North Yorkshire County Council

Agenda

Meeting: Audit Committee

Venue: Brierley Room, 3 Racecourse Lane (former Magistrates' Court Building), Northallerton, DL7 8QZ (location map at page 5)

Date: Friday 25 October 2019 at 1.30 pm

Note: Members are invited to attend a private meeting with both External Audit and Internal Audit at 1pm in the Brierley Room, 3 Racecourse Lane (former Magistrates' Court Building), Northallerton, DL7 8QZ

Recording is allowed at County Council, committee and sub-committee meetings which are open to the public. Please give due regard to the Council's protocol on audio/visual recording and photography at public meetings, a copy of which is available to download below. Anyone wishing to record is asked to contact, prior to the start of the meeting, the Officer whose details are at the foot of the first page of the Agenda. We ask that any recording is clearly visible to anyone at the meeting and that it is non-disruptive. http://democracy.northyorks.gov.uk

Business

1. **Apologies for Absence**

2. **Minutes of the meeting held on 22 July 2019**

(Pages 6 to 9)

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

3. **Any Declarations of Interest**

4. **Public Questions or Statements**

Members of the public may ask questions or make statements at this meeting if they have given notice (including the text of the question/statement) to Ruth Gladstone of Democratic Services *(contact details at the foot of page 1)* by midday on Tuesday 22 October 2019. 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.

5. **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 10 to 12)**

6. **Annual Audit Letter** – Letter from Deloitte **(NOT YET AVAILABLE – TO FOLLOW)**

7. **Annual Report of the Audit Committee** - Report of the Chair of the Audit Committee **(Pages 13 to 21)**

8. **Progress on 2019/20 Internal Audit Plan** - Report of the Head of Internal Audit **(Pages 22 to 62)**

9. **Health and Adult Services Directorate:-**

   (a) **Internal Audit Work** - Report of the Head of Internal Audit **(Pages 63 to 73)**

   (b) **Internal Control Matters** - Report of the Corporate Director – Health and Adult Services **(Pages 74 to 100)**

10. **Internal Audit Report on Information Technology, Corporate Themes and Contracts** - Report of the Head of Internal Audit **(Pages 101 to 114)**

11. **Business Continuity – Update Report** - Report of the Head of Resilience and Emergencies **(Pages 115 to 118)**

12. **Fees and Charges Strategy** - Report of the Corporate Director – Strategic Resources **(Pages 119 to 125)**

13. **Audit Committee Work Programme** – Report of the Corporate Director – Strategic Resources **(Page 126)**

14. 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:

1. **The Brierley Building (main County Hall building) is closed now until July 2020.** All Committee meetings will be held in either No 1 or No 3 Racecourse Lane, Northallerton, DL7 8QZ. Please note the venue above for the location of this meeting. Please report to main reception which is located in No 3 Racecourse Lane.

2. **Emergency Procedures for Meetings**

   Fire

   The fire evacuation alarm is a continuous Klaxon. On hearing this you should leave the building by the nearest safe fire exit. Once outside the building please proceed to the fire assembly point in the rear car park / L'Espec Street.

   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

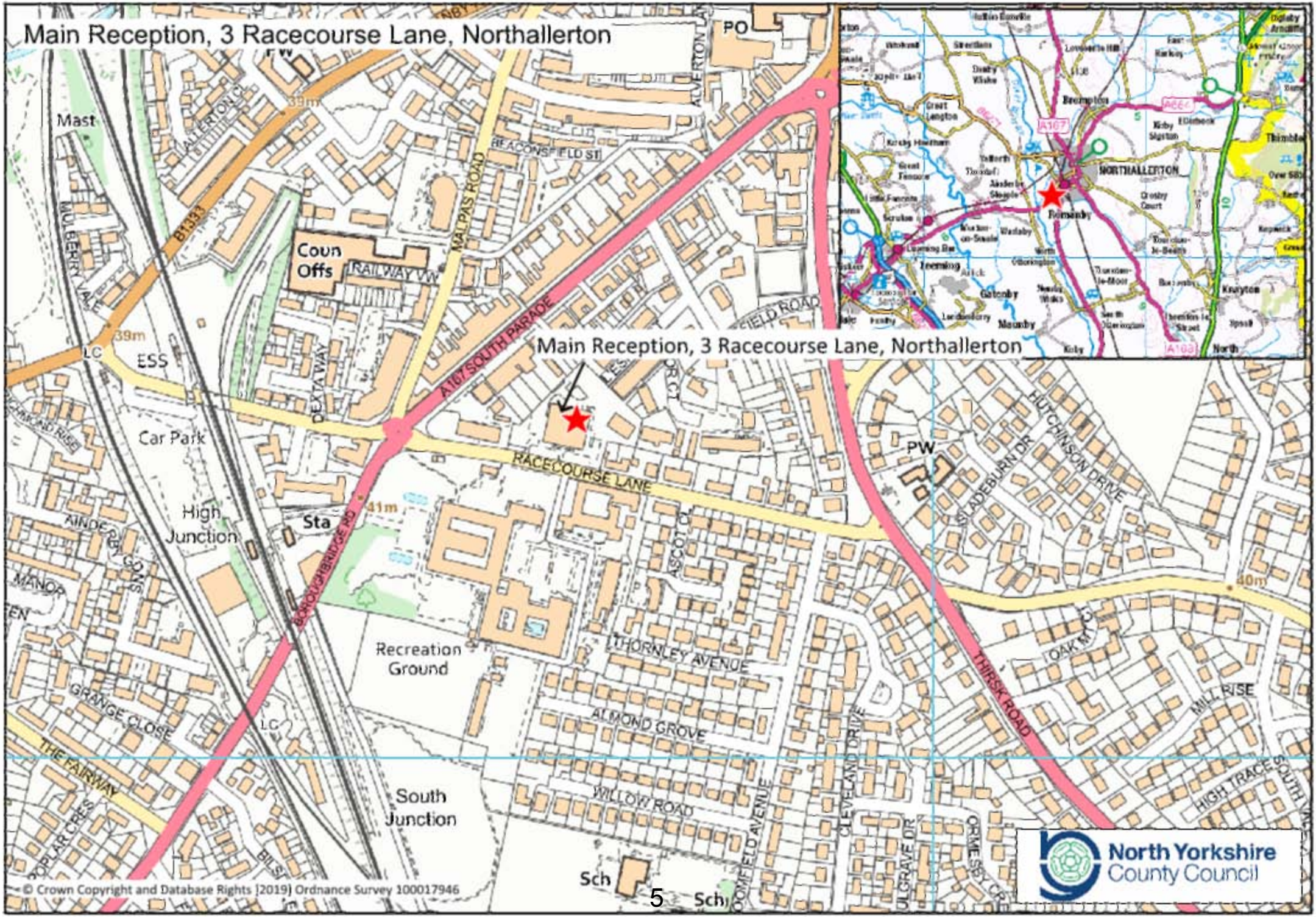
County Councillors (8)			
	Councillors Names		*Political Group*
1	ARTHUR, Karl		Conservative
2	ATKINSON, Margaret	Vice-Chairman	Conservative
3	BAKER, Robert		Conservative
4	CLARK, Jim		Conservative
5	HUGILL, David		Conservative
6	LUNN, Cliff	Chairman	Conservative
7	MACKAY, Don		NY Independents
8	WEBBER,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

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			

The term of appointment of Independent Members to the Audit Committee shall be four years from 31 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.


Main Reception, 3 Racecourse Lane, Northallerton
Main Reception, 3 Racecourse Lane, Northallerton
NORTHALLERTON
A167 SOUTH PARADE
RACECOURSE LANE
HALPAS ROAD
BOROUGHBRIDGE RD
THIRSK ROAD
THORNLEY AVENUE
ALMOND GROVE
WILLOW ROAD
ASCOT CL
HUTCHINSON DRIVE
SLADEBURN DR
MILL RISE
GRANGE CLOSE
THE FAIRWAY
POPLAR CRES
MULBERRY VALE
B1333
ALVERTON CL
REACONSFIELD ST
RAILWAY VW
DEXTA WAY
Coun Offs
Car Park
High Junction
South Junction
Recreation Ground
Sta
Sch
PO
PW
Mast
LC
ESS
39m
41m
40m
© Crown Copyright and Database Rights [2019] Ordnance Survey 100017946
North Yorkshire County Council

North Yorkshire County Council

Audit Committee

Minutes of the meeting held on Monday 22 July 2019 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, Robert Baker, Jim Clark, David Hugill, Don Mackay, Andy Paraskos (as Substitute for Margaret Atkinson) and Geoff Webber

Independent Member of the Committee:-

Mr David Portlock

In Attendance:-

County Councillor Carl Les (Leader of the County Council)

Deloitte Officers:- Paul Thomson and Nick Rayner

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

Apology for absence:-

An apology for absence was presented to the meeting on behalf of Mr David Marsh (Independent Member).

Copies of all documents considered are in the Minute Book

---

133. Minutes

Resolved -

That the Minutes of the meeting held on 21 June 2019, having been printed and circulated, be taken as read and be confirmed and signed by the Chairman as a correct record.

134. Declarations of Interest

There were no declarations of interest.

135. Public Questions or Statements

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

136. External Audit Reports 2018/19 on North Yorkshire County Council and North Yorkshire Pension Fund

Considered -

The reports of Deloitte which summarised the key findings in relation to the 2018/19 external audits of the County Council and North Yorkshire Pension Fund.

The report relating the County Council was introduced by Paul Thomson of Deloitte who highlighted that the audit had generally gone well. However, there was a significant item outstanding, namely, Deloitte's Actuary's consideration of the County Council's pensions liability following the McCloud judgement. (The McCloud judgement related to transitional protection on pensions and had implications for the whole of the local government sector.) Paul Thomson explained that the County Council had asked its Actuary to update the calculation of the County Council's pensions liability following the McCloud judgement. The information from the County Council's Actuary had come back late during the previous week and Deloitte had subsequently asked their Actuary to review the information from the County Council's Actuary. Paul Thomson advised that such action was necessary because the pension liability was a significant risk area and was judgemental. He further advised that Deloitte anticipated receipt of their Actuary's opinion during the 24-48 hours following this meeting. However, that information was not available for reporting to this meeting.

Paul Thomson clarified that, subject to the situation regarding the McCloud judgement being resolved, Deloitte were happy to issue a "clean" opinion on the County Council's Statement of Final Accounts for 2018/19 by 31 July 2019.

The Committee discussed the decisions it could make at this meeting to address the situation described above. (The Committee's subsequent decision is recorded in paragraph (b) of the Resolution to Minute 138.)

Paul Thomson and Nick Rayner of Deloitte then introduced the other issues set out in Deloitte's reports and responded to Members' questions.

Paul Thomas expressed Deloitte's thanks to the County Council for the high quality of the working papers and very good support. He advised that there was a high degree of transparency in the County Council and that Deloitte had good dialogue with the County Council.

Resolved -

That the reports be noted.

137. Report of the Members' Working Group following the Detailed Review of the Draft Statement of Final Accounts (incorporating Annual Governance Statement) for 2018/19

Considered -

The report of the Members' Working Group which set out the Group's recommendation concerning the Annual Governance Statement 2018/19 and the Statement of Final Accounts 2018/19.

Mr David Portlock introduced the report, highlighting that it gave an indication of the areas and issues which the Group had discussed with officers. He also advised that the Group recommended the Audit Committee, at the next item of business on the agenda for today's meeting, to approve the Statement of Final Accounts and the Annual Governance Statement for 2018/19.

Mr David Portlock commended Fiona Sowerby (Corporate Risk and Insurance Manager) in respect of the Annual Governance Statement, and John Raine (Head of Technical Finance) in respect of the Statement of Accounts, advising that they were very professional and very much engaged, and had responded very quickly to any issues which were raised.

Resolved -

That the report be noted.

138. Statement of Final Accounts for 2018/19 including Letter of Representation

Considered -

The report of the Corporate Director - Strategic Resources which advised of developments since the Committee's meeting held on 21 June 2019 and invited the Committee to approve the Letter of Representation to the External Auditor, the Statement of Final Accounts for 2018/19 following completion of the external audit of those accounts, and the Annual Governance Statement for 2018/19.

John Raine (Head of Technical Finance) introduced the report, highlighting that minor changes had been made to the Statement of Accounts, including the insertion of an extra sentence in the Note relating to fees and charges, subsequent to the Committee's meeting on 21 June 2019.

John Raine reported that a Letter of Representation in respect of the North Yorkshire Pension Fund also required approval. That letter was broadly the same as the proposed letter relating to the County Council which was at Appendix A to the report. He recommended the Committee to authorise its Chairman to sign both Letters of Representation.

In response to Members' questions, the Corporate Director – Strategic Resources confirmed that he was content to sign the Letters of Representation. Also Amanda Alderson (Senior Accountant - Strategic Resources) clarified that the Actuary had not wished to make any changes to the Statement of the Actuary dated 30 April 2019.

The Corporate Director – Strategic Resources expressed his thanks to Paul Thomson and Nick Rayner of Deloitte for their work and for the very courteous manner in which they always acted; to the Members' Working Group and in particular Mr David Portlock who devoted significant time to looking at the draft Statement of Accounts; and to John Raine (Head of Technical Finance) and Amanda Alderson (Senior Accountant - Strategic Resources) and their Teams for all their work.

Resolved –

(a) That the Chairman be authorised to sign, on behalf of the Audit Committee:-

(i) the Letter of Representation in respect of North Yorkshire County Council, as set out at Appendix A to the report; and

(ii) the Letter of Representation in respect of North Yorkshire Pension Fund.

(b) That, in relation to the Statement of Final Accounts 2018/19:-

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

(ii) the Final Statement of Final Accounts for 2018/19, as set out at paragraph 5.2 of the report, be approved;

(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; and

(iv) the Corporate Director – Strategic Resources advise the Chairman of the outcome of Deloitte's Actuary's consideration of the County Council's pensions liability and take any further action which the Corporate Director – Strategic Resources considers necessary and subsequently inform the remainder of the Committee's membership of the situation.

(c) That the Annual Governance Statement 2018/19 be approved and that the Chairman be authorised to sign, on the Committee's behalf, the Annual Governance Statement.

139. Audit Committee Work Programme

Considered -

The Committee's Programme of Work which identified items of business scheduled to be considered at each of the Committee's forthcoming meetings.

Ruth Gladstone (Principal Democratic Services Officer) advised that a survey of Members had identified that Monday afternoons were the most convenient time of the week for holding Audit Committee meetings. The County Council's calendar of meetings for 2020/21 was currently being prepared and a request had been submitted for the Committee's meetings, from June 2020 onwards, to be held on Monday afternoons. There was no intention to change the dates of meetings scheduled for the afternoons of Friday 25 October and Friday 20 December 2019 and Friday 27 March 2020.

Members asked that no changes be made to meeting dates once they had been published and notified to Members.

Resolved -

That the Work Programme be noted.

The meeting concluded at 2.20pm.

RAG/JR

NORTH YORKSHIRE COUNTY COUNCIL

AUDIT COMMITTEE

25 October 2019

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?
10.10.18	93 – Audit Committee Terms of Reference / Review of Effectiveness	That a working group be set up to undertake a review of the Committee's effectiveness and that the Chair and Gary Fielding seek working group volunteers via email.	Working group established and meetings held – see minute 107 below	✓
07.03.19	107 – Progress on Issues Raised by the Committee	That the Committee's Chairman, Vice-Chairman, Mr Nick Grubb and Mr David Portlock be appointed to comprise a group, facilitated by Max Thomas to:- Discuss how this Committee is functioning; seek feedback from others such as the CD –SR and External Audit; review the findings; submit any proposed changes to a future meeting of the Committee for decision, and Full Council if	In progress	X

Date	Minute number and subject	Audit Committee Resolution	Comment	Complete?
		appropriate; and complete the CIPFA questionnaire with input from the CD – SR		
07.03.19	118 – Central Services Directorate – Internal Audit Work and Control Matters	That the CD – SR reinforce the importance of County Councillors including, on their mileage and subsistence claims, information which is sufficiently detailed to enable the claim to be processed without delay.	Latest position checked and improvement notes. Further reminder still to be progressed at some point.	X
21.06.19	128 – 2019/20 Internal Audit Plan	That the Internal Audit Plan for 2019/20, as set out in Appendix 1 to the report, be approved, subject to the following:- with regard to Children and Young People's Services, 15 Audit days be allocated for Home to School Transport, rather than for Adult Learning, for the purpose explained in the meeting.	This change was made. However, a subsequent variation means Home to School Transport audit will now be done in 2020/21	✓
21.06.19	128 – 2019/20 Internal Audit Plan	That the CD, SR keep CC Geoff Webber informed of the work which is being undertaken to look at the procedure operating in the Health and Adult Services Directorate under which debts are written-off.	Cllr Webber provided with update.	✓
21.06.19	132 – Audit Committee Programme of Work 2019/29	That Seminars concerning the following issues be held at 1 pm prior to future meetings of the Committee – • Pension Governance • Beyond 2020, including the approach to property rationalisation	Sessions added to the Programme of Work with a date for each of the sessions to be decided.	✓
21.06.19	132 – Audit Committee Programme of Work 2019/20	That officers look into the issue of whether Friday afternoons are convenient to Members for attending Audit Committee meetings and discuss the matter with the Chairman.	A subsequent survey of Members identified that Monday afternoons would be best for Audit Committee meetings. The Calendar of Meetings for the year commencing May 2020 (due to be finalised in November 2019) puts Audit Committee meetings on Monday afternoons (5 pa).	✓

Date	Minute number and subject	Audit Committee Resolution	Comment	Complete?
22.07.19	138 – Statement of Final Accounts for 2018/19 including Letter of Representation	The CD, SR advise the Chairman of the outcome of Deloitte's Actuary's consideration of the County Council's pensions liability and take any further action which the CD, SR considers necessary and subsequently inform the remainder of the Committee's membership of the situation.	There were no further changes to the Statement of Accounts following sign off by Audit Committee on 19 July and no further action was necessary within the final SOFA. A judgemental difference of £5m was noted in the final report. The note in the report highlighted the difference between NYCC's assessment of the impact of McCloud and that of Deloitte.	✓

3.0 TREASURY MANAGEMENT

3.1 The Government announced on 9 October that it had legislated to increase the statutory limit on Public Works Loan Board (PWLB) borrowing levels and increased the interest rates offered on all new loans. The Government indicated the change in policy was a response to an increase over the summer in borrowing from PWLB (the HMT department that issues loans to local authorities) due to a fall in the cost of borrowing to historically low levels.

3.2 The announcement has increased the interest rates of all new PWLB loans by 1% on top of existing loans terms. The County Council has no current plans to borrow funds from the PWLB, with the Capital Financing Requirement (need to borrow) on a reducing trajectory. However, as a result of the announcement, any potential future plans will now include an additional 1% premium.

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

25 October 2019

Background Documents: Report to, and Minutes of, Audit Committee meetings held on 21 June and 22 July 2019

NORTH YORKSHIRE COUNTY COUNCIL

AUDIT COMMITTEE

25 OCTOBER 2019

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 2019, 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

30 September 2019

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 2019. 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 five occasions in the year to 30 September 2019, 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 and the internal auditors, Veritau. The committee also received reports from the previous and current external auditors, KPMG and Deloitte. 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.

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

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

The Committee:

External Audit

1 Received and considered the external auditor's annual audit letter in respect of the 2017/18 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 Considered the external audit plan prepared by Deloitte for the audit of the 2018/19 financial statements and the review of the County Council's arrangements for securing value for money;

3 Received and considered the results of Deloitte's work in relation to the audit of the 2018/19 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. Deloitte had also issued an unqualified value for money conclusion;

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

Internal Audit

5 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;

6 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;

7 Received and approved the Internal Audit Plan for 2019/20. 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;

8 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;

9 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 2018/19 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;

10 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 areas which require further improvement including information security and contract management;

11 Assessed the performance of the County Council's internal audit provider, Veritau Limited against the targets set for 2018/19, and considered the performance targets for 2019/20. The Committee also considered the outcome of the internal audit quality assurance and improvement programme (QAIP) and an external assessment of internal audit working practices completed during the year. The Committee was pleased that internal audit practices continue to meet the required professional standards and therefore continued reliance could be placed on the arrangements operating within the County Council;

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

Risk Management

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

14 Considered changes to an updated Corporate Risk Management Policy;

15 Reviewed the progress made by the County Council to identify and address corporate risks. This included consideration of the updated Corporate Risk Register. It was noted that Brexit had been added as a new risk during the year, recognising the need to plan for the possible impacts of the United Kingdom leaving the European Union. A number of the existing risks had also been modified to reflect recent developments. For example, the Commercial Strategy is now treated as a directorate risk and the Savings and Transformation Programme has been updated to reflect 'Beyond 2020'. 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 Allerton Waste Recovery Park, the Harrogate Railway Line Improvement and the UCI World Championships 2019);

Corporate Governance

17 Considered changes to the Local Code of Corporate Governance prior to approval;

18 Considered and approved the Annual Governance Statement for 2018/19 of the County Council;

19 Considered other changes made or planned to the County Council's governance arrangements;

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 60 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 also considered a number of anticipated changes in some key partnerships over the next year, including possible changes to the York, North Yorkshire and East Riding Local Enterprise Partnership (LEP), the creation of Local Education Partnerships and Local Inclusion Steering Groups, changes to children's safeguarding arrangements and new or changed arrangements resulting from increasing health and social care integration. The Committee concluded 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 done to mitigate cyber security risks and to comply with the requirements of the General Data Protection Regulation (GDPR) and Data Protection Act 2018. The Committee also considered recent data security incidents, technical security changes to the Council's e-mail to enable the secure transfer of data to other public sector bodies and the introduction of new 'audit' and authorisation processes to improve information security during office moves. The Committee shares the view that information governance remains a key corporate risk;

22 Received a report detailing the progress made to implement the Procurement and Contract Management Strategy, and the Strategy Action Plan. Committee noted that procurement savings of £869k had already been delivered against the 2020 target of £1.15m. The expectation was that the target would therefore be achieved. The Committee also noted the plans in place to address possible price uncertainty or supply chain problems arising from Brexit, improvements to the Council's contract management arrangements and plans to introduce real time supplier financial and risk monitoring. The Committee was pleased to note that Procurement and Contract Management Service had won the GO National Procurement Leadership of the Year award for Local Government, and had also been highly commended in the National Procurement Team of the Year category. The Head of Procurement and Contract Management is also the chair of the YorProcure Strategic Procurement Group. This has allowed the Council to play a key role in developing the national procurement strategy for local government as well as participate in other regional and national groups;

23 Considered proposed changes to the County Council's Procurement and Contract Procedure Rules and the Constitution prior to their approval by the Executive and Full Council. The changes will help to clarify when procurement and contract award decisions should be treated as key decisions, and the process to follow when a contract is terminated early. The changes also provide further guidance to improve contract management, the approvals required in respect of the gateway process, the

use of grants, the process to follow in respect of low value contracts, and the support available to small and medium enterprises.

24 Received a report outlining the County Council's current resilience and business continuity arrangements. The report provided details of the Business Continuity Plan and how the County Council had responded to a number of recent incidents.

Financial Statements

25 Considered and approved the Statement of Accounts for 2018/19 of the County Council and the North Yorkshire Pension Fund. The Committee was pleased to note that the external auditors, Deloitte had reported that they had received good cooperation and support from the County Council. However, the recent McCloud judgement had caused problems for all local authorities given its proximity to the statutory deadline for completing the audit of 31 July;

26 Received details of the revised Code of Practice on Local Authority Accounting which was issued by CIPFA in April 2018. The updated Code resulted in certain changes to the classification and measurement of financial assets and the treatment of revenue from contracts. The actual impact of these changes on the Statement of Accounts was however minimal. The Committee also noted that some additional or changed disclosure notes were required to the 2018/19 Statement of Accounts. The Committee also noted that the treatment of leases will change from 2020/21. It was recognised that the resulting reclassification of certain operating leases could have an impact on the Council's prudential borrowing.

Other

27 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 are helping to drive further improvements in value for money, including the review of all service areas as part of the Better Efficiency through Sustained Transformation programme (BEST). 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;

28 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 2019/20. 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;

29 Received briefings from officers on a number of topics including the Council's Treasury Management and Commercial Investment activities, the Property Rationalisation programme and the systems to monitor suppliers' financial health in 'real time';

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

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

32 During the year, the Committee benefitted from the attendance and participation of its three independent members, David Portlock, David Marsh and Nick Grubb. I would like to extend my thanks to them for their contribution to the work of the Committee and their ongoing diligence, enthusiasm and support.

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. In respect of **External Audit**

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

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 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

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

25 OCTOBER 2019

PROGRESS ON 2019/20 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 2019/20 Internal Audit Plan and any developments likely to impact on the Plan throughout the remainder of the financial year.

1.2 To seek approval for changes to the Audit Charter.

2.0 BACKGROUND

2.1 Members approved the 2019/20 Audit Plan on the 21 June 2019. The total number of planned audit days for 2018/19 is 1,090 (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 2019/20 Audit Plan is progressing.

3.0 INTERNAL AUDIT PLAN PROGRESS BY 30 SEPTEMBER 2019

3.1 The internal audit performance targets for 2019/20 were set by the County Council's client officer. Progress against these performance targets, as at 30 September 2019, 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 2020 (the cut off point for 2019/20 audits). **Appendix 2** provides details of the final reports issued in the period. A further 6 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, 34 cases of suspected fraud or malpractice have been referred to Veritau for investigation. 9 of these are internal fraud cases, 12 relate to social care and 5 relate to external fraud, debt recovery, or abuse of the council's financial assistance scheme. A further 8 cases relate to applications for a school place. A number of these investigations are still ongoing.

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 30 September 2019 is 470 compared with 658 requests received during the corresponding period in 2018/19. The County Council is currently below the performance response target of 95% for 2019/20 with approximately 77% of requests so far being answered within the statutory 20 day deadline. Actions continue to be taken to improve performance in this area. The IGT also coordinates the County Council's subject access requests (SARs) and has received 171 such requests between 1 April 2019 and 30 September 2019 compared to 115 requests received during the corresponding period in 2018/19.

3.5 Veritau acts as the County Council's Data Protection Officer following the implementation of the General Data Protection Regulation (GDPR) and Data Protection Act 2018. The IGT provides advice and support to the County Council on data protection matters, reviews compliance with the legislation and liaises with the regulator, the Information Commissioner's Office (ICO). Other work includes preparing data sharing agreements, recording data security incidents and investigating serious data security incidents. 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 confidential information.

Variations to the 2019/20 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:

Safeguarding (HAS)	-20 days
Harrogate Adult Community Services Health and Social Care Integration (HAS)	-25 days
Reduction in Continuing Healthcare (HAS) (20 days)	-15 days
Home to School Transport (CYPS)	-15 days
Reduction in Financial Processes (CS) (15 days)	-5 days
Contingency (10 days)	-10 days
Additional allocation to Information Governance work	+45 days
Additional allocation to Corporate Fraud work	+45 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.

Audit Charter / CIPFA Statement on the Role of the Head of Internal Audit

3.8 Some minor amendments to the County Council's Internal Audit Charter are proposed. The proposed changes reflect recently updated guidance published by the Chartered Institute of Public Finance and Accountancy (CIPFA). A number of other minor drafting changes are also proposed. The updated Charter with tracked changes highlighted is attached at **Appendix 3**.

3.9 CIPFA has also recently published an updated Statement on the Role of the Head of Internal Audit. This replaces the previous 2010 edition. The updated Statement represents best practice. It also reflects some of the challenges now facing internal audit including changes in service delivery, resourcing pressures and new technology. The Principles have also been updated and are now aligned to the requirements of the Public Sector Internal Audit Standards. A copy of the revised Statement is attached as **Appendix 4** for information.

4.0 **RECOMMENDATION**

Members are asked to:

4.1 note the progress made in delivering the 2019/20 Internal Audit programme of work and the variations agreed by the client officer.

4.2 approved the proposed changes to the Internal Audit Charter.

4.3 note the updated CIPFA Statement on the Role of the Head of Internal Audit.

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

Max Thomas
Head of Internal Audit
Veritau Limited
County Hall
Northallerton

8 October 2019

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

Appendix 1

PROGRESS AGAINST 2019/20 PERFORMANCE TARGETS (AS AT 30/9/2019)

Indicator	Milestone	Position at 30/9/2019
To deliver 93% of the agreed Internal Audit Plan	93% by 30/4/20	23.68%
To achieve a positive customer satisfaction rating of 95%	95% by 31/3/20	100%
To ensure 95% of Priority 1 recommendations made are agreed	95% by 31/3/20	0%
To ensure at least 30% of investigations completed result in a positive outcome (management action, sanction or prosecution)	30% by 31/3/20	41.46%
To identify actual fraud savings of £50k (quantifiable savings)	£50k by 31/3/20	£39,668
To ensure 95% of FOI requests are answered within the Statutory deadline of 20 working days	95% by 31/3/19	77.02%

Appendix 2

FINAL 2019/20 AUDIT REPORTS ISSUED TO DATE

Audit Area	Directorate	Overall Opinion
Information security compliance – Legal Services	Corporate	Substantial assurance
Visits to Care Providers - Botton Village / Avalon	HAS	No opinion
Visits to Care Providers - Castle Grange (Scarborough)	HAS	No opinion
Developing Stronger Families - June claim	CYPS	No opinion
Developing Stronger Families - September claim	CYPS	No opinion

North Yorkshire County Council
Internal Audit Charter

25 October~~22 June~~ 2019~~7~~

1 Introduction

1.1 There is a statutory duty on the County Council to undertake an internal audit of the effectiveness of its risk management, control and governance processes. The Accounts and Audit (England) Regulations 2015 also require that the audit takes into account public sector internal auditing standards or guidance. The Chartered Institute of Public Finance and Accountancy (CIPFA) is responsible for setting standards for proper practice for local government internal audit in England.

1.2 From 1 April 2017 CIPFA adopted revised Public Sector Internal Audit Standards (PSIAS)[1] compliant with the Institute of Internal Auditors' (IIA) International Standards. The PSIAS and CIPFA's local government application note for the standards represent proper practice for internal audit in local government. This charter sets out how internal audit at North Yorkshire County Council will be provided in accordance with this proper practice.

1.3 This charter should be read in the context of the wider legal and policy framework which sets requirements and standards for internal audit, including the Accounts and Audit Regulations, the PSIAS and application note, and the County Council's constitution, regulations and governance arrangements.

2 Definitions

2.1 The standards include reference to the roles and responsibilities of the "board" and "senior management". Each organisation is required to define these terms in the context of its own governance arrangements. For the purposes of the PSIAS these terms are defined as follows at the County Council.

"Board" – the Audit Committee fulfils the responsibilities of the board in relation to internal audit standards and activities.

"Senior Management" – in the majority of cases, the term senior management in the PSIAS should be taken to refer to the Corporate Director – Strategic Resources in their ~~his~~ role as Chief Financial Officers~~151 officer~~. This includes all functions relating directly to overseeing the work of internal audit. In addition, senior management may also refer to the Chief Executive and/or any other Corporate Director (acting individually) or collectively as the County Council's Management Board in relation to:

- enabling direct and unrestricted access for reporting purposes
- consulting on risks affecting the County Council for audit planning purposes
- approving the release of information arising from audit work to any third party.

[1] The PSIAS were adopted jointly by relevant internal audit standard setters across the public sector.

2.2 The standards also refer to the "chief audit executive". This is taken to be the Head of Internal Audit (Veritau).

3 Application of the standards

3.1 In line with the PSIAS, the mission of internal audit at the County Council is:

"To enhance and protect organisational value by providing risk-based and objective assurance, advice and insight."

3.2 The County Council requires that the internal audit service aspires to achieve the mission through its overall arrangements for delivery of the service. In aiming to achieve this, the council expects that the service:

- demonstrates integrity
- demonstrates competence and due professional care
- is objective and free from undue influence (independent)
- aligns with the strategies, objectives, and risks of the organisation
- is appropriately positioned and adequately resourced.
- demonstrates quality and continuous improvement.
- communicates effectively.
- provides risk-based assurance.
- is insightful, proactive, and future-focused.
- promotes organisational improvement.

3.2 The PSIAS defines internal audit as follows.

"Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes."

3.3 The County Council acknowledges the mandatory nature of this definition and confirms that it reflects the purpose of internal audit. The County Council also requires that the service be undertaken in accordance with the code of ethics and standards set out in the PSIAS. To provide optimum benefit, the County Council requires that internal audit works in partnership with management to improve the control environment and to help the organisation achieve its objectives.

4 Scope of internal audit activities

4.1 The scope of internal audit work will encompass the County Council's entire control environment[2], comprising its systems of governance, risk management, and control.

4.2 The scope of audit work also extends to services provided through partnership arrangements, irrespective of what legal standing or particular form these may take. The Head of Internal Audit, in consultation with all relevant parties and taking account of audit risk assessment processes, will determine what work will be carried out by the internal audit service, and what reliance may be placed on the work of other auditors.

5 Responsibilities and objectives

5.1 The Head of Internal Audit is required to provide an annual report to the Audit Committee. The report will be used by the Committee to inform its consideration of the County Council's annual governance statement. The report will include:

- the Head of Internal Audit's opinion on the adequacy and effectiveness of the Council's framework of governance, risk management, and control
- any qualifications to the opinion, together with the reasons for those qualifications (including any impairment to independence or objectivity)
- any particular control weakness judged to be relevant to the preparation of the annual governance statement
- a summary of work undertaken to support the opinion including any reliance placed on the work of other assurance bodies
- an overall summary of internal audit performance and the results of the internal audit service's quality assurance and improvement programme
- a statement on conformance with the PSIAS (including the code of ethics and standards) and the results of the quality assurance and improvement programme.

5.2 To support the opinion the Head of Internal Audit will ensure that an appropriate programme of audit work is undertaken. In determining what work to undertake the service should:

- adopt an overall strategy setting out how the service will be delivered in accordance with this Charter
- draw up an indicative risk based audit plan on an annual basis following consultation with the Audit Committee and senior management. The audit plan

[2] For example the work of internal audit is not limited to the review of financial controls only.

will also reflect the requirements of the Charter, the strategy, and proper practice

- consider trends and emerging issues that may impact the organisation

5.3 In undertaking this work, the responsibilities of the internal audit service will include:

- providing assurance to the board and senior management on the effective operation of governance arrangements and the internal control environment operating at the County Council[3]
- objectively examining, evaluating and reporting on the probity, legality and value for money of the Council's arrangements for service delivery
- reviewing the Council's financial arrangements to ensure that proper accounting controls, systems and procedures are maintained and, where necessary, for making recommendations for improvement
- helping to secure the effective operation of proper controls to minimise the risk of loss, the inefficient use of resources and the potential for fraud and other wrongdoing
- acting as a means of deterring all fraudulent activity, corruption and other wrongdoing; this includes conducting investigations into matters referred by Members, officers, and the public and reporting findings of those investigations to the relevant officers and Members as appropriate for action
- advising the Council on relevant counter fraud and corruption policies and measures.

5.4 The Head of Internal Audit will ensure that the service is provided in accordance with proper practice as set out above and in accordance with any other relevant standards – for example County Council policy and/or legal or professional standards and guidance.

5.5 In undertaking their work, internal auditors should have regard to:

- the mission of internal audit, core principles and standards as set out in the PSIAS and reflected in this charter
- the code of ethics in the PSIAS[4]
- the codes of any professional bodies of which they are members
- standards of conduct expected by the County Council
- the Committee on Standards in Public Life's *Seven Principles of Public Life*.

[3] where third parties place reliance on the assurance provided then they do so at their own risk
[4] Veritau has adopted its own code of ethics which fulfil the requirements of the PSIAS.

6 Organisational independence

6.1 It is the responsibility of corporate directors to maintain effective systems of risk management, internal control, and governance. Auditors will have no responsibility for the implementation or operation of systems of control and will remain sufficiently independent of the activities audited to enable them to exercise objective professional judgement.

6.2 Audit advice and recommendations will be made without prejudice to the rights of internal audit to review and make further recommendations on relevant policies, procedures, controls and operations at a later date.

6.3 The Head of Internal Audit will put in place measures to ensure that individual auditors remain independent of areas they are auditing for example by:

- rotation of audit staff
- ensuring staff are not involved in auditing areas where they have recently been involved in operational management, or in providing consultancy and advice[5]
- .

7 Accountability, reporting lines, and relationships

7.1 Internal audit services are provided under contract to the Council by Veritau Limited. The company is a separate legal entity[6]. Staff undertaking internal audit work will be employed by Veritau or another Veritau group company. Staff may also be seconded to Veritau from the County Council. The Corporate Director – Strategic Resources acts as client officer for the contract, and is responsible for overall monitoring of the service.

7.2 In its role in providing an independent assurance function, Veritau has direct access to Members and senior managers and can report uncensored to them as considered necessary. Such reports may be made to the:

- Council, Executive, or any committee (including the Audit Committee)
- Chief Executive
- Corporate Director – Strategic Resources (Chief Financial Officers~~s151 officer~~)
- Monitoring Officer
- Any other corporate director and/or service manager.

[5] auditors will not be used on internal audit engagements where they have had direct involvement in the area within the previous 12 months

[6] Veritau is part-owned by the County Council. The company provides internal audit services to a number of member councils and other public sector organisations.

7.3 The Corporate Director – Strategic Resources (Chief Financial Officeras s151 officer) has a statutory specific responsibilitiesy for ensuring that the County Council has an effective systems of risk management and internal control. The role includes a responsibility to ensure that the County Council has put in place arrangements for effective internal audit. In recognition of the importance of the relationship between the Chief Financial Officer and internal audit (recognised in the standards), a protocol has been drawn up setting out the relationship between them. internal audit in place. In recognition of this, a protocol has been drawn up setting out the relationship between internal audit and the Corporate Director – Strategic Resources. This is included in Annex 1.

7.4 The Head of Internal Audit will report independently to the Audit Committee[7] on:

- proposed allocations of audit resources
- any significant risks and control issues identified through audit work
- theirhis/her annual opinion on the Council's control environment.

7.5 The Head of Internal Audit will informally meet in private with members of the Audit Committee, or the committee as a whole as required. Meetings may be requested by committee members or the Head of Internal Audit.

7.6 The Audit Committee will oversee (but not direct) the work of internal audit. This includes commenting on the scope of internal audit work and approving the annual audit plan. The committee will also protect and promote the independence and rights of internal audit to enable it to conduct its work and report on its findings as necessary[8].

8 Fraud, consultancy services and non-audit services

8.1 The primary role of internal audit is to provide assurance services to the County Council. However, the service may also be required to undertake fraud investigation and other consultancy work to add value and help improve governance, risk management and control arrangements.

8.2 The prevention and detection of fraud and corruption is the responsibility of management. However, all instances of suspected fraud and corruption should be notified to the Head of Internal Audit, who will decide on the course of action to be taken in consultation with the relevant corporate director and/or other advisors (for example human resources). Where appropriate, cases of suspected fraud or corruption will be investigated by Veritau.

8.3 Where appropriate, Veritau may carry out other consultancy related work, for example specific studies to assess the economy, efficiency, and effectiveness of

[7] The committee charged with overall responsibility for governance at the county council.
[8] The relationship between internal audit and the Audit Committee is set out in more detail in Annex 2.

elements of service provision. The scope of such work will be determined in conjunction with the relevant corporate directors and/or service managers. Such work will only be carried out where there are sufficient resources and skills within Veritau and where the work will not compromise the assurance role or the independence of internal audit. Details of all significant consultancy assignments completed in the year will be reported to the Audit Committee.

8.4 Where Veritau provides non-audit services (for example information governance), appropriate safeguards will be put in place to ensure audit independence and objectivity are not compromised. These safeguards include the work being performed by a separate team with different line management arrangements. Separate reporting arrangements will also be maintained. The Head of Internal Audit will report any instances where audit independence or objectivity may be compromised to the Corporate Director – Strategic Resources and the Audit Committee. The Head of Internal Audit will also take steps to limit any actual or perceived impairment that might occur (for example by arranging for the audit of these services or functional activities to be overseen externally).

9 Resourcing

9.1 As part of the audit planning process the Head of Internal Audit will review the resources available to internal audit, to ensure that they are appropriate and sufficient to meet the requirements to provide an opinion on the County Council's control environment. Where resources are judged to be inadequate or insufficient, recommendations to address the shortfall will be made to the Corporate Director – Strategic Resources and to the Audit Committee.

10 Rights of access

10.1 To enable it to fulfil its responsibilities, the County Council gives internal auditors employed by Veritau the authority to:

- enter all Council premises or land, at any reasonable time
- have access to all data, records, documents, correspondence, or other information - in whatever form - relating to the activities of the Council
- have access to any assets of the Council and to require any employee of the Council to produce any assets under their control
- be able to require from any employee or Member of the Council any information or explanation necessary for the purposes of audit.

10.2 Corporate directors and service managers are responsible for ensuring that the rights of Veritau staff to access premises, records, and personnel are preserved, including where the County Council's services are provided through partnership arrangements, contracts or other means.

11 Review

11.1 This charter will be reviewed periodically by the Head of Internal Audit. Any recommendations for change will be made to the Corporate Director – Strategic Resources and the Audit Committee, for approval.

Relationship between the Corporate Director – Strategic Resources (the Chief Financial Officers~~151 Officer~~) and internal audit

1 In recognition of the statutory duties of the Council's Corporate Director – Strategic Resources (the Corporate Director)~~ for internal audit~~, this protocol has been adopted to form the basis for a sound and effective working relationship between the Corporate Director and internal audit.

(i) The Head of Internal Audit (HoIA) will seek to maintain a positive and effective working relationship with the Corporate Director.

(ii) Internal audit will review the effectiveness of the Council's systems of control, governance, and risk management and report its findings to the Corporate Director (in addition to the Audit Committee).

(iii) The Corporate Director will be asked to comment on those elements of internal audit's programme of work that relate to the discharge of their~~his/her~~ statutory duties. In devising the annual audit plan and in carrying out internal audit work, the HoIA will give full regard to the comments of the Corporate Director.

(iv) The HoIA will notify the Corporate Director of any matter that in the HoIA's professional judgement may have implications for the Corporate Director in discharging their~~his/her~~ statutory~~151~~ responsibilities.

(v) The Corporate Director will notify the HoIA of any concerns that they~~he/she~~ may have about control, governance, or suspected fraud and corruption and may require internal audit to undertake further investigation or review.

(vi) The HoIA will be responsible for ensuring that internal audit is provided in accordance with proper practice.

(vii) If the HoIA identifies any shortfall in resources which may jeopardise the ability to provide an opinion on the County Council's control environment, then they~~he/she~~ will make representations to the Corporate Director, as well as to the Audit Committee.

(viii) The HoIA will report to the Corporate Director (and the Audit Committee) any instances where internal audit independence or objectivity is likely to be compromised, together with any planned remedial action.

(ix). The HoIA will report to the Corporate Director (and the Audit Committee) any instances where audit work has not conformed to the code of ethics and/or the standards. This includes the reasons for non-conformance and the possible impact on the audit opinion.

(x) The Corporate Director will protect and promote the independence and rights of internal audit to enable it to conduct its work effectively and to report as necessary.

Annex 2

Relationship between the Audit Committee and internal audit

1 The Audit Committee plays a key role in ensuring that the County Council maintains a robust internal audit service and it is therefore essential that there is an effective working relationship between the Committee and internal audit. This protocol sets out some of the key responsibilities of internal audit and the Committee.

2 The Audit Committee will seek to:

(i) raise awareness of key aspects of good governance across the County Council, including the role of internal audit and risk management

(ii) ensure that adequate resources are provided by the County Council so as to ensure that internal audit can satisfactorily discharge its responsibilities

(iii) protect and promote the independence and rights of internal audit to conduct its work properly and to report on its findings as necessary.

3 Specific responsibilities in respect of internal audit include the following.

(i) Oversight of, and involvement in, decisions relating to how internal audit is provided.

(ii) Approval of the internal audit charter.

(iii) Consideration of the annual report and opinion of the Head of Internal Audit (HoIA) on the County Council's control environment.

(iv) Consideration of other specific reports detailing the outcomes of internal audit work.

(v) Consideration of reports dealing with the performance of internal audit and the results of its quality assurance and improvement programme.

(vi) Consideration of reports on the implementation of actions agreed as a result of audit work and outstanding actions escalated to the Committee in accordance with the approved escalation policy.

(vii) Approval (but not direction) of the annual internal audit plan.

4 In relation to the Audit Committee, the HoIA will:

(i) attend its meetings and contribute to the agenda

(ii) ensure that overall internal audit objectives, workplans, and performance are communicated to, and understood by, the Committee

(iii) provide an annual summary of internal audit work in accordance with the agreed work programme of the Committee, and an opinion on the Council's

control environment, including details of unmitigated risks or other issues that need to be considered by the Committee

(iv) establish whether anything arising from the work of the Committee requires changes to the audit plan or vice versa

(v) highlight any shortfall in the resources available to internal audit or any instances where the independence or objectivity of internal audit work may be compromised (and make recommendations to address these to the Committee)

(vi) report any significant risks or control issues identified through audit work which the HoIA feels necessary to specifically report to the Committee. This includes risks which management are failing to address but which the HoIA considers are unacceptable for the County Council.

(vii) report any actual or attempted interference in the performance or reporting of internal audit work

(viii) participate in the Committee's review of its own remit and effectiveness

(ix) discuss the outcomes of the quality assurance and improvement programme, and consult with the board on how external assessment of the internal audit service will conducted (required once every five years).

5 The HoIA will informally meet in private with members of the Audit Committee, or the committee as a whole as required. Meetings may be requested by committee members or the HoIA.

CIPFA The Chartered Institute of Public Finance & Accountancy

CIPFA Statement on

the role of the head of internal audit

in Public Service Organisations

(2019 edition)

CIPFA, the Chartered Institute of Public Finance and Accountancy, is the professional body for people in public finance. Our 14,000 members work throughout the public services, in national audit agencies, in major accountancy firms, and in other bodies where public money needs to be effectively and efficiently managed.

As the world's only professional accountancy body to specialise in public services, CIPFA's qualifications are the foundation for a career in public finance. We also champion high performance in public services, translating our experience and insight into clear advice and practical services.

Globally, CIPFA shows the way in public finance by standing up for sound public financial management and good governance.

Head of internal audit

The executive responsible for the organisation's internal audit service, including drawing up the internal audit strategy and annual plan and giving the annual audit opinion. This could be someone from another organisation where internal audit is contracted out or shared with others. In PSIAS this role is referred to as the chief audit executive.

Contents

\ introduction

The head of internal audit (HIA) occupies a critical position in any organisation, helping it to achieve its objectives by evaluating the effectiveness of governance, risk management and internal control arrangements and playing a key role in promoting good corporate governance. The aim of this Statement is to set out the role of the HIA in public service organisations and to help ensure organisations engage with and support the role effectively.

The UK Public Sector Internal Audit Standards (PSIAS) provide clear standards for internal audit but heads of internal audit in the public services face challenges ensuring professional standards are maintained and their internal audit teams remain effective. One key reason for this is that the organisation in which they operate has a direct impact on the resources, scope and authority given to internal audit. While HIAs must step up and deliver a professional service to the best of their ability, it is important to recognise this responsibility does not lie solely with the HIA. As one of the setters of the PSIAS, CIPFA considers it essential that public service organisations properly support their internal auditors to enable them to meet the standards.

For this reason it is critical that the CIPFA statement sets out not only the responsibilities of the HIA but also those of the organisation. CIPFA champions good governance and strong public financial management in public services and believes internal audit has an essential role to play in supporting those objectives. CIPFA considers that HIAs need recognition for their contributions, together with support and encouragement. For these reasons we believe the time is right for an updated CIPFA Statement.

Many heads of internal audit have already risen to the challenges and so alongside the updated CIPFA Statement we are publishing examples of how they are putting principles into practice, providing excellent support and assurance to their organisations and clients. We hope the Statement and this resource will both inspire and support internal audit going forward.

This edition ensures there is alignment to the PSIAS 2017. It explicitly links to the Core Principles for the Professional Practice of Internal Auditing, helping to demonstrate how the HIA role supports internal audit effectiveness.

The intended audience for this statement is not just HIAs in the public services. It should be read by all those with a leadership role in public bodies and by members of audit committees. CIPFA recommends those bodies evaluate their organisational arrangements for internal audit and consider the extent to which they align to the principles. We hope it will be the basis of conversations between the HIA, the leadership team and the audit committee and that the vital role of the HIA is given its due recognition and support.

Let's create the conditions in which heads of internal audit and their teams can thrive.

Rob Whiteman
Chief Executive, CIPFA

status of the CIPFA Statement

The Statement is principle-based and should be relevant to all public service organisations and their HIAs. It is intended to be helpful to a wide audience including leadership teams, chief executives, audit committees and other stakeholders as well as HIAs themselves.

We believe organisations should see the Statement as best practice and use it to support their HIA arrangements and drive up audit quality and governance arrangements.

We also commend the Statement to individual internal audit professionals. It articulates the core responsibilities of the HIA, as well as the personal and professional skills that they need.

The CIPFA Statement and the Public Sector Internal Audit Standards

The Relevant Internal Audit Standard Setters (RIASS)[1] mandate the PSIAS for their respective areas of responsibility in the public services. They work together to agree standards taking advice from the Internal Audit Standards Advisory Board.

In PSIAS, as in the International Professional Practices Framework, the term chief audit executive is used to describe the role of the person responsible for managing internal audit. CIPFA has decided to use the more familiar term head of internal audit for the benefit of the wider readership of this Statement.

Statement approach and structure

The Statement sets out the five principles that define the core activities and behaviours that belong to the role of the HIA in public service organisations and the organisational arrangements needed to support them. Successful implementation of each of the principles requires the right ingredients in terms of:

- the organisation
- the role
- the individual.

For each principle the Statement sets out the organisation's responsibilities to ensure HIAs are able to operate effectively and perform their core duties. The Statement also sets out the core responsibilities of the HIA, consistent with PSIAS. Where responsibilities are delegated the nominated HIA retains overall accountability.

Summaries of personal skills and professional standards then detail the leadership competencies and technical expertise organisations can expect from their HIA. These include the requirements of CIPFA and the other professional bodies' codes of ethics and the PSIAS Code of Ethics to which the HIA is bound. The personal skills support all five principles and are shown together, providing a handy reference for the person specification of the HIA.

1 The Relevant Internal Audit Standard Setters are: HM Treasury in respect of central government; the Scottish Government, the Department of Finance and Personnel Northern Ireland and the Welsh Government in respect of central government and the health sector in their administrations; the Department of Health in respect of the health sector in England (excluding Foundation Trusts); and the Chartered Institute of Public Finance and Accountancy in respect of local government across the UK.

The Principles

The head of internal audit in a public service organisation plays a critical role in delivering the organisation's strategic objectives by:

1 objectively assessing the adequacy and effectiveness of governance and management of risks, giving an evidence-based opinion on all aspects of governance, risk management and internal control

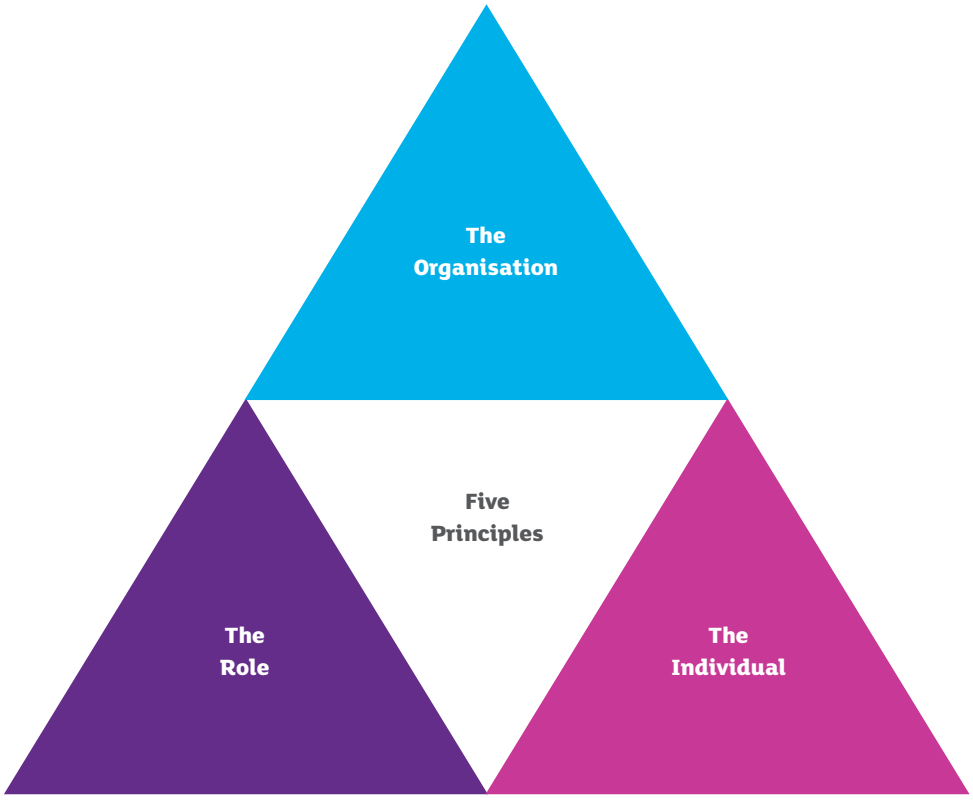
2 championing best practice in governance and commenting on responses to emerging risks and proposed developments.

To perform this role the head of internal audit must:

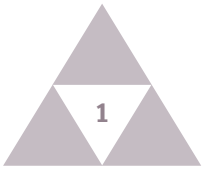
3 be a senior manager with regular and open engagement across the organisation, particularly with the leadership team and with the audit committee

4 lead and direct an internal audit service that is resourced appropriately, sufficiently and effectively

5 be professionally qualified and suitably experienced.



\ principle 1



The head of internal audit (HIA) plays a critical role in delivering the organisation's strategic objectives by objectively assessing the adequacy and effectiveness of governance and management of risks, giving an evidence-based opinion on all aspects of governance, risk management and internal control.

The UK Public Sector Internal Audit Standards (PSIAS) set out the mission of internal audit which is to 'enhance and protect organisational value by providing risk-based and objective assurance, advice and insight'. They also set out Core Principles for the Professional Practice of Internal Auditing which taken as a whole articulate internal audit effectiveness.

The following core principles are of particular relevance for Principle 1 of the CIPFA Statement:

- Provides risk based assurance.
- Is objective and free from undue influence (independent).
- Aligns with the strategies, objectives, and risks of the organisation.

Organisational responsibilities

To enable the HIA to fulfil their role the leadership team should ensure they:

- set out the responsibilities of the leadership team for internal audit
- establish an internal accountability and assurance framework including how internal audit works with other providers of assurance
- set out how the framework of assurance supports the annual governance statement and identify internal audit's role within it. The HIA should not be responsible for the statement
- set out the responsibilities of the HIA and ensure the independence of the role is preserved. If additional responsibilities are taken on then appropriate safeguards should be put in place
- ensure internal audit is independent of external audit
- establish clear lines of reporting of the HIA to the leadership team and to the audit committee
- ensure the HIA reports in their own right and that the annual internal audit opinion and report are issued in the name of the HIA
- ensure the internal audit charter and plan are approved by the audit committee in accordance with the PSIAS.

Core HIA responsibilities

To fulfil Principle 1 the HIA should:

- ensure that internal audit's work is risk-based and aligned to the organisation's strategic objectives and will support the annual internal audit opinion
- identify where internal audit assurance will add the most value or do most to facilitate improvement
- produce an evidence-based annual internal audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

Commentary

Independence and objectivity

The leadership team is responsible for the organisation achieving its objectives and for the underlying governance arrangements and effective frameworks of risk management and internal control. The HIA's unique role is to evaluate these arrangements and provide independent assurance on their effectiveness. So it is important that the HIA is independent of operational management and is seen to provide objective views and opinions. Where the HIA has responsibilities beyond internal audit the risks to independence must be recognised and adequate safeguards need to be approved by the audit committee and put in place to protect independence and objectivity.

Broad scope of assurance

The leadership team needs regular assurance that the organisation has good governance arrangements and is effectively managing its risks. The assurance framework that provides this will have a number of sources including a clearly defined management accountability framework, performance management and risk management, together with internal compliance functions such as legal, HR and health and safety. Assurance is also available from external inspectors and agencies and external auditors. Some organisations use the 'three lines of defence' model to explain these relationships. Setting out this framework of assurance should also help in explaining to others how internal audit fits into the wider governance picture.

The annual HIA opinion is on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control in accordance with PSIAS. It is the most important output from the HIA and is one of the main sources of objective assurance that chief executives and the leadership team have for their annual governance statement. The HIA opinion is unique within the wider assurance framework in that is independent and objective and in accordance with professional standards. This opinion must reflect the work done during the year and it must summarise the main findings and conclusions together with any specific concerns the HIA has. To build a robust opinion on the adequacy of the governance, risk and control framework the HIA will need to review and if appropriate place reliance on the work of others.

Evidence-based assurance

The HIA's opinion must be well founded if it is to give proper assurance to the organisation and improve governance and control arrangements. This means internal audit planning must be well focused and in accordance with professional standards.

The HIA may look to the work of other functions, partner organisations and other agencies as evidence for their assurance. Here the HIA must understand the basis for their assurances and its adequacy and whether the HIA needs to carry out any additional review work. A summary of assurances given and relied upon should be included in the HIA's annual report.

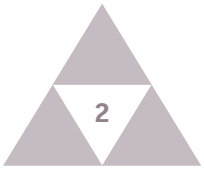
One of the HIA's key relationships must be with the external auditor. The role of the external auditor is to provide an opinion on the financial statements of the organisation together with wider reporting on value for money or best value. The external auditor will share internal audit's interest in the governance risk and control environment and both auditors should share their plans and findings on a regular basis.

Develop and implement a risk-based audit approach

Risk management is key to the effective delivery of public services. Organisations are becoming more mature in how they identify, evaluate and manage risks and opportunities. The HIA should encourage the organisation to improve its approach to risk management and the HIA opinion on the adequacy and effectiveness of risk management will provide assurance on an annual basis.

The audit plan must identify the priorities for internal audit based on an assessment of the key risks to organisational objectives and the extent of alternative sources of assurance, as well as the resources and skills needed to deliver it. Responsibility for effective governance, risk management and control arrangements remains with the organisation; the HIA cannot be expected to prevent or detect all weaknesses or failures in internal control nor can the internal audit plan cover all areas of risk across the organisation.

\ principle 2



The head of internal audit (HIA) in a public service organisation plays a critical role in delivering the organisation's strategic objectives by championing best practice in governance and commenting on responses to emerging risks and proposed developments.

The UK Public Sector Internal Audit Standards set out Core Principles for the Professional Practice of Internal Auditing which taken as a whole articulate internal audit effectiveness. The following core principles are of particular relevance for Principle 2 of the CIPFA Statement:

- Aligns with the strategies, objectives, and risks of the organisation.
- Is insightful, proactive, and future-focused.
- Promotes organisational improvement.

Organisational responsibilities

To enable the HIA to fulfil their role the leadership team should ensure that they:

- establish top level commitment to the principles of good governance, recognising its importance for achieving strategic objectives
- set out the HIA's role in good governance and how this fits with the role of others
- recognise and support the role internal audit can play in providing advice and consultancy internally
- ensure that the HIA has the opportunity to advise on or provide assurance on all major projects, programmes and policy initiatives
- take account of the HIA's advice in new and developing systems.

Core HIA responsibilities

To fulfil Principle 2 the HIA should:

- work with others in the organisation to promote and support good governance
- help the organisation understand the risks to good governance
- give advice to the leadership team and others on the control arrangements and risks relating to proposed policies, programmes and projects
- promote the highest standards of ethics and standards across the organisation based on the principles of integrity, objectivity, competence and confidentiality
- demonstrate the benefits of good governance for effective public service delivery and how the HIA can help
- offer advisory or consulting services where appropriate
- give advice on risk and internal control arrangements for new and developing systems, including major projects, programmes and policy initiatives whilst maintaining safeguards over independence.

Commentary

Promoting good governance

Good governance is fundamental to establishing confidence in public services. All managers have a responsibility for exercising good governance but the HIA can promote the principles of good governance across the organisation through their assurance and advisory work, encouraging good practice. This is consistent with the Core Principles for the Professional Practice of Internal Auditing. The internal audit charter sets out the scope of internal audit activities and provides the opportunity to outline how the HIA will fulfil this role.

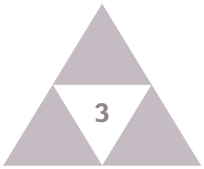
Good governance is core to achieving strategic aims and demonstrating that public money is used well. The HIA can support the leadership team in establishing, maintaining and improving governance by promoting the benefits of good governance, interpreting and advising on the application of governance principles as well as reporting on governance risks. There are also benefits for the HIA in taking such an approach as this helps staff and the audit committee see the wider purpose of internal audit's work and the support they can provide. While the HIA is not responsible for the organisation's public report on governance, the HIA can provide support to ensure the assessment is robust and the statement itself is effective.

The HIA should understand the range of risks to good governance the organisation faces, such as entering into new collaborative arrangements, managing resource pressures or taking on new statutory responsibilities. The HIA should then assess how best to support good governance and organisational improvement.

Advising on proposed developments

The HIA will seek to ensure the work of internal audit is aligned to the organisation's strategic goals and governance responsibilities. To facilitate this HIAs must be asked to consider the impact of proposed policy initiatives, programmes and projects as well as responses to emerging risks. HIAs should be made aware of major new systems and proposed initiatives such as new collaborative or commercial arrangements to help ensure risks are properly identified and evaluated and appropriate controls built in. Managers and the HIA must therefore be clear on the scope of any internal audit work here and of the kind of advice that is given to ensure the independence of other audit work and the HIA annual opinion is not compromised.

\ principle 3



The HIA must be a senior manager with regular and open engagement across the organisation, particularly with the leadership team and with the audit committee.

The UK Public Sector Internal Audit Standards set out core principles for the Professional Practice of Internal Auditing which taken as a whole articulate internal audit effectiveness. The following core principles are of particular relevance for Principle 3 of the CIPFA Statement:

- Is objective and free from undue influence (independent).
- Is appropriately positioned and adequately resourced.

Organisational responsibilities

To enable the HIA to fulfil their role the leadership team should:

- designate a named individual as HIA in line with the principles in this Statement. The individual could be someone from another organisation where internal audit is contracted out or shared. Where this is the case then the roles of the HIA and the client manager must be clearly set out in the contract or agreement
- ensure that where the HIA is an employee they report functionally to a member of the leadership team. The HIA should be sufficiently senior and independent within the organisation's structure to allow them to carry out their role effectively and be able to provide credibly constructive challenge to management
- engage constructively with the HIA and facilitate their role throughout the organisation
- ensure the audit committee terms of reference[2] includes oversight of internal audit including the monitoring of adherence to professional standards
- ensure the HIA's reporting relationship with the audit committee and its chair as set out in the internal audit charter is applied
- ensure the organisation's governance arrangements give the HIA:
  - direct access to the chief executive, other leadership team members, the audit committee and external audit; and
  - attendance at meetings of the leadership team and management team when the HIA considers this to be appropriate
- set out unfettered rights of access for internal audit to all papers and all people in the organisation, as well as appropriate access in arms-length bodies
- set out the HIA's responsibilities relating to organisational partners including collaborations and outsourced and shared services.

2 In Local Government and Police CIPFA's Position Statement and supporting guidance include examples of audit committee terms of reference, including the committee's responsibilities for internal audit. *Audit Committee Practical Guidance for Local Government and Police*, CIPFA, 2018

Core HIA responsibilities

To fulfil Principle 3 the HIA should:

- ensure the internal audit charter clearly establishes appropriate reporting lines that facilitate engagement with the leadership team and audit committee
- escalate any concerns about maintaining independence through the line manager, chief executive, audit committee and leadership team or external auditor as appropriate
- contribute to the review of audit committee effectiveness, advising the chair and relevant managers of any suggested improvements
- consult stakeholders, including senior managers and non-executive directors/elected representatives on internal audit plans.

Commentary

Senior manager

Heads of internal audit face increasing challenges and higher expectations from stakeholders, especially in helping organisations look forward. Regardless of how the internal audit is provided the HIA must be able to operate at the heart of the organisation, challenging and supporting the leadership team with authority and credibility. They should also be seen as a leader, promoting improvement and good governance. To do this effectively, make an impact and add value, the HIA position must be at a senior management level.

The HIA must also have unfettered access to key people across the organisation, especially to the chief executive, leadership team and audit committee chair.

The HIA role must be filled by a named individual so that all are clear about lines of responsibility. Where the service is provided in-house this should be straightforward. Where the service is contracted out or shared with others then the organisation must decide whether the HIA should come from within the organisation or from the supplier of the audit service. In the latter case the relationship between the HIA and the organisation, including the audit committee, must be clearly set out and arrangements made to ensure there is adequate access and visibility of the HIA to the leadership team. In practice it is likely that the HIA will be the person who is responsible for drawing up the internal audit charter and plan, issuing the HIA annual internal audit opinion and engaging with the audit committee.

Engagement with the leadership team

The leadership team in public service organisations takes many forms, with different mixes of executive and non–executive members, as well as elected representatives. Collectively the leadership team is responsible for setting the strategic direction for the organisation, its implementation and the delivery of public services. The HIA must also have a right of access to individual members of the leadership team and should expect the support of the team consistent with reporting relationships set out in PSIAS.

Wherever the HIA is in the organisational structure the HIA will need to ensure and demonstrate adequate independence and objectivity. A senior position supports this, alongside appropriate safeguards if they have other management responsibilities.

Engagement with the audit committee

The HIA's relationship with the audit committee, and especially the chair, is crucial. They should be mutually supportive in their aim to be objective and to provide challenge and support across the organisation and improve governance, risk management and internal control. The HIA must work closely with the audit committee chair so that they are clear about their respective roles and make best use of internal audit.

\ principle 4

The HIA must lead and direct an internal audit service that is resourced appropriately, sufficiently and effectively.

The UK Public Sector Internal Audit Standards set out Core Principles for the Professional Practice of Internal Auditing which taken as whole articulate internal audit effectiveness. The following core principles are of particular relevance for Principle 4 of the CIPFA Statement:

- Demonstrates integrity.
- Is appropriately positioned and adequately resourced.
- Demonstrates quality and continuous improvement.

Organisational responsibilities

To enable the HIA to fulfil their role the leadership team should:

- provide the HIA with the status, resources, expertise and systems necessary to perform their role effectively
- ensure the audit committee contributes to a performance framework for the HIA and the internal audit service and takes action as appropriate
- ensure an external review of internal audit quality is carried out at least once every five years in accordance with PSIAS
- ensure the audit committee provides support for and participates in the quality assurance and improvement programme as set out in PSIAS.

Core HIA responsibilities

To fulfil Principle 4 the HIA should:

- lead and direct the internal audit service so that it meets the needs of the organisation and external stakeholders and fulfils professional standards
- demonstrate how internal audit adds value to the organisation
- determine the resources, expertise, qualifications and systems for the internal audit service that are required to meet internal audit's objectives
- inform the leadership team and audit committee as soon as they become aware of insufficient resources to carry out a satisfactory level of internal audit, and the consequence for the level of assurance that may be given
- ensure the professional and personal training needs for staff are assessed and that these needs are met
- establish a quality assurance and improvement programme that includes:
  - ensuring professional internal audit standards are complied with
  - reviewing the performance of internal audit and ensuring the service provided is in line with the expectations and needs of its stakeholders
  - providing an efficient and effective internal audit service – demonstrating this by agreeing key performance indicators and targets with the line manager and audit committee; annually reporting achievements against targets
  - putting in place adequate ongoing monitoring and periodic review of internal audit work and supervision and review of files, to ensure that audit plans, work and reports are evidence-based and of good quality
  - seeking continuous improvement in the internal audit service
- keep up to date with developments in governance, risk management, control and internal auditing, including networking with other HIAs and learning from them, implementing improvements where appropriate.

Commentary

Meeting the needs of the business

Effective governance is critical in public service organisations and internal audit needs to play its part. The HIA must have a firm grasp and understanding of the organisation's business as well as its control environment. This will allow HIAs to give an opinion to the leadership team on how well these arrangements are working.

Whether internal audit is provided in-house, through a shared service or outsourced, the internal audit resources available must be proportionate to the size, complexity and risk profile of the organisation and must be enough for the HIA to give a reliable annual internal audit opinion on the organisation's framework of governance, risk management and control. Responsibility for ensuring that an effective and appropriately resourced internal audit service is in place rests with the organisation.

The HIA must set out the audit coverage and audit resources needed to give a sound, evidence-based annual audit opinion and must advise the audit committee and the leadership team where the available resources are inadequate and the consequences for the level of assurance that the HIA is able to give. Where concerns are raised by the HIA it is vital that they are listened to and the consequences understood.

Appropriately developed internal audit skills

A great deal of reliance is placed on the work of internal audit and the HIA must ensure all the work, including planning and individual assignments, is consistently of a high quality and in line with professional standards. The HIA must also ensure that all staff demonstrate the highest ethical standards. The HIA therefore has a responsibility to ensure that internal audit staff have appropriate qualifications, knowledge, skills and competencies and have access to development opportunities.

The HIA must provide clear guidance for internal audit staff with appropriate quality assurance for internal audit as a whole and for each audit assignment. The HIA has a duty to ensure their staff comply with the PSIAS and must have systems to verify this. More widely the HIA should ensure they and the team are up to date on current issues affecting their organisation and on internal audit techniques and developments.

\ principle 5

The HIA must be professionally qualified and suitably experienced.

The UK Public Sector Internal Audit Standards set out Core Principles for the Professional Practice of Internal Auditing which taken as a whole articulate internal audit effectiveness. The following core principles are of particular relevance for Principle 5 of the CIPFA Statement:

- Demonstrates competence and due professional care.
- Communicates effectively.

Organisational responsibilities

To enable the HIA to fulfil their role the leadership team should:

- appoint a professionally qualified HIA[3] whose core responsibilities include those set out in the PSIAS as well as under the other principles in this statement and ensure that these are properly understood throughout the organisation
- ensure the HIA has the skills, knowledge and internal audit experience, together with sufficient resources to perform effectively in the role
- support continuing professional development of the HIA.

Core HIA responsibilities

To fulfil Principle 5 the HIA should:

- be a full member of an appropriate professional body and have an active programme for personal professional development
- adhere to professional internal audit and ethical standards (and where appropriate accounting and auditing standards).

3 PSIAS requires that the HIA must hold a professional qualification (CCAB, CMIIA or equivalent).

Commentary

Demonstrating professional and interpersonal skills

The HIA must be able to demonstrate their own professional credibility to exercise influence throughout the organisation. The HIA must be professionally qualified.

The HIA must adhere to the professional values of accuracy, honesty, integrity, objectivity, impartiality, transparency, confidentiality, competence and reliability and promote these throughout the internal audit service.

The HIA must be able to operate effectively in different modes including directing, influencing, evaluating and informing. The HIA must be able to give objective opinions and advice even if this may be unwelcome and to intervene with authority where necessary. The HIA must be able to challenge the status quo and be a catalyst for change, achieving results through influence, without direct authority.

The HIA must be sensitive to the complexities and pressures facing organisations.

Applying business and professional experience

The HIA must have an understanding and commitment to the organisation's wider business and its delivery objectives, to inspire respect, confidence and trust amongst colleagues, with the leadership team, audit committee and other stakeholders.

The HIA must have a good understanding of business processes and governance including strategic planning and performance, financial and risk management.

The HIA should be seen as a catalyst to improving governance and internal control and also supporting the organisation in its wider business objectives. The HIA's leadership must set the tone that good governance, risk management, and internal control matter to everyone in the organisation.

personal skills and professional standards

This section sets out the personal skills and professional standards of the HIA that are necessary to support the five principles in practice.

Principle 1

- Give clear, professional and objective advice.
- Report on what is found, without fear or favour.
- Demonstrate integrity to staff and others in the organisation.
- Exercise sound judgement in identifying weaknesses in the organisation's control environment and a balanced view on how significant these are.
- Work well with others with specific responsibilities for internal control, risk management and governance including (as appropriate to the sector) the chief executive, chief legal officer, chief financial officer, audit committee, non-executive directors and elected representatives.
- Work positively and constructively, influencing the leadership team, audit committee and others to ensure the HIA's recommendations are implemented.
- Be a role model – dynamic, determined, positive and robust. They should demonstrate resilient leadership and the ability to inspire confidence and exemplify high standards of conduct.

Principle 2

- Provide leadership by giving practical examples of good governance that will inspire others.
- Deploy effective facilitating and negotiating skills.
- Build and demonstrate commitment to supporting continuous improvement of the organisation.

Principle 3

- Network effectively to raise the profile and status of internal audit.
- Adopt a flexible style, being able to collaborate, advise and challenge as appropriate.
- Build productive professional relationships both internally and externally.
- Work effectively with the leadership team and audit committee, showing political awareness and sensitivity.
- Be seen to be objective and independent but also pragmatic where appropriate.

Principle 4

- Demonstrate leadership and be an ambassador for internal audit.
- Create, communicate and implement a vision for the internal audit service.
- Create a customer-focused internal audit service.
- Establish an open culture, built on effective coaching and a constructive approach.
- Promote effective communication within internal audit, across the broader organisation and with external stakeholders.
- Manage and coach staff effectively.
- Comply with professional standards and ethics.
- Require the highest standards of ethics and standards within internal audit based on the principles of integrity, objectivity, competence and confidentiality.

Principle 5

- Demonstrate a range of skills including communicating, managing and influencing, as well as an understanding of IT and consulting services.
- Understand and have experience of strategic objective setting and management.
- Understand the internal audit and regulatory environment applicable to public service organisations.
- Demonstrate a comprehensive understanding of governance, risk management and internal control.
- Undertake appropriate development or obtain relevant experience in order to demonstrate an understanding of the full range of the organisation's activities and processes.

definitions used throughout the document

The public services have a wide variety of organisational structures and governance arrangements. The definitions used in this document are primarily based on those used in CIPFA's Role of the Chief Financial Officer Statement and in the Public Sector Internal Audit Standards (PSIAS).

Annual governance report

The mechanism by which an organisation publicly reports on its governance arrangements each year.

Assurance

An objective examination of evidence for the purpose of providing an independent assessment on governance, risk management and control processes for the organisation.

Assurance can come from a variety of sources and internal audit can be seen as the 'third line of defence' with the first line being the organisation's policies, processes and controls and the second being managers' own checks of this first line.

Assurance framework

This is the primary tool used by a board to ensure that it is properly informed on the risks of not meeting its objectives or delivering appropriate outcomes and that it has adequate assurances on the design and operation of the systems in place to mitigate those risks.

Audit committee

The governance group charged with independent assurance of the adequacy of the risk management framework, the internal control environment and the integrity of financial reporting.

Board

The group of people charged with setting the strategic direction for the organisation and responsible for its achievement.

Chief financial officer

The organisation's most senior executive role charged with leading and directing financial strategy and operations.

Control environment

The attitude and actions of the board and management regarding the importance of control within the organisation. The control environment provides the discipline and structure for the achievement of the primary objectives of the system of internal control. The control environment includes the following elements:

- Integrity and ethical values.
- Management's philosophy and operating style.
- Organisational structure.
- Assignment of authority and responsibility.
- Human resource policies and practices.
- Competence of personnel.

Governance[4]

The arrangements put in place to ensure that the intended outcomes for stakeholders are defined and achieved.

Head of internal audit opinion

The opinion issued each year by the HIA on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

The opinion is used by the chief executive in some public service organisations as a key source in drafting the annual governance report.

4 The International Framework: Good Governance in the Public Services (CIPFA/IFAC, 2014)

Internal audit

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

Leadership team

Comprises the board and management team.

Managers

The staff responsible for the achievement of the organisation's purpose through services/ businesses and delivery to its clients/customers.

Management team

The group of executive staff comprising the senior management charged with the execution of strategy.

Public service organisation

One or more legal bodies managed as a coherent operational entity with the primary objective of providing goods or services that deliver social benefits for civic society, are not privately owned and receive public and/or charitable funding.

Risk management

A process to identify, assess, manage and control potential events or situations to provide reasonable assurance regarding the achievement of the organisation's objectives.

CIPFA The Chartered Institute of Public Finance & Accountancy

Registered office:
77 Mansell Street, London E1 8AN
T: 020 7543 5600 F: 020 7543 5700
www.cipfa.org

INVESTORS IN PEOPLE

NORTH YORKSHIRE COUNTY COUNCIL

AUDIT COMMITTEE

25 OCTOBER 2019

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 2019 for the Health and Adult Services Directorate (HAS).

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 Health and Adult Services Directorate (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 work of internal audit is reported in accordance with an agreed programme of work with this report covering audits finalised in the year to 31 August 2019. 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 2019

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 a number of other areas of work in respect of the directorate. This work has included:

(a) Investigating cases that have either been communicated via the Whistleblowers' hotline or have arisen from issues and concerns referred to Veritau by HAS management.
(b) investigating data matches received from the National Fraud Initiative (NFI). These matches can indicate possible fraud or error.
(c) providing 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**. Where the audits undertaken focused on systems development, the review of specific risks as requested by management or value for money then no audit opinion has been given.

3.4 It is important that 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.

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

10 October 2019

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 2019

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
A	Visits to care provider establishments: • Camphill Village Trust (Botton Village) • Stepping Stones (Skipton) • Avalon and Shared Lives (Botton Village) • Castle Grange (Scarborough)	Various: 1 x Substantial Assurance 3 x No opinion given	The audits were tailored to the risks highlighted in respect of each provider. A variety of work has been undertaken including the review of: • Previous findings to establish whether agreed improvements have been made • Arrangements for managing and safeguarding the financial affairs of service users • Financial controls to ensure they were in place and operating effectively. • Controls to ensure the property of service users is protected.	Various	At Camphill Village Trust there had been an improvement in the governance of residents' finances. There was now a suitable policy and scheme of delegation in place, which if enforced, will provide the necessary level of control. At Stepping Stones we helped to reconcile the financial accounts so these were accurate. We also highlighted weaknesses in the cash handling processes. At Avalon we found good progress had been made in the handover of all customer information and in the practical arrangements for managing and safeguarding the financial affairs of service users. At Castle Grange we found no issues.	**Two P3 actions were agreed - Stepping Stones (Skipton).** **Responsible Officer: Learning Disability Manager, Care and Support, Care and Support Provider Services.** The processes at Stepping Stones will be reviewed. This will include the possibility of transferring responsibility for invoicing to NYCC Finance and the closure of the community fund. The manager will implement the agreed improvements in cash handling.
B	Financial Safeguarding Procedures	No opinion given	We reviewed a specific financial safeguarding case to assess if internal procedures had been followed and whether there were any areas for improvement.	October 2018	We found officers had followed the correct internal policies and procedures. The complexities of the case has however helped to raise awareness of	**No actions for improvement were highlighted.**

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
					some of the potential risks in financial safeguarding cases.	
C	Scarborough Mencap	No opinion given	Scarborough Mencap deliver a range of services for the Council including day care, respite care and flex-support in homes and the community. Services are provided through Individual Service Contracts (ISC) or through Direct Payments. The audit reviewed the following areas: • Financial procedures and controls • Budget/cash flow projections/forecasting • Improvement plans / support for the financial and other changes required for the business • Governance arrangements The audit was a follow up visit following work completed in 2016/17.	November 2018	Some improvements had been made since the previous audit visit. An action plan had also been prepared by Mencap to help implement the agreed actions from the previous audit. Mencap had completed a review of financial procedures. Invoicing procedures now include the required controls. Security practices have also been updated to manage the risk of further financial abuse. However, key financial procedures and controls such as bank reconciliations, and a scheme of delegation were not in place. Management accounts and the annual financial statements were also not being completed promptly. An annual budget for 2018/19 had also not been prepared. A Business Improvement Plan for 2018-2020 had been prepared. However, it was not possible to assess whether the plan would deliver the required changes. There were clear governance challenges for the organisation with a small number of trustees and difficulties in attracting additional skills.	**Seven P2 and four P3 actions were agreed.** **Responsible Officer: Quality Assurance Manager** Progress on the actions was being considered by HAS officers, alongside their own improvement actions. Regular meetings are being held between representatives of NYCC and Scarborough Mencap. These meetings are focused on the steps being taken by the Provider. The SAGE System is now being used and financial arrangements are in place having been transferred to the Finance Administrator. The Scarborough Mencap Finance Administrator has since finalised the accounts.

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
D	Deprivation of Assets	Substantial Assurance	Financial assessments are undertaken for service users to calculate their health and social care contributions. In some cases an individual may try to avoid paying for care and support costs by deliberately depriving themselves of assets. We reviewed the procedures and controls in place to ensure: • that where asset deprivation is detected it is investigated appropriately and consistently. • sufficient evidence is obtained to identify cases where there may be deprivation of assets. • decisions are recorded and evidenced.	December 2018	All cases reviewed were accurately identified by the BACS team and the correct capital analysis was performed. There was sufficient evidence obtained to identify and evidence cases of possible deprivation. In one case the council was not using the most cost-effective method to recover the funds. In another case there was no deprivation decision record, notice of deprivation decision, letter notification or financial assessment recorded.	**Three P3 actions were agreed.** **Responsible Officer: BACS Manager** Team managers were reminded to reflect the recovery method in the decision record. This includes recording whether they have applied Section 69 or Section 70 of the Care Act when making recovery decisions. Relevant officers were reminded to ensure that all relevant documents are saved into ContrOCC.
E	Public Health	High Assurance	We reviewed Public Health services to ensure: • Savings plans had been prepared, the plans were reasonable and monitoring arrangements were in place	May 2019	There was a comprehensive savings plan which had identified a list of savings options to help achieve a cumulative balanced budget by 2020/21 and an ongoing balanced budget from 2021/22.	**No actions identified.**

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			to help ensure savings could be achieved. • Processes for requesting and completing public health data intelligence requests were robust. • Monitoring and reporting arrangements for training for a specific provider were effective.		This plan was being monitored on a regular basis by Finance. There are frequent progress meetings being held, including with the Corporate Director of Health and Adult Services and the Director of Public Health. We found the process for requesting and completing public health data intelligence requests was robust. We reviewed the monitoring and reporting arrangements for training delivered by Drugtrain for the North Yorkshire Alcohol Strategy. There were effective systems in place to monitor the delivery of training against outcomes.	
F	Deferred Payment Agreements	Substantial Assurance	A Deferred Payment Agreement (DPA) is an arrangement between the Council and a service user to use the value of their homes to offset the cost of care fees. The Care Act 2014 sets out the criteria a local authority must follow when setting up a deferred payment agreement with service users. A DPA provides service users with the option to not be forced to sell their home during their lifetime to pay care home bills.	May 2019	We found effective controls were in place to help ensure DPA's were completed in line with the Care Act and were being monitored. Before a service user enters into a DPA they are provided with guidance and advice about paying for care. The Council completes financial assessments to ensure service users have sufficient assets to fund the cost of their care. The Council does not always obtain evidence that the service user has an	**One P2 action and three P3 actions were agreed.** **Responsible Officer: Benefits, Assessments and Charging Manager** The client information pack will be updated to inform service users that they must send a valid insurance certificate for any asset used as security. The council will also request individuals with a DPA to send a valid insurance certificate on an annual basis.

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			The audit reviewed whether: • Deferred Payment Agreements were compliant with the Care Act. • There was an effective and efficient process in place for creating, monitoring and recovering deferred payments.		up to date insurance policy in place for the asset(s) they are using as security. Details for all DPA cases are manually recorded, managed and monitored using a spreadsheet. Information is also recorded in ContrOCC. However, ContrOCC is not able to be used to manage cases. The spreadsheet is also used and updated by a number of people, which increases the likelihood of inaccuracies and error.	There has been ongoing work to increase the functionality of ContrOCC. Once this work has been completed, the spreadsheets will no longer be required for monitoring purposes.
G	Direct Payments	High Assurance	We reviewed the Direct Payment system to ensure: • Payments were made accurately and in a timely manner. • Monitoring of direct payment accounts were performed appropriately. • Possible fraudulent use of direct payments was identified and reported to Veritau's fraud team. • Progress has been in implementing previously agreed actions	April 2019	In the majority of cases Direct Payments were processed in an accurate and timely manner. Monitoring had also been undertaken in a timely manner for most of the Direct Payments reviewed. We reviewed 20 cases where the service user was potentially in receipt of both Direct Payments and support for being in residential care. We found no significant issues. Good progress has been made in implementing previous audit actions. A new policy has been introduced to allow DPAs to escalate their concerns about the use of Direct Payments. A Disabled Children's Services policy is also due to be introduced in Autumn 2019.	**No actions identified.**

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
H	Solutions4Health	No opinion given	Solutions4Health ran the North Yorkshire Smoke Free Service from December 2015. The Council decided to take the contract back 'in house' from 1 April 2019. As part of the transfer process, the Council reviewed all operational areas. As part of this process several discrepancies were noted the 2018/19 invoices. We therefore reviewed Solutions4Health 2018/19 invoices to ensure: • invoices being received from Solutions4Health were in accordance with the contract • the correct payments had been made to Solutions4Health	July 2019	Our review of Nicotine Replacement Therapy (NRT) invoices noted that Solutions4Health purchased NRT products at one rate and then uplifted the rate charged to the Council. The uplift percentage rate Solutions4Health used generally varied from 11% to 43% between the individual NRT products. The correct level of uplift was not specified in the contract. Payments made in 2018/19 matched the Solutions4Health invoices received. However, a full set of delivery notes was only available for two of the invoices.	**One P3 action was agreed.** **Responsible Officer: Senior Quality Assurance and Contracting Officer** The Senior Quality Assurance and Contracting Officer has been raising queries with the organisation and ensuring final payments take into account the issues raised by the audit. There is also future learning for contract management that goes wider than this service and the public health team. This will be picked up by contracting teams.
I	Liquid Logic – Access Controls and Data Reporting	No opinion given	The purpose of this audit was to review: • Access controls and security settings for both the Liquid Logic and ContrOCC systems, and to assess whether they complied with the Corporate IT Access Policy.	July 2019	No issues were found regarding access controls for Liquid Logic and ContrOCC. There was good awareness within the directorate about the importance of data quality. Internally a number of areas to improve data reporting had been identified. For example, the Liquid	**One P2 and four P3 actions were agreed.** **Responsible Officer: AD – Care and Support, ABC Project Sponsor, Head of Data and Intelligence, and HAS Data Governance Lead** The Data Quality Improvement Plan which has been commissioned will

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			• Whether the management information reported from the Liquid Logic and ContrOCC systems to the HAS directorate was complete and accurate. The review also helped Veritau to gain a better understanding and knowledge in the reporting capabilities of both the systems to help inform future internal audit work.		Logic and ContrOCC Business Development Officers have produced a programme of work. The timescales to deliver these improvements however needed to be finalised. Both Liquid Logic and ContrOCC include a number of generic reports as well as the facility to produce tailored ad hoc reports. These reporting facilities were not regularly being used. A number of Liquid Logic performance dashboards have been made available. These are potentially beneficial as teams will have easy access to up to date information. However, some operational teams have a lack of understanding of the benefits of the performance dashboards that are being developed. It was noted that Deprivation of Liberty Safeguards (DoLS) and Livingwell cases are being managed using spreadsheets.	detail the approach, the required quality outputs, and review mechanisms to deliver improved data quality. We will look at which reports are required now and in the future. The audit work will also be used to inform future systems development. The use of the dashboards will be encouraged. For DoLS we will consider a 'portal' that will provide HAS with the functionality it needs to drive forward a) its digital ambitions, for example online self or supported assessments and b) enhance partnership working. The Living Well dashboard will be reviewed to help deliver improvements.

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

25 OCTOBER 2019

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

3.2.1 Adult Social Care accounts for over 41% of County Council spend and this share has increased since 2010 due to the relative protection of these budgets. £18.5m savings have been made countywide in the service since 2015, with a further £7.5m to be delivered by 2022 – at this stage. The current financial year has a target of £4.4m. 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. The focus of the NHS is moving away from Delayed Transfers of Care, with an expectation improved performance will be maintained, to reducing Length of Stay. This has potential to create additional

pressures. Temporary (and reducing) funding has been allocated through the Improved Better Care Fund (IBCF) and Winter Funding to assist with some of these pressures but there is currently no guarantee of these 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.

3.2.2 A significant issue for the council is the ongoing overspend within Care and Support. This was £4m in 2017-18 and £4.7m in 2018-19. Despite growth of £2m and inflation, is estimated at this stage to be £5m in 2019-20.

3.2.3 We are also planning for significant reductions in the public health grant which will mean reductions to public health budgets and in contributions to other council spend that contribute to public health outcomes. We are in negotiation with our providers to deliver these savings and have agreed to enter into section 75 agreements with Harrogate District Foundation Trust and York Teaching Foundation Trust to deliver Health Child Programme and sexual health services, respectively.

3.3 Reducing Budget Pressures

3.3.1 We continue to look at areas where we can reduce costs, while at the same time delivering in-year savings of more than £4m. These can be split into three main areas:

Practice

3.3.2 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. We will continue to develop and implement a programme of work to ensure decision making is appropriate and consistent across the county.

Productivity

3.3.3 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.

Market

3.3.4 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.

3.3.5 Over 91% of new residential admissions cost us more than our agreed rates with providers in Harrogate. This equates to £8m. Across NYCC the position is 51% and £15m.

3.3.6 Since April 2017 average residential costs have increased by 21.45%, nursing costs by 52.65%. NYCC rates have increased by 7.8% and 8.3% respectively in this time.

3.3.7 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. Our revised approach includes:

- Developing a business case to determine the viability of developing a complex care dementia village in Harrogate
- Revised approach to the Actual Cost of Care exercise which sets the Councils recommended funding levels each year for the care market
- New approach to Supported Living to improve accommodation and reduce inequalities across the care pathway
- A one year negotiated settlement for 2020/21 outside of the ACOC process
- Development of a quality pathway to support the care market more proactively

3.4 Workforce Issues

3.4.1 There is a risk to workforce and service continuity around current EU workers where they do not apply for post-Brexit settled status. This will be both direct for HAS and the wider sector (18 and 105 workers currently identified respectively) And also indirect, where we face competition for non-UK EU nationals from the hospitality and retail sectors.

3.4.2 We are encouraging awareness amongst such workers to ensure sign-up to settled status where required.

3.4.3 As well as workforce issues, the demand within the market may also lead to pay inflation and we will monitor both of these issues over the next year.

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 2020

4.6 There has been one new risk added to the risk register since October 2018 (date of last progress report to the Committee) follows:

4.7 One risk has been deleted from the Directorate risk register since October 2018. This was around Transformation of Care and Support as the service has embedded new approaches, achieving savings while maintaining personal independence.

4.8 The significant actions that were achieved include the following:

- Financial Pressures/Transformation – review of revised practice within the care pathway and development of action plan to tackle overspend
- Major Failure due to Quality and/or Economic Issues in the Care Market – recruitment to quality and improvement team
- Workforce Planning and Development – development and implementation of programme to enable managers to take ownership of and prioritise their responsibilities, and hold them to account, so that their roles are carried out efficiently
- Deprivation of Liberty (DoLs) Supreme Court Ruling – implementation of actions following the LEAN review
- Partnership and Integration with the NHS – review of governance arrangements of Health and Wellbeing Board (required to deliver joint Health and Wellbeing Strategy); launch of Harrogate and Rural Alliance

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
25 October 2019

Health and Adult Services Directorate

Risk Register: **Month 0 (August 2019) – detailed**
Next Review Due: **February 2020**
Report Date: **10th September 2019 (pw)**

Phase 1 - Identification							
Risk Number	3/264	**Risk Title**	3/264 - Confident and consistent practice	**Risk Owner**	CD HAS	**Manager**	HAS AD C&S (Asmt.)
Description	Failure to establish the workstreams and processes needed to embed the confident and consistent practice programme across the county resulting in poor outcomes for individuals, missed opportunities to change and improve the service, inability to realise budgetary savings and criticism			**Risk Group**	Change Mgt	**Risk Type**	C&S 1/222

Phase 2 - Current Assessment											
Current Control Measures			Programme developed;								
Probability	H	**Objectives**	H	**Financial**	H	**Services**	H	**Reputation**	H	**Category**	1

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	1/360 - Robustly review and take learning from various practice areas	HAS AD C&S (Asmt.)	Sun-31-May-20	
Reduction	1/444 - Ensure consistent decision making to improve outcomes for people and ensure value for money – undertake diagnostic of decision making across the pathway.	HAS AD C&S (Asmt.)	Sun-31-May-20	
Reduction	1/446 - Implementation and review of new safeguarding operational guidance and practice	HAS AD C&S (Asmt.)	Sun-31-May-20	
Reduction	1/511 - Use technology better to reduce operational costs (travel to meetings etc.)	HAS AD C&S (Asmt.)	Sun-31-May-20	
Reduction	1/571 - Improve well-being of teams	HAS AD C&S (Asmt.)	Sun-31-May-20	
Reduction	1/572 - Promote culture of continuous improvement including managing risk safely, dynamic risk taking and strength based approaches	HAS AD C&S (Asmt.)	Sun-31-May-20	
Reduction	1/573 - Compare costs of commissioned packages of care to the costs of packages funded through direct payments	HAS AD C&S (Asmt.)	Sun-31-May-20	
Reduction	1/574 - Agree new targets for the uptake of direct payments.	HAS AD C&S (Asmt.)	Sun-31-May-20	
Reduction	1/575 - Re-develop a programme of training and learning for teams about the benefits and impacts of direct payments and support practice through sharing of case examples and local area guidance.	HAS AD C&S (Asmt.)	Sun-31-May-20	
Reduction	1/576 - Redevelop the NYCC offer of Individual Service Fund arrangements for people to be supported in managing a direct payment.	HAS AD C&S (Asmt.)	Sun-31-May-20	
Reduction	1/577 - Review the provision of Direct Payments for carers (Carers Grants) in partnership with the revised carers pathway and offer and in keeping with the Care Act and requirements around personal budgets	HAS AD C&S (Asmt.) HAS C&S Ho TP	Sun-31-May-20	
Reduction	1/578 - Review current and design new carers pathway, to include a focus on young carers	HAS C&S Ho TP	Sun-31-May-20	

Reduction	1/579 - Carers assessments (to look at either adopting Trusted Assessor mode or look at commissioning) to be strength based	HAS C&S Ho TP	Sun-31-May-20	
Reduction	1/580 - Living Well (as a carer) opportunities to be explored	HAS C&S Ho TP	Sun-31-May-20	
Reduction	1/581 - Agree targets for consistency county wide in order to strive for equity	HAS C&S Ho TP	Sun-31-May-20	
Reduction	1/582 - Embed the widened short breaks offer - as countywide and for wider user group	HAS C&S Ho TP	Sun-31-May-20	
Reduction	1/617 - Review of front door to improve demand management, addresses safeguarding and take a proactive approach to review activity	HAS AD C&S (Asmt.)	Sun-31-May-20	
Reduction	1/618 - Understand the pressure and ensure/improve resilience in place as CAS LT level	HAS AD C&S (Asmt.)	Sun-31-May-20	
Reduction	1/619 - Implement training around section 117 protocols	HAS AD C&S (Asmt.)	Sun-31-May-20	

Phase 4 - Post Risk Reduction Assessment

Probability	M	**Objectives**	M	**Financial**	H	**Services**	M	**Reputation**	M	**Category**	2

Phase 5 - Fallback Plan

		Action Manager
Fallback Plan	1/15 - Review performance and capacity including access to additional funding	HAS AD C&S (Asmt.)

Health and Adult Services Directorate

Risk Register: **Month 0 (August 2019) – detailed**
Next Review Due: **February 2020**
Report Date: **10th September 2019 (pw)**

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; Harrogate feasibility study by consultants for new care facility completed; action plan to address the care and support overspend developed;										
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. SBR now business as usual and being introduced to supported living	HAS AD C&S (Asmt.)	Sun-30-Jun-19	Sun-30-Jun-19
Reduction	1/545 - Develop an action plan to address the care and support overspend	CSD AD SR (AH) HAS AD C&S (Asmt.)	Thu-31-Jan-19	Thu-31-Jan-19
Reduction	1/615 - Implement Phase 1 SBA within Mental Health (from May 2019)	HAS AD C&S (Asmt.)	Tue-30-Jun-20	
Reduction	1/616 - Achieve earlier, clearer budget position with Team Managers responsible for budget management including forecasting	HAS AD C&S (Asmt.)	Tue-30-Jun-20	
Reduction	3/247 - Continue to revise and update a market position statement (revision published Jul 2019); this is now an online statement with different aspects being updated as and when required	HAS AD C&Q	Tue-30-Jun-20	
Reduction	3/379 - Budget review which models cost drivers, demand and complexity of cases and implement revised budgets across the Directorate (ongoing)	CSD AD SR (AH)	Tue-31-Mar-20	
Reduction	3/421 - Complete phase 2 of the strength based assessments working with complex people	HAS AD C&S (Asmt.)	Tue-30-Jun-20	
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 HI	Tue-31-Mar-20	
Reduction	3/460 - Ensure that we account for the BCF and IBCF funding as per the Regulations on a quarterly basis	CSD AD SR (AH)	Mon-31-Aug-20	
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; IBCF monies used for Recruitment Hub and Learning4Care) and regularly report to ISPB	HAS HoHR	Wed-30-Sep-20	

Reduction	3/551 - Carry out more focussed and timely budget monitoring for areas of concern	CSD AD SR (AH)	Sun-31-Mar-19	Thu-31-Jan-19
Reduction	3/561 - Continue to carry out feasibility study on development of new care facility to help alleviate care home affordability issue. (need to expand on potential work in this area and also develop business cases for new nursing home provision)	HAS AD C&Q	Tue-30-Jun-20	
Reduction	3/562 - Monitor proportion of care packages within affordable budget to ensure we remain within the parameters of the Cost of Care Agreement (ongoing)	HAS AD C&Q	Fri-31-Jul-20	
Reduction	3/566 - Implement the action plan to address the care and support overspend. Ongoing regular finance meetings	CSD AD SR (AH) HAS AD C&S (Asmt.)	Tue-31-Mar-20	
Reduction	3/567 - Complete full business case for new Dementia Care Village with Commercial team	HAS AD C&Q	Mon-30-Sep-19	
Reduction	3/568 - Monitor proportion of care packages within affordable budget to ensure we remain within the parameters of the Cost of Care Agreement (ongoing)	HAS AD C&Q	Fri-31-Jul-20	
Reduction	3/631 - Commissioning team (in their service improvement role) will be acting as an internal peer challenge around high cost spend and market ability to enable the development of a Locality service improvement plan	HAS AD C&Q	Tue-31-Mar-20	
Reduction	3/632 - Develop and implement OD Programme (in stages) for HAS Managers to encompass People, Pounds, Performance, Practice and Partnerships	HAS HoHR	Wed-31-Mar-21	
Reduction	47/523 - Engage consultants to carry out feasibility study on development of new care home to help alleviate care home affordability issue. (need to expand on potential work in this area and also develop business cases for new nursing home provision)	HAS AD C&Q	Sun-31-Mar-19	Thu-31-Jan-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 2019) – detailed**
Next Review Due: **February 2020**
Report Date: **10th September 2019 (pw)**

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; Learning4Care and Recruitment Hub to support the independent and voluntary sector in place (to be reviewed Mar 2020 - funding); monthly performance reports including service delivery reports, complaints and commendations and workforce metrics, and Q workforce reports to HASLT; Strength based approach in place; Living Well Service in place; management arrangements for Mental Health services in place; Phase 2 Dir Mgt restructure carried out; PIR of Care and Support restructure; new manager programme developed; New Manager Development Programme implemented, Manager Skills Audit undertaken to inform OD Programme;										
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 - Provision of training through Learning4Care to support the independent and voluntary sector with the ICG and providers	HAS HoHR	Tue-31-Mar-20	
Reduction	3/207 - Provision of Recruitment Hub to support the independent and voluntary sector with the ICG and providers	HAS HoHR	Tue-31-Mar-20	
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	Mon-31-Aug-20	
Reduction	3/231 - Continue to 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	Mon-31-Aug-20	
Reduction	3/340 - Provide HR and WD advice and support to Managers leading Transformation Projects (ongoing)	HAS HoHR	Mon-31-Aug-20	
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	Mon-31-Aug-20	
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	Mon-31-Aug-20	
Reduction	3/476 - Support staff to operate into integrated teams and arrangements (ongoing)	HAS AD C&S HAS HoHR	Mon-31-Aug-20	
Reduction	3/547 - Develop and implement OD Programme (in stages) for HAS Managers to encompass People, Pounds, Performance, Practice and Partnerships	HAS HoHR	Wed-31-Mar-21	

Reduction	3/548 - Continue delivery of New Manager Development Programme	HAS HoHR	Tue-31-Mar-20	
Reduction	3/549 - Implement wider Mental Health team structures	HAS AD C&S HAS HoHR	Fri-31-May-19	Fri-31-May-19
Reduction	3/1964 - Continue to engage with and contribute to all 2020 North Yorkshire workstreams (ongoing)	HAS LT	Mon-31-Aug-20	

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

Health and Adult Services Directorate

Risk Register: **Month 0 (August 2019) – detailed**
Next Review Due: **February 2020**
Report Date: **10th September 2019 (pw)**

Phase 1 - Identification								
Risk Number	3/180	**Risk Title**	3/180 - Partnership and Integration with Health	**Risk Owner**	CD HAS	**Manager**	HAS AD HI 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 reviewed and revised 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; Joint 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 developed with CCGs and agreed at Health and Wellbeing Board; 2020 Health Programme focussing on integration established; York and North Yorkshire SLE in place with a work programme of 10 priorities; joint commissioning boards for HRW and Scarborough in place (but in abeyance pending re-organisation of NY CCGs;									
Probability	H	**Objectives**	M	**Financial**	H	**Services**	M	**Reputation**	H	**Category**	1

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	Tue-30-Jun-20	
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	Tue-30-Jun-20	
Reduction	3/384 - Agree and implement Harrogate and Rural Alliance (Sept 2019) integration of community health and social care services and also further new models of care when emerging new Primary Care Networks are established.	CD HAS	Tue-31-Mar-20	
Reduction	3/385 - Engage wider HASLT in testing the implications of different integration models (ongoing)	HAS AD C&Q HAS AD HI	Tue-30-Jun-20	
Reduction	3/420 - Develop proposals to align to the emerging new Primary Care Networks which will be established.	HAS AD HI	Thu-30-Apr-20	
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. – HI overview with C&S delivery, continued progress on the social care element but still reliant on the NHS areas	HAS AD C&S HAS AD HI	Tue-30-Jun-20	
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 HI	Tue-30-Jun-20	
Reduction	3/460 - Ensure that we account for the BCF and IBCF funding as per the Regulations on a quarterly basis	CSD AD SR (AH)	Mon-31-Aug-20	
Reduction	3/467 - Actively work with Partners on a new way for the health system to work in North Yorkshire	HAS AD HI	Tue-31-Mar-20	

Reduction	3/563 - Manage relationships at Trust and CCG level as a result of leadership changes (ongoing)	CD HAS	Tue-31-Dec-19	
Reduction	3/564 - Carry out a post implementation review of HARA	HAS AD HI	Tue-30-Jun-20	
Reduction	3/565 - Continue to play an active role on the Continuing Healthcare Board (ongoing)	CSD AD SR (AH) HAS AD C&S (Prov.)	Mon-31-Aug-20	
Reduction	324/491 - Review arrangements relating to time limited additional social care funding.	CD HAS CD SR	Fri-31-Jan-20	

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

Health and Adult Services Directorate

Risk Register: **Month 0 (August 2019) – detailed**
Next Review Due: **February 2020**
Report Date: **10th September 2019 (pw)**

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; Recruitment Hub implemented, Learning4Care training delivery for independent sector providers; 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	3/247 - Continue to revise and update a market position statement (revision published Jul 2019); this is now an online statement with different aspects being updated as and when required	HAS AD C&Q	Tue-30-Jun-20	
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 (brokerage pilots in place)	HAS AD C&Q	Tue-30-Jun-20	
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	Tue-30-Jun-20	
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; IBCF monies used for Recruitment Hub and Learning4Care) and regularly report to ISPB	HAS HoHR	Wed-30-Sep-20	
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	Thu-30-Apr-20	
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, working through any remaining data sharing issues with Data Governance	HAS AD C&Q	Tue-30-Jun-20	
Reduction	47/221 - Continue to work with Veritau on audits of individual suppliers (ongoing) -	HAS C&Q Ho Q&M	Tue-30-Jun-20	
Reduction	47/434 - 2020 Market shaping/development project work through the action plan from state of market exercise incl. framework and work on micro enterprises	HAS AD C&Q	Mon-30-Sep-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	Tue-30-Jun-20
Reduction	47/533 - Begin the preparation for next Actual Cost of Care exercise and then develop revised commissioning model to help address affordability issues; started the process, Health & Social Care systems approach	HAS AD C&Q	Mon-30-Sep-19
Reduction	47/587 - Developing a quality pathway, revising processes and procedure and incorporating best practice adopting a risk based / predictive approach	HAS C&Q Ho Q&M	Thu-30-Apr-20
Reduction	47/600 - Rewriting policies with input from Veritau	HAS C&Q Ho Q&M	Tue-30-Jun-20
Reduction	47/601 - Ensure clarity around commissioning intentions using place based intelligence	HAS AD C&Q	Tue-30-Jun-20
Reduction	47/602 - Work with ICG to ensure provider BCPs are in place and evidence of testing can be provided	HAS AD C&Q	Tue-30-Jun-20
Reduction	47/603 - Consideration of market interventions, including development of a provider arm or a proposal to bring organisations together	HAS AD C&Q	Wed-30-Sep-20

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 2019) – detailed**
Next Review Due: **February 2020**
Report Date: **10th September 2019 (pw)**

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 and adequately prepare for the implementation of Liberty Protection Safeguards 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 of the process carried out; regular briefings to HASLT, staff and providers; continue to monitor and manage capacity and resource issues; project steering group										
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 (Prov.)	Tue-30-Jun-20	
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; ongoing	HAS AD C&S (Prov.)	Tue-30-Jun-20	
Reduction	1/525 - Continue to manage the Court of Protection applications demand using the same approach for DoLs (ADASS prioritisation tool) and work with partners and extra care providers to ensure cases aren't missed; will be changing as a result of LPS	HAS AD C&S (Prov.)	Tue-30-Jun-20	
Reduction	1/559 - Looking at process of reviews so that concerns can be picked up earlier	HAS AD C&S (Prov.)	Tue-30-Jun-20	
Reduction	1/594 - Ensure appropriate interim arrangements are put in place to cover the departure of existing service manager	HAS AD C&S (Prov.)	Tue-31-Dec-19	
Reduction	1/595 - Carry out options appraisal for revised approach required to meet new legislation	HAS AD C&S (Prov.)	Tue-31-Mar-20	
Reduction	3/255 - Prepare for implementation of Liberty Protection Safeguards	HAS AD C&S (Prov.)	Thu-30-Apr-20	
Reduction	3/320 - Form a project steering group with external partners to scope the outputs against the required changes in legislation	HAS AD C&S (Prov.)	Tue-30-Jun-20	

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. Options appraisal.	HAS AD C&S

Health and Adult Services Directorate

Risk Register: **Month 0 (August 2019) – detailed**
Next Review Due: **February 2020**
Report Date: **10th September 2019 (pw)**

Phase 1 - Identification							
Risk Number	3/27	**Risk Title**	3/27 - Safeguarding Arrangements	**Risk Owner**	CD HAS	**Manager**	HAS AD C&S HAS AD HI
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 service 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; recommendations from the commissioned independent review of safeguarding practice taken into consideration as part of the preparations for the implementation of the latest policy and procedures; local arrangements with Children's Safeguarding Board and Community Safety Partnerships reviewed; training for in house provider									
Probability	M	**Objectives**	H	**Financial**	H	**Services**	M	**Reputation**	H	**Category**	2

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
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 (Asmt.)	Tue-30-Jun-20	
Reduction	1/560 - Consider whether new procedures could be established to give a more proportionate response to notifications; roll out of new safeguarding system	HAS AD C&S (Prov.)	Thu-31-Oct-19	
Reduction	3/145 - Continue to ensure Partners are fully engaged with Safeguarding Boards centrally and locally, particularly new health partners (CCGs); inter board network in place with community safety and children's board	HAS AD C&S (Asmt.) HAS AD HI	Tue-30-Jun-20	
Reduction	3/187 - Continue to work with Commissioning and Quality 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; near miss system in place, considerable extra work done over the past 12 months	HAS AD C&S (Asmt.) HAS AD HI	Tue-30-Jun-20	
Reduction	3/217 - Ensure training in respect of latest policies and procedures for elected Members, staff and Partners is reviewed and delivered; member training reviewed over summer;	HAS AD C&S (Asmt.)	Tue-31-Mar-20	
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 HI	Tue-31-Mar-20	Sun-30-Jun-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 (Asmt.)	Tue-30-Jun-20	
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 HI	Tue-31-Mar-20	

Reduction	324/336 - Carry out the supervisory body role for DoLS to ensure the system is as effective as possible within existing resources and prepare for Liberty Protection Safeguarding Bill, details expected Oct 2019 and will become law by Apr 2020 (linked to action 324/343)	HAS AD HI	Thu-31-Oct-19
Reduction	324/343 - Continue with scoping work in preparation for implementing the Liberty Protection Safeguarding Bill (linked to action 324/336)	HAS AD C&S HAS AD HI	Thu-30-Apr-20
Reduction	324/546 - Implement the new safeguarding policies and procedures (internal SG board is leading to ensure operational guidance is in place)	HAS AD HI	Thu-31-Oct-19

Phase 4 - Post Risk Reduction Assessment

Probability	M	**Objectives**	H	**Financial**	H	**Services**	M	**Reputation**	H	**Category**	2

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

Health and Adult Services Directorate

Risk Register: **Month 0 (August 2019) – detailed**
Next Review Due: **February 2020**
Report Date: **10th September 2019 (pw)**

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 (DIGG group); regular security sweeps, asset owner training completed; regular updates on Inf Gov and data issues to HASLT and CASLT; 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 HI	Tue-30-Jun-20	
Reduction	3/148 - Continue to implement awareness raising campaign for information governance	HAS AD HI	Tue-30-Jun-20	
Reduction	3/227 - Continue to ensure and promote use of secure methods of data transfer	HAS AD HI	Tue-30-Jun-20	
Reduction	3/364 - Review disposal arrangements of documents following issue of refreshed corporate policy and guidance	HAS AD HI	Tue-30-Jun-20	
Reduction	3/365 - Ensure 'lessons learned' reports are reviewed following any breach	HAS AD HI	Tue-30-Jun-20	
Reduction	3/373 - Work closely with Data Governance on review and monitoring of local Info gov arrangements	HAS AD HI	Tue-30-Jun-20	
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 HI	Tue-31-Mar-20	
Reduction	3/431 - Review and revise current arrangements regarding statutory inspections to ensure compliance for example lifting equipment	CSD AD SR (AH)	Tue-31-Mar-20	
Reduction	3/543 - Develop and implement a work programme for the DIGG with monthly meeting covering eg. IAR, adherence to a single document retention policy, priorities around info sharing agreements; monthly meeting in place	HAS AD HI	Sun-30-Jun-19	Sun-30-Jun-19
Reduction	3/544 - Regular updates to leadership team / forum to look at Info Gov data trends; updates through the agreed Directorate governance framework with reports to HASLT	HAS AD HI	Sun-30-Jun-19	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)	Thu-30-Apr-20	

Reduction	3/552 - Develop an HAS governance framework to improve services	HAS AD HI	Tue-31-Mar-20
Reduction	6/124 - Progress data sharing issues with Health colleagues to ensure the benefits of this are realised; still issues around DToC hoping that LHCRE may help this	HAS AD HI	Tue-30-Jun-20
Reduction	324/397 - Roll out the unannounced office work area checks on a countywide basis	HAS AD HI	Tue-30-Jun-20

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)

Health and Adult Services Directorate

Risk Register: **Month 0 (August 2019) – detailed**
Next Review Due: **February 2020**
Report Date: **10th September 2019 (pw)**

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 and manage within the available funding 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; Health and Wellbeing Board; H & W Strategy; Link to relevant Em Planning/Health Protection structures in place; 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	M	**Objectives**	M	**Financial**	H	**Services**	M	**Reputation**	M	**Category**	2

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	3/233 - Ensure effective arrangements are in place for the Healthy Child Programme (ensure implementation of the agreed way forward in or before Apr 2020)	Dir Public Health	Tue-31-Mar-20	
Reduction	5/246 - Continue to ensure Public Health statutory functions are met	Dir Public Health	Tue-30-Jun-20	
Reduction	5/247 - Continue development of the Public Health Advisory Service for CCGs	Dir Public Health	Tue-30-Jun-20	
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	Tue-30-Jun-20	
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	Tue-30-Jun-20	
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	Tue-30-Jun-20	
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	Tue-30-Jun-20	
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. Further meeting planned and work to continue on the funding gap proposals	Dir Public Health	Tue-31-Dec-19	
Reduction	5/557 - Stop Smoking Service: Continue to support the in-house smoking cessation services and build the necessary relationships with Live Well Smoke Free and build the required governance and reporting arrangements	Dir Public Health	Tue-30-Jun-20	

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

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

Health and Adult Services Directorate

Risk Register: **Month 0 (August 2019) – detailed**
Next Review Due: **February 2020**
Report Date: **10th September 2019 (pw)**

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	Thu-31-Mar-22	
Reduction	3/378 - Develop bespoke programme for each Scheme	HAS AD C&Q	Thu-31-Mar-22	
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	Thu-31-Mar-22	
Reduction	3/426 - Carry out implementation reviews and consider lessons learned for future schemes	HAS AD C&Q	Thu-31-Mar-22	
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	Thu-31-Mar-22	
Reduction	47/81 - Look at innovative approaches for new models for schemes	HAS AD C&Q	Thu-31-Mar-22	
Reduction	47/82 - Ensure effective utilisation of an agreed consultation process for procurement in respect of EPHs (ongoing)	HAS AD C&Q	Thu-31-Mar-22	

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

Risk Register: **Month 0 (August 2019) – summary**
Next Review Due: **February 2020**
Report Date: **10th September 2019 (pw)**

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
- new -	**3/264 - Confident and consistent practice**	Failure to establish the workstreams and processes needed to embed the confident and consistent practice programme across the county resulting in poor outcomes for individuals, missed opportunities to change and improve the service, inability to realise budgetary savings and criticism	CD HAS	HAS AD C&S (Asmt.)	H	H	H	H	H	1	19	31/05/2020	M	M	H	M	M	2	Y	HAS AD C&S (Asmt.)
◀▶	**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	19	30/09/2019	M	H	H	M	M	2	Y	CSD AD SR (AH)
◀▶	**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	12	31/03/2020	M	M	M	H	L	2	Y	CD HAS
◀▶	**3/180 - Partnership and Integration with Health**	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 HI HAS AD C&S Dir Public Health HAS AD C&Q	H	M	H	M	H	1	13	31/12/2019	M	M	H	M	H	2	Y	CD HAS
◀▶	**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	15	30/09/2019	H	M	M	M	M	2	Y	HAS AD C&Q

Health and Adult Services Directorate

Risk Register: **Month 0 (August 2019) – summary**
Next Review Due: **February 2020**
Report Date: **10th September 2019 (pw)**

Identity			Person		Classification								Post						Fallback Plan	
					Pre						RR									
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
◀▶	**3/217 - 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 and adequately prepare for the implementation of Liberty Protection Safeguards resulting in financial and reputational issues including potential legal action	CD HAS	HAS AD C&S	M	H	H	H	H	**2**	8	31/12/2019	M	H	H	H	H	**2**	Y	HAS AD C&S
▲	**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 HI	M	H	H	M	H	**2**	11	31/10/2019	M	H	H	M	H	**2**	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**	14	31/03/2020	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 and manage within the available funding 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	M	M	H	M	M	**2**	9	31/12/2019	M	M	M	M	M	**4**	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	31/03/2020	L	L	L	L	L	**5**	Y	HAS AD C&Q

Health and Adult Services Directorate

Risk Register: **Month 0 (August 2019) – summary**
Next Review Due: **February 2020**
Report Date: **10th September 2019 (pw)**

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

25 OCTOBER 2019

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 2019 in respect of information technology (IT), corporate themes and contracts.

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 2019. 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 reviewed every year and updated by the Chief Executive and Management Board in September / October. A six monthly review is then carried out in March / May. The latest updated Corporate Risk Register was presented to the Committee in December 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 2019

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;
- contributing to the development and roll-out of the procurement strategic action plan, including participation in a number of delivery areas;
- reviewing processes and procedures in place within property services for managing the responsive repairs contract;
- carrying out a number of investigations into 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 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 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.**

3.6 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.

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 respect of information technology, corporate and contract arrangements is both adequate and effective.

Max Thomas
Head of Internal Audit

Veritau Ltd
County Hall
Northallerton

10 October 2019

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 2019

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
A	Concerto system audit	Reasonable Assurance	The Concerto system is the County Council's property management system. It is used to manage activities such as repairs and maintenance, servicing of equipment, and building projects. The purpose of the audit was to provide assurance that: • Data held within the Concerto system is only available to authorised individuals (Section 9 [Access Control] of ISO 27001). • the Concerto system is secure (Section 12 [Operations Security] of ISO 27001). • Use of the system complies with legal and contractual requirements (including information governance) (Section 18.1 of ISO 27001).	August 2019	The management of the Concerto system generally conforms to the requirements of the areas of the standards reviewed. All changes to the Concerto system are authorised, tested, logged and completed within a reasonable timescale. The audit also noted recent improvements in control in areas such as authorisation of access to the system for new users and regular review of user accounts. Work is underway to ensure that contracts with third parties who access the system on behalf of the council (e.g. works contractors) include provisions to ensure their use of the system is secure and in line with data protection requirements. However, a number of system weaknesses were identified. These included the following: • A lack of comprehensive audit logs for actions other than financial transactions, and no logging of activity for some users with a high level of access to the system.	**Two P2 & Eight P3 actions was agreed.** **Responsible Officer: Technology & Change Assistant Director** All user action will be logged. A review of all users access will be completed, with a focus on those with heightened and shared access first. Work will start in June following contractor changes. The password parameters for Concerto have now been updated to reflect the corporate policy. Current password reset options will be reviewed with a view to removing the less secure reset type if possible. The implications of this change will need to be discussed with Property Services. The contract with Concerto has been updated to include relevant data protection clauses. The Current G-cloud contract will be reviewed to assess whether NYCC requirements for backup are

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
					• A number of users within Property Services retain system administration privileges despite this role having transferred to Technology and Change. • A large number of shared user accounts exist (as opposed to unique usernames for everyone accessing the system), in contravention of corporate policy.	adequately reflected. A variation to the contract will be considered if current arrangements do not meet the requirements.
B	Information Security Management	Reasonable assurance	Information security is the practice of preventing unauthorised access, use, disclosure, disruption or destruction of information. The Council has a number of policies in place that define the desired behaviour of staff with respect to data, IT systems and other assets. The purpose of the audit was to provide assurance that: • The council's Information Security Policies meet ISO 20000 and 27001 standards and • The policies are being followed by Technology and Change staff.	April 2018	Overall we found that the Council has a range of concise information security policies in place. In most cases the policies match the working practices within Technology and Change. However, we identified some differences, as follows; • When external contractors are required to enter the data centre they are escorted at all times. However, no log of visitors is kept. • The Council carries out internal vulnerability scans of the network on a weekly basis. A large number of vulnerabilities including vulnerabilities classed as critical are detected. There is no evidence of any risk	**One P2 & Six P3 actions was agreed.** **Responsible Officer: Technology & Change Assistant Director** A log of all contractors entering the data centre has been implemented. A risk assessment for the critical vulnerabilities will be carried out. A server log will be implemented. An investigations procedure has been implemented but requires further work to align with HR processes. The IT Monitoring Policy will be updated to reflect changes in monitoring of internet usage.

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
					assessment for the critical vulnerabilities. • There has been no formal risk assessment carried out to decide why server logging is not activated. • The audit trail for investigations carried out by Technology & Change is not located in a central place. • Privileged user accounts are used to give administrator access to databases, systems and applications. Users with privileged user accounts are not monitored to ensure that the accounts are used appropriately.	Privileged user accounts are due to be reviewed during the next Information Security Meeting.
C	Software Development	Substantial Assurance	An in-house IT development team develops and maintains applications and services used across the Council, such as its website and intranet. The Council also purchases and uses 'off-the-shelf' and customised software solutions provided by third parties. Regardless of its source, information security is a critical part of any software solution.	June 2019	The internally developed Customer Portal and Individual Performance Management systems were reviewed as examples. Good arrangements are in place. There is an established process for identifying security requirements during software acquisition and development, with third party suppliers. For in-house systems, security requirements are included as part of the technical specifications provided to developers.	**One P2 & Six P3 actions was agreed.** **Responsible Officer: Technology & Change Assistant Director** A new Secure Software Development Policy will be created. A definition of security functionality requirements and relevant testing will be created and added into the development team's procedure library.

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			The purpose of the audit was to provide assurance that: • Access to systems is suitably controlled and restricted • Information security and continuity requirements are identified and incorporated during software development • Any software development or changes are done in a secure environment following an appropriate software development lifecycle • The development team receives sufficient assurance that software solutions provided by third parties have been appropriately and securely developed.		The arrangements for access to one of the Development team's primary development tools, were reviewed and found to be appropriate. The Development Team Manager is also preparing a system testing procedure.	Security testing will be added to the checklist. The results of security testing and any changes made as a result of testing will be recorded prior to the release of new software.

Appendix 2

CORPORATE THEMES - FINAL AUDIT REPORTS ISSUED IN THE YEAR TO 31 AUGUST 2019

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
A	Compliance with the Transparency Code	High Assurance	The Transparency Code requires local authorities to publish certain sets of data in specific timeframes. Audit work in 2017 concluded only 3 of the relevant sections of the Code had related information published correctly and in accordance with the required timelines. This audit examined the progress made to improve the collation and publication of the required data sets. This included testing to see whether: • the Council complies with all required sections of the Local Transparency Code • appropriate training has been provided to information asset owners and operational employees • individuals have been identified and allocated specific responsibilities	November 2018	The Council now has a strong framework in place and is complying with the Transparency Code regulations. All mandatory fields are now published correctly and within the required timescales. Relevant training is in place and is operating effectively. Training is provided as a combination of 1:2:1, group meetings and through e-learning. Relevant officers understand their responsibilities. There is also overarching oversight and guidance from the Data Governance Team. Checks are made at different stages to ensure all mandatory fields have been published on the Data North Yorkshire website and within the appropriate timescales.	**No actions identified**

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			• sufficient checks are now in place to ensure compliance with the Code.			
B	Payroll-HR	Substantial Assurance	Maternity, Paternity, Adoption and Maternity Support Leave and Pay policies are in place and apply to all Council employees. There are some differences in entitlement depending on the conditions of service that apply. Keep in Touch (KIT) payments may be paid to employees on maternity or adoption leave at the employees' hourly contractual rate for up to ten days or sessions. The purpose of this review was to provide assurance that: • Maternity, Paternity, Adoption, Maternity Support leave and pay were correctly calculated and paid only to employees who qualify; • KIT payments were calculated and paid correctly.	September 2018	A review of payments made for employees on paternity and adoption leave was undertaken. Except for one minor error the calculations were found to be correct. One employee had notified their manager that they were adopting. However, no Matching Certificate could be found on Lagan for this employee. Documentation for maternity cases was also not always available on the Wisdom system. A number of KIT claim forms and managers' records were missing from the Wisdom system.	**Four P3 actions were agreed.** **Responsible Officer: Assistant Chief Executive (Business Support), HR and OD.** Guidance in relation to the adoption leave process has been updated to prompt administrators to request the matching certificate from the line manager/employee and to escalate to their line manager should no response be received within one working week. Regular communications to managers regarding uploading of documents onto Wisdom will be placed on Team Brief. The Payroll team will do spot checks on these cases to ensure the required forms are present on Wisdom.

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
C	Risk Management (CYPS and HAS)	Substantial Assurance	The purpose of this audit was to provide assurance that: • There are appropriate tools in place to effectively manage risks at a service level; • Service level risk management is understood consistently throughout the Council; • Service risk registers are effective, complete, and up to date. The focus of the audit was on HAS and CYPS. The audit scope did not include the Council's corporate risk management arrangements.	November 2018	Responsibility is clearly defined within the Corporate Risk Management strategy. Generally the risk registers for both HAS and CYPS appear to be up to date, and include emerging risks. Significant improvements have been made recently to the risk management process within HAS. A directorate strategic risk management group has been created and the risk register has been reviewed and updated to ensure all risks are adequately addressed. There is no similar group within CYPS. It was evident that although there is an understanding of risk management across the directorate, there is little joint review or discussion of service risk registers.	**Two P3 actions were agreed.** **Responsible Officer: CYPS & HAS Assistant Directors.** A directorate risk management group to be recreated for CYPS with agreed terms of reference. An updated directorate risk register to be discussed twice a year at Leadership team.
D	Contractor Due Diligence	Limited Assurance	The Council has a significant number of contracts. Many of these contracts deliver key projects and services which the Council relies on to achieve its objectives. There may therefore be significant and detrimental financial and reputational risks if any of these key contracts fail. The purpose of this audit was to provide assurance that:	May 2019	There is currently no corporate approach to contractor due diligence across the Council. There is also no guidance that outlines the risk of supplier failure, and how to reduce and manage this risk effectively. Arrangements are not in place throughout the Council to review suppliers/contractors on a regular basis, to check financial resilience through the life of the contract.	**Three P2 actions were agreed.** **Responsible Officer: Head of Procurement and Contract Management.** The Council plans to develop and introduce: • The major suppliers/supplier monitoring dashboard.

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			• Arrangements were in place throughout the Council to review suppliers/contractors on a regular basis, to check financial resilience through the life of the contract; • Up to date and accurate information was being captured and used effectively by the Council; • All contract managers were being adequately informed in order to deliver effective due diligence.		The Council is aware of these weaknesses and plans are therefore in place to improve contractor due diligence arrangements. For instance a supplier dashboard is currently being designed, which will help to identify the highest risk (based on price and contract) suppliers and monitor them based on live information streams.	• Contract management e-learning (to include contractor due diligence). • A contract management toolkit (to include contractor due diligence) to provide practical help to officers involved in contract management. It is envisaged that these improvements will be completed by December 2019.
E	Information Security compliance audits	Various compliance visits: 2x High Assurance 3x Substantial Assurance 1x Reasonable Assurance	We completed unannounced information security compliance visits to the following offices: • Jesmond House, Harrogate • North Yorkshire House, Scarborough • Legal Services, County Hall Northallerton (two visits) • South Block, County Hall Northallerton • Manor Road, Knaresborough	Various	Following each visit, a detailed report was sent to the Senior Information Risk Owner (SIRO), as well as to relevant directorate managers. Data security practices and compliance with council policies was found to be poor in a number of instances.	**Four P2 and Six P3 actions were agreed.** **Responsible Officers: various** Responses have been obtained from relevant directorate managers following each audit. The findings have been taken seriously and management has taken immediate action where issues have been discovered. Follow up visits have been arranged where significant information risks have been identified.

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
		3x Limited Assurance	• Sandpiper House, Selby • North Block, County Hall, Northallerton • MAST, Northallerton			

Appendix 3

CONTRACTS - FINAL AUDIT REPORTS ISSUED IN THE YEAR TO 31 AUGUST 2019

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
A	Best Value Forms Compliance	Reasonable Assurance	Where quotations are not sought for low value purchases (below £25k), officers are required to complete Best Value Forms (BVF). The purpose of this audit was to provide assurance that: • The BVF submitted are being completed to the required standard • A consistent approach is followed across all directorates. The audit reviewed forms completed between October 2017 and March 2018.	September 2018	Improvements have been made to the quality and completion of the forms compared to the previous audit in 2017. However, incomplete or inaccurate BVF were still evident. Some forms had no budget manager approval, others were unsigned and some were incomplete. We also found differences in the number of forms being completed by each directorate. For example, the number of forms completed by BES and Central Services was higher than HAS. This disparity may warrant further investigation. The Best Value Form was originally introduced to deliver more simplicity and flexibility to the procurement procedure. It was unclear at this stage whether the envisaged benefits had been realised.	**Two P2 and One P3 actions were agreed.** **Responsible Officer: Head of Procurement & Contract Management.** The role of the Procurement Team in processing BVF to be discussed at the Procurement Board. Communication with regards to appropriate usage, purpose and benefits of the BVF and FPP to be issued to relevant officers. This communication will also be reiterated to managers in the 'Managers Mail'.

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

25 October 2019

BUSINESS CONTINUITY – UPDATE REPORT

1 Purpose of Report

1.1 To provide an overview of the current 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 The NYCC Resilience & Emergencies Team (RET) is tasked with ensuring that all NYCC directorates and service areas have robust arrangements in place to ensure they are able to deal with a variety of impacts capable of disrupting their provision of service to the communities of North Yorkshire.

The business continuity arrangements have evolved to ensure that directorates have plans in place to mitigate and manage any disruptive incidents such as a loss of staff, buildings or disruption to information technology or supply chains. This requirement has been magnified recently by the challenges of preparing for Brexit and the hosting of the 2019 UCI Road World Cycling Championships. This process continues to consider recent audit recommendations to ensure a consistent and corporate approach to BC planning across the organisation.

The NYCC Resilience and Emergencies Team continue to consider internal audit reviews and work with NYCC BC Champions via the Corporate Risk Management Group (CRMG) to maintain a dialogue with each service area, to focus on reducing bureaucracy, improving engagement and transparency and ensuring a consistent corporate process for business continuity across North Yorkshire County Council

2.2 The NYCC Business Continuity plans consist of two key documents for all service provision;

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 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 The NYCC corporate Business Continuity share-point site is the central portal for all relevant service-area and directorate documentation and is monitored and overseen by a Senior Resilience & Emergencies Officer from the Resilience and Emergencies Team, ensuring compliance and currency.

The share-point site is easily accessible and regularly updated providing service area practitioners and management, with up to date information, allowing informed business continuity decisions to be made. This also provides a framework for assurance during any disruption of service, information for the Corporate Risk Management Group and a mitigation pathway for loss of priority services.

3 Corporate Business Continuity Policy

3.1 Corporate Business Continuity (BC) and disruption to NYCC services continue to be addressed through an embedded assessment considering loss of staff, equipment, technology, buildings and key suppliers. These impacts are assessed through risk assessment and mitigation measures documented in service area BC plans.

3.2 Each directorate is required to work with their allocated RET officer to assess their BC planning and their most likely risks. RET continue to facilitate BC exercises with all directorates to raise awareness and train relevant staff. This ensures that staff are regularly provided with realistic and current scenarios and what to expect during any relevant incident.

3.3 Policy adherence is overseen by named RET officers, designated with the task of reviewing service area BC arrangements. A reporting regime is in place and every directorate now has a designated BC champion to oversee their business continuity arrangements, to take ownership of the process and to represent their directorate at the Corporate Risk Management Group (CRMG).

3.4 The Corporate Director (Strategic Resources) continues to have overall responsibility for Business Continuity within NYCC, with the function co-ordinated and facilitated by the designated officers from the Resilience and Emergencies Team. The Corporate Risk Management Group oversee the BC process. The executive portfolio for resilience, emergency planning and business continuity continues to sit with Leader of the Council, Cllr. Carl Les.

3.5 The CRMG have strategic oversight for business continuity and BC Champions work closely with relevant directors to ensure satisfaction with information and process to provide annual statements of assurance. Directorates report a BC RAG (Red, Amber, Green) status update to the CRMG every quarter.

4 Corporate Business Continuity Plan

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

The Business Continuity Management System will be updated in 2020 in line with the current corporate Business Continuity Plan and will adhere with the latest Business Continuity Institute (BCI) good practice guidelines.

In the past 12 months two members of the NYCC Resilience and Emergencies Team have successfully passed their professional BCI examinations to enhance their understanding and application of business continuity within NYCC.

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 senior management across the organisation enabling them to identify priorities in the restoration of priority services.

4.2 North Yorkshire County Council has continued to evolve the embedded BC arrangements to meet recent challenges. NYCC has had to step up when dealing with the flash flooding of August 2019 in the Yorkshire Dales, organising and delivering the UCI 2019 Road World Cycling Championships in severe weather, delivery of the Tour of Yorkshire 2019 and in working around the planned loss of the Brierley building. NYCC continue to meet the numerous challenges and impacts of dealing with Brexit planning, recent cyber-attacks, loss of technology, utility failure and community impacts. The solid foundation for dealing with all of these incidents and many others has been our business continuity planning.

4.3 In the last 12 months**,** NYCC RET have continued to ensure that NYCC take every opportunity offered in ensuring on-going learning and development for BC. NYCC have worked collaboratively with a wide spectrum of multi-agency partners and have hosted and facilitated BC focused workshops and exercises together with Local Resilience Forum (LRF) partners, government departments and internal directorates. The training and exercises have focused on Cyber impacts, social care, health outbreaks, our capacity to work from home and the expected impacts of Brexit. RET ensure that any organisational learning from incidents is captured by a robust de-brief process and recommendations embedded in future practice.

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 continue to be part of an auditable annual work-plan.

4.5 It is acknowledged that Business continuity is a key part of overall Resilience and that BC planning continues to be an evolving process. RET and directorate BC Champions are committed to continuing this process.

4.6 RET continue to work closely with Veritau to ensure audit validation and assurance on the progress made with BC against evolving challenges and a changing landscape. This progress has been acknowledged in the latest Veritau audit report (December 2018) indicating **Reasonable Assurance** for business continuity arrangements within NYCC.

5 Recommendations

5.1 Audit Committee to note the recent challenging incidents that have been managed by the NYCC Directorates, overseen by the Business Continuity Champions and fully supported by the Resilience & Emergencies Team and the continued efforts of all service areas at North Yorkshire County Council to embed resilient practice.

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

NORTH YORKSHIRE COUNTY COUNCIL

AUDIT COMMITTEE

25 October 2019

Fees and Charges Strategy

Report of the Corporate Director – Strategic Resources

1.0 PURPOSE OF THE REPORT

1.1 To seek approval for the proposed Fees & Charges strategy that has been developed for North Yorkshire County Council.

2.0 BACKGROUND

2.1 Fees and Charges income for the County Council totalled £59.8m in 2018/19. Within the Council's Constitution, directors are responsible for establishing and reviewing Fees and Charges within their directorate. With the ever increasing budget pressures facing the public sector it is important for NYCC to increase resilience and independence wherever possible and one of main areas this can be explored is through Fees and Charges. To ensure a consistent approach to Fees and Charges across the Council's Directorates, and to ensure this area is regularly reviewed and updated, the proposed strategy has been developed.

2.2 Ensuring that a robust charging strategy is in place for the council will help to ensure that a more equitable approach to service provision is in place, thereby ensuring that the costs of provision for a service are increasingly charged to the users of said service. With the increasing budgetary pressures indicated above, adopting such an approach will help ensure that services the council provides on a discretionary basis have as minimal impact on the Council Tax requirement as is possible.

3.0 FEES AND CHARGES STRATEGY

3.1 A Strategy document to inform a Council-wide approach to Fees and Charges is something that is in place in a number of other Local Authorities. These existing strategies have been used to inform the development of North Yorkshire's Fees & Charges Strategy.

3.2 The main body of the Strategy (see Appendix A) contains the background to the document and why a guiding strategy is deemed relevant. A major benefit envisioned through the adoption of this strategy is to allow for a more uniform approach to this area across the Councils Directorates, as research into this area has identified certain inconsistencies.

3.3 In summary the strategy will provide a framework which will:

- Maximise consistency across Directorates;
- Ensure Fees and Charges are robust and up to date;
- Ensure that Fees and Charges are clearly understood;
- Maximise Council income.

3.4 Wherever possible and appropriate the default charging policy will be full cost recovery although the strategy recognises the will be instances where the Council wishes to adopt an alternative approach, for example potentially subsidising service delivery. Where this is the case it is intended that this be as a result of a clearly documented rationale.

3.5 If approved, responsibility for implementing this strategy will lie with the various Council Directorates. Complementary documentation to assist this process has been developed, including a list of all existing Fees and Charges in operation across the council, and an optional calculator for frontline staff to utilise when reviewing and setting charges. This supporting documentation will be provided to Council Directorates to help implement the strategy if approved.

3.6 The impact of the strategy will be reviewed annually to ensure the objectives are being met. Any amendments that may be identified as required will be passed to the Corporate Director – Strategic Resources for review.

4.0 RECOMMENDATION

4.1 Members are asked to comment on the Fees and Charges strategy for North Yorkshire County Council.

GARY FIELDING
Corporate Director – Strategic Resources
25 October 2019

Appendix A – Fees and Charges Strategy 2019

North Yorkshire County Council

Fees & Charges Strategy - 2019

1. Introduction and Context

The principle aims of a Fees and Charges Strategy are to support future Budget / Medium Term Financial Planning Processes and to provide a framework for the Council's approach to charging for services. The Strategy is to be reviewed annually and any required amendments will be passed to the Corporate Director – Strategic Resources for final review and the Strategic Resources Management Team for approval.

1.1. What is the Strategy about?

1.1.1 Within the Council's Constitution, Directors are responsible for establishing and reviewing fees and charges within their Directorate. Fees and charges should be reviewed annually unless one of the four conditions apply;

- they are regulated by an existing contract, or set by Government legislation or regulations; or
- there is a specific agreement between the Council and relevant third parties setting a different frequency; or
- a different frequency is agreed by the Corporate Director-Strategic Resources; or
- there is a particular need to review them in advance of the next annual review.

1.2. Why is a Fees and Charges strategy necessary?

1.2.1 An effective Fees and Charges strategy will help to raise income & lower the burden to Council Tax payers of providing various council services, instead ensuring that it is the users of these services who are making the appropriate contribution towards the costs of these services

1.2.2 It is also important to ensure that the fee charged for a council service are reflective of the council's costs of provision, to ensure that services are not being inadvertently subsidised without a positive decision to this effect.

1.2.3 From 2019/2020 service income budgets will rise in line with inflation. As budgeted income targets are set to increase it is important fees and charges are regularly reviewed and updated to help in meeting this increased level of budgeted income.

1.2.4 With this in mind, this strategy has been developed, to provide Service Managers with a centralised framework to consider when reviewing their fees and charges. A centralised framework will also help to ensure a consistent approach and policy across NYCC.

1.3. What is in and out of scope?

1.3.1 This Strategy applies to:

- Non-Discretionary (Statutory) Services that a Local Authority is mandated, or has a duty to provide, where the maximum permissible fee is prescribed in legislation.
- Discretionary Services: Services that an authority has the power, but is not obliged, to provide. These charges are limited to cost recovery which includes a fair share of overheads.

1.3.2 This Strategy does not apply to:

- NYCC Traded Services, traded through North Yorkshire Education Services (NYES)
- NYCC wholly controlled companies

1.3.3 The entities covered in paragraph 1.3.2. have separate charging strategies in line with their governance arrangements.

2 Objectives of the Strategy.

2.1 With the ever increasing budget pressures facing the public sector it is important for NYCC to increase resilience and independence wherever possible and one of the main areas this can be explored is through fees and charges.

2.2 Whilst it is acknowledged that a full review of each charge implemented by the Council will not be required each financial year, it is considered that as a minimum the Fees and Charges already charged by the Council are to be adjusted in line with inflation each year. This will ensure that any inflationary change to the costs of providing a service will be matched by a corresponding change to the charge made for said service.

2.3 In line with the Council's savings requirements and commercial stance, it is vital to regularly review the continuing provision of those discretionary services where the council is unable, or unwilling, to recover the full costs of service. It is also important to ensure that where there is an opportunity to introduce new fees and charges, this opportunity is investigated fully to understand the implications of doing so.

2.4 The Fees and Charges strategy therefore has the following objectives:

2.4.1 Maximising consistency across Directorates:

- To move towards a more consistent “council wide” approach to fees and charges, the implementation strategy below has been developed. Furthermore, to this end a list of Fees and Charges currently in place for each directorate has been compiled, which requires standard information to be input for each fee or charge. This new approach is to be adopted from 25/10/2019.

2.4.2 Ensuring Fees and Charges are robust and up to date:

- All Fees and Charges to be reviewed on an annual basis, using the Implementation strategy below to inform this review. Any departure from the agreed strategy should be clearly documented and clearly explained, the standard list of Fees and Charges will allow Directors and Service Managers to record when a charge was last reviewed and what was considered. This new approach is to be adopted from 25/10/2019, whereupon each Directorate will establish a prudent time to review each Fee and Charge it has in operation. To assist with this process, an optional fees and charges calculation tool has been developed.

2.4.3 Ensuring that Fees and Charges are clearly understood:

- As part of the annual review of Fees and Charges, the cost of providing each service, & any legislation pertaining to this service is to be considered as part of this review. The optional Fees and Charges calculation tool will allow Directors and Service managers to calculate the cost of providing a service, and record any relevant legislation and store this information for future reference.

2.4.4 Maximising Council income:

- When reviewing existing fees and charges, or when considering the implementation of a new charge, the charge should be set at such a level as to maximise the income received by the Council. Please see section 3.1.2 for further guidance on the approach to use when determining a Fee and Charge.

3 **Implementation – How do we plan to get there?**

3.1 Unless an alternative approach is agreed by the Corporate Director - Strategic Resources, the following approach to Fees and Charges should be adopted:

3.1.1 Regularity of Review:

- All Fees and Charges are be reviewed annually unless a compelling reason not to do so exists, e.g. a decision has been made to subsidise a service for four years in support of another council priority. Should an annual review of a fee or charge not take place, then as a minimum any such charges should be reviewed every three years.
- Unless limited by Statute, as a minimum this review should consist of uplifting each fee and charge by inflation, to match the corresponding increase in providing each service.
- As part of the annual review, any opportunities to introduce new Fees and Charges should be investigated to ensure that the council is not failing to recover any costs.

- NYCC's Commercial agenda requires all staff to become more "cost-savvy" to ensure we can save money which can be used to protect front-line services. Ensuring all fees & charges are reviewed regularly, & exploring any viable opportunities to trade commercially will ensure this agenda can be achieved

3.1.2 Costing approach:

- Fees and Charges should be aimed towards full-cost recovery, including an appropriate share of corporate & departmental overheads.
- If a Fee or Charge is determined by statute, then the statutory charge will apply.
- If the Council is unable, or unwilling, to recover the full costs of providing a discretionary service, then as part of the annual review the continued provision of this service should be considered along with the rationale of the charging policy adopted.
- When finalising the costs of each Fee and Charge, consideration should be given to any wider implications of setting the charge at the proposed rate, to avoid any unintended consequences.

3.1.3 Utilising benchmarking:

- Fees and Charges should be benchmarked against other local authorities to help identify potential best practice. When appropriate to the Fee and Charge in question, benchmarking against other relevant competitors should also be undertaken.

3.1.4 Understanding legislation.

- When setting/reviewing a charge, all relevant legislation should be identified and its impact on the charge documented for future reference.

3.2 An optional Fees and Charges calculation tool has been developed to help guide the implementation of the Fees and Charges strategy, as has a list of all current Fees and Charges in place across each Directorate. Each Directorate is responsible for ensuring that their Fees and Charges are appropriately monitored and up to date. Each Directorate's list of Fees and Charges is to be overseen by the Directorate's lead business partner.

3.3 Once the review of existing fees and charges has been completed, or any proposal for a new fee and charge has been developed, then these will still need to pass through each Directorate's agreed approval process before implementation.

3.4 It is envisioned that there will be a regular review of each list of Fees and Charges being maintained by the Directorates, to ensure that the strategy is being followed, that the objectives of the Strategy are being met, and to allow feedback on the strategy and its implementation.

4 **Appendix**

4.1 Policy Documents:

4.1.1 NYCC MTFS: https://www.northyorks.gov.uk/our-key-strategies-plans-and-policies

4.1.2 NYCC Constitution: https://www.northyorks.gov.uk/council-constitution

4.1.3 NYCC Council Plan: https://www.northyorks.gov.uk/council-plan

AUDIT COMMITTEE - PROGRAMME OF WORK 2019 / 20

	ANNUAL WORKPLAN Audit Committee Agenda Items	JULY 19	OCT 19	DEC 19	MAR 20	JUNE 20	JULY 20	OCT 20
A	Training for Members (as necessary)		1					
	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 (ISA 260)	×					×	
	Interim Audit Report					×		
C	Statement of Final Accounts including AGS (NYCC + NYPF)	x				×	x	
	Letter of Representation	x					x	
	Chairman's Annual Report		×					×
	Audit Committee - terms of reference / effectiveness			×				
	Changes in Accounting Policies				×			
	Corporate Governance – review of Local Code + AGS				×	×		
	– annual report inc re AGS					×		
	Risk Management (inc Corporate R/R) – annual report			×	×			
	Partnership Governance – annual report					×		
	Information Governance – annual report				×			
	Review of Finance,/Contract/Property Procedure Rules	**TBA**	**TBA**	**TBA**		**TBA**	**TBA**	**TBA**
	Business Continuity – annual report		×					×
	Counter Fraud (inc risk assessment) – annual report				×			
	Procurement and Contract Management – annual report					×		
	Treasury Management – Executive February				×			
	VFM – annual assurance 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	22/07	25/10	20/12	27/03			

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

☼ **before formal meeting**
1 External and Internal Audit
2
3
Sessions to be sorted
Pension Governance
Beyond 2020 including Property rationalisation