appendix A** for information.

Audit Committees are a key component of corporate governance and provide an important source of assurance about the organisation's arrangements for managing risk, maintaining an effective control environment, and reporting on financial and other performance.

The Chartered Institute of Public Finance and Accountancy (CIPFA) has issued guidance to local authorities to help ensure that Audit Committees are operating effectively[1]. The guidance recommends that audit committees should report annually on how they have discharged their responsibilities.

WORK UNDERTAKEN AND OPINION

The Audit Committee has met on four occasions in the year to 30 September 2018, in accordance with its Programme of Work.

During this period, the Committee has assessed the adequacy and effectiveness of the County Council's risk management arrangements, control environment and associated counter fraud arrangements through regular reports from officers, the internal auditors, Veritau and the external auditors, KPMG. The Committee has sought assurance that action has been taken, or is otherwise planned, by management to address any risk related issues that have been identified by the auditors during this period. The Committee has also sought to ensure that effective relationships continue to be maintained between the internal and external auditors, and between the auditors and management.

The Committee has continued to focus its attention on the County Council's key priorities and challenges including funding pressures, the impact on services caused by an ageing population, the increased demand for children's social care services, the need to manage cyber security and information security risks, and the need to strengthen partnership working.

The Audit Committee is satisfied that the County Council has maintained an adequate and effective control framework through the period covered by this report.

The specific work undertaken by the Committee is set out below.

[1] CIPFA – Audit Committees Practical Guidance for Local Authorities and Police, 2018

The Committee:

External Audit

1 Received and considered the external auditor's annual audit letter in respect of the 2016/17 audit year. The Committee was pleased to note that the external auditors had not raised any significant issues and had given unqualified audit opinions for both the County Council and the North Yorkshire Pension Fund. KPMG had also issued an unqualified value for money conclusion and an unqualified opinion on the Whole of Government Accounts return;

2 Received and considered the external auditor's plan for the audit of the 2017/18 financial statements and the review of the County Council's arrangements for securing value for money;

3 Received and considered the results of KPMG's work in relation to the audit of the 2017/18 financial statements of the County Council and the North Yorkshire Pension Fund. The Committee was pleased to note that the auditors had not identified any issues and had given unqualified audit opinions for both the County Council and the North Yorkshire Pension Fund. KPMG had also issued an unqualified value for money conclusion;

4 Held an informal private meeting with KPMG to discuss their work;

5 Met with representatives from Deloitte, the County Council's new external auditors from 2018/19 onwards.

Internal Audit

6 Continued to oversee the internal audit arrangements for the County Council and North Yorkshire Pension Fund. No changes were required to the Internal Audit Charter during the period;

7 Received and considered the results of internal audit work performed in respect of each Directorate and across different thematic areas. Monitored the progress made by management during the period to address identified control weaknesses;

8 Received and approved the Internal Audit Plan for 2018/19. The plan ensures that limited internal audit resources are prioritised towards those systems and areas which are considered to be the most risky or which contribute most to the achievement of the County Council's corporate objectives;

9 Monitored the delivery of the annual Internal Audit plans through regular update reports presented by the Head of Internal Audit. Reviewed variations to the Audit plans which were considered necessary to reflect new or changed County Council priorities;

10 Considered the County Council's overall counter fraud arrangements in the light of emerging risks (both national and local). Received and considered the outcome of the annual 2017/18 Fraud and Loss Risk Assessment. The Committee also reviewed the work of Veritau in respect of suspected fraud including the results of

investigations into matters reported via the County Council's whistleblowing facilities or directly by management;

11 Received and considered the Annual Report of the Head of Internal Audit which provided an overall opinion on the County Council's control environment. The Committee noted that the work of internal audit is primarily focused on those areas which represent the highest risk for the County Council. The Head of Internal Audit confirmed that the Council's framework of governance, risk management and control provided substantial assurance. In forming this opinion, the Head of Internal Audit had considered the progress made by management during the year to address identified control weaknesses. The Head of Internal Audit also drew the Committee's attention to a number of specific control weaknesses identified during audit work including examples of poor practice with the handling of personal data and compliance issues with the Transparency Code;

12 Assessed the performance of the County Council's internal audit provider, Veritau Limited against the targets set for 2017/18, and considered the performance targets for 2018/19. The Committee also considered the outcome of the internal audit quality assurance and improvement programme (QAIP). The QAIP is an ongoing process which helps to ensure internal audit work is conducted in accordance with established professional standards. The Committee was pleased that internal audit practices met the required standards and therefore continued reliance could be placed on the arrangements operating within the County Council;

13 Held an informal private meeting with the Head of Internal Audit to discuss the work of the internal auditors;

Risk Management

14 Continued to oversee the County Council's risk management arrangements and strategy;

15 Reviewed the progress made by the County Council to identify and address corporate risks. This included consideration of the updated Corporate Risk Register. Whilst no new risks have been identified in the period, a number of the existing risks have been modified to reflect recent developments. For example, the risks around information governance were updated to reflect the General Data Protection Regulation (GDPR) and new Data Protection Act 2018. The new Commercial Strategy and the improved governance arrangements for the County Council's owned companies were also recognised. The Committee noted that many of the risks identified were complex in nature and/or had potentially significant financial implications;

16 Assessed the adequacy and effectiveness of each Directorate's risk management arrangements through consideration of the risks and mitigating actions identified in each Directorate Risk Register. The Committee also noted the outcomes of workshops which had helped to identify risks associated with a number of specific activities or projects (for example the A59 Kex Gill Realignment and the Tour de Yorkshire);

17 Considered the outcome of the annual insurance renewals. The Committee noted that Employer's Liability, Public Liability and motor premiums had all increased due to

changes in the Personal Injury Discount Rate set by government. The rate of Insurance Premium tax had also increased from 10% to 12% in the year;

Corporate Governance

18 Considered changes to the Local Code of Corporate Governance prior to approval. These changes included the addition of links to other documents on the County Council's website, the inclusion of a new protocol relating to the role of the Leader and Chief Executive in the ethical framework and reference to the General Data Protection Regulation (GDPR);

19 Considered and approved the Annual Governance Statement for 2017/18 of the County Council;

20 Considered the annual report on partnership governance. The report included details of the County Council's current partnerships, changes which had occurred in the year and the arrangements in place to monitor the management and performance of key partnerships. The report included details of 57 partnerships. The governance arrangements of all high and medium risk partnerships are monitored on a regular basis. The Committee noted that none of the partnerships were identified as being high risk and there had been no governance failures in the year. The Committee consider that partnership governance remains effective and the existing arrangements are proportionate and commensurate to the risks;

21 Considered the ongoing work of the Corporate Information Governance Group (CIGG) which is responsible for updating the corporate information policy framework, identifying new or emerging risks, sharing best practice, and monitoring compliance with corporate information governance standards. The Committee received details of the work being done to mitigate cyber security risks and to prepare for the introduction of the General Data Protection Regulation (GDPR) and new Data Protection Act in May 2018. The Committee also considered the results of the information security compliance checks performed by internal audit and the causes of recent data security incidents. The Committee shares the view that information governance remains a key corporate risk;

22 Received a report detailing the progress made to implement the new Procurement and Contract Management Strategy, and the Strategy Action Plan. The Strategy was adopted in May 2018 and seeks to build on the progress made to date to develop more effective procurement processes within the County Council. The intention now is to invest more time on the pre-procurement 'discovery' stage as well as post procurement contract and supplier management. Committee noted that procurement savings of £882k had already been delivered against the 2020 target of £1.15m. The expectation was that the target would therefore be achieved;

23 Received a report outlining the arrangements put in place to ensure effective governance of the County Council's owned companies.

Financial Statements

24 Considered and approved the Statement of Accounts for 2017/18 of the County Council and the North Yorkshire Pension Fund. This year, the Council County had to prepare the annual accounts and governance statement by 31 May (one month earlier than in previous years) and to publish the audited and approved accounts and

governance statement by 31 July (two months earlier than previously). This change to the timetable was challenging for both the County Council and the external auditors, KPMG. The Committee was pleased to note that the external auditors had reported that the County Council had appropriate processes in place to prepare the financial statements and that the associated working papers were of a good standard. Officers were also proactive in dealing with the external auditor's queries and requests for information;

25 Received details of the revised Code of Practice on Local Authority Accounting which was issued by CIPFA in April 2017. Whilst no changes were required to the Council's accounting policies, some additional or changed disclosure notes were required to the 2017/18 Statement of Accounts. The anticipated change to the valuation of highways network assets from April 2017 onwards was however postponed indefinitely by CIPFA because the cost of implementation outweighed the possible benefits of adoption. The Committee also noted a number of potential future changes to the Code of Practice including changes to the classification and measurement of financial instruments, and the treatment of leases and income from customers. It was recognised that the resulting reclassification of certain operating leases could have an impact on the Council's prudential borrowing.

Other

26 Considered the County Council's arrangements for securing value for money. These arrangements include the Council Plan which aligns strategic goals and objectives, the 2020 North Yorkshire Programme which includes a focus on transformational change to deliver efficiencies, the medium term financial strategy (MTFS) and annual budget setting process, and individual service planning. The Committee also received details of a number of development areas which will drive further improvements in value for money, including more regular and consistent performance reporting, greater use of data to manage performance and increased use of self-service and automated processes. The Committee noted that improved procurement and contract monitoring had also made a significant contribution to the achievement of the County Council's savings targets;

27 Continued to scrutinise the County Council's treasury management arrangements. This included reviewing the updated Treasury Management policy statement and the annual Treasury Management and Investment Strategy for 2018/19. The Strategy includes authorised and operational limits on external debt, a minimum revenue provision policy and a policy to cap capital financing costs as a proportion of the annual net revenue budget;

28 Received briefings from officers on a number of topics including the work of Health and Adult Services, an update on health issues in North Yorkshire and the Future Financial Plan. Members also attended a full day training session on the role and responsibilities of audit committees, delivered by CIPFA;

29 Reviewed the progress which had been made by officers to address other issues raised at meetings of the Committee;

30 Reviewed the Committee's Terms of Reference. We concluded that some limited changes were required to reflect recent best practice guidance;

31 During the year, the Committee benefitted from the attendance and participation of its two independent members, David Portlock and David Marsh. I would like to extend my thanks to both of them for their contribution to the work of the Committee and their ongoing diligence, enthusiasm and support. The term of office for both independent members however ended on 31 July 2018. I'm therefore pleased that, after a recruitment exercise, we have re-appointed both David Portlock and David Marsh for a further four years, to 31 July 2022. We have also appointed a third independent member, Nick Grubb for the same term.

Councillor Clifford Lunn
Chairman of the Audit Committee

APPENDIX A

AUDIT COMMITTEE

TERMS OF REFERENCE

1. In respect of **Internal Audit**

   - to approve the Internal Audit Charter, Annual Audit Plan and performance criteria for the Internal Audit Service.
   - to review summary findings and the main issues arising from internal audit reports and seek assurance that management action has been taken where necessary.
   - to review the effectiveness of the anti-fraud and corruption arrangements throughout the County Council.
   - consider the annual report from the Head of Internal Audit.
   - to obtain assurance that the work of internal audit conforms to the Public Sector Internal Audit Standards.

2. To review the workplan and performance of External Audit.

3. To review, and recommend to the Executive, changes to Contract, Finance and Property Procedure Rules.

4. In respect of **financial statements**

   For both the County Council and the North Yorkshire Pension Fund

   - to approve the respective annual Statements of Final Accounts
   - to receive and review the Annual Audit Letters and associated documents issued by the External Auditor
   - to review changes in accounting policy

5. In respect of **Corporate Governance**

   - to assess the effectiveness of the County Council's Corporate Governance arrangements
   - to review progress on the implementation of Corporate Governance arrangements throughout the County Council.
   - to approve Annual Governance Statements for both the County Council and the North Yorkshire Pension Fund.
   - to liaise, as necessary, with the Standards Committee on any matter(s) relating to the Codes of Conduct for both Members and Officers.
   - to review the arrangements in place for ensuring good governance in the County Council's key partnerships and owned companies

6. In respect of **Risk Management**

   - to assess the effectiveness of the County Council's Risk Management arrangements.
   - to review progress on the implementation of Risk Management throughout the County Council.

7. In respect of **Information Governance**

- to review all corporate policies and procedures in relation to Information Governance.
- to oversee the implementation of Information Governance policies and procedures throughout the County Council.

8. In respect of **Treasury Management**

- to be responsible for ensuring effective scrutiny of the County Council's Treasury Management strategy and policies as required by the CIPFA Treasury Management Code of Practice.
- To review these Treasury Management strategies, policies and arrangements and make appropriate recommendations to the Executive.

9. In respect of **Value for Money**

- to have oversight of the arrangements across the County Council in securing Value for Money.

10. To consider any other relevant matter referred to it by the County Council, Executive or any other Committee. In addition any matter of concern can be raised by this Committee to the full County Council, Executive or any other Member body.

11. To exercise all functions in relation to the making and changing of policy relating to such audit and counter-fraud matters which fall within the remit of the Committee (save as may be delegated otherwise).

12. To periodically review the effectiveness of the Audit Committee itself.

13. To meet not less than four times a year on normal business and review its Terms of Reference on an annual basis.

NORTH YORKSHIRE COUNTY COUNCIL

AUDIT COMMITTEE

10 OCTOBER 2018

AUDIT COMMITTEE TERMS OF REFERENCE / REVIEW OF EFFECTIVENES

Report of the Corporate Director – Strategic Resources

1.0 PURPOSE OF THE REPORT

1.1 To consider whether any changes are required to the Audit Committee's Terms of Reference. Members are also asked to consider whether to proceed with a review of the Committee's effectiveness, and the form and scope of any such review.

2.0 BACKGROUND

2.1 The Audit Committee last reviewed its Terms of Reference at its meeting on 30 November 2017. At that time some limited changes were considered necessary.

2.2 It is best practice to formally review the Terms of Reference on a regular basis and to make changes as necessary. This report therefore seeks to identify any further changes that may now be required as a result of recent legislation, developments in recommended best practice or changes in the Council's governance arrangements. Members' views are also sought on whether the current Terms of Reference enable the Committee to continue to discharge its responsibilities effectively.

2.3 The Chartered Institute of Public Finance and Accountancy (CIPFA) has recently published updated guidance on the operation of audit committees in local government. A copy of CIPFA's Position Statement on audit committees is attached as **Appendix 1**.

3.0 PROPOSED CHANGES TO THE TERMS OF REFERENCE

3.1 The current Terms of Reference are attached as **Appendix 2.** Some limited changes are proposed to the Terms of Reference to reflect the updated CIPFA guidance.

4.0 REVIEW OF THE EFFECTIVENESS OF AUDIT COMMITTEE

4.1 An effectiveness questionnaire was circulated to all Members of the Audit Committee in March 2017. A similar questionnaire was sent to officers who regularly attend meetings of the Audit Committee and the external auditors. The headline results of the survey were reported to the June meeting of the Committee.

4.2 At the November 2017 meeting, Members discussed whether to undertake a full review of effectiveness and concluded that the Committee was working well. It was therefore decided to postpone any review until after November 2018.

4.3 Members may now wish to again consider whether there are benefits to undertaking a review of the Committee's effectiveness, the timing of such a review and how it will be progressed. Assuming there is agreement to proceed then several options exist for how such a review might be undertaken. The Committee could undertake the review collectively with support from officers, set up a working group (with support from officers) or arrange an external assessment (for example a peer review by an audit committee chair from a neighbouring authority or a review by a suitable expert). There may be budget and procurement implications if an external assessment is chosen as the preferred option. Given previous experience, the working group option is preferred.

4.4 Assuming the working group option is chosen, the Committee will also need to consider the scope of the review and expected timescales.

5.0 RECOMMENDATION

Members are asked to consider:

5.1 the proposed changes to the Terms of Reference of the Audit Committee prior to submission of these changes to the County Council for approval.

5.2 whether to proceed with a review of the Committee's effectiveness, and if so, what form it should take.

GARY FIELDING
Corporate Director – Strategic Resources

County Hall
NORTHALLERTON

20 September 2018

Background Documents:

None

CIPFA The Chartered Institute of Public Finance & Accountancy

CIPFA's Position Statement: Audit Committees in Local Authorities and Police

The scope of this Position Statement includes all principal local authorities in the UK, the audit committees for PCCs and chief constables in England and Wales, and the audit committees of fire and rescue authorities.

1 Audit committees are a key component of an authority's governance framework. Their function is to provide an independent and high-level resource to support good governance and strong public financial management.

2 The purpose of an audit committee is to provide to those charged with governance independent assurance on the adequacy of the risk management framework, the internal control environment and the integrity of the financial reporting and governance processes. By overseeing both internal and external audit it makes an important contribution to ensuring that effective assurance arrangements are in place.

3 Authorities and police audit committees should adopt a model that establishes the committee as independent and effective. The committee should:

- act as the principal non-executive, advisory function supporting those charged with governance
- in local authorities, be independent of both the executive and the scrutiny functions and include an independent member where not already required to do so by legislation
- in police bodies, be independent of the executive or operational responsibilities of the PCC or chief constable
- have clear rights of access to other committees/functions, for example, scrutiny and service committees, corporate risk management boards and other strategic groups
- be directly accountable to the authority's governing body or the PCC and chief constable.

4 The core functions of an audit committee are to:

- be satisfied that the authority's assurance statements, including the annual governance statement, properly reflect the risk environment and any actions required to improve it, and demonstrate how governance supports the achievement of the authority's objectives
- in relation to the authority's internal audit functions:
  - oversee its independence, objectivity, performance and professionalism

  - support the effectiveness of the internal audit process
  - promote the effective use of internal audit within the assurance framework
- consider the effectiveness of the authority's risk management arrangements and the control environment, reviewing the risk profile of the organisation and assurances that action is being taken on risk-related issues, including partnerships and collaborations with other organisations
- monitor the effectiveness of the control environment, including arrangements for ensuring value for money, supporting standards and ethics and for managing the authority's exposure to the risks of fraud and corruption
- consider the reports and recommendations of external audit and inspection agencies and their implications for governance, risk management or control
- support effective relationships between external audit and internal audit, inspection agencies and other relevant bodies, and encourage the active promotion of the value of the audit process.
- review the financial statements, external auditor's opinion and reports to members, and monitor management action in response to the issues raised by external audit.

5 An audit committee can also support its authority by undertaking a wider role in other areas including:

- considering governance, risk or control matters at the request of other committees or statutory officers
- working with local standards and ethics committees to support ethical values
- reviewing and monitoring treasury management arrangements in accordance with Treasury Management in the Public Services: Code of Practice and Cross-Sectoral Guidance Notes (CIPFA, 2017)
- providing oversight of other public reports, such as the annual report.

6 Good audit committees are characterised by:

- a membership that is balanced, objective, independent of mind, knowledgeable and properly trained to fulfil their role. The political balance of a formal committee of a council will reflect the political balance of the council, however, it is important to achieve the right mix of apolitical expertise
- a membership that is supportive of good governance principles and their practical application towards the achievement of organisational objectives
- a strong independently minded chair – displaying a depth of knowledge, skills and interest. There are many personal qualities needed to be an effective chair, but key to these are:
  - promoting apolitical open discussion
  - managing meetings to cover all business and encouraging a candid approach from all participants
  - an interest in and knowledge of financial and risk management, audit, accounting concepts and standards, and the regulatory regime
- unbiased attitudes – treating auditors, the executive and management fairly

- the ability to challenge the executive and senior managers when required.

7 To discharge its responsibilities effectively the committee should:

- meet regularly – at least four times a year, and have a clear policy on those items to be considered in private and those to be considered in public
- be able to meet privately and separately with the external auditor and with the head of internal audit
- include, as regular attendees, the CFO(s), the chief executive, the head of internal audit and the appointed external auditor. Other attendees may include the monitoring officer (for standards issues) and the head of resources (where such a post exists). These officers should also be able to access the committee, or the chair, as required
- have the right to call any other officers or agencies of the authority as required, while recognising the independence of the chief constable in relation to operational policing matters
- report regularly on its work to those charged with governance, and at least annually report an assessment of their performance. An annual public report should demonstrate how the committee has discharged its responsibilities.

Additional guidance to support those acting as audit committee members in local authorities can be found in CIPFA's publication *Audit Committees: Practical Guidance for Local Authorities and Police* (2018), available from www.cipfa.org.uk/publications

AUDIT COMMITTEE

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- consider the annual report from the Head of Internal Audit.
- to obtain assurance that the work of internal audit conforms to the Public Sector Internal Audit Standards.

2. In respect of ~~To review the workplan and performance of~~ **External Audit**

- to ensure the independence of External Audit is maintained
- to review the annual audit plan and monitor its delivery

~~2.~~3. To review, and recommend to the Executive, changes to C**ontract, Finan**ce and Property Procedure Rules.

~~3.~~4. In respect of **financial statements**

For both the County Council and the North Yorkshire Pension Fund

- to approve the respective annual Statements of Final Accounts
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- to liaise, as necessary, with the Standards Committee on any matter(s) relating to the Codes of Conduct or both Members and Officers
- to work with the Standards Committee to promote good ethical standards within the County Council
- to review the arrangements in place for ensuring good governance in the County Council's key partnerships and owned companies

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~~11.~~12. To periodically review the effectiveness of the Audit Committee itself.

~~12.~~13. To meet not less than four times a year on normal business and review its Terms of Reference on an annual basis.

AUDIT COMMITTEE - PROGRAMME OF WORK 2018 / 19

	ANNUAL WORKPLAN Audit Committee Agenda Items	JULY 18	OCT 18	DEC 18	MAR 19	JUNE 19	JULY 19	OCT 19	DEC 19
A	Training for Members (as necessary)	1	2	3					
	Annual Internal Audit Plan				×	×			
	Annual report of Head of Internal Audit								
	Progress Report on Annual Internal Audit Plan		×		×			×	
	Internal Audit report on Children and YP's Service					×			
	Internal Audit report on Computer Audit/Corporate Themes/Contracts		×					×	
	Internal Audit report on Health and Adult Services		×					×	
	Internal Audit report on BES			×					×
	Internal Audit report on Central Services				×				
B	*Annual Audit Letter*		×					×	
	Annual Audit Plan (NYCC & NYPF)				×				
	Annual Report / Letter of the External Auditor	×					×		
	Interim Audit Report					×			
	Discussion with External Auditor on 1-to-1 basis				×				
C	Statement of Final Accounts including AGS (NYCC + NYPF)	x				×	x		
	Letter of Representation	x					x		
	Chairman's Annual Report		×					×	
	Effectiveness of Audit Committee		×			×		×	
	Changes in Accounting Policies				×				
	Corporate Governance – review of Local Code + AGS				×	×			
	– progress report inc re AGS					×			
	Risk Management (inc Corporate R/R) – progress report			×		×			×
	Partnership Governance – progress report					×			
	Information Governance – progress report				×				
	Review of Finance,/Contract/Property Procedure Rules	**TBA**	**TBA**	**TBA**	**TBA**	**TBA**	**TBA**	**TBA**	**TBA**
	Business Continuity		×					×	
	Audit Committee Terms of Reference			×					×
	Counter Fraud				×				
	Contract Management								
	Governance of external companies			×					×
	Treasury Management – Executive February				×				
	Corporate Procurement Strategy (including Contract Mgt)					×		×	
	Audit Committee Work Programme	×							
	VFM Review				×				
D	*Work Programme*	×	×	×	×	×	×	×	×
	Progress on issues raised by the Committee (inc Treasury Management)		×	×	×	×		×	×
E	Agenda planning / briefing meeting								
	Audit Committee Agenda/Reports deadline								
	Audit Committee Meeting Dates	26/07	10/10	20/12	07/03	21/06	26/07	25/10	20/12

A = Internal Audit
B = External Audit
C = Statement of Final Accounts / Governance
D = Other
E = Dates

☼ **before formal meeting**
1 HAS
2 Treasury Management and Commercial Investments
3 External and Internal Auditors
Sessions to be sorted