Agenda

Notice of a public meeting of **Audit Committee**

To: **Councillors Cliff Lunn (Chairman), Alyson Baker, Philip Broadbank, Mark Crane, George Jabbour (Vice-Chair), Nigel Knapton, Stuart Parsons, Karin Sedgwick, Neil Swannick and Matt Walker, and Independent Co-opted Members (non-voting) Mr David Marsh and Mr David Portlock**

Date: **Monday, 12th December, 2022**

Time: **1.30 pm**

Venue: **Council Chamber, County Hall, Northallerton**

Business

1. Apologies for Absence

2. Minutes of the Committee Meeting held on 28 November 2022 **(Pages 3 - 8)**

3. 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 Wednesday 7 December 2022. 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 anyone who may be taking a recording to cease while you speak.

5(a)	**Health and Adult Services Directorate - Internal Audit Work** Report of the Head of Internal Audit	**(Pages 9 - 18)**
5(b)	**Health and Adult Services Directorate - Internal Control Matters** Report of the Corporate Director – Health and Adult Services	**(Pages 19 - 54)**
6.	**Counter Fraud Policy Framework** Report of the Head of Internal Audit	**(Pages 55 - 120)**
7.	**Risk Management - Progress Report** Report of the Corporate Director – Strategic Resources	**Pages 121 - 146)**
8.	**Internal Audit Report on Information Technology, Corporate Themes and Contracts** Report of the Head of Internal Audit	**(Pages 147 - 156)**
9.	**Procurement and Contract Management Update** Report of the Corporate Director – Strategic Resources	**Pages 157 - 164)**
10.	**Commercial Governance Review** Report of the Corporate Director – Strategic Resources	**Pages 165 - 170)**
11.	**Programme of Work 2022/23**	**Pages 171 - 172)**
12.	**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

Friday, 2 December 2022

North Yorkshire County Council

Audit Committee

Minutes of the meeting held on Monday, 28th November, 2022 commencing at 1.30 pm at County Hall, Northallerton.

Committee Members present: County Councillor Cliff Lunn in the Chair; plus County Councillors Alyson Baker, George Jabbour, Mike Jordan (as Substitute for Mark Crane), Nigel Knapton, Karin Sedgwick, Neil Swannick and Matt Walker, and Mr David Portlock

Officers present: Gary Fielding, John Raine, Fiona Sowerby and Ruth Gladstone

Other Attendees: Nicola Wright (Deloitte) and Nick Rayner (Deloitte)

Apologies: County Councillor Philip Broadbank and Stuart Parsons and Mr David Marsh

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Copies of all documents considered are in the Minute Book

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26 Minutes of the Committee meeting held on 24 October 2022

Resolved –

That the Minutes of the meeting held on 24 October 2022, having been printed and circulated, be taken as read and be confirmed and signed by the Chairman as a correct record.

27 Declarations of Interest

There were no declarations of interest.

28 Public Questions or Statements

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

29 Progress on Issues Raised by the Committee

Considered: The joint report of the Corporate Director – Strategic Resources and the Assistant Chief Executive (Legal and Democratic Services) which advised of progress made on issues the Committee had raised at previous meetings, and other matters that had arisen since the Committee's last meeting which related to the work of the Committee.

Gary Fielding (Corporate Director – Strategic Resources), in introducing the report, advised that CIPFA had produced, during summer 2022, guidance regarding local authority commercial activities. County Council officers had undertaken work to review that guidance and the outcome was due to be reported to the Shareholder Committee. Gary Fielding advised that he would forward a copy of the report for the Shareholder Committee to all Audit Committee Members.

Members enquired about the effect on Council budgets of increased inflation rates. Gary Fielding advised that 1% inflation represented about £2.7m. He undertook to provide a fuller response following the meeting.

Resolved –

That the report be noted.

30 2021/22 External Audit of the North Yorkshire Pension Fund

Considered: The draft report issued by Deloitte on 17 November 2022 concerning the 2021/22 audit of North Yorkshire Pension Fund.

Nicola Wright (Audit Partner, Deloitte) introduced the draft report, highlighting that the Deloitte audit was responsibly well progressed. She provided an update on the matters that still had to be completed, and advised of the findings to date. Nicola Wright highlighted that, subject to the satisfactory receipt and the completion of the outstanding items, Deloitte expected to issue an unmodified audit opinion on the Pension Fund included within the financial statements of North Yorkshire County Council.

In response to Members' questions, Nicola Wright confirmed the following:-

- most of the matters identified as not complete on page 4 of the Deloitte draft report, issued on 17 November 2022, had now been completed;
- she anticipated that the audit of North Yorkshire Pension Fund would be signed off before Christmas; and
- additional fees were being discussed for the audit of the Pension Fund with Public Sector Audit Appointments (PSAA) because this was the only way, under the current scale fees regime, that Deloitte was able to recover a fee which recognised the significant size of North Yorkshire Pension Fund and the audit work required. Discussions with PSAA had not yet concluded.

Nicola Wright undertook to share, with Gary Fielding, the list of outstanding journal entries relating to the Pension Fund.

Resolved –

That the draft report be noted.

31 2021/22 External Audit of North Yorkshire County Council

Considered: The progress report issued by Deloitte on 17 November 2022 concerning the 2021/22 audit of North Yorkshire County Council.

Nicola Wright (Audit Partner, Deloitte) reported that the Statutory Instrument relating to Infrastructure Assets, discussed at the Committee's previous meeting, was scheduled to be published on 30 November 2022 and be effective from 25 December 2022. In addition, CIPFA planned to issue guidance which would amend the Code, and a bulletin in relation to the disclosure requirements in North Yorkshire County Council's Accounts. Deloitte had asked to see the guidance prior to publication, but had not yet seen it. Gary Fielding advised that he too had not yet seen the CIPFA guidance and commented that that guidance might not give 'ultra-clear' advice. Nicola Wright advised that, due to the situation regarding the Statutory Instrument, the Accounts of North Yorkshire County Council were unlikely to be signed-off until January 2023 and that many local authorities were in a similar same position.

Members asked to be kept updated on the situation relating to the Statutory Instrument. They also asked for a copy of the CIPFA guidance, once published, to be forwarded to them.

Nicola Wright expressed her thanks to the County Council's Finance Team for all the work they had undertaken as part of the audit of the 2021/22 accounts, in particular recognising the work that the Team had simultaneously had to do in relation to local government reorganisation in North Yorkshire.

Nick Rayner (Deloitte) introduced the progress report issued by Deloitte on 17 November 2022 concerning the 2021/22 audit of North Yorkshire County Council.

Members discussed the misstatement within the accounts relating to care home prepayments. (This comprised a debit of £5.6m on the income statement, and a credit of £5.6m in net assets.) Members expressed support for the decision made by the Council's management to not correct this misstatement because a sizeable piece of work would be required and this would be out of proportion to the risk involved. Members recognised that a similar misstatement would be disclosed in the Council's accounts in future years. Members accepted that the misstatement would not have a meaningful effect on the Council's Accounts.

In response to questions from Mr Portlock, Nick Rayner confirmed that the management accounting papers had generally been accurate and produced to a high quality. However, there had been a consolidation error as part of the accounting papers. This had now been corrected.

In response to questions from Mr Portlock regarding the timescale for the PSAA to agree the additional fee to be charged by Deloitte for Covid-19 work, Nicola Wright advised that she hoped the fee for 2020/21 would be resolved soon, and that discussions about the fee for 2021/22 had not yet commenced. She considered the 2020/21 additional fee would be in the region of £16k and suggested that, bearing in mind the size of the organisation, that amount was not unreasonable.

Resolved –

That the progress report be noted.

32 Report Following the Detailed Review of the draft Statement of Final Accounts for 2021/22

Considered: The report of the Members' Working Group concerning issues identified during the detailed review of the draft Statement of Final Accounts (SOFA) and the Annual Governance Statement (AGS) for 2021/22, actions taken as a result of issues being identified, and offering an opinion on the draft SOFA and draft AGS for 2021/22.

Mr David Portlock (Chair of the Members' Working Group) introduced the report and highlighted that, at the time when the Members' Working Group had come to the conclusions set out at section 4 of the report, they had not seen the updated reports from Deloitte. He advised that it had been his intention, as Chair of the Members' Working Group, to recommend to today's meeting that the Audit Committee approve the SOFA and AGS which appeared as the next item of business on the agenda for today's meeting. He advised that he had heard nothing at today's meeting which suggested that that should not be the Members' Working Group's recommendation. However, he was now not sure whether the Members' Working Group was in a position to make a recommendation given the comments from the External Auditors, unless advised otherwise, and highlighted that the Committee was due to meet again on 12 December 2022. Mr David Portlock advised that the Members' Working Group was happy to move forward but they were waiting for

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Deloitte to finish their work. He was, however, happy to say to Members that the Committee should delegate authority to the Chair and section 151 Officer to sign the various documents in due course. Gary Fielding commented that work on the accounts was unlikely to be any further forward at the time of the Committee's meeting on 12 December 2022 and therefore it would be useful for authority to be delegated at today's meeting.

Resolved –

That the report of the Members' Working Group, together with the additional information and advice provided by Mr David Portlock as recorded in the preamble to this minute, be noted.

33 Statement of Final Accounts for 2021/22 including Letter of Representation

Considered: The report of the Corporate Director – Strategic Resources concerning the 2021/22 Letter of Representation, Statement of Final Accounts, and Annual Governance Statement.

John Raine (Head of Finance Technical), in introducing the report, advised that he had no further information to add.

Mr David Portlock referred to the Annual Governance Statement and highlighted that section 7 had some formatting issues. In addition, the date of 28 November 2022 appeared several times within the Statement. Gary Fielding (Corporate Director – Strategic Resources) undertook to ensure that the appropriate corrections were made.

In response to a question from Mr David Portlock, Gary Fielding advised that he would be very happy to sign the Letter of Representation in due course. Gary Fielding highlighted that, until the accounts were signed and finished, the Council needed to be alive to new issues and needed to regard it as a 'living, breathing' document. As such, something might still happen which could have an impact on the balance sheet at that particular time. He was mindful of this and the potential impacts on the Annual Governance Statement and the Letter of Representation. He advised that, at the point when the Chair and he were content to exercise their delegated authority, they would communicate that to Audit Committee Members. Similarly, if there were any changes, such changes would be communicated to Audit Committee Members. A Member asked for this to be recorded in the Minutes of the meeting.

Resolved –

(a) That authority be delegated to the Chairman and Section 151 Officer to sign the Letter of Representation set out in Appendix A to the report on behalf of the Audit Committee.

(b) That, in relation to the Statement of Final Accounts 2021/22:-

  (i) the changes to the Final SOFA, as set out in paragraph 4 of, and Appendix B to, the report be noted;
  (ii) subject to the satisfactory completion of Deloitte's audit work, the Final SOFA for 2021/22 be approved and authority delegated to the Chairman and Section 151 Officer to sign the Accounts on behalf of the Committee;
  (iii) authority be delegated to the Chairman and Section 151 Officer to sign the Statement of Responsibilities for the Statement of Accounts, as attached at Appendix C to the report.

(c) That the Annual Governance Statement 2021/22 be approved and authority be delegated to the Chairman and Section 151 Officer to sign the Annual Governance Statement on behalf of the Committee.

34 Commercial Governance Review

The Chairman advised that this item of business had been withdrawn from the agenda for this meeting. *(See also the preamble at Minute 29.)*

The meeting concluded at 2.25 pm.

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NORTH YORKSHIRE COUNTY COUNCIL

AUDIT COMMITTEE

12 DECEMBER 2022

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 October 2022 for the Health and Adult Services (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 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 second part is presented by the Corporate Director 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 OCTOBER 2022

3.1 Internal audit work is planned and delivered on the basis of risk. Veritau has met regularly with HAS management to maintain an ongoing awareness and understanding of key risk areas and to prioritise internal audit work. Areas considered have included the cost of care reforms, discharges from care, changes to the CQC assurance framework, and the Emergency Duty team. Attendance at meetings of the fortnightly Supply Chain Resilience Board has also provided assurance on how key risks and financial challenges relevant to the directorate are being managed.

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

3.3 Veritau has also been involved in a number of other areas of work in respect of the directorate. This work has included:

- investigating cases that have been communicated via the Whistleblowers' hotline or have arisen from issues and concerns referred to Veritau by HAS management.

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- investigating data matches received from the National Fraud Initiative (NFI). These matches can indicate possible fraud or error.
- providing support to directorate management in respect of a number of safeguarding alerts, issues with providers and other matters.

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 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. The work completed for the directorate and the opinions given following each audit contribute to the annual report and opinion of the Head of Internal Audit.

3.5 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.

4.0 **RECOMMENDATION**

4.1 That Members note the results of internal audit work performed in the period for the Health and Adult Services directorate.

MAX THOMAS
Head of Internal Audit

Veritau Ltd
County Hall
Northallerton

25 November 2022

BACKGROUND DOCUMENTS

Relevant audit reports kept by Veritau.

Report prepared by Stuart Cutts, Assistant Director – Audit Assurance, Veritau and presented by Max Thomas, Head of Internal Audit, Veritau

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APPENDIX 1

FINAL AUDIT REPORTS ISSUED IN THE YEAR ENDED 31 OCTOBER 2022

	System/ Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
A	Deferred Payments	Reasonable Assurance	The Care Act 2014 includes provisions to allow people who own their own home and who move into a care home on a long-term basis, to use the value of the property to help pay for fees through a Deferred Payment Agreement (DPA). The local authority pays for any assessed care costs on the individual's behalf, and this is paid back either once the individual sells their home or after their death. The audit reviewed whether: • A robust process was in place to manage DPA applications. • DPA recording and monitoring processes were efficient, effective and followed legislation.	March 2022	The majority of cases reviewed had a fully complete and signed application on file. In some of the complex cases, there were however areas for improvement. Some issues were found with obtaining evidence of insurance and property maintenance during annual reviews. There were also some instances where the council had failed to consider alternative forms of security for a DPA where a charge could not be placed on the land or property. DPA information was being recorded on two spreadsheets and the financial system ContrOCC creating duplication of work. The existing system requires improvement to enable all information to be recorded in one place.	**2 P2 and 3 P3 actions were agreed.** **Responsible Officer(s):** Assistant Director, Strategic Services (HAS) Officers agreed a number of actions to help address the areas in the report, including: • To review relevant old cases • To adopt tighter deadlines and clarity of consequences for insurance and maintenance evidence • The addition of a note on the checklist to ensure Power of Attorneys (POAs) cover finance and property

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	System/ Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
						• To work with Legal Services to explore alternate forms of security • To combine spreadsheets to reduce input work. All actions have been completed.
B	Visits to Care Providers – Isabella Court, Pickering	No opinion	The Council has a number of contractual arrangements with providers to support adults with learning and physical disabilities. The purpose of this audit was to provide assurance that the contracted supplier had been providing the required care and support as set out within the contracts and support plans that had been agreed. The audit supported wider value for money work being undertaken by NYCC brokerage.	March 2022	The period under review was one where the Covid 19 pandemic was creating sector wide problems for providers. We analysed a sample of paper-based staff rotas covering a total of 14 weeks during 2021. We found that the contracted supplier was regularly not providing the contracted staffing levels. The lowest staffing levels usually being at the weekends. The provider was also unable to provide sufficient information to show that the contracted 1:1 hours were being provided.	**2 actions were agreed.** **Responsible Officer(s):** Quality Assurance Manager (HAS) The Quality Assurance Manager reviewed the rotas again in 2022, and received appropriate assurances on staffing levels.

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	System/ Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
C	Harrogate Day Services Amenity Funds	No opinion	There are a number of Amenity Funds used by service users who receive support at Elderly People's Homes, Day Centres and Respite Services. The HAS Amenities Funds policy provides guidance for the use of such funds. Officers highlighted three amenity funds which had been operating outside of NYCC policy and not been independently reviewed. We reviewed the three funds to ensure records from 2019 to 2021 were complete, accurate, consistent with bank account information and followed key aspects of the NYCC policy.	June 2022	We found no evidence the amenity funds were being misused. The largest fund had minimal movement so there was little risk of significant fraud or misappropriation of funds. However, there were a number of weaknesses highlighted with the quality of record keeping for all 3 'amenity' accounts when compared with NYCC policy.	HAS will take steps to ensure that the bank accounts are closed. HAS will also work with Finance to identify any other unrecognised bank accounts registered to NYCC addresses. A new Amenity Funds Procedure will be prepared which sets out roles and responsibilities, including within Finance and Business Support.
D	Visits to Care Providers -	Limited Assurance	The Lodge provides respite and residential care for the elderly. Previous audit work	July 2022	The provider's policy on the Handling of Residents Money was not sufficiently detailed and did	**2 P2 and 2 P3 actions were agreed.**

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	System/ Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
	The Lodge, Scarborough		in 2017 had highlighted weaknesses around the controls for managing and safeguarding service users' financial affairs. Following a referral from NYCC Social Care, a further audit was undertaken to establish whether: • arrangements were now in place to manage and safeguard financial affairs. • Financial controls were in place and operating effectively. • Financial arrangements were robust to ensure the property of service users was protected.		not include current procedures for staff handling service users' finances. Financial risk assessments and/or financial support plans were not being completed and stored in resident care files. Sufficient reconciliations on resident cash sheets were not being performed. A reconciliation could not be performed during the audit as separate bank accounts did not exist. Receipts were not being retained for money received or services provided at the residential home. We also could not confirm that entries on the petty cash sheet were accurate as no statement of services received could be viewed during the audit.	**Responsible Officer(s):** Quality Assurance Officer The Quality Assurance and Improvement Team (QAIT) agreed to ensure that: • the policy was reviewed and in line with current practice, including the requirement for receipts. • financial risk assessments are carried out and evidenced. • a standard cash sheet format is in place and these are reconciled. • no pooled bank accounts are used. An updated policy has now been received and reviewed. Work is ongoing with the provider to help progress the required improvements.

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	System/ Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
E	Learning Disability and Autism	Reasonable Assurance	Transforming Care Partnerships (TCPs) exist to support people with a learning disability and/or autism. The partnership involves various Health and Local Government organisations within North Yorkshire. The NYCC TCP team was established in 2020, for an initial period of two years, to aid discharges and to prevent further admissions. The audit was intended to support management's future plans by assessing whether the current arrangements were achieving the aims of: • reducing reliance on inpatient services by increasing discharge rates. • improving quality of care by ensuring support plans are in place.	July 2022	The number of service users supported by the team has grown by 28 in a 17-month period. This has impacted on caseloads and the team's ability to complete all required tasks, such as completing reviews in a timely manner. As at March 2020, four people had been discharged from inpatient services, one of whom had been in long term care. In addition, five service people had been admitted and discharged between March 2020 and August 2021. Given the complexity of needs experienced by the individuals supported by the team these levels of discharges are a positive outcome. It was noted that the TCP team's aims do not fully align with expected outcomes nationally and were not always linked to supporting users of the service. There is currently no single record maintained by the team	**4 P2 and 4 P3 actions were agreed.** **Responsible Officer(s):** Assistant Director, Care and Support Services With partners, the team's purpose and aims will be reviewed and where necessary redesigned. The criteria for referral to, and discharge from, the team, will be re-scoped and a skills review will be undertaken. A Team Manager will be appointed to oversee the team's work. The use of the Liquid Logic system will be reviewed, and training provided to improve monitoring over service users. Completion of these actions is due by 31

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	System/ Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			• improving quality of life by supporting access to local services.		which provides the information necessary to conduct effective monitoring of service users accessing support.	December 2022, with one medium term strategic action due by October 2023.
F	Visit to Care Providers – Chopsticks, Northallerton	No opinion	NYCC provides funding to the contracted supplier for services through Individual Service Contracts. The purpose of the audit was to review the financial procedures at Chopsticks following concerns being raised.	October 2022	By the time of the audit visit some of the concerns had already been mitigated by actions taken by the provider. However, we found a number of weaknesses including inappropriate and unauthorised purchases. The provider also had no written policies in place for the use of company credit cards, personal expenses and cash sales/handling.	The Quality Assurance and Improvement Team, are holding regular meetings with the provider to help address the issues identified in the audit, as well as from wider work undertaken by HAS.

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APPENDIX 2

AUDIT OPINIONS AND PRIORITIES FOR ACTIONS

Audit Opinions	
Our work is based on using a variety of audit techniques to test the operation of systems. This may include sampling and data analysis of wider populations. It cannot guarantee the elimination of fraud or error. Our opinion relates only to the objectives set out in the audit scope and is based on risks related to those objectives that we identify at the time of the audit.	
Opinion	**Assessment of internal control**
Substantial Assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.
Reasonable Assurance	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.
Limited Assurance	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.
No Assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.

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.

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AUDIT COMMITTEE

12 DECEMBER 2022

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 is set out in more detail below:

COVID-19

3.2 The COVID-19 pandemic continues to pose a threat to health in North Yorkshire. Whilst in recent months there have been fewer changes in guidance as we continue with the Living with COVID agenda, cases have remained high. The health protection team continues to provide consistent leadership through intelligence-lead decision making for communicating to staff and residents, and managing outbreaks in critical settings including the Care sector to minimise transmission and protect the most vulnerable.

3.3 In April 2022 the North Yorkshire Outbreak Management Hub, who had provided a centralised public health response to COVID-19 since autumn 2020, was stood down, and a Health Protection team established within the local authority public health team. Since April the response to COVID has continued through assurance giving, and guidance interpretation and support, alongside managing outbreaks that continue in designated settings including Education and Adult Social Care. As a result, North Yorkshire remains well placed with skills and resources to respond in an escalation

process to COVID-19, and other infectious diseases, using the existing team and Local Resilience Forum partners as required.

3.4 There remains a degree of unpredictability about the course ahead. Over time we can expect further waves of transmission because of waning immunity and the emergence of new variants. National modelling suggests waves are likely in autumn and then again in early 2023. Disadvantaged areas are likely to be more at risk from surges and outbreaks, the severity of these episodes will vary depending on a range of factors including behaviour, vaccine uptake and seasonality. Vaccinations and advances in treatment and care, as well as public health advice and information, will enable us to manage the virus with a much-reduced response. However, a much-reduced response does not mean no response. Living safely and fairly with COVID-19 will mean a sensible path of working with communities to adopt safe behaviours, achieve high levels of vaccination whilst maintaining capability to scale up a rapid response to VOCS (Variant of Concern) and outbreaks if required.

3.5 The emphasis continues to be on learning to Live with COVID-19 whilst balancing the risk of COVID-19 infection against new variants with varying levels of immune interaction, with the need to address deepening health inequalities. The focus of our outbreak response has moved towards protecting our higher risk settings including care homes, and other social care settings, by providing guidance and advice to settings via our Care Setting Support Officers, and retained COVID-19 Locality Officer, and Trading Standards Officer. Guidance has continued to be shared and provided to educational settings, with a refresh produced for colleagues in preparation for schools returning in September.

3.6 Throughout Quarter 2 we worked on the 2022 Director of Public Health Annual Report – Lessons Learned from the COVID-19 Pandemic, which is available online here Director of Public Health annual report 2022 | North Yorkshire Partnerships (nypartnerships.org.uk).

MTFS: 2020, Beyond 2020 Savings and Budget Pressures

3.7 The Q2 estimate for the Directorate's 2022/23 position shows an overspend of £2.6m. This is a worsening position from Q1, where the directorate was forecasting to spend on budget, however the additional pay award is impacting on the position at Q2, and the directorate is expected to receive additional budget for over the next quarter.

3.8 It is important to note that to arrive at the Q2 position, the directorate will need to utilise all of the additional contingencies set aside as part of the budget setting process. These are:

- the full £5.6m of additional unallocated growth allocated by Council
- an additional £3.9m of the corporately held inflation contingency
- hospital discharge contingency of £1.75m agreed for a one year period.
- market pressures funding of £2.2m

3.9 The position is also dependent on the full use of the £2.0m available temporary iBCF (improved Better Care Fund) funding.

3.10 We have continued to see increasing ASC Pressures, in particular:

- Increased discharge Costs and Temporary Placements following the end of the hospital discharge funding from central government at the end of 2021/22. This is described further below.
- Inflationary pressures arising from cost of living and issues in the provider market resulting in an increased number of sustainability requests from care providers, seeking additional support to continue to operate. Since September 2021 we have received 41 sustainability requests from care providers, of these 20 have been approved, 11 declined and 10 are in progress. Pre-pandemic we would only expect to see four or five per year. These requests, where we have agreed support, will result in additional annual costs of £1.8m and we expect this trend to continue and perhaps accelerate.
- Impact of Cost of Care exercise for residential and nursing packages of care
- Increased average costs for new packages of care, for example the average weekly bed cost for older people has risen by almost £60 in-year. The full year cost of this increase alone would be over £5.5m.

3.11 In addition to these, we have not yet seen the impact of the re-procurement of the Approved Provider List and the implementation of the Fair Cost of Care for domiciliary packages. These areas are expected to show very significant price uplifts.

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3.12 There is a risk that **Public Health** budget figures are hidden within the overall HAS Directorate budget as expenditure is matched by grant income and planned use of reserves to show a break-even position.

3.13 Public Health has a gross budget of £23.9m but is balanced to a net zero in the Council's Quarterly monitoring reports. The Public Health grant has reduced in real terms in recent years and is currently £22.3m. The difference is being funded from reserves. This is a planned use of the earmarked reserve on agreed investments and projects while the service reduces cost to match grant by 2023/24.

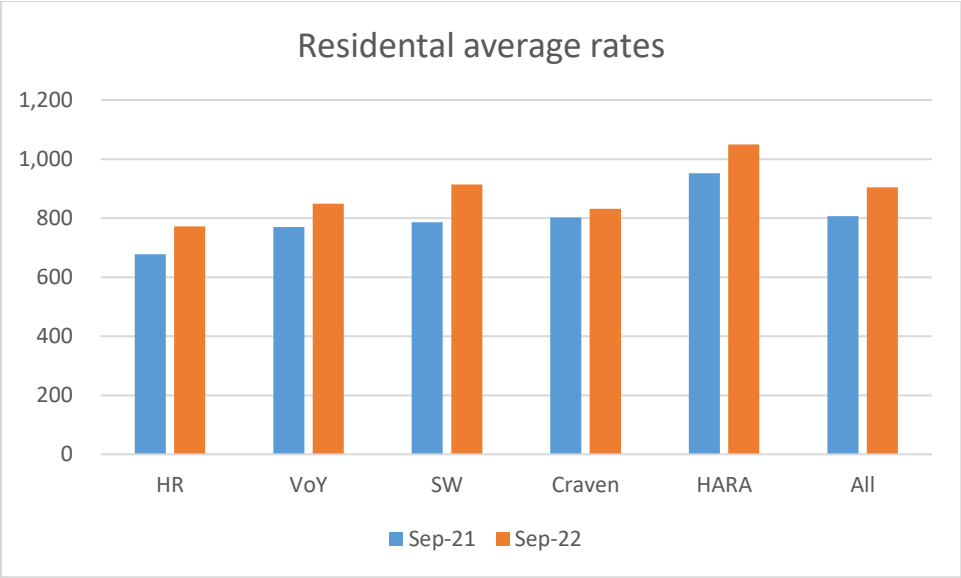
THE SOCIAL CARE MARKET

3.14 An Actual Cost of Care (ACOC) Exercise for residential and nursing care was undertaken in 2019/20 and, after pausing due to Covid, has been implemented from April 2022. The new rates set out below will be implemented for existing packages over three years. In essence that means that each package would receive 1/3rd of the difference between the current rate and the ACOC rate, reaching full ACOC by April 2024. This is a significant increase in care rates paid to providers in North Yorkshire as we move to full implementation of ACOC, but it is necessary to ensure continued provision for people with care needs in the county and to support providers. For those packages that were receiving the previous county rates of £592 (nursing) and £599 (residential), they have seen an increase in the rate of up to 16% from April 2022. The rates for 2022/23 are:

- Residential: £742
- Residential with Dementia: £784
- Nursing: £819
- Nursing with Dementia: £826

3.15 Despite this, we continue to experience increased market pressures:

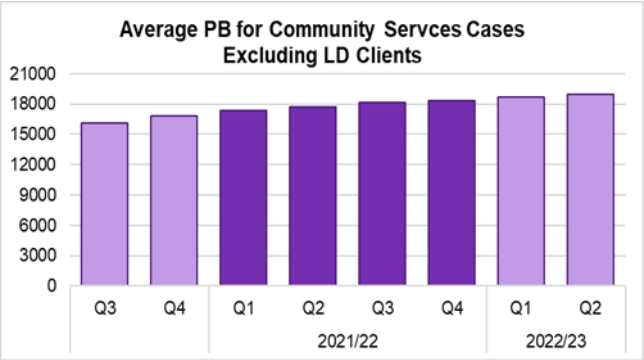
- As stated above, the average cost of new placements for the 65+ age group is increasing – approximately £60 since April. The rate in September 2022 was £904 which is an increase of £98 or 12.2% compared with this time last year. All locality average costs continue to be above the approved rate. The cost in Harrogate is 16% (£145) per week higher. The disparity across the county can be seen in the graph below.



Key:
HR: Hambleton and Richmondshire
VoY: Vale of York
SW: Scarborough and Whitby
HARA: Harrogate and Rural Alliance

- The market rates variability across the county is due to availability and demand. Where there is low demand and high availability, market rates are often lower. This is a particular issue in Harrogate as can be seen above.

- The average Personal Budget for non-LD cases was £18.9k at the end of September, an increase of £0.3k against the average PB for Q1 (see below). This represents a 15.8% increase year on year (£2,424), compared with a 8.0% increase (£1,304) reported in Q1.



3.16 A survey of care providers was undertaken in June 2022 sharing feedback on their current position and some of the key messages that came from that exercise included:

- Recruitment and retention of workforce
- Fuel and energy costs
- Rising insurance premiums
- Inflation

3.17 Hospital Discharge: The Covid-driven policy of taking people into social care before assessments are undertaken will continue. For some of the previous financial year, the Council was funded for the first six weeks of this care whilst the social care assessment was completed. Now however the cost responsibility falls to the council although agreement has been reached with the Integrated Care Board that some of these will be shared. A one-off budget was set for 2022/23 of £1.75m to cover such costs. However the current additional requirement is estimated to be around £3m, and this is contributing to the overspend.

3.18 As reported last year, provider failure is having a significant impact across all localities. Since June 22 we have lost 69 beds of capacity in the residential and nursing sector.

3.19 We continue to see packages of care being handed back to the Council to either re-source or find alternative solutions to keep people safe. This is putting significant pressure on and impacting our in-house provision as we try to find solutions for people or fill the gaps using staff from our services. This affects our ability to provide reablement and respite services. We are seeing Domiciliary Care Providers handing packages back at short notice, the main reasons are on-going staffing concerns, including a lack of staff or not being able to recruit new staff. In addition we are seeing care home providers withdraw from providing nursing care or withdraw completely from the market. All of this has a financial consequence and continues to put additional pressure on the care market as a whole. Three recent care home closures have had a full year financial effect to HAS of £393,162.

3.20 Inflationary pressures arising from cost of living and issues in the provider market are resulting in an increased number of sustainability requests from care providers, seeking additional support to continue to operate. Since September 2021 we have received 41 sustainability requests from care providers, of these 20 have been approved, 11 declined and 10 are in progress. Pre-pandemic we would only expect to see four or five per year. These requests, where we have agreed support, will result in additional annual costs of £1.8m and we expect this trend to continue and perhaps accelerate.

3.21 To assist providers further with acute financial pressures, including increased fuel and energy costs, a one-off payment was made in recent weeks to residential homes (£500) and to all community-based care (an increase of 50p per hour for three months).

3.22 A Strategic Market Development Board is in place to address the wide range of challenges in the social care market, and to provide a strategic focus on the implementation of solutions.

3.23 The Board has a multi-agency membership, and has set key priorities for its development work. One of the key areas of work highlighted in previous reports relates to the £170 Million spent each year via three approved provider lists (APLs), covering care homes and extra care, day services, and domiciliary care. A procurement exercise has been taking place over the last year which has given providers the opportunities to refresh their rates for new placements in line with the increased rates above. These new APLs have gone live from 1 November.

REDUCING BUDGET PRESSURES

3.24 Despite the increased financial pressures set out above, we continue to look at areas where we can reduce costs as part of an Adult Social Care Budget Recovery Plan. As reported to previous meetings of the Committee, the Directorate has an action plan which aims to reduce the financial pressures in Care and Support, while continuing to look for other savings to support the Council's overall budget position.

3.25 In addition to this, the following areas of work have are being undertaken or are in place to assist management of the budget:

- Revised Scheme of Delegation
- Budget Management Skills
- Improved Forecasting and other business processes
- Improved data monitoring and budget tracking
- Development of a budget performance and activity dashboard
- Practice Review meetings
- Introduction of training materials
- Professional Reasoning checklist
- Closer scrutiny of adult social care activity, practice and performance
- Clear exit strategies for temporary funding and projects
- Ensuring the correct split of costs between NYCC and NHS (especially Continuing Health Care) and people who use our services

WORKFORCE

3.26 Providers are reporting that many staff are choosing to leave the sector, due to no longer having a desire to work in social care, many are reporting the impact of the pandemic on a feeling of burn out and others are leaving due to higher pay in other sectors. This has been a significant factor in the 300+ packages of care handed back to the Local Authority in the last 12 months.

3.27 Workforce pressures are significant with a heavy reliance upon agency staff to maintain safe services. The shortage of registered nurses has seen 212 nursing care beds lost with homes de-registering in the last 2 years due to lack of registered nursing personnel. A number of homes are reporting a future intention to de-register. Workforce and retention issues are leading to vacancies in care homes which cannot be staffed.

3.28 Across the County there is a shortage of placements for people with very complex requirements including dementia care. There is also a legacy of provider failure with 173 Nursing beds and 82 residential beds closed in the last 2 years.

3.29 NYCC currently commissions 130 domiciliary care providers to support people over the age of 18. There is a significant level of diversity in the domiciliary care provider market.

3.30 Domiciliary Care providers employ approximately 5,162 staff ranging from services employing as little as 3 staff and one as many as 800 staff.

3.31 Absence levels in social care remain high, with a workforce exhausted by the protracted period of the pandemic, the impact of ongoing staff shortages, significant vacancy levels and staff experiencing Covid-19 in residential settings. The Human Resources team is working closely with managers to ensure proactive absence management and to reduce absence rates. Refresher training for managers regarding management of sensitive and / or complex absence cases has also been delivered.

3.32 Vacancy levels across social care services continued to run at unprecedented levels during Q2, with capacity in care and support teams remaining below 80% of the established full-time equivalent staff numbers.

3.33 An international recruitment programme is underway to recruit 30 social workers and to date 22 offers of appointment for social work posts have been made and accepted. The first group of recruits have arrived with the next cohort arriving at the end of November. Comprehensive induction and pastoral support arrangements are in place.

3.34 At the end of Quarter 2, adult social care services were recruiting to 2840 vacant hours (77 fte) across in-house care homes, reablement, extra care and day services. Whilst recruitment campaigns are continuing, appointment of new staff is just keeping up with current turnover rather than reducing the overall number of vacant hours. Following implementation of the pay award in September 2022, early indications are that the number of applicants for adult social care vacancies has increased.

3.35 Looking longer term, workforce mapping is being developed as part of North Yorkshire's role as a trailblazer for the introduction of the social care charge cap. This work is looking at potential increases in demand across social care and financial assessment processes from people who self-fund their care and support. The workforce needs analysis covers the core assessment functions but also includes Business Support, Brokerage and the management requirements of the local response.

3.36 Weekly resilience reporting across the York and North Yorkshire health and care system continues to highlight similar pressures for the City of York, with the response to sustained levels of demand being hampered by vacancies and staff sickness absence. The use of agency staff provides some short-term mitigation, but the authority is also engaged in on-going recruitment activity to bring about a longer term, sustainable solution.

3.37 Colleagues within the NHS are also facing similar challenges with recruitment of staff, the combined impact of which is limited community-based services across health and social care.

3.38 Human resource directors across the area continue to work collaboratively to develop co-ordinated actions to mitigate workforce issues. However, this is a national supply issue, rather than a local one, and the care sector across North Yorkshire has seen a 70% drop in job applicants since July 2022.

3.39 These workforce issues, specifically the difficulty in recruiting and retaining front line care workers are significant issues for both health and social care in terms of the continuing health care services and in relation to the availability of care to enable safe and timely hospital discharges.

3.40 The Health and Adult Services directorate has also recruited its first cohort of social work apprentices and is also developing a similar approach for occupational therapists.

CHARGING FOR SOCIAL CARE

3.41 Previously, and as part of our response to the discussion on the funding of social care, we have advised that there needed to be a decision regarding the split of care costs that are the responsibility of the state and those that fall to individuals and families.

3.42 Last year the government published proposals that sought to address this issue. This would have meant that anyone with assets of less than £20,000 would not have had to pay anything towards the cost of care either at home or in residential care from October 2023. The proposals meant that people with more than £100,000 in assets would pay all such costs until they reached a maximum of £86,000. Those with assets of £100,000 or less would pay a means-tested proportion towards their care costs, again until they reached a maximum of £86,000.

3.43 One of the conditions of the changes was that each local authority had to undertake Fair Cost of Care exercises for residential/nursing and homecare support. As we had already carried out and implemented our Actual Cost of Care review, we were given permission from the DHSC to use that, rather than undertake the exercise again. We did however undertake a Cost of Care exercise for homecare (as did all other councils) and were awaiting further instruction form the Department before we looked into how and when that would be implemented. That exercise therefore is not yet fully complete and new rates have not yet been agreed

3.44 North Yorkshire had agreed to be one of six “Trailblazers” for the new proposals and has been working with those other councils and the DHSC to look at the impact of the proposals.

3.45 From the outset we have been concerned about the financial impact on councils of the proposals and were firmly of the view that the DHSC was underestimating this. Our own calculations, echoed by other councils showed a significant potential gap between funding and costs, running into tens of millions of pounds on an annual basis. We made it clear that any final decision on our participation in the Trailblazer project was dependent on central government recognising and filling the funding gap, or at least underwriting any excess costs.

3.46 In response to this, the department and all trailblazers agreed to undertake a mutual deep dive of all calculations and this work was ongoing when the government announced a delay to the reforms for two years.

3.47 This means that although we do not have to implement the changes in the immediate future we will be taking stock of the work we have already undertaken to prepare for the changes and determine whether some of this would bring about improvements and efficiencies in our services. For example, we had determined that the extra workload created by the proposals (including a significant increase in the number of social care and financial assessments required) would mean an increase in staffing which would have been difficult to recruit. Therefore, progress towards more digital self-service models – where appropriate – would greatly assist this. This is one area we will continue to pursue as it will deliver savings which will be much needed in the current financial climate.

3.48 The government has confirmed that the funding made available for Charging Reform will continue to be available to councils to support with other pressures. While this is true, it should also be noted that this funding is now to cover pressures in adults and children's social care. Also worth noting is that, as mentioned above, all councils have undertaken Cost of Care exercises, which has included involvement with providers. This had therefore led to an expectation from the market that implementation is imminent and has inevitably led to requests for increases in payment rates already. Therefore although the Reforms will not be implemented in the next financial year, councils are already seeing the costs associated with them.

CQC ASSURANCE FRAMEWORK

3.49 Over the next twelve months or so the CQC will be rolling out its new regulatory model and assessment framework for adult social care which was first described in A new strategy for the changing world of health and social care (cqc.org.uk) launched in May 2021.

3.50 It is envisaged that the new assessment framework will measure four key areas of adult social care:

- Working with people
- Providing support
- Ensuring Safety
- Leadership

3.51 Understanding the current baseline will be a key priority for the directorate over the coming months, undertaking mock assessments, identifying gaps, risks, priorities for improvement, developing action plans and agreeing areas for further development with clear timescales and accountabilities.

The provisional dates for implantation of the framework are outlined below:

ASC Data Framework published	June	2022
DHSC sign off approach and methodology	Aug	2022
DHSC launch updated ASCOF	Sept	2022
DHSC publish draft high level framework	Dec	2022
CQC Begin LA/ICS baseline assessments	April	2023
New CQC Assessment Framework live	Jan	2024

3.52 In preparation for the launch of the new Framework, the directorate has developed new performance and practice frameworks and has agreed an action plan with clear timescales to consider the learning & improvement required to achieve the best possible rating by January 2024

4.0 DIRECTORATE RISK REGISTER (AH to update)

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 April 2023.

4.6 A new risk is highlighted with respect to In-House Social Care Provider Services (including regulated services).

4.7 The significant actions on the previous risk register that were achieved include the following:

- Major Failure due to Quality and/or Economic Issues in the Care Market – new Head of Service (joint with NHS); work with Independent Care Group (ICG) to ensure provider Business Continuity Plans in place and tested; ethical decision-making framework in place and being used and reviewed
- Workforce Planning and Development – Provider Services panel in place to support recruitment; new model of training delivery implemented; social work apprentice role implemented; business support arrangements for assessment and provider services teams reviewed and agreed
- Confident and Consistent Practice – ethical decision-making framework in place and being reviewed; culture of continuous improvement including managing risk safety, dynamic risk taking and strength-based approaches; waiting list action plan in place
- Financial Pressures – Phase 1 of Strength-Based Approach implemented within Mental Health service; Budget recovery action plan with ongoing quarterly review;

HAS 2025 plan published

- Public Health: maximisation of grant (including £500k efficiencies towards MTFS) while bringing expenditure into line with grant allocation
- Safeguarding Arrangements – work begun to prepare for implementation of Liberty Protection Safeguards

4.8 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 notes the Risk Register for the Health and Adult Services Directorate and provide feedback or comments thereon.

RICHARD WEBB
Corporate Director – Health & Adult Services
December 2022

APPENDIX A

Health and Adult Services Directorate

Risk Register: **Month 0 (Oct 2022) – detailed**
Next Review Due: **April 2023**
Report Date: **27th October 2022 (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 PSD (AB)
Description	Major failure of provider/key providers results in the Directorate being unable to meet the needs of people who use services. 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**	ASC 1/159

Phase 2 - Current Assessment											
Current Control Measures	Regular review and monitoring of contracts in addition to close working relationship with corporate procurement colleagues. Quality Improvement Team now embedded into the service and continuing to work well, with new Head of Service (joint with NHS) joining the service after Easter 22. Market position statement created as an online tool to support commissioning and interventions into the market. Work underway to develop a quality pathway with enhanced market surveillance to ensure market oversight in line with The Care Act. Sustainability process in place to enable financial assistance to the market where value for money and strategic need can be evidenced. Service Development function now created linked to locality working to identify market issues at an early stage and appropriate market support strategies are created. Ongoing rolling programme of audits by Veritau of individual suppliers. Business case being developed further for Intervention into Harrogate market. Enhanced care homes services in place during Coronavirus pandemic to provider wrap around support to the market; worked with ICG to ensure provider BCPs in place and tested. Ethical decision making framework in place and being used and reviewed.										
Probability	H	**Objectives**	M	**Financial**	M	**Services**	M	**Reputation**	H	**Category**	1

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	1/658 - Work at a system level (ICS) with partners to mitigate the impact of workplace shortages	HAS All ASC ADs HAS HoHR	Sat-30-Sep-23	
Reduction	1/659 - Complete recommissioning of all approved provider lists; being evaluated	HAS AD PSD (AB)	Wed-30-Nov-22	
Reduction	1/660 - Seek opportunities to gain national support for workforce issues in the care system	CD HAS HAS All ASC ADs	Sat-30-Sep-23	
Reduction	1/688 - Launch PAMMS to aid early identification of risk and support the quality pathway	HAS AD ASC (RB)	Sat-30-Sep-23	
Reduction	1/689 - Separate quality and contract management to provide additional capacity to contract management	HAS AD ASC (RB) HAS AD PSD (AB)	Sat-30-Sep-23	
Reduction	1/690 - Use the review of the QIT pilot to plan future quality oversight	HAS AD ASC (RB)	Sat-30-Sep-23	
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 with use of national capacity tracker and contingencies in place	HAS AD PSD (AB)	Sat-30-Sep-23	
Reduction	47/221 - Continue to work with Veritau on audits of individual suppliers (rolling programme in place of focussed work in particular areas)	HAS AD PSD (AB) HAS C&Q Ho Q&M	Sat-30-Sep-23	

North Yorkshire County Council

Health and Adult Services Directorate

Risk Register: **Month 0 (Oct 2022) – detailed**
Next Review Due: **April 2023**
Report Date: **27th October 2022 (pw)**

Reduction	47/486 - Monitor issues caused by the changing landscape of ICS and LGR and raise at HASLT where appropriate - ongoing	HAS AD PSD (AB)	Sat-30-Sep-23	
Reduction	47/587 - Develop a Quality Pathway, revising processes and procedure and incorporating best practice adopting a risk based / predictive approach; being introduced from Nov 22	HAS AD ASC (RB)	Wed-30-Nov-22	
Reduction	47/600 - Rewriting quality policies as part of Quality Pathway with input from Veritau as part of focussed review	HAS AD ASC (RB)	Wed-30-Nov-22	
Reduction	47/603 - Consideration of market interventions, including development of a provider arm or a proposal to bring organisations together (initial business case approved for intervention into Harrogate market); need to consult and then get agreement for revised costs	HAS AD PSD (AB)	Sat-31-Dec-22	
Reduction	47/646 - Work with market development board to monitor and manage interventions in the care market	HAS AD PSD (AB)	Sat-30-Sep-23	

Phase 4 - Post Risk Reduction Assessment

Probability	H	**Objectives**	M	**Financial**	M	**Services**	M	**Reputation**	H	**Category**	1

Phase 5 - Fallback Plan

		Action Manager
Fallback Plan	3/523 - Make people 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 PSD (AB) HAS AD ASC (RB)

North Yorkshire County Council

Health and Adult Services Directorate

Risk Register: **Month 0 (Oct 2022) – detailed**
Next Review Due: **April 2023**
Report Date: **27th October 2022 (pw)**

Phase 1 - Identification							
Risk Number	3/184	**Risk Title**	3/184 - Workforce Recruitment and Retention	**Risk Owner**	CD HAS	**Manager**	HAS HoHR
Description	Failure to recruit and retain sufficient numbers and categories of staff in Social Care and / or develop managers and staff in line with transformation agenda including the impact of Coronavirus and to ensure service continuity 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			Regular review at HASLT and other meetings, with actions taken as required; panel in place for Provider Services to support recruitment and similar model to be emulated for community teams; OD Group in place, with agreed work programme; Workforce Strategy and OD Plan refreshed and agreed by HAS LT; HR representation on programme/project groups with regular monitoring by HASLT; Directorate Plan in place; regular DJCC meetings with Unison; training plan in place; ASYE implemented; assessment pathway programme; Practice team in place; Practice development sessions for practitioners rolled out; Learning4Care and Recruitment Hub to support the independent and voluntary sector in place; 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 and wider Mental Health team structures implemented; new manager programme developed and implemented; Manager Skills Audit undertaken to inform OD Programme; new working patterns in Care and Support in place; Coronavirus controls including: Weekly wider leadership team meeting, monthly locality HAS connected meetings (all staff included); Outbreak management plan; care home liaison team established for the independent sector; on call rotas established; Covid infection and protection control training in place; new ASC operating model and staffing arrangements in place; New Manager Development Programme and Meet the Director Programme in place; new model of training delivery implemented; social work apprentice role implemented; business support arrangements for assessment and provider services teams reviewed and agreed;						
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	Thu-31-Mar-22	Thu-31-Mar-22
Reduction	3/207 - Consider options relating to recruitment and agency agreements to support the independent and voluntary sector with the ICG and providers (ongoing)	HAS HoHR	Sat-30-Sep-23	
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 SMs to ensure delivery (ongoing)	HAS AD ASC (CJK) HAS AD ASC (RB) HAS HoHR	Tue-31-Oct-23	
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	Sat-30-Sep-23	
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 people who use service and partners (ongoing)	HAS LT	Sat-30-Sep-23	

North Yorkshire County Council

Health and Adult Services Directorate

Risk Register: **Month 0 (Oct 2022) – detailed**
Next Review Due: **April 2023**
Report Date: **27th October 2022 (pw)**

Reduction	3/463 - Continue to develop and implement the Make Care Matter campaign including a flexible approach to candidate need and availability, to ensure recruitment across the Sector encompassing ideas from people who have lived experience and operational staff (ongoing)	HAS AD ASC (CJK) HAS AD ASC (RB) HAS HoHR	Sat-30-Sep-23	
Reduction	3/476 - Support staff to operate into integrated teams and arrangements (ongoing)	HAS AD ASC (CJK) HAS AD ASC (RB) HAS HoHR	Sat-30-Sep-23	
Reduction	3/649 - Support managers with tools, techniques, communication and sign posting to support workforce wellbeing	HAS HoHR	Sat-30-Sep-23	
Reduction	3/653 - Conclude - stage 2 of ASC operating model and staffing arrangements	HAS AD ASC (CJK) HAS AD ASC (RB) HAS AD PSD (AB) HAS HoHR	Tue-31-May-22	Tue-31-May-22
Reduction	3/655 - Develop and implement locality team arrangements in provider services including rationalisation of grading, flexible deployment and rota management including review of the registered manager role	HAS AD ASC (RB) HAS HoHR	Fri-31-Mar-23	
Reduction	3/657 - Review and bolster business support arrangements for assessment and provider services teams	HAS LT	Thu-30-Jun-22	Thu-30-Jun-22
Reduction	3/672 - International recruitment of 30 social workers and 5 occupational therapists (20 offered Oct 2022)	HAS ASC Ho P&P	Tue-28-Feb-23	
Reduction	3/694 - Evaluate effectiveness and outcomes of business support arrangements for assessment and provider services teams?	HAS LT	Fri-31-Mar-23	
Reduction	3/695 - Implementation and recruitment of the new advanced practitioner role	HAS HoHR	Tue-31-Jan-23	
Reduction	3/696 - Develop an occupational therapy apprentice?	HAS HoHR	Sat-30-Sep-23	
Reduction	3/1964 - Continue to engage with and contribute to NHS and local government workforce priorities (ongoing)	HAS LT	Sat-30-Sep-23	

Phase 4 - Post Risk Reduction Assessment

Probability	H	**Objectives**	M	**Financial**	M	**Services**	H	**Reputation**	L	**Category**	1

Phase 5 - Fallback Plan

		Action Manager
Fallback Plan	3/531 - Review and revise workforce arrangements including managers' responsibilities	CD HAS

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North Yorkshire County Council

Health and Adult Services Directorate

Risk Register: **Month 0 (Oct 2022) – detailed**
Next Review Due: **April 2023**
Report Date: **27th October 2022 (pw)**

Phase 1 - Identification							
Risk Number	3/265	**Risk Title**	3/265 - National Social Care Reforms and Trailblazer	**Risk Owner**	CD HAS	**Manager**	CSD AD SR (AH)
Description	Failure to be able to implement the national Social Care Reforms in sufficient time and on a fully funded basis, resulting in people in North Yorkshire not being able to access the benefits of the social care charging reforms that they need at a planned cost to them, their families, the council and care providers			**Risk Group**		**Risk Type**	

Phase 2 - Current Assessment												
Current Control Measures			Health and Social Care White Papers on Integration and Charging									
Probability	H	**Objectives**	H	**Financial**	H	**Services**	H	**Reputation**	H	**Category**	1	

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	3/324 - Participation in national Trailblazer (funding, IT and workforce are the key challenges)	CD HAS	Tue-31-Oct-23	
Reduction	3/325 - Lobby for sufficient funding for implementation and delivery of the social care reforms	CD HAS	Tue-31-Oct-23	
Reduction	3/329 - Ensure sufficient staff availability to meet higher activity as a result of the social care reforms such as organisation of care for self-funders	CD HAS	Tue-31-Oct-23	
Reduction	3/340 - Ensure awareness of hidden costs of care fee harmonisation between council and self-funder payment rates	CD HAS	Tue-31-Oct-23	
Reduction	3/343 - Prepare for Adult Social Care Assurance system at a time when the care sector faces unprecedented pressures and also LGR in North Yorkshire	CD HAS	Wed-31-Jan-24	
Reduction	3/369 - Implement additional system capabilities to help manage forecast the increase in demand	HAS AD PSD (AB)	Tue-31-Jan-23	

Phase 4 - Post Risk Reduction Assessment												
Probability	H	**Objectives**	H	**Financial**	H	**Services**	H	**Reputation**	H	**Category**	1	

Phase 5 - Fallback Plan		
		Action Manager
Fallback Plan	3/571 - Continue to prepare for the national proposals for Social Care Reforms	CD HAS

North Yorkshire County Council

Health and Adult Services Directorate

Risk Register: **Month 0 (Oct 2022) – detailed**
Next Review Due: **April 2023**
Report Date: **27th October 2022 (pw)**

Phase 1 - Identification							
Risk Number	3/264	**Risk Title**	3/264 - Confident and consistent practice/Managing Waiting Lists	**Risk Owner**	CD HAS	**Manager**	HAS All ASC ADs
Description	Failure 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**	ASC 1/222

Phase 2 - Current Assessment											
Current Control Measures	Programme developed; new safeguarding operational guidance and practice; compared costs of commissioned packages of care to the costs of packages funded through direct payments; section 117 protocol training implemented; designed new carers pathway including a focus on young carers; Living Well (as a carer) opportunities explored; embedded the widened short breaks offer; 'front door' reviewed to improve demand management; new SG procedures in place and additional resource into the customer resource centre; elements of this work picked up in Assess and Decide programme; ethical decision making framework in place and being reviewed for a report back to Management Board and to Members which will also cover waiting list issues; culture of continuous improvement including managing risk safely, dynamic risk taking and strength based approaches; waiting list action plan in place;										
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; completed the diagnostic self audit with managers and practitioners, now need to implement the identified improvements and investigate and understand reasons for variations in practice; ongoing (practice team have been doing deep dives into locality practice, with request for improvement plans)	HAS AD ASC (CJK)	Sat-30-Sep-23	
Reduction	1/444 - Ensure consistent decision making to improve outcomes for people and ensure value for money; introduced scheme of delegation around financial decisions, then reviewed and extended it to self-authorisation by frontline staff, needs further testing and embedding (now built into Liquid Logic); also introduced practice support sessions to explore alternative support options with service users; need to update the case file audit to reflect practice and confirm consistency of decision making; case file audit updated and new tool used for practice and outcomes	HAS AD ASC (CJK)	Sat-30-Sep-23	
Reduction	1/571 - Improve well-being of teams; continue to carry out the demand and capacity work (including improving resilience for ASC leadership); festival of practice held, with self-help sessions for staff; introducing locality sessions with ADs to reinforce this work and keep this key area in focus	HAS AD ASC (CJK)	Sat-30-Sep-23	
Reduction	1/575 - Ongoing programme of training and learning for teams about the benefits and impacts of direct payments and support practice through a data informed, targeted approach, sharing of case examples and local area guidance.	HAS AD ASC (CJK)	Sat-30-Sep-23	
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; work on new pathway started; now introducing a carers conversation record	HAS AD ASC (CJK) HAS ASC Ho TP	Sat-30-Sep-23	
Reduction	1/581 - Agree targets for consistency county wide in order to strive for equity; more to do, practice framework will include targets and performance aspects; some KPIs in service plan need to translate into practice; practice framework complete, looking at practice standards linked to assurance framework	HAS ASC Ho TP	Fri-31-Mar-23	
Reduction	3/151 - Implement an action plan to proactively manage and mitigate risk to people waiting for adult social care	HAS AD ASC (CJK)	Sat-30-Sep-23	

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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 ASC (CJK)

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Phase 1 - Identification							
Risk Number	3/229	**Risk Title**	3/229 - Financial Pressures (carry out further review due to economic climate)	**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 and unexpected costs, Better Care Fund contributions, and given care system pressures and continued impact of Covid on the budget and complexity of people's 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	Regular performance and governance ASC and HAS LT finance and performance tracking 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; 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; phase 1 of full business case for new Dementia Care Village completed; action plan to address the care and support overspend developed; SBR now business as usual and being introduced to Supported Living; budget recovery action plan in place; proportion of care packages within affordable budget monitored to ensure we remain within the parameters of the Cost of Care Agreement; Commissioning team (in their service improvement role) acting as an internal peer challenge around high cost spend and market ability to enable the development of a Locality service improvement plan; Phase 1 SBA implemented within Mental Health; Budget recovery action plan with ongoing review on a quarterly basis; HAS 2025 plan published										
Probability	H	**Objectives**	H	**Financial**	H	**Services**	H	**Reputation**	H	**Category**	1

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	1/569 - Seek to better understand financial impact of decisions made as part of the Confident and Consistent Practice model and diagnostic work; introduced new scheme of delegation to ensure consistent sign off; practice support meetings introduced	HAS AD PSD (AB) HAS All ASC ADs	Sat-30-Sep-23	
Reduction	1/616 - Achieve earlier, clearer budget position with Team Managers responsible for budget management including forecasting (all team managers are now forecasting with approvals by ASC ADs); linked to budget recovery plan work, now in place and ongoing	HAS AD PSD (AB) HAS All ASC ADs	Sat-30-Sep-23	
Reduction	1/633 - Fortnightly budget clinic with heads of service reviewing all activity including high cost placement starters and leavers	HAS AD PSD (AB) HAS All ASC ADs	Sat-30-Sep-23	
Reduction	1/648 - Continue to monitor and fully understand and assess the budget impact of Covid and ensure proper accounting of one-off funds, including assessing risk of clawback from central government	CSD AD SR (AH) HAS AD PSD (AB)	Sat-30-Sep-23	
Reduction	1/662 - Monitor new requirements on hospital discharge and ensure National Government and ICB funding settlements are adequate as these have the potential to create additional pressures on adult social care	HAS All ASC ADs	Sat-30-Sep-23	
Reduction	1/687 - Monitor the impact of provider sustainability applications and the procurement of the APL to identify further mitigation	HAS All ASC ADs	Sat-30-Sep-23	
Reduction	3/421 - Complete phase 2 of the strength based assessments working with people with complex needs	HAS AD PSD (AB) HAS All ASC ADs	Sat-30-Sep-23	

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Reduction	3/423 - Analyse work undertaken as part of Trailblazer to improve market and cost information, service standards and information security	CSD AD SR (AH)	Fri-31-Mar-23	
Reduction	3/547 - Continue to develop and implement OD Programme (in stages) for HAS Managers to encompass People, Pounds, Performance, Practice and Partnerships	HAS HoHR	Mon-31-Oct-22	
Reduction	3/652 - Develop a business case for a new care facility to help alleviate care home affordability issue (expand on work in this area and develop business cases for new nursing home provision); need to consult and then get agreement for revised costs	HAS AD PSD (AB)	Sat-31-Dec-22	
Reduction	3/673 - Ensure actions from Focussed Review on Financial Assessments feed into a fundamental review of the service in preparation for Trailblazer so that income is collected in a timely manner, reducing the risk of payments being lost and work with NHS partners to ensure an appropriate split of costs for joint packages	CSD AD SR (AH)	Mon-31-Oct-22	
Reduction	3/677 - Work with supply chain resilience board to ensure adequate support for providers in financial distress	CSD AD SR (AH)	Fri-31-Mar-23	
Reduction	3/678 - Review actual cost of care exercise for residential and nursing and undertake new cost of car exercise for domiciliary care to maximise use of market sustainability fund	CSD AD SR (AH)	Fri-31-Mar-23	
Reduction	3/679 - Feed into budget process around any increased financial pressures and costs	CSD AD SR (AH)	Wed-30-Nov-22	
Reduction	3/699 - Continue to monitor the budget for Public Health and associated spending	Dir Public Health	Sat-30-Sep-23	
Reduction	5/532 - Work with Exec and others to agree PH spending including both what the budget will be and on what it will be spent on.	Dir Public Health	Fri-30-Sep-22	Sun-31-Jul-22
Reduction	324/520 - Ongoing National review of NYCC performance against key targets (including Discharge to Assess and Right to reside) which could impact funding	HAS All ASC ADs	Sat-30-Sep-23	

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)

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Phase 1 - Identification							
Risk Number	3/180	**Risk Title**	3/180 - Partnership and Integration with the NHS	**Risk Owner**	CD HAS	**Manager**	Dir Public Health HAS All ASC ADs
Description	Failure to achieve the best outcomes from working jointly with the NHS 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 ICSs; regular finance and commissioning meetings in place (building on Covid response); North Yorkshire Place Board and Silver Command overseeing Covid response and other key interface business; s75 agreements in place for Harrogate and Rural Alliance; investment of IBCF and BCF to protect social care; Joint Health and Well-being Strategy in place (due to be refreshed); extensive hospital discharge arrangements in places;							
Probability	H	**Objectives**	M	**Financial**	H	**Services**	M	**Reputation**	H	**Category**	1

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	1/682 - Continue pilot of multi agency Quality Improvement Team and plan evaluation	HAS AD ASC (RB)	Sat-30-Sep-23	
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	Sat-30-Sep-23	
Reduction	3/384 - Review the Harrogate and Rural Alliance integration of community health and social care services to inform future model and governance arrangements from Apr 22	CD HAS	Thu-31-Mar-22	Thu-31-Mar-22
Reduction	3/429 - Work through the statutory ICS arrangements and the development of the NYY Strategic Partnership; underway	CD HAS Dir Public Health	Fri-31-Mar-23	
Reduction	3/638 - Continue to lobby nationally for the continuation of Hospital Discharge funding (ongoing)	CD HASCD SR	Fri-31-Mar-23	
Reduction	3/650 - Work jointly with CCGs and NHSFTs to develop post-Covid discharge pathways (underpinned by lobbying via LGA/CCN/SCT and others to ensure any changes are funded and with appropriate legislation in place)	HAS AD PSD (AB)	Fri-31-Mar-23	
Reduction	3/654 - Work closely with NHS partners to triage highest priorities for hospital and community capacity and pressures and undertake LRF exercise to plan for contingencies	CD HAS HAS All ASC ADs	Fri-31-Mar-23	
Reduction	3/656 - Present HARA paper to MB and Exec to provide update and priorities for the next 5 years	CD HAS HAS All ASC ADs	Sat-31-Dec-22	
Reduction	3/697 - Ensure there is a joint plan in place with ICB colleagues to manage winter pressures	HAS AD PSD (AB)	Fri-31-Mar-23	
Reduction	47/536 - Embed the working of the complex care partnership board for the continuing health care and s117 work	HAS AD PSD (AB)	Sat-30-Sep-23	

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

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

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Phase 1 - Identification							
Risk Number	3/167	**Risk Title**	3/167 - Public Health	**Risk Owner**	CD HAS	**Manager**	Dir Public Health
Description	Failure to manage the response to Coronavirus whilst at the same time deliver a distinctive public health agenda for North Yorkshire and carry out the statutory public health functions and manage within the available funding, together with the impact of the new National Health Strategy, 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, ICS and Districts; Public Health service plan in place; MOU for Advice Service with ICS 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	H	**Objectives**	M	**Financial**	H	**Services**	M	**Reputation**	M	**Category**	1	

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	3/233 - Implement and embed the arrangements for the Healthy Child Programme (s75 in place, service went live Jul 2021)	Dir Public Health	Fri-31-Mar-23	
Reduction	3/341 - Virus Control – Develop and implement (when necessary) an effective Local Outbreak Management and Control Plan	Dir Public Health	Fri-30-Sep-22	Fri-31-Dec-21
Reduction	3/382 - Ensure awareness of and monitor impact of the publication of the new National Health Strategy which may place additional unfunded burden on the service	Dir Public Health	Sat-30-Sep-23	
Reduction	3/427 - Continue to embed the s75 arrangement for the Sexual Health services	Dir Public Health	Sat-30-Sep-23	
Reduction	3/430 - Implement the Drug and Alcohol treatment plan in light of the combatting drugs strategy	Dir Public Health	Sun-31-Mar-24	
Reduction	3/699 - Continue to monitor the budget for Public Health and associated spending	Dir Public Health	Sat-30-Sep-23	
Reduction	5/246 - Continue to ensure Public Health statutory functions are met	Dir Public Health	Sat-30-Sep-23	
Reduction	5/247 - Continue development of the Public Health Advisory Service for ICS with the focus on population health management approaches; ongoing	Dir Public Health	Sat-30-Sep-23	
Reduction	5/248 - Ensure 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); some additional funding, will need to revisit, current savings targets met; paper to management board and savings plan agreed up to 2024	Int Fin Acc	Fri-31-Mar-23	
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	Sat-30-Sep-23	

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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; still pressures around PH Consultant and PH Intelligence posts	Dir Public Health	Sat-30-Sep-23	
Reduction	5/313 - Reinforce the use of good systems for monitoring our performance against the PHOF by reporting as part of the Council's performance framework	Dir Public Health	Sat-30-Sep-23	
Reduction	5/532 - Work with Exec and others to agree PH spending including both what the budget will be and on what it will be spent on.	Dir Public Health	Fri-30-Sep-22	Sun-31-Jul-22
Reduction	5/557 - Stop Smoking Service: Continue to support the in-house smoking cessation services around the use of e-cigarettes	Dir Public Health	Sat-30-Sep-23	
Reduction	5/590 - Ensure contract arrangements for the Sexual Health services remain on track - now BAU	Dir Public Health	Sat-30-Apr-22	Sat-30-Apr-22
Reduction	5/644 - Seek to understand the impacts of changes to NHS, UK HAS and OHID structures and impact of LGR	Dir Public Health	Sat-30-Sep-23	

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	3/526 - Further develop and implement alternative delivery models taking into account good practice elsewhere	Dir Public Health

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Phase 1 - Identification							
Risk Number	3/217	**Risk Title**	3/217 - Deprivation of Liberty Safeguards (DoLS) Supreme Court Ruling	**Risk Owner**	CD HAS	**Manager**	HAS AD ASC (CJK)
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**	ASC 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; HASLT paper December 2019; BACKLOG IMPROVED; regular Liberty Protection Safeguards preparation updates provided to HASLT;							
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 continue to adhere to the DoLS supreme court judgement ongoing	HAS AD ASC (CJK)	Sat-30-Sep-23	
Reduction	1/502 - Continue to work through backlog management plan for the lower risk (as defined by ADASS) people including proposal for extra resource to assist in this area; two additional posts at Best Interest Assessor (BIA) level appointed to ensure appropriateness of rating of those on the outstanding list; BIA have helped reduce overspend and we are continuing to increase BIA capacity to take pressure off op teams	HAS AD ASC (CJK)	Sat-30-Sep-23	
Reduction	1/525 - Continue to manage the Court of Protection (CoP) 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, coming to an end; have agreed use of agency staff to assist with backlog reduction and they are working through the backlog; now impacted by CoP delays	HAS AD ASC (CJK)	Sat-30-Sep-23	
Reduction	1/559 - Looking at process of reviews so that concerns can be picked up earlier; continuous improvement sought	HAS AD ASC (CJK)	Sat-30-Sep-23	
Reduction	1/595 - Carry out options appraisal for revised approach required to meet new legislation	HAS AD ASC (CJK)	Sat-30-Sep-23	
Reduction	3/255 - Prepare for implementation of Liberty Protection Safeguards; LPS guidance and legislation delayed due to impact of Coronavirus; draft statutory guidance received in 2022, expecting the full guidance early 2023	HAS AD ASC (CJK)	Fri-31-Mar-23	
Reduction	3/320 - Form a project steering group with external partners to scope the outputs against the required changes in legislation; is in place but will need to reconvene as required; will be stepped up when we receive the statutory guidance	HAS AD ASC (CJK)	Sat-30-Sep-23	

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

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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 ASC (CJK)

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Phase 1 - Identification							
Risk Number	3/27	**Risk Title**	3/27 - Safeguarding Arrangements	**Risk Owner**	CD HAS	**Manager**	HAS AD ASC (CJK) Dir Public Health
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**	ASC 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 in place with regular meetings of the InterBoard Network; reviewed; training for in house provider; new safeguarding policies and procedures implemented; including a Quality Monitoring Tool, monthly strategic meetings with CQC and Healthwatch; training in respect of latest policies and procedures for elected members, staff and partners in place; safeguarding work to deliver the Transforming Care programme incl. the Care Act role of Principal Social Worker and Safeguarding Board Manager embedded; supervisory body role for DoLS to ensure the system is as effective as possible;										
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)	Dir Public Health HAS AD ASC (CJK)	Sat-30-Sep-23	
Reduction	3/145 - Continue to ensure Partners are fully engaged with Safeguarding Boards centrally and locally, particularly health and district council partners particularly as we move to LGR	Dir Public Health	Sun-30-Apr-23	
Reduction	3/187 - Continue to work with directorate colleagues 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; new organisational Safeguarding Procedure is mapped against the quality pathway	Dir Public Health HAS AD ASC (CJK)	Sat-30-Sep-23	
Reduction	3/255 - Prepare for implementation of Liberty Protection Safeguards; LPS guidance and legislation delayed due to impact of Coronavirus; draft statutory guidance received in 2022, expecting the full guidance early 2023	HAS AD ASC (CJK)	Fri-31-Mar-23	
Reduction	3/321 - Continue joint work with CYPS and the Community Safety Partnership with quarterly meetings of the InterBoard Network	Dir Public Health	Sat-30-Sep-23	
Reduction	3/374 - Put in place governance arrangements reflecting the ethical framework for social care to evidence and record decision making and ensure the best possible solutions for people in the circumstances (Pressures in the care market mean that the best solutions for people are not always available and may lead to safeguarding concerns being raised.); ethical framework considerations complete	HAS AD ASC (CJK)	Fri-30-Sep-22	Fri-30-Sep-22

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Reduction	324/161 - Continue to report regularly to HASLT, Care and Independence O&S Committee and Health and Wellbeing Board	Dir Public Health	Sat-30-Sep-23	
Reduction	324/336 - Continue to 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 (LPS guidance and legislation delayed, draft statutory guidance received in 2022, expecting the full guidance early 2023)	Dir Public Health HAS AD ASC (CJK)	Fri-31-Mar-23	

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 safeguarding adults reviews	HAS AD ASC (CJK) Dir Public Health

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Phase 1 - Identification							
Risk Number	3/266	**Risk Title**	3/266 - In-House Social Care Provider Services (incl Regulated Services)	**Risk Owner**	CD HAS	**Manager**	HAS AD ASC (RB)
Description	Failure to maintain compliant (safe, effective, caring, responsive and well led) and cost effective regulated and non regulated services with robust governance arrangements (including workforce and health and safety) in place enabling scrutiny at every level of the organisation resulting in enforcement action, service closure and reputational impact			**Risk Group**	Performance	**Risk Type**	ASC 1/257

Phase 2 - Current Assessment											
Current Control Measures			Robust management structure across registered services; non-regulated services (i.e. day-care); quality audits undertaken managers; established networks and forums for exploring legislative requirements; communication and relationship with CQC; improved system for recording dom care; target areas of specific concern; near miss and notifications log and analysis completed by Quality and Contracting and service lead								
Probability	M	**Objectives**	L	**Financial**	L	**Services**	M	**Reputation**	H	**Category**	2

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	1/517 - Complete annual health and safety reviews with H&S Advisor; continue to monitor via Directorate Risk Management Group (immediate remedial action to single glazed windows and fire safety issues to complete) to ensure that prioritisation of required action within the directorate but also within property services	HAS ASC Ho PS	Sat-30-Sep-23	
Reduction	1/518 - Complete the service development plans and work though action plans for those domains that require improvement following issues raised by CQC	HAS ASC Ho PS	Sat-30-Sep-23	
Reduction	1/526 - Ensure we maintain sufficient appropriate provision at EPHs involved in the replacement programme, setting clear expectations of standards and quality that are to be maintained through transition via the quality framework; working on a business case to explore alternative approaches to current "close eph/replace with extra care"	HAS AD ASC (RB) HAS AD PSD (AB)	Sat-30-Sep-23	
Reduction	1/620 - Implement an assurance framework for regulated services that feeds into directorate framework; Quality Pathway work will ensure regulated services are held to same standards as external providers; also applying the standards and outcomes framework in APL to in-house providers	HAS ASC Ho PS	Wed-30-Nov-22	
Reduction	1/663 - Make safe any in sourcing following provider failure before passing on to the market	HAS All ASC ADs	Sat-30-Sep-23	
Reduction	1/664 - Implement business continuity plans to secure safe staffing levels whilst aiming to recruit additional workforce capacity	HAS AD ASC (RB)	Sat-30-Sep-23	
Reduction	1/680 - Continue with the monthly cross directorate governance meeting	HAS AD ASC (RB)	Sat-30-Sep-23	
Reduction	1/681 - Hold lessons learned "rapid review" following serious incident or any unplanned closure of an external care setting.	HAS AD ASC (RB)	Sat-30-Sep-23	
Reduction	1/691 - Recruit to the Provider Development Manager post	HAS AD ASC (RB)	Wed-30-Nov-22	
Reduction	3/375 - Continue to proactively recruit through Make Care Matter whilst taking steps to attract more applicants through the Resilience Plan actions.	HAS AD ASC (RB) HAS HoHR	Sat-30-Sep-23	

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

Phase 5 - Fallback Plan		
		Action Manager
Fallback Plan		

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Risk Register: **Month 0 (Oct 2022) – detailed**
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Report Date: **27th October 2022 (pw)**

Phase 1 - Identification							
Risk Number	3/164	**Risk Title**	3/164 - Information Governance and Health and Safety	**Risk Owner**	CD HAS	**Manager**	Dir Public Health 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 and continued promotion of the use 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; work programme for the DIGG with monthly meetings; regular updates to leadership team / forum to look at Info Gov data trends; updates provided through the agreed Directorate governance framework with reports to HASLT; Classification of emails and chat logs used to ensure no sensitive breaches; DIGG sessions continued throughout Covid 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; robust risk management group in place within the directorate; regular H&S data updates to HASLT										
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	Dir Public Health	Sat-30-Sep-23	
Reduction	3/148 - Continue to implement awareness raising campaign for information governance	Dir Public Health	Sat-30-Sep-23	
Reduction	3/364 - Ensure appropriate arrangements are put in place for hybrid working	Dir Public Health	Sat-30-Sep-23	
Reduction	3/365 - Ensure early notification of incidents (eg via Veritau) to enable lessons can learned following any breach	Dir Public Health	Sat-30-Sep-23	
Reduction	3/373 - Continue to work closely with Data Governance on review and monitoring of local Info gov arrangements	Dir Public Health	Sat-30-Sep-23	
Reduction	3/423 - Analyse work undertaken as part of Trailblazer to improve market and cost information, service standards and information security	CSD AD SR (AH)	Fri-31-Mar-23	
Reduction	3/552 - Continue to embed the HAS governance framework to improve services; being implemented on an iterative basis pending directorate wide launch in 22/23	Dir Public Health	Sat-30-Sep-23	
Reduction	3/669 - Consider impact of LGR on info gov / data sharing activities and whether further training would be beneficial	Dir Public Health	Sat-30-Sep-23	
Reduction	3/675 - Work with Provider services and Property colleagues to ensure that all risks in care establishments are dealt with on a timely basis, reporting through the Directorate Risk Group to HASLT	CSD AD SR (AH)	Fri-30-Sep-22	

Health and Adult Services Directorate

Risk Register: **Month 0 (Oct 2022) – detailed**
Next Review Due: **April 2023**
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Reduction	3/676 - Draw up an ongoing risk log to be treated as a live document which will identify all H&S issues in HAS and progress against them which will be used to report to HASLT	CSD AD SR (AH)	Fri-30-Sep-22	
Reduction	3/698 - Ensure consistent reports of H&S incidents and data in some remaining services particularly PLD and Mental Health through revised governance arrangements in provider services and HASLT	CSD AD SR (AH) HAS AD ASC (RB)	Fri-31-Mar-23	
Reduction	5/693 - Launch the Governance Framework for HAS	Dir Public Health	Sat-30-Sep-23	
Reduction	324/397 - Consider need for continued unannounced office work area checks on a countywide basis and encourage practice that will ensure that home working arrangements have the same level of security	Dir Public Health	Sat-30-Sep-23	
Reduction	324/640 - Maintain awareness of response times in relation to FOI and SAR requests within statutory timescales; quarterly reporting to HASLT	Dir Public Health	Sat-30-Sep-23	

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) Dir Public Health

North Yorkshire County Council

APPENDIX B

Health and Adult Services Directorate

Risk Register: **Month 0 (Oct 2022) – summary**
Next Review Due: **April 2023**
Report Date: **27th October 2022 (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
◀▶	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 the needs of people who use services. 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 PSD (AB)	H	M	M	M	H	1	13	30/11/2022	H	M	M	M	H	1	Y	HAS AD PSD (AB) HAS AD ASC (RB)
◀▶	3/184 - Workforce Recruitment and Retention	Failure to recruit and retain sufficient numbers and categories of staff in Social Care and / or develop managers and staff in line with transformation agenda including the impact of Coronavirus and to ensure service continuity resulting in reduction in quality of service and transformation objectives not achieved, staff unclear about their roles and an inability to implement new ways of working	CD HAS	HAS HoHR	H	M	H	H	M	1	16	31/01/2023	H	M	M	H	L	1	Y	CD HAS
◀▶	3/265 - National Social Care Reforms and Trailblazer	Failure to be able to implement the national Social Care Reforms in sufficient time and on a fully funded basis, resulting in people in North Yorkshire not being able to access the benefits of the social care charging reforms that they need at a planned cost to them, their families, the council and care providers	CD HAS	CSD AD SR (AH)	H	H	H	H	H	1	6	31/01/2023	H	H	H	H	H	1	Y	CD HAS
◀▶	3/264 - Confident and consistent practice/Managing Waiting Lists	Failure 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 All ASC ADs	H	H	H	H	H	1	7	31/03/2023	M	M	H	M	M	2	Y	HAS AD ASC (CJK)

North Yorkshire County Council

Health and Adult Services Directorate

Risk Register: **Month 0 (Oct 2022) – summary**
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Report Date: **27th October 2022 (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
◀▶	3/229 - Financial Pressures (carry out further review due to economic climate)	Financial pressures arising from difficulties in delivering MTFS Savings requirements, managing in year financial overspends and unexpected costs, Better Care Fund contributions, and given care system pressures and continued impact of Covid on the budget and complexity of people's 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	H	H	1	17	31/10/2022	M	H	H	M	M	2	Y	CSD AD SR (AH)
◀▶	3/180 - Partnership and Integration with the NHS	Failure to achieve the best outcomes from working jointly with the NHS across the NYCC footprint, a negative impact on the customer experience and the possibility of fragmented care and poor outcomes.	CD HAS	Dir Public Health HAS All ASC ADs	H	M	H	M	H	1	10	31/12/2022	M	M	H	M	H	2	Y	CD HAS
◀▶	3/167 - Public Health	Failure to manage the response to Coronavirus whilst at the same time deliver a distinctive public health agenda for North Yorkshire and carry out the statutory public health functions and manage within the available funding, together with the impact of the new National Health Strategy, 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	H	M	H	M	M	1	16	31/03/2023	M	M	H	M	M	2	Y	Dir Public Health
◀▶	3/217 - Deprivation of Liberty Safeguards (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 ASC (CJK)	M	H	H	H	H	2	7	31/03/2023	M	H	H	H	H	2	Y	HAS AD ASC (CJK)

North Yorkshire County Council

Health and Adult Services Directorate

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Identity			Person		Classification														Fallback Plan	
					Pre						RR		Post							
Change	Risk Title	Risk Description	Risk Owner	Risk Manager	Prob	Obj	Fin	Serv	Rep	Cat	RRs	Next Action	Prob	Obj	Fin	Serv	Rep	Cat	FBPlan	Action Manager
◀▶	3/27 - Safeguarding Arrangements	Failure to have an effectively monitored, robust, Safeguarding regime and partnership arrangements in place and ensure that we fulfil our wider lead authority role (under the Care Act) results in risk to service users, inability to reach required standard on CQC and adverse effect on Directorate reputation.	CD HAS	HAS AD ASC (CJK) Dir Public Health	M	H	H	M	H	**2**	8	31/03/2023	M	H	H	M	H	**2**	Y	HAS AD ASC (CJK) Dir Public Health
◀▶	3/266 - In-House Social Care Provider Services (incl Regulated Services)	Failure to maintain compliant (safe, effective, caring, responsive and well led) and cost effective regulated and non regulated services with robust governance arrangements (including workforce and health and safety) in place enabling scrutiny at every level of the organisation resulting in enforcement action, service closure and reputational impact	CD HAS	HAS AD ASC (RB)	M	L	L	M	H	**2**	10	30/11/2022	L	L	L	M	H	**3**	N	
◀▶	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	Dir Public Health CSD AD SR (AH)	M	L	M	L	H	**2**	14	30/09/2022	L	L	M	L	H	**3**	Y	CSD AD SR (AH) Dir Public Health

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

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NORTH YORKSHIRE COUNCIL

AUDIT COMMITTEE

12 DECEMBER 2022

COUNTER FRAUD POLICY FRAMEWORK

Report of the Head of Internal Audit

1.0 **PURPOSE OF THE REPORT**

1.1 To seek member approval for the counter fraud policy framework for the new North Yorkshire Council.
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2.0 **BACKGROUND**

2.1 Fraud is a serious risk to the public sector in the UK. When fraud is committed against the public sector, money is diverted from important services into the hands of criminals. Fraudsters are constantly refining their tactics and techniques in order to circumvent the checks and controls put in place to prevent fraud from occurring. In order to protect resources, public sector bodies must therefore continuously review and develop their counter fraud arrangements to meet these evolving threats.

3.0 **THE COUNTER FRAUD POLICY FRAMEWORK**

3.1 As a unitary authority, North Yorkshire Council will be responsible for counter fraud arrangements across a number of new service areas, including business rates, council tax, benefits and housing. The total value of fraud risk facing the Council will therefore be significantly higher than for the County Council. It is therefore important that the Council has a policy framework in place on vesting day in order to effectively address the risks of fraud.

3.2 The draft Counter Fraud and Corruption Policy is attached at **appendix 1**. The policy sets out how suspected fraud should be reported, investigated, and what sanctions can be applied when fraud is found, including prosecution. The policy also contains an Anti-Bribery policy to protect the Council from fraud occurring within the organisation.

3.3 The draft Whistleblowing Policy is attached at **appendix 2**. The policy sets out a process for people working for the Council to report concerns that are in the public interest. It is important that employees and contractors feel comfortable to report concerns and are aware of the protections in law which apply to people who ‘blow the whistle’. It is equally important that managers are aware of what to do when a member of staff reports a concern. The policy therefore contains an appendix which provides a procedure for managers to follow in such circumstances.

3.4 The draft Anti-Money Laundering and Terrorist Financing Policy is attached at

appendix 3. The purpose of the policy is to protect the Council from criminals who try to 'launder' assets obtained through crime and make them appear legitimate. The Council has a legal obligation to report suspicions of money laundering to the National Crime Agency and when undertaking certain types of activity to follow the money laundering regulations.

3.5 The policies contain references to certain posts, other related policies, and service areas which are yet to be determined. The references have been highlighted and will be confirmed ahead of vesting date.

3.6 Further fraud related work is required ahead of vesting day. A draft Counter Fraud Strategy and Fraud Risk Assessment will be presented to the Committee in March 2023, along with the annual counter fraud work programme. Awareness raising and training for staff in all the North Yorkshire councils will also continue up to vesting day to help ensure fraud risks are mitigated.

4.0 **RECOMMENDATION**

4.1 Members are asked to approve the Counter Fraud and Corruption Policy, the Whistleblowing Policy, and the Anti-Money Laundering and Terrorist Financing Policy.

M A THOMAS
Head of Internal Audit

12 December 2022

BACKGROUND DOCUMENTS

None

Report prepared by Jonathan Dodsworth (Veritau – Counter Fraud) and presented by Max Thomas (Head of Internal Audit).

Veritau - Assurance Services for the Public Sector
County Hall
Northallerton

The new council for NORTH YORKSHIRE

COUNTER FRAUD AND CORRUPTION POLICY

Incorporating the Fraud and Corruption Prosecution Policy and the Anti-Bribery Policy

1 Introduction

1.1 Fraud committed against the Council represents the theft of taxpayer's money. It is unlawful and deprives the Council of resources which should be available to provide services to the public. The Council must have effective measures in place to counter risks of fraud and corruption, to help reduce losses and to minimise the impact on services.

1.2 This document sets out the Council's policy on countering fraud and corruption risks. It includes overall arrangements and responsibilities for preventing, detecting and deterring fraud. It includes the Fraud and Corruption Prosecution Policy at annex A and the Anti-Bribery Policy at annex B. It forms part of the Council's overall policy framework for combating fraud and corruption and should be read in conjunction with other relevant guidance and policies including the following.

- The Constitution
- Financial Procedure Rules
- Procurement and Contract Procedure Rules
- Counter Fraud and Corruption Strategy
- Whistleblowing Policy
- Anti-Money Laundering policy
- Disciplinary Procedures

2 Definitions and Scope

2.1 For the purpose of this policy, the term fraud is used broadly to encompass:

- acts which would fall under the definition in the Fraud Act (2006)
- anything which may be deemed fraudulent in accordance with the generally held view of fraud as causing loss or making a gain at the expense of someone by deception and dishonest means
- any offences which fall under the Council Tax Reduction Schemes Regulations (2013) and the Prevention of Social Housing Fraud Act (2013)
- any act of bribery or corruption including specific offences covered by the Bribery Act (2010)
- acts of theft
- any other irregularity which is to the detriment of the Council whether financially or otherwise, or by which someone gains a benefit they are not entitled to.

2.2 This policy does not cover fraud or corruption against third parties, except in circumstances where there may also be a detriment to the Council. It does not cover other acts – for example offences involving violence –

which may affect the Council, which in most cases should be reported directly to the police.

3 Principles

3.1 The Council will not tolerate fraud or corruption in the administration of its responsibilities, whoever commits it. This includes, for example:

- councillors
- officers
- customers receiving services
- third party organisations contracting with the Council
- organisations or individuals receiving funding from the Council
- any other agencies the Council has business dealings with

3.2 There is a basic expectation that councillors, employees, and contractors' staff will act with integrity and with due regard to matters of probity and propriety. All representatives of the Council are required to act lawfully and comply with all rules, procedures and practices set out in legislation, the Constitution, the Council's policy framework, and all relevant professional and other codes of practice.

3.3 The Council will seek to assess its exposure to risks of fraud and corruption. It will prioritise resources available to prevent and deter fraud to help minimise this risk.

3.4 The Council will take all allegations and suspicions of fraud seriously, regardless of the source. It will consider any issues raised and if appropriate will undertake an investigation to confirm whether fraud has occurred and determine appropriate outcomes. Investigations undertaken will be proportionate to the circumstances of the issues raised. The Council may refer any incident of suspected fraud to the police or other agencies for investigation, where appropriate.

3.5 To act as a deterrent, the Council will take action in all cases where fraud (or an attempt to commit fraud) is proven, in proportion to the act committed and through any appropriate route. This may include prosecution, application of internal disciplinary procedures, referral under relevant codes of conduct or to a professional body, or any other action appropriate to the offence. Prosecution decisions will be made in accordance with the Fraud and Corruption Prosecution Policy which is contained in annex A.

3.6 As a further deterrent, and to minimise losses, the Council will attempt to recover any losses incurred through civil or legal action. In addition, the

Council will seek to apply any appropriate fines or penalties, and recover any costs incurred in investigating and prosecuting cases.

3.7 The Council will not tolerate any form of bribery. This includes bribes offered to or by employees, councillors, or suppliers. Any act of bribery puts the Council at risk of committing a criminal offence. Further details about the Council's measures to prevent and detect bribery are contained in the Anti-Bribery Policy which is attached at annex B.

4 Responsibilities

4.1 Overall responsibility for counter fraud arrangements rests with the [CFO / s151 officer] on behalf of the Council. The [CFO / s151 officer] has a responsibility for ensuring the Council has appropriate measures for the prevention and detection of fraud and corruption.

4.2 The Audit Committee has a responsibility to consider the effectiveness of counter fraud and anti-corruption arrangements at the Council. This includes monitoring of Council policies on raising concerns at work and countering the risks of fraud and corruption.

4.3 [Management board / CMT] are collectively responsible for ensuring that the Council has effective counter fraud and corruption procedures; that these comply with best practice and good governance standards; and that they are embedded across the organisation.

4.4 [Veritau] (who provide internal audit and counter fraud services to the Council) is responsible for reviewing the Council's counter fraud and corruption policies on a regular basis and recommending any changes needed. In addition, [Veritau] leads on fraud prevention and detection for the Council and is responsible for investigating suspected cases of fraud or corruption. The internal audit team carries out audit work to ensure that systems of control are operating effectively. This helps to reduce opportunities for fraud to be committed.

4.5 All managers are responsible for preventing and detecting fraud in their service areas. This includes maintaining effective systems of control and ensuring that any weaknesses identified are addressed promptly.

4.6 The Council has a Chief Money Laundering Compliance Officer (CMLCO) who has oversight of all Council anti-money laundering arrangements and is specifically responsible for overseeing money laundering regulations.

4.7 All staff should be aware that fraud and corruption is a threat to the Council and are required to report any suspicions of fraud to [Veritau]. Where appropriate, staff can use the Whistleblowing Policy to raise concerns anonymously.

4.8 Officers within Human Resources are responsible for supporting service departments when pre-disciplinary investigations are required, or disciplinary processes are to be applied.

5 Overall Counter Fraud Arrangements

Introduction

5.1 The purpose of this section is to set out the Council's overall framework for countering the risks of fraud and corruption. The Council aims to follow best practice in countering fraud risks[1], but recognises that new and emerging fraud risks require a dynamic approach to fraud prevention and detection.

Measurement

5.2 The Council will assess potential risks and losses due to fraud and corruption. It will use this information to prioritise counter fraud activity and determine the resources needed to mitigate those risks. A summary of fraud risks and proposed counter fraud activity will be reported to the Audit Committee on an annual basis.

Culture

5.3 The Council will promote a culture where all employees, councillors, service users, and contractors are aware that fraud or corruption in any form is unacceptable. To do this, it will:

- ensure that there are clear arrangements in place for anyone to report suspicions of fraud or corruption (including employees, councillors, partners, contractors, the public or any other stakeholders)

- investigate suspicions reported and take appropriate action wherever evidence of fraud or corruption is found

- ensure that the consequences of committing or taking part in fraud or corruption are widely publicised.

Prevention and Detection

<u>Controls</u>

5.4 As part of normal operations the Council aims to ensure that proper systems of internal control are in place. This includes controls that can directly prevent and detect fraud. For example, separation of duties,

[1] For example the CIPFA Code of Practice on Managing the Risk of Fraud and Corruption.

management review, vetting as part of recruitment processes, and systems for declaring interests or gifts and hospitality. The effectiveness of the systems of control are monitored by internal audit and reported to the Audit Committee.

5.5 Services will be encouraged to consider the risk of fraud as part of the Council's risk management process. Any information on risks identified will be used to inform the annual review of counter fraud activity.

Proactive Work

5.6 The Council will carry out targeted project work (for example data matching exercises) to identify fraud and corruption in known high risk areas. This work will be carried out by [Veritau] as part of its annual work plan. Resources will be prioritised based on an annual assessment of fraud and corruption risks. Work may include joint exercises with other agencies, including other councils.

5.7 The Council will take part in projects led by other agencies that can help to identify potential fraud and corruption – for example the Cabinet Office's National Fraud Initiative. Resources will be allocated to take part in these exercises and to follow up any high risk data matches identified. [Veritau] will support service departments to ensure data is available to be used for matching exercises – for example advising on data protection considerations.

Relationships

5.8 The Council will establish and maintain relationships with external agencies that can help it prevent and detect fraud. These include:

- the police
- the courts
- the Cabinet Office
- the Department for Levelling Up, Housing, and Communities
- the Department for Work and Pensions
- other councils
- other public sector organisations (eg housing associations)
- charities, community and voluntary groups.

5.9 [Veritau] will work with Council departments to ensure that systems for reporting and investigating suspected fraud and corruption are robust.

Fraud Awareness Training

5.10 As part of the annual counter fraud workplan, [Veritau] will provide targeted fraud awareness training to groups of staff in areas at higher risk of fraud and corruption.

Investigation

5.11 Suspected cases of fraud, corruption, theft, or other irregularities considered a high risk will be investigated. The nature of the investigation will depend on the circumstances of each case. Any suspected fraud should be reported to [Veritau] in the first instance. [Veritau] will assess all cases referred and provide advice on whether other agencies should be notified (such as the police). In more complex cases, the extent of investigation required will be decided in consultation with the [CFO / s151 officer], [Monitoring Officer], service department, and human resources, as appropriate. Where necessary, [Veritau] may refer cases to other agencies (for example the police) at the discretion of the Head of Internal Audit. Figure 1 overleaf outlines the fraud referral and investigation process.

5.12 All staff involved in the investigation of fraud will be appropriately trained. They will be required to comply with any relevant legislation and codes of practice. For example, the Police and Criminal Evidence Act (PACE), Regulation of Investigatory Powers Act (RIPA), the UK General Data Protection Regulation (UK GDPR), the Criminal Procedure and Investigations Act (CPIA), and any relevant guidance from the Attorney General. Investigators will consider the individual circumstances of anyone subject to investigation; adjustments to procedure will be made where necessary to ensure that all parties are treated equitably (where it is appropriate and reasonable to do so).

5.13 Every investigation will consider whether weaknesses in controls have contributed to the fraud or error occurring, in addition to other objectives. Where needed, recommendations to improve controls will be made.

Figure 1: North Yorkshire Council investigation process

Fraud suspected by officer, member, contractor or other third party - **reported directly to Veritau** via fraud hotline or fraud email address.

Veritau conduct initial assessment of referral including review of readily available information. Cases with insufficient information to support suspicion of fraud (or insufficient information to investigate) closed and referred back for management action if necessary.

Cases referred to other officers under whistleblowing policy:

- Officer notifies Veritau, who will record details.
- Consultation between officer and Veritau to determine who (if anyone) investigates.
- Where the officer (or someone they nominate) investigates then the outcome will be reported to Veritau for recording purposes.
- Where Veritau investigates, officer to be consulted on progress and at conclusion of case.

Third party frauds: eg adult social care fraud.

Veritau investigate to establish facts. Evidence gathered to criminal investigation standards.

Veritau consult CDSR if there are any sensitive issues or if referral to police is considered.

Veritau consult service departments as necessary during investigation.

Fraud proven:

- recommendation to authorised officer about action (eg prosecution/ sanction)
- refer any management action required to service department.

Fraud not proven: case closed - refer any management action required to service department.

All cases - report control weaknesses to service and copy in CDSR.

Internal fraud: internal fraud cases which may require pre-disciplinary investigation.

- Where appropriate consult CDSR on conduct of case.
- Liaise with HR on potential for disciplinary issues.
- Veritau consult CDSR if referral to police

FACT FINDING INVESTIGATION TO CRIMINAL STANDARD

Fact finding investigation started by Veritau. Evidence gathered to criminal investigation standard.

During conduct of investigation:

- Maintain contact with CDSR, HR, and service managers as appropriate.
- Liaise with HR and service where pre-disciplinary investigation may need to be started.
- Keep under review whether the case needs to be referred to the police or another agency (and liaise with CDSR if so)
- Liaise with investigating manager on ongoing basis if pre-disciplinary investigation commenced.

Interviews:

- If pre-disciplinary investigation started interview witnesses and employee(s) concerned jointly with pre-disciplinary IM unless an interview under caution (IUC) is required.
- IUC to be considered if main areas requiring investigation are sufficiently advanced and there is clear evidence that offences may have been committed, which need to be put to the employee concerned.

Fraud proven - full investigation report produced including:

- recommendation that service consider pre-disciplinary investigation (if not started)
- recommendations about other appropriate sanctions for CDSR to authorise
- details of any control or other issues that require addressing by the service.

Fraud not proven - full investigation report produced which outlines the findings and includes details of any control issues that require addressing by the service.

PRE-DISCIPLINARY INVESTIGATION

Pre-disciplinary investigation to start at the point there is clear evidence of potential employment related misconduct to be investigated.

This is often at the conclusion of the fact finding investigation. However, the need to act promptly and fairly may mean the pre-disciplinary investigation commences earlier. Where suspension may be appropriate (for example to preserve evidence) then a pre-disciplinary investigation will commence.

Where pre-disciplinary investigation commences before end of the fact finding investigation:

- Service appoint an investigating manager (IM).
- IM determines what information is needed in relation to the pre-disciplinary investigation and will instruct Veritau, who will gather the evidence.
- IM / Veritau investigating officers to liaise on ongoing basis.
- IM interviews witnesses and employee(s) concerned jointly with Veritau investigators, unless the fact finding investigation has determined an interview under caution with the employee concerned is required.
- IM to request interim report from Veritau once the fact finding investigation has substantially concluded (ie there are no significant avenues of investigation that are incomplete). Interim report to contain all details required for IM to draw conclusions.
- Veritau investigators available as witnesses for any subsequent disciplinary process.

Civil action may be taken in relation to any investigation which identifies financial loss to the council, or where financial redress may be sought. This will generally commence later in the investigation, once clear evidence of any actual loss to the council has been gathered through the fact finding investigation. In some cases, accredited financial investigators may be employed at an early stage to identify and restrain assets related to criminal activity.

5.14 The Head of Internal Audit will ensure that systems for investigating fraud are reviewed on an ongoing basis, to ensure that they remain up to date and comply with best practice.

Publicity

5.15 Targeted publicity will be used to raise awareness of fraud risks to employees, councillors, the public, and other agencies. This will include internal and external publicity. The aim of this will be to ensure that stakeholders:

- are alert to the risks of fraud and corruption
- know how to report suspicions of fraud
- are aware of the Council's zero tolerance approach to fraud and corruption.

5.16 The Council will publicise all successful prosecutions by itself or by partner organisations, to act as a deterrent against future fraud.

Recovery of Monies

5.17 Fraud and corruption will generally result in a loss to the Council or additional costs being incurred. Where this is the case, the Council will seek to recover its loss (or costs) from the individual or organisation responsible. This action helps to reduce the financial impact of fraud and acts as a deterrent. As a further deterrent, the Council will seek to apply any appropriate fines or penalties where it is possible and desirable to do so.

5.18 Methods of recovery include (but are not limited to):

- civil enforcement through the courts
- recovery from assets held by the organisation or individual using the Proceeds of Crime Act or other relevant legislation
- recovery from salary payments for Council employees
- recovery from pension benefits for members of the LGPS
- petitioning for bankruptcy if appropriate.

6 Monitoring & Review Arrangements

6.1 The arrangements set out in this policy will be reviewed on an annual basis as part of the counter fraud workplan. If required, updates will be presented to the Audit Committee for approval.

POLICY APPROVED XX XX 2022

ANNEX A

The new council for
NORTH
YORKSHIRE

FRAUD AND CORRUPTION PROSECUTION POLICY

1 Scope and Purpose

1.1 The Council is committed to deterring fraud and corruption and recovering public funds. The decision to prosecute an individual is always a serious matter; however fair and effective enforcement is essential in protecting the Council from fraud.

1.2 Prosecution has a serious effect on suspects, witnesses, victims, and the public, so it is essential that the Council makes fair, consistent, and timely decisions in all cases. Where appropriate, lesser sanctions can be considered instead of prosecution.

1.3 This policy sets out the decision-making process for those cases where fraud or corruption has been found to have been committed against the Council.[2] Decisions should be fair, appropriate, and in the best interests of both the public and the Council.

1.4 The policy is based on principles set out in the Crown Prosecution Service's Code for Crown Prosecutors.

2 Principles

2.1 All decisions on intended prosecutions should be transparent and independent from the investigating officer(s) involved in the case. Any decision to prosecute should only be made after a review by appropriate officers and be authorised by a senior council officer. All decisions and the reasons for them should be properly documented.

2.2 When making decisions on prosecutions, officers must be fair and objective. They must not let any personal views about the ethnic or national origin, gender, disability, age, religion or belief, sexual orientation or gender identity of the suspect, defendant, victim or any witness influence their decisions. Neither must they be motivated by political considerations. In prosecuting individuals, the Council must always be acting in the interests of justice and not solely for the purpose of obtaining a conviction. Decisions should be consistent with Council policy and the law on equalities and human rights. The circumstances of the offence and any mitigation offered by the offender should be taken into consideration when making a decision.

2.3 The consistent application of the policy will help ensure that those who have perpetrated fraud and corruption are appropriately penalised. It will also act as a meaningful deterrent to those who are contemplating

[2] This policy does not cover internal disciplinary procedures which are the subject of separate policies, nor does it cover offences other than fraud and corruption which are dealt with by relevant service departments under other policies and specific legal powers.

committing fraud or corruption. The Council recognises the deterrent value of good publicity and therefore information regarding successful prosecutions and sanctions will be made public.

2.4 Staff and members who are found to have committed fraud or corruption against the Council may be prosecuted in addition to such other action(s) that the Council may decide to take, including disciplinary proceedings in the case of staff, and referral to the Standards Committee in the case of members. Any decision not to prosecute a member of staff for fraud and corruption does not preclude action being taken in accordance with the Council's disciplinary procedures or other policies.

2.5 Irrespective of the action taken to prosecute the perpetrators of fraud and corruption, the Council will take whatever steps necessary to recover any losses incurred, including taking action in the civil courts.

3 Prosecution

3.1 Local authorities are granted the power to prosecute under the Local Government Act 1972 (section 222). The legislation states that these powers should only be used for "the promotion or protection of the interests of the inhabitants of their area".

3.2 Not every contravention of the law should be considered for prosecution. The Council should weigh the seriousness of the offence alongside other relevant factors, including the circumstances of the offender, the level of any financial loss to the Council, mitigating circumstances and other public interest criteria.

3.3 A prosecution should only be considered if the investigation has passed two tests: the evidential test and the public interest test.

3.4 To pass the evidential test, authorised officers must be satisfied that there is a realistic prospect of conviction based on the available evidence (that is, there must be sufficient admissible, substantial and reliable evidence to secure a conviction). They should also consider what the defence case may be, and how it is likely to affect the prospects of conviction.

3.5 In deciding whether there is sufficient evidence to prosecute, the Council should consider the following questions:

- Is the evidence admissible in court
- Is the evidence reliable
- Is the evidence credible

- Is there any unused or unexamined material that might undermine the proposed charges
- Is there any additional evidence that could be obtained through further reasonable lines of enquiry?

3.6 Where there is sufficient evidence to justify a prosecution, authorised officers should consider whether a prosecution is required in the public interest. They should consider:

- How serious is the offence committed
- What is the level of culpability of the suspect
- What are the circumstances of, and harm caused to the victim
- What was the suspect's age and maturity at the time of the offence
- What is the impact on the community
- Is prosecution a proportionate response
- Do sources of information require protecting?

3.7 Where an investigation is found to meet the evidential test, but not the public interest test consideration should be given to lesser sanctions such as a formal written warning or a financial penalty (where appropriate).

3.8 Investigating officers and prosecutors will review the appropriateness of pre-charge engagement where prosecution is considered. This is likely to occur where such engagement may lead the defendant to volunteer additional information that may identify new lines of inquiry. Pre-charge engagement may be instigated by the investigating officer, the Council prosecutor, the defendant's representative or a defendant themselves (if unrepresented).

4 Alternatives to Prosecution

4.1 If a case is considered strong enough for prosecution but there are mitigating circumstances which cast a doubt as to whether a prosecution is appropriate then the Council may consider the offer of a sanction instead. The two sanctions available are:

- a formal written warning
- a financial penalty.

Formal Written Warnings

4.2 A formal written warning can be given to a person who has committed an offence, as an alternative to prosecution in certain circumstances. All warnings are recorded internally and kept for six years. If a person who has received a formal warning re-offends then this will influence the decision on whether to prosecute or not.

4.3 For less serious offences a formal warning will normally be considered where all of the following apply:

- there is no significant public interest in prosecuting
- it was a first offence, and
- a financial penalty is not considered to be appropriate (for Council Tax Support offences).

Only in very exceptional circumstances will a further warning be issued for a second or subsequent offence of the same nature.

4.4 Offenders will usually be asked to attend the Council's offices to receive the formal written warnings in person. For more minor offences an advisory letter can be issued by post.

Financial Penalties

4.5 In cases of Council Tax Support fraud, legislation[3] allows for a financial penalty to be offered to offenders as an alternative to prosecution. The penalty is set at 50% of the amount of the excess reduction, subject to a minimum of £100 and a maximum of £1,000. Once a penalty is accepted, the claimant has 14 days to consider their decision.

4.6 Subject to the criteria set out in the guidelines below, a financial penalty will normally be offered by the Council in the following circumstances:

- the council believes that there is sufficient evidence to prosecute
- it was a first offence or a previous offence was dealt with by way of a formal warning, and
- in the opinion of the Council, the circumstances of the case mean it is not overwhelmingly suitable for prosecution, and
- the claimant has the means to repay both the overpayment and the penalty, and
- there is a strong likelihood that both the excess reduction and the penalty will be repaid.

4.7 It is important to note that the claimant does not need to have admitted the offence for a financial penalty to be offered. Financial penalties will be administered by authorised officers. If a financial penalty is not accepted or the acceptance is later withdrawn then the Council will usually consider the case for prosecution. In such cases the court will be informed that the defendant was offered a penalty but declined to accept it.

[3] The Council Tax Reduction Schemes (Detection of Fraud and Enforcement) (England) Regulations 2013

5 Proceeds of Crime Act 2002 (POCA)

5.1 In addition to the actions set out in this policy, the Council reserves the right to refer all suitable cases for financial investigation with a view to applying to the courts for restraint and/or confiscation of identified assets. A restraint order will prevent a person from dealing with specific assets. A confiscation order enables the Council to recover its losses from assets which are found to be the proceeds of crime.

6 Implementation Date

6.1 This policy is effective from 1 April 2023 and covers all decisions relating to prosecutions and sanctions after this date.

ANNEX B

ANTI-BRIBERY POLICY

1 Introduction

1.1 The Bribery Act became law in 2011. It enables appropriate action to be taken against all forms of bribery.

1.2 Bribery is defined as the offering, giving, receiving, or soliciting of any item of value to influence the actions of an official or other person in charge of a public or legal duty. The act of bribery is the intention to gain a personal, commercial, regulatory, or contractual advantage. The Council does not tolerate any form of bribery.

1.3 Facilitation payments are unofficial payments made to public officials to secure or expedite actions. These are not tolerated and are illegal.

1.4 This policy should be read in conjunction with the [Council's Gifts and Hospitality Protocol].

2 Principles

2.1 The Council is committed to preventing, detecting, and deterring bribery. It aims to:

- ensure all employees, workers, councillors, and other relevant groups are aware of their responsibilities under this policy by publicising it and providing training
- encourage employees to be vigilant and report any suspicions of bribery
- investigate any allegations of bribery or assist the police or other agencies in any investigations or prosecutions they undertake
- take action against anyone involved in bribery in relation to Council business.

3 Scope

3.1 This policy relates to all Council activities. It applies to employees, workers, agency staff, volunteers, consultants, and councillors.

3.2 For partners, joint ventures, and suppliers, we will seek to promote the adoption of policies consistent with the principles set out in this policy.

3.3 The Council requires employees, councillors and other relevant people to:

- raise concerns if they believe that this policy has been breached or may be breached in the future

- comply with the spirit, as well as the letter, of the laws and regulations of all jurisdictions in which the Council operates, in relation to the lawful and responsible conduct of activities.

3.4 As well as potential civil action and criminal prosecution, employees breaching this policy may face disciplinary action. This could result in dismissal in cases of gross misconduct.

4 Offences

4.1 There are four key offences under the Bribery Act 2010.

Section 1 – Offence of bribing another person

4.2 This section makes it an offence when a person offers, promises, or gives a financial or other advantage to another person and intends the advantage to induce a person to perform improperly a relevant function or activity or to reward a person for the improper performance of such a function or activity.

4.3 It is also an offence when a person offers, promises, or gives a financial or other advantage to another person and knows or believes that the acceptance of the advantage would itself constitute the improper performance of a relevant function or activity.

Section 2 – Being bribed

4.4 This section makes it an offence when a person requests, agrees to receive or accepts a financial or other advantage intending that, in consequence, a relevant function or activity should be performed improperly.

4.5 It is an offence when a person requests, agrees to receive or accepts a financial or other advantage and the request, agreement, or acceptance itself constitutes the improper performance of the person of a relevant function or activity.

4.6 It is an offence if a person requests, agrees to receive or accepts a financial or other advantage as a reward for the improper performance of a relevant function or activity.

4.7 It is also an offence if a person in anticipation of or in consequence of the person requesting, agreeing to receive, or accepting a financial or other advantage, a relevant function or activity is performed improperly.

Section 6 – Bribery of foreign public officials

4.8 Under this section of the Act an offence is committed when a person intends to influence a foreign official in their official capacity and intends to obtain or retain business or an advantage in the conduct of business.

4.9 It is also an offence to offer, promise or give any financial or other advantage to a foreign public official.

Section 7 – Failure of a commercial organisation to prevent bribery

4.10 A relevant commercial organisation is guilty of an offence if a person associated with the organisation bribes another person intending to obtain or retain business for the organisation or to obtain or retain an advantage in the conduct of business for the organisation and the organisation fails to take reasonable steps to implement adequate procedures to prevent such activity.

Corporate responsibility

4.11 While the first three offences of the Bribery Act relate to the actions of people, a section 7 offence relates to the inaction of an organisation to prevent bribery. The legislation was drafted with commercial businesses in mind and after the legislation was adopted there was some debate as to whether public sector organisations could be found liable of the offence. In 2012 the government published guidance which clarified that any public sector organisation that "engages in commercial activities, irrespective of the purpose for which profits are made"[4] could be found guilty of a Section 7 offence.

4.12 North Yorkshire Council should be considered as commercial organisation under the legislation and could therefore be found to be corporately responsible for acts of bribery that occur within it. It is therefore important that it takes steps to prevent bribery from occurring.

4.13 If an offence has occurred, then the courts will consider six tests to determine whether the Council had any responsibility for the act.

[4] Paragraph 35 of Bribery Act 2010: Guidance to help commercial organisations prevent bribery https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832011/bribery-act-2010-guidance.pdf

- Does the Council have proportionate procedures in place to prevent bribery by persons associated with it? These should be clear, practical, and accessible?
- Is there top-level commitment to preventing bribery? This includes support by councillors as well as officers.
- Is the Council's exposure to potential external and internal risks of bribery periodically assessed?
- Does the Council take a proportionate and risk based approach to mitigate bribery risks?
- Are anti-bribery policies and procedures embedded and understood throughout the organisation? Are they communicated internally and externally?
- Are procedures monitored and reviewed regularly?

Penalties

4.14 A person guilty of an offence under sections 1, 2, or 6 of the Bribery Act may be sentenced to:

- a maximum prison sentence of 12 months and/or a fine not exceeding £5,000 (if convicted in a magistrates court)
- a maximum prison sentence of 10 years and/or an unlimited fine (if convicted at a crown court).

4.15 An organisation found guilty of allowing bribery offences to occur may be subject to an unlimited fine that is in part determined by the gain that was sought to be made through bribery offences and an assessment of an organisation's culpability by the court.

5 How to raise a concern

5.1 All stakeholders have a responsibility to help the Council prevent and detect bribery and corruption. Any suspicions should be reported as soon as possible.

5.2 Members of staff should report suspicious activity to the counter fraud hotline on [0800 9179247 or by email to counter.fraud@veritau.co.uk.]. Alternatively, employees, workers, or contractors may raise concerns through the Council's Whistleblowing arrangements.

5.3 The Council will support anyone who reports suspicions or raises concerns, even if those concerns prove to be incorrect. It is committed to ensuring nobody suffers detrimental treatment because they refuse to take part in bribery or corruption, or because they report a concern that they believe is true.

6 What to do if someone reports a concern

6.1 All reports of possible bribery should be reported without delay to the Council's [CFO / s151 officer], [Monitoring Officer], and [Veritau].

The new council for
NORTH
YORKSHIRE

WHISTLEBLOWING POLICY

OFFICIAL

1 INTRODUCTION

1.1 This policy provides a framework for employees, workers, and contractors to raise concerns about issues happening at the Council. For example, health and safety risks, criminal or unlawful activity, or activities that could damage the environment. It sets out how concerns can be raised and the protection that people working for the Council have if they raise an issue.

1.2 This policy covers concerns raised by employees, workers, and contractors. It reflects the specific protections they have in law when making a protected disclosure. This is also known as raising a whistleblowing concern or blowing the whistle. Further information on what a protected disclosure is, and who the law protects is set out below.

1.3 North Yorkshire Council is committed to maintaining high standards of integrity and accountability. It aims to create an open environment in which employees and those working on behalf of the Council can raise issues and be confident that they will be acted upon. The Council's message to anyone working for the council is straightforward - <u>if in doubt, raise it!</u>

1.4 The Public Interest Disclosure Act 1998 (PIDA) is the law that protects people against detrimental treatment or dismissal if they make a protected disclosure. It is part of the Employment Rights Act 1996. This policy is designed to reflect the legislation[1] as well as guidance from the government and other organisations[2].

1.5 A guide for managers and other employees on what to do if they receive a whistleblowing report is contained in appendix A of this policy. A training package for managers on whistleblowing can be found on the Council's Learning Zone. The Learning Zone also includes a training package for all employees about whistleblowing. This provides further information on the issues set out in this policy.

2 AIMS AND SCOPE OF THE POLICY

2.1 This policy aims to:

- encourage workers to raise concerns they have about their workplace or working practices
- make sure managers know what a whistleblowing concern is and how they must address it

[1] PIDA 1998 was updated by the Enterprise and Regulatory Reform Act 2013.
[2] Whistleblowing guidance has been issued by the Department for Business, Energy & Industrial Strategy, the National Audit Office and the charity, PROTECT.

- ensure that workers receive a response to any concern raised
- inform workers about how they can pursue an issue further if they are not satisfied with the action taken by the Council
- reassure workers that they will be protected from dismissal or negative treatment if they raise concerns.

2.2 This policy applies to most people working for the Council. This includes employees, workers, staff in maintained schools, agency personnel, contractors and staff seconded to or from a third party. Throughout the rest of the policy, the terms worker, or workers is used to mean anyone covered by the policy and the protections of PIDA.

2.3 PIDA does not provide protection under the law for job applicants, genuinely self-employed workers, or volunteers.

Definitions

2.4 Protected disclosures are concerns raised that are protected under PIDA. To be a protected disclosure, anyone raising a concern must:

- reasonably believe that their concern is in the public interest – this is explained in paragraph 2.6.
- reasonably believe their concern is a type of wrongdoing covered by the law – a list of the types is included in paragraph 2.7.
- raise it in a way that that is in accordance with the law – further information on this is provided in section 7.

2.5 A reasonable belief is one where the whistleblower has some reasonable grounds or basis for believing there has been wrongdoing. It does not actually have to be true. For example, it does not matter if it turns out they were mistaken if they had reasonable grounds for believing it when they originally raised the concern.

2.6 An issue in the public interest means that it will usually affect people other than just the person raising it. Something that relates only to an individual's own employment may not be covered by the law. Although there are some circumstances when this could still be in the public interest. For example, an issue about bullying or harassment that reflects a wider cultural issue in a team. This policy is intended to cover workers raising an issue in the public interest. If a person needs to address a problem that relates only to their own employment, then they should refer to the [Raising Concerns at Work Policy].

2.7 The list below sets out the types of concerns that qualify for protection under the law if they are raised.

- A criminal offence – for example corruption, theft, or fraud.
- Failure to comply with a legal obligation such as a statutory requirement, a contract, or common law obligations (eg negligence).
- A miscarriage of justice.
- Health and safety risks. This includes risks to anyone, not just workers – for example risks to customers and service users.
- Environmental damage – any wrongdoing that endangers or damages the environment.
- Cover up. This includes anything where wrongdoing in any of the above areas has been deliberately concealed.

3 SAFEGUARDS

3.1 The Council recognises that a decision to report a concern can be a difficult one. In many cases it is workers who are best placed to learn of wrongdoing within service areas and schools or to hear about issues where standards have fallen below those that the Council and public expect. The Council is grateful to everyone who reports their concerns.

3.2 Workers should have nothing to fear by reporting their concerns if they have grounds for believing what they are reporting is true. Even if it is later found to be incorrect. No action will be taken against anyone genuinely reporting a concern.

3.3 While rare, deliberately false reports are sometimes made. If false or deliberately misleading information is provided, then this would be considered a serious matter. It could result in action being taken under the Council's disciplinary policy. Equally, deterring another worker from reporting a genuine concern is also a serious matter and may result in disciplinary action being taken.

3.4 The Council will not tolerate any negative treatment (including harassment or victimisation) of a worker who has raised a whistleblowing concern, by anyone (including colleagues and managers). Any allegations of negative treatment of someone raising a concern will be investigated. Where evidence of mistreatment is found then this could result in disciplinary action being taken.

3.5 The Council recognises that workers may want to raise a concern in confidence under this policy. If a worker asks the Council to protect their anonymity, then efforts will be made to protect their identity from being disclosed. However, this cannot be guaranteed. For example, if evidence needs to be presented in court, or revealed as part of a subsequent investigation. If it becomes clear that a whistleblower's anonymity cannot

be protected, then this will be discussed with them before any disclosure is made.

3.6 The Council encourages workers to put their names to information they disclose. Concerns expressed anonymously will be considered by the Council. However, they can be harder to investigate. This may make it more difficult to gather evidence to confirm wrongdoing. It will also not be possible to provide feedback to an anonymous whistleblower during or following an investigation. Anonymous reports are however preferred to silence.

4 HOW TO RAISE A CONCERN

4.1 Many whistleblowing concerns are raised and properly addressed within individual service areas. In most cases, workers are therefore encouraged to raise concerns with their line manager in the first instance[3]. Line managers will provide feedback to the whistleblower about the action they are taking. Contractors should report issues to the Council's designated contract or client manager.

4.2 Concerns do not have to be made in writing. Any issues raised verbally will be treated just as seriously.

4.3 If a worker raises an issue with their line manager but it is not adequately addressed or if the concern involves the line manager, then they should speak to a more senior officer. School-based workers can escalate issues to the chair of governors.

4.4 The Council recognises that there may be times when whistleblowers feel unable to speak to anyone in their own service area. For example, if they believe the issue involves more senior officers or if the issue has already been raised through the normal channels but has not been addressed. In this situation workers can contact the Council's independent whistleblowing hotline on [0800 9179 247, which is overseen by Veritau].

4.5 If anonymous concerns are raised through social media, then they will be considered under the more general counter fraud or complaints policies unless it is beyond doubt that the person raising the concern would fall under the whistleblowing policy.

[3] People raising a concern may not directly say they are whistleblowing or making a protected disclosure. It is therefore essential that managers understand when an issue raised with them would be considered whistleblowing. Further information is available in the guidance notes included with this policy. Training is also available through the Learning Zone. Managers can also contact [Veritau] for advice on any issues raised.

5 HOW THE COUNCIL WILL RESPOND

5.1 All whistleblowing reports will be carefully considered. Initial enquiries will be made to help decide whether an investigation is needed or what action may be required.

5.2 The Council aims to acknowledge all whistleblowing reports within five working days. The line manager or other officer dealing with a whistleblowing issue will try to write or speak to the whistleblower promptly, to provide additional information on what is being done. For example, whether an investigation is needed or if specific action is to be taken.

5.3 If an investigation is undertaken, the line manager or investigating officer will provide feedback on the outcome, and details of action to be taken as far as possible. Although it may not always be possible to provide full details. For example, it would not be appropriate to share personal data about other people.

6 INVESTIGATION AND REPORTING PROCESS

6.1 The steps line managers need to take will depend on the nature, complexity, and seriousness of the issue raised. An outline of the process managers should follow is set out below. Further information for managers on who they need to inform about whistleblowing issues is set out in the guidance at appendix A.

6.2 Straightforward whistleblowing issues may be dealt with directly by line managers. The manager must ensure the requirements for acknowledging concerns and providing feedback are followed (see section 5 above). When the issue has been dealt with, the line manager must provide details to [Veritau] of the concern raised and the outcomes ([Veritau] keeps a record of all whistleblowing concerns raised, on behalf of the Council).

6.3 For more complex cases, and any case involving suspected fraud, corruption, or theft, managers must refer the issue to [Veritau] at the outset. [Veritau] will liaise with the manager to decide how the issue should be investigated. The officers assigned to investigate each case will depend on the nature of the issue. For example, safety issues may be investigated by the Health & Safety Team, alleged fraud or criminality by the Counter Fraud Team, or employment issues by the manager or a manager from another team, with support from Human Resources.

6.4 The amount of contact between officers investigating whistleblowing concerns and the whistleblower will depend on the nature of the matters

raised and the clarity of the information provided. If necessary, further information may be sought from the whistleblower.

6.5 If a face to face meeting is necessary or desirable the whistleblower has the right, if they so wish, to be accompanied by a Union representative or a colleague who is not involved in the area of work to which the concern relates.

6.6 The Council will take steps to support whistleblowers during an investigation, where possible. For example, if they are required to give evidence in any proceedings, the Council will provide advice and support with the process as far as appropriate. Whistleblowers should contact HR if they suffer any negative treatment as a result of raising an issue. Investigating managers should be alert to the possibility of a whistleblower being mistreated and should liaise with the Head of HR or relevant HR business partner if they have concerns.

6.7 All whistleblowing issues raised will be logged centrally by Veritau. The Chief Executive, [CFO / s151 officer], and [Monitoring Officer] will be notified of relevant whistleblowing issues. Numbers of whistleblowing concerns raised and significant trends will also be reported annually to the Audit Committee.

7 HOW MATTERS CAN BE TAKEN FURTHER

7.1 This policy aims to provide workers with the means to raise concerns within the Council. If workers have reported an issue in accordance with the policy, but are not satisfied that it has been addressed then they may contact the following prescribed bodies:

- the Council's External Auditor – [TBD]
- the NSPCC or Ofsted (for concerns about children at risk of abuse)[4]
- relevant professional bodies or regulatory organisations[5], for example, the Information Commissioner's Office, Care and Quality Commission (CQC), and the Health and Safety Executive.

7.2 Disclosure of issues to a non-prescribed body (such as a newspaper or through social media) does not provide whistleblowers with protection under PIDA. Workers who are considering making a disclosure, other than to the prescribed bodies, should obtain specialist legal advice before doing so.

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[4] The NSPCC and Ofsted offer dedicated national whistleblowing hotlines (see www.nspcc.org.uk and www.gov.uk/government/organisations/ofsted for further details).

[5] The Department for Business, Innovations and Skills maintains a list of prescribed persons and organisations who may be contacted, www.gov.uk/government/publications/blowing-the-whistle-list-of-prescribed-people-and-bodies--2/whistleblowing-list-of-prescribed-people-and-bodies.

8 INDEPENDENT ADVICE

8.1 Free confidential advice on how to raise a concern about malpractice at work can be sought from the independent charity PROTECT. They can be found at www.protect-advice.org.uk, or contacted by email at info@protect-advice.org.uk. The charity's lawyers can give free confidential advice about how to raise a concern about serious malpractice at work.

9 DATA PROTECTION

9.1 When managing whistleblowing reports, the Council processes personal data collected in accordance with its information governance policies. Data collected following receipt of a whistleblowing concern is held securely. It is only accessed or disclosed to individuals as necessary to manage, investigate, or take action in relation to the concern raised.

10 REVIEW OF THE POLICY

10.1 This policy will be reviewed at least every three years or when any significant changes to whistleblowing legislation, guidance or case law occurs.

Appendix A

Managers' Guidance on Whistleblowing

1 Introduction

1.1 The Council's whistleblowing policy aims to encourage employees, workers, and contractors[6] to raise concerns about activities in the workplace. It contains further information about what whistleblowing is and should be read alongside this guidance.

1.2 All managers are expected to take concerns raised by workers seriously and to follow the process set out in this guidance. Further training on whistleblowing is available through the Council's Learning Zone.

2 What is a whistleblowing complaint?

2.1 Managers need to consider any concern raised by a worker about working practices or malpractice, to assess whether it is a whistleblowing issue.

2.2 The concern does not have to be raised in writing. Issues raised verbally should be treated as seriously as those raised in writing. You should carefully document anything raised verbally with you.

2.3 It is not necessary for the term "whistleblowing" or "protected disclosure" to be used for an issue to be considered whistleblowing. Any concern that falls under the types of issues covered by the policy (see paragraph 2.7 of the main policy) may be a whistleblowing issue. The range of issues that could qualify is very broad and could include problems that may not initially appear very serious. For example, relatively minor breaches of health and safety processes or issues concerning a breach of contract. Care must therefore be taken to assess any issue raised with you, to consider whether it is whistleblowing.

2.4 Whistleblowing will generally be about issues that relate to more people than the individual who raised it. If it is clear that a concern relates only to an individual worker, then it should be considered under the [Resolving Issues at Work Policy]. However, care is needed when deciding this. For example, a report of bullying could just be about one worker. However, it could also reflect a culture of bullying and harassment in a service area. In this case the concern may be whistleblowing.

2.5 Whistleblowing reports can only come from people who work for the Council (including contractors). Further detail about who can report a concern is set out in paragraphs 2.2 and 2.3 of the policy. Concerns raised by members of the public or other groups would not be considered as whistleblowing. They should still be taken seriously though and directed to

[6] Throughout the rest of the guidance, the terms worker, or workers is used to mean anyone covered by the whistleblowing policy and the protections of PIDA.

the relevant team. For example, the Council's [complaints and feedback team] or the counter fraud team.

2.6 Whistleblowing reports are often made anonymously. Where an anonymous report is made, you should try to encourage (but not pressure) the person to give their name. For example, if you are taking information by phone or have an email address you can respond to. Make it clear that it can be more difficult to investigate concerns if contact with the whistleblower is not maintained.

2.7 Concerns or complaints about councillors are not covered by the whistleblowing policy. They would come under the Council's Standards procedures. Any issues relating to councillors should be referred to the [Monitoring Officer] for advice.

2.8 If you are not sure whether an issue should be classed as whistleblowing then advice can be sought from [Veritau] [7].

3 Reporting the receipt of a whistleblowing concern

3.1 Section 6 of the policy sets out what managers should do when they receive a whistleblowing concern. Managers should also notify their assistant director (or the chair of governors, for schools). They should also inform the Head of HR or HR business partner responsible for their area.

3.2 If the issue involves any of the people named above then you should tell a more senior officer such as the corporate director, [CFO / s151 officer], the Head of Internal Audit or the [assistant director for education] (in the case of schools).

3.3 [Veritau] maintains a central log of all whistleblowing reports received. Where a whistleblowing issue is handled within a service area or directorate, the outcome of any investigation and action taken should be reported to [Veritau] once the matter is completed.

3.4 If you are unsure about how to deal with a whistleblowing issue then you can seek advice from [Veritau]. Any complex issues, or any case involving fraud, corruption or theft should be reported to [Veritau] immediately. [Veritau] will determine how the issue should be investigated, in consultation with other relevant officers.

3.5 If you receive details of a whistleblowing concern raised with an external body (one of the prescribed persons and organisations set out in section 7 of the policy), the information should be forwarded to [Veritau].

[7] [Veritau] can be contacted by email on whistleblowing@veritau.co.uk

4 Initial response

4.1 If you are notified of a concern, you should acknowledge it immediately. Unless it was raised anonymously (with no reply address) then this should usually be done by email. If you are notified verbally, you should try to find out as much information as possible and document it. Try to obtain contact details if possible. Where information is received in writing you should usually try to arrange a meeting with the whistleblower to gather further information.

4.2 This initial meeting can be done in person, in or outside of the Council's offices, or by telephone. It is important to find an environment that the whistleblower feels comfortable with. They may be supported by a trade union representative or colleague. A note taker can be brought to the meeting with prior agreement from the whistleblower.

4.3 If anonymity is requested then every effort should be made to keep the whistleblower's identity concealed. However, anonymity cannot be guaranteed and you should not promise this. If it becomes apparent that a whistleblower's identity may become known, then they should be told about this as soon as possible.

4.4 All information relating to a whistleblowing report or gathered during a subsequent investigation should be kept confidential. Information should only be shared on a strictly need to know basis.

4.5 A record of any meetings with the whistleblower should be made either contemporaneously or as soon as possible afterwards. These notes must be kept securely.

4.6 No commitments should be made about the process or outcome of a whistleblowing investigation. However, the whistleblower should be reassured that their concerns will be taken seriously.

4.7 Any additional information you obtain should be shared with the people you have already notified (paragraphs 3.1 and 3.2 above) or with [Veritau], if the issue is to be referred to them.

5 Conducting an investigation

5.1 At the start of an investigation, the person looking into the issue should inform the whistleblower that they are investigating the matter.

5.2 Updates should be provided to the whistleblower during the investigation if this is possible. However, only appropriate information can be shared. Personal data about other people must not be shared. Nor can any

information that may prejudice the investigation. In some cases, it may be better to wait until the end of the investigation before sharing any details (although personal data cannot be shared at any point).

5.3 Notes should be made throughout the investigation about the action being taken and evidence collected. Conclusions should also be documented.

5.4 The investigator should consider whether any action to be taken during the investigation is likely to lead to the identity of the whistleblower becoming known. If it becomes apparent that the investigation cannot be pursued without the whistleblower's identity becoming known, then they should be made aware of this before further action is taken. The whistleblower's name should only be made known to other people on a need-to-know basis.

5.5 Investigations should be completed as quickly as possible. Where a whistleblowing investigation leads to other Council processes being considered or commencing (such as a pre-disciplinary investigation) then relevant officers should be made aware at an early stage.

5.6 At the conclusion of an investigation a report should be prepared setting out all of the evidence gathered and stating whether it confirms or contradicts the original issue raised. It should also set out the conclusions reached, and recommendations. The report should be shared with those notified of the issue originally (paragraphs 3.1 and 3.2 above). A copy should also be sent to [Veritau].

6 Special circumstances

Safeguarding concerns

6.1 If a concern raised includes issues relating to safeguarding, then the manager notified should ensure that it is raised immediately through normal Council safeguarding arrangements.

Anonymous concerns

6.2 If a concern has been made anonymously then it must still be treated as credible and dealt with through the procedure detailed in this guidance.

Negative treatment of the whistleblower

6.3 The Council will not tolerate any negative treatment of whistleblowers. If any manager becomes aware of any mistreatment of a whistleblower, they should report this to the Head of HR or relevant HR business partner as soon as possible. The Council may be in contravention of whistleblowing legislation if action is not taken to address this behaviour.

Vexatious or malicious reports

6.4 If a whistleblower acts in bad faith or raises malicious, vexatious, or knowingly untrue concerns then they may be subject to disciplinary action. If you have reasonable grounds to suspect that this may be the case, then the matter should be reported to the Head of HR or relevant HR business partner.

External disclosures

6.5 It is important to be supportive and encouraging to those raising a concern. However, if a worker indicates that they are considering taking their concerns outside of the Council, for example to the media or social networking sites, you should advise them of the following:

- You will not be able to support them if they take this action
- Their disclosure may not be covered by the whistleblowing policy and relevant legislation
- Their action may represent an unauthorised disclosure
- They could jeopardise any legal protection that they may have in law
- They could be subject to disciplinary action themselves.

6.6 If a whistleblower makes an external disclosure, then this should be reported to [Veritau] as soon as possible. Some types of disclosure are covered by legislation. However, consideration of whether the action taken is appropriate or not will need to be considered on a case by case basis.

Support

6.7 If you have any queries or issues about whistleblowing then you can seek further advice from [Veritau].

The new council for
NORTH
YORKSHIRE

ANTI-MONEY LAUNDERING & TERRORIST FINANCING POLICY

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1 Introduction

1.1 Money laundering is the process of taking profits from crime and corruption and transforming them into legitimate assets. It takes illegally obtained money and converts it into other assets so they can be reintroduced into legitimate commerce. This process conceals the true origin or ownership of the funds, and so 'cleans' or 'launders' them. Money or assets gained as a result of crime can ultimately be used to fund terrorism.

1.2 The Council undertakes transactions and delivers services which can fall under UK anti-money laundering legislation, which includes, but is not limited to:

- the Terrorism Act 2000
- the Proceeds of Crime Act 2002
- the Money Laundering, Terrorist Financing, and Transfer of Funds (Information on Payer) Regulations 2017
- the Criminal Finance Act 2017
- the Money Laundering Regulations.

1.3 Anti-money laundering legislation has been updated regularly by the Government in recent years. While the legislation does not specifically target local authorities, some types of council activity can fall under the requirements of the law. It is therefore important for councils to assess money laundering risks and put sufficient controls in place to prevent their organisation from being used for money laundering.

1.4 All employees should be aware of the threat of money laundering, the need to report suspicions of money laundering, and the consequences of not following the principles and processes set out in this Policy. A list of key risk factors for employees to be aware of is included in **Appendix A**.

1.5 The Council has a Money Laundering Reporting Officer (MLRO) who is responsible for raising awareness of the issue within the Council and reporting appropriate concerns to the National Crime Agency (NCA) when they arise. The MLRO is [insert job title] and can be contacted on [insert telephone]. If the MLRO is unavailable the Council has a Deputy MLRO. The Deputy MLRO is [insert job title] and can be contacted on [insert telephone].

1.6 Some types of work undertaken by the Council may fall under the definition of regulated activity in the legislation (see paragraph 2.3). There are more specific detailed requirements for employees working in these areas and guidance is set out in **Appendix B**. The Council has a Chief Money Laundering Compliance Officer (CMLCO) who has oversight of all Council

anti-money laundering arrangements and is specifically responsible for overseeing regulated activity. The CMLCO is the Council's [Monitoring Officer] and can be contacted on [insert telephone].

1.7 This Policy contains a form that should be submitted to the MLRO when money laundering concerns arise (**Appendix D**). This form may be used by any employee to report a suspected issue.

2 Scope of the Policy

2.1 This Policy applies to all employees of the Council. It aims to maintain the high standards of conduct expected by the Council by preventing criminal activity through money laundering.

2.2 To ensure the Council complies with its legal obligations, all employees must be aware of the content of this Policy. Failure by an employee to comply with the procedures set out in this Policy may lead to disciplinary action being taken against them and could constitute a criminal offence. Any disciplinary action will be dealt with in accordance with the Council's [Disciplinary Policy and Procedure].

2.3 Money laundering legislation sets out some activities that are subject to specific requirements. These are areas that are at greater risk of being targeted by criminals for money laundering (for example certain financial and legal services, and those dealing in property sales and acquisitions). These areas, amongst others, are known as regulated activities. Some work undertaken by the Council may fall under the definition of regulated activity. This is generally in higher risk areas, where the Council carries out work on behalf of other organisations such as:

- accounting and treasury management services
- legal and company related work
- property services
- payroll services.

2.4 Employees undertaking work that could be considered regulated activity need to be aware of the more detailed requirements set out in **Appendix B**. If anyone is unsure of whether their work falls into this category, further advice can be sought from the CMLCO, the MLRO, or the Deputy MLRO.

3 What is money laundering?

3.1 Money laundering is a general term for any method of disguising the origin of assets obtained through crime. Assets including money and property are described as "criminal property" in legislation. Criminal property may be the

proceeds of any criminal activity including terrorism, drugs trafficking, corruption, tax evasion and theft. The purpose of money laundering is to hide the origin of the criminal property so that it appears to have come from a legitimate source. Unfortunately, no organisation is safe from the threat of money laundering, particularly where it is receiving funds from sources where the identity of the payer is unclear. There is therefore a real risk that the Council may be targeted by criminals seeking to launder the proceeds of crime.

3.2 It is possible that the proceeds of crime may be received from individuals or organisations who do not know that the assets involved originated from criminal activity. However, this could still be an offence under the legislation. It is no defence for a payer or recipient of funds to claim that they did not know that they were committing an offence if they should have been aware of the origin of assets. All employees dealing with the receipt of money or having contact with third parties from whom money may be received need to be aware of the possibility of money laundering taking place. This includes a wide range of service areas. As an example, an area where money laundering may need to be considered includes cases where the Council takes possession of money belonging to a customer, for safekeeping, under its statutory care duties.

3.3 Money laundering offences include:

- concealing, disguising, converting, transferring criminal property or removing it from the UK;

- entering into or becoming concerned in an arrangement which you know or suspect facilitates the acquisition, retention, use or control of criminal property by or on behalf of another person;

- acquiring, using or possessing criminal property;

  - an attempt, conspiracy or incitement to commit such an offence; or
  - aiding, abetting, counselling or procuring such an offence

- becoming concerned in an arrangement facilitating concealment, removal from the jurisdiction, transfer to nominees or any other retention or control of terrorist property.

3.4 The broad definition of money laundering means that the legislation applies to a very wide range of everyday activities within the Council. This means that any employee (irrespective of what sort of work they do at the Council) could encounter money laundering and be required to report it.

3.5 Whilst the risk to the Council of contravening the legislation is relatively low, **it is important that all employees are familiar with their responsibilities. Serious criminal sanctions may be imposed for breaches of the legislation**. Any person found guilty of a money laundering offence is liable to imprisonment (maximum sentence of 14 years), a fine or both. However, an offence is not committed if any suspected money laundering activity is reported to the Council's MLRO and, where necessary, official permission is obtained to continue with a transaction[1].

Potential signs of money laundering

3.6 It is impossible to give a definitive list of how to spot potential money laundering or how to decide whether to make a report to the MLRO. The following are examples of major risk factors which may, either alone or cumulatively with other factors, suggest the possibility of money laundering activity. A more exhaustive list is contained in **Appendix A**.

General factors

- Payment of a substantial sum in cash (over £10,000).
- A secretive client or customer: for example, they refuse to provide requested information without a reasonable explanation, don't want to provide identification, or they supply unsatisfactory identification.
- Concerns about the honesty, integrity, identity, or location of a client or customer.
- The cancellation or reversal of an earlier transaction (where the client or customer is likely to request the return of previously deposited monies).
- Any other activity which by its nature is likely to be related to money laundering, tax evasion, or terrorist financing.

Property transactions

- A cash buyer.
- Funds received for deposits or prior to completion from an unexpected source, or where instructions are given for settlement funds to be paid to an unexpected destination.
- No clear explanation as to the source of funds along with a lack of clarity as to how the client would be in a position to finance the purchase.

3.7 Property transactions are a higher risk for the Council. Tenants have the ability to purchase their council property under the Right to Buy scheme and the Council may choose to sell land to a developer or other third party. In

[1] Where money laundering is suspected the MLRO will report this to the National Crime Agency (NCA). The NCA may give permission to proceed with a suspect transaction – for example to avoid those involved becoming alert to suspicions having been raised.

any sale of property or land, checks need to be made to establish the source of funding and ensure that money laundering offences are not occurring. In addition, if a buyer has no legal representation, then client identification must be sought before business is conducted. If a buyer has legal representation, then that representative is responsible for undertaking the required identification.

3.8 Facts which tend to suggest that something odd is happening may be sufficient for a reasonable suspicion of money laundering to arise. Be on the look-out for anything out of the ordinary. If something seems unusual, stop and question it. If anyone is unsure of any transaction then further advice should be sought from the MLRO.

4 How to report concerns

4.1 Where an employee knows or suspects that money laundering activity is taking place (or has already) they must disclose this as soon as possible to the MLRO.

4.2 The disclosure should be made to the MLRO using the form attached in **Appendix D**. The report must include as much detail as possible. It should contain all available information to help the MLRO decide whether there are reasonable grounds to show knowledge or suspicion of money laundering. The MLRO will use this information to prepare a report to the National Crime Agency (NCA) if needed. Copies of any relevant supporting documentation should be sent to the MLRO along with the form.

4.3 Once an issue has been reported to the MLRO employees must follow any directions they may give. Employees must not make any further enquiries into issues themselves. If an investigation is needed it will be carried out by the NCA. All employees are required to cooperate with the MLRO and the NCA (or other external authorities such as the police) during any subsequent money laundering investigation.

4.4 Employees must at no time and under no circumstances voice any suspicions to people who they suspect of money laundering (or to anyone other than a line manager (unless possibly implicated) or the MLRO). Doing so could result in a criminal offence (“tipping off”) being committed.

4.5 No references should be made on any Council files or systems that a report has been made to the MLRO. If a client exercised their right to see a file (for example through a subject access request under data protection legislation) then a note could tip them off to a report having been made. The MLRO will keep appropriate records in a confidential manner.

4.6 The MLRO will advise the employee of the timescales in which they will respond to the report. They may wish to discuss the report with the employee and gather further information.

5 Responsibilities

5.1 The Council has a responsibility to prevent money laundering from occurring within the organisation whether that be in the course of day-to-day business or in work that is considered to be regulated activity. It is the responsibility of every employee to be vigilant and report any concerns of money laundering.

5.2 The Chief Money Laundering Compliance Officer has overall responsibility for monitoring anti-money laundering policy, regulations and procedures. The CLMCO will appoint a MLRO and deputy MLRO. The CMLCO will ensure appropriate procedures for regulated activity are in place and obtain approval of the policy from the Audit Committee. The CMLCO will also ensure that directorate departments undertaking regulated activity have appropriate training and risk assessments in place.

5.3 The Money Laundering Report Officer (and deputy) have responsibility for receiving reports of suspicions of money laundering, considering those reports and, where appropriate, submitting reports to the National Crime Agency (see **Appendix C**). The MLRO will convey instructions from the NCA eg, to halt or proceed with a transaction. They will also maintain records of all reports on behalf of the Council.

5.4 The [Head of Internal Audit] will ensure there is an independent audit function to evaluate and make recommendations about the policies, controls, and compliance in relation to anti-money laundering. [Veritau] will regularly promote awareness of the Anti-Money Laundering Policy to all employees.

6 Policy review

6.1 This Policy will be reviewed every three years or as soon as any significant changes to anti-money laundering legislation, regulations, or guidance occurs.

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Appendix A

Signs of potential money laundering

It is not possible to give a definitive list of ways in which to identify money laundering or how to decide whether to make a report to the Money Laundering Reporting Officer. However, the following are types of risk factors which may, either alone or cumulatively, suggest possible money laundering activity.

Concerns about transactions

- Payment of a substantial sum in cash (over £10,000).
- Complex or unusually large transactions or systems.
- The source or destination of funds differs from the original details given by the client.
- Movement of funds overseas, particularly to a higher risk country or a tax haven[2].
- Where, without reasonable explanation, the size, nature and frequency of transactions or instructions (or the size, location, or type of a client) is out of line with normal expectations. For example, the use of cash where other means of payment are normal.
- Unusual patterns of transactions which have no apparent economic, efficient, or visible lawful purpose.
- Transactions at substantially above or below fair market rates.

Other activity of concern

- Transactions that don't seem logical from a third party's perspective. For example, receipt of unexpected funds, or unnecessary routing of transactions through another party's accounts.
- Overpayments by a client (or money given on account). Care needs to be taken, especially with requests for refunds. For example, if a significant overpayment is made which results in repayment being needed – this should be properly investigated and authorised before payment.
- Helping to set up trusts or company structures, which could be used to obscure ownership of property.
- The cancellation or reversal of an earlier transaction (where the client is likely to request the return of previously deposited monies).

[2] See Financial Action Task Force list of high risk countries, https://www.fatf-gafi.org/publications/high-risk-and-other-monitored-jurisdictions/?hf=10&b=0&s=desc(fatf_releasedate)

- Requests for release of client account details other than in the normal course of business.
- Companies and trusts:
    - Bodies with a complicated ownership structure, which could conceal underlying beneficiaries.
    - Extensive use of corporate structures and trusts in circumstances where the client's needs are inconsistent with the use of such structures.
- Any other activity which by its nature is likely to be related to money laundering, tax evasion, or terrorist financing.

<u>Concerns about a client</u>

- A secretive client: for example, they refuse to provide requested information without a reasonable explanation, don't want to provide identification, or they supply unsatisfactory identification.
- A client you have not met.
- Difficulties in establishing the identity of the client.
- Concerns about the honesty, integrity, identity, or location of a client. For example, a client who is not present in the area and where there is no good reason why they would have dealings with the Council; or information reveals that a client is linked with criminality.
- Involvement of an unconnected third party without logical reason or explanation.
- Absence of an obvious legitimate source of the funds.
- Poor business records or internal accounting controls.
- Individuals or companies that are insolvent yet have funds.
- A previous transaction for the same client which has been, or should have been, reported to the MLRO.

<u>Concerns about property transactions</u>

- A cash buyer.
- Sudden change of buyer.
- The client's financial profile does not fit.
- Unusual property investment transactions if there is no apparent investment purpose or rationale.
- Instructions to receive and pay out money where there is no linked substantive property transaction involved (surrogate banking).

- Funds received for deposits or prior to completion from an unexpected source, or where instructions are given for settlement funds to be paid to an unexpected destination.
- No clear explanation as to the source of funds along with a lack of clarity as to how the client would be in a position to finance the purchase.
- Money comes from an unexpected source.

Appendix B

Guidance for officers undertaking Regulated Activity

1 Introduction

1.1 Money laundering legislation and guidance defines a number of commercial activities that are subject to specific anti-money laundering requirements. These are areas that are at greater risk of being targeted by criminals for laundering money (for example financial services, and those dealing in property sales and acquisitions). These areas are known as regulated activities. Further details on regulated activities are set out in paragraph 2.1 below.

1.2 It is clear from the money laundering regulations and guidance from supervisory bodies, that councils and their in-house lawyers and accountants are not intended to be caught within the definition of regulated activities when carrying out normal council business. For example, because they are not acting as external or independent advisors for their council.

1.3 However, with the growth in external commercial work being undertaken by councils in recent years, there are a growing number of circumstances where lawyers, accountants and others working for councils could be caught within the scope of the legislation. For example, where employees undertake work for organisations other than the Council under contract. Such external work may be classed as being undertaken "by way of business" and could bring those activities within the regulated sector. Guidance issued by supervisory bodies states that where there is uncertainty over the application of the regulations, the broadest possible approach to compliance with the regulations should be undertaken.

2 Definition of regulated activity

2.1 Regulated activity is defined as:

- material aid or assistance or advice in connection with the tax affairs of another person by a practice or sole practitioner (whether provided directly or through a third party);
- the provision to other persons of accountancy services by a firm or sole practitioner who by way of business provides such services to other persons;
- legal or notarial services involving the participation in financial or real property transactions concerning:
  - the buying and selling of real property or business entities;
  - the managing of client money, securities, or other assets;

- the opening or management of bank, savings, or securities accounts;
- the organisation of contributions necessary for the creation, operation, or management of companies;
- the creation, operation or management of trusts, companies, or similar structures;

by a firm or sole practitioner who by way of business provides legal or notarial services to other persons (a person participates in a transaction by assisting in the planning or execution of the transaction or otherwise acting for a client in relation to it);

- forming companies or other legal persons;
- acting, or arranging for another person to act:
  - as a director or secretary of a company;
  - as a partner of a partnership;
  - in a similar position in relation to other legal persons;
- providing a registered office, business address, correspondence or administrative address or other related services for a company, partnership or any other legal person or arrangement;
- acting, or arranging for another person to act, as:
  - a trustee of an express trust or similar legal arrangement;
  - a nominee shareholder for a person other than a company whose securities are listed on a regulated market.

2.2 In general, the areas where the Council is carrying out activities that may fall within the definition of regulated activities relate to accounting services, treasury management, payroll services and legal services in relation to financial, company or property transactions. However, this will only be the case if the work is carried out for external clients. Work undertaken on behalf of Council services (including traded services where there is no separate legal entity involved) would not fall under the scope of regulated activity.

3 Responsibilities

3.1 All officers undertaking regulated activity within the Council should be aware of the potential to become involved in money laundering and terrorist financing. Members of staff may be liable to criminal charges if they fail to report their concerns. These criminal charges relate to someone's actions (or lack of them) where money laundering activity is suspected. A criminal offence could be committed if an employee:

- knows or suspects (or has reasonable grounds to do so) that another person is engaged in money laundering;

- can identify a money launderer or the whereabouts of laundered property (or they believe, or it is reasonable to expect them to believe, that information held would assist in identifying a money launderer or the whereabouts of laundered property); and
- does not disclose information held to the MLRO as soon as practicable.

3.2 As set out in paragraph 1.7 of the Policy, the [Monitoring Officer] is the senior officer within the Council responsible for ensuring compliance with anti-money laundering requirements (the Chief Money Laundering Compliance Officer – CMLCO). The CMLCO is responsible for ensuring that the Council has appropriate policy, procedures, and controls in place to manage money laundering risks.

3.2 In relation to regulated activities, the CMLCO will:

- ensure there are arrangements in place within the Council for conducting money laundering and terrorist financing, and tax evasion risk assessments;
- establish appropriate systems, policies, controls and procedures to address identified risks of money laundering – and ensure that the arrangements have been approved by the relevant body or bodies;
- ensure arrangements are in place to screen relevant employees, including an assessment of their skills, knowledge, and expertise to carry out their functions effectively and of their conduct and integrity;
- support and facilitate independent internal audit of money laundering arrangements;
- ensure training on anti-money laundering is provided to relevant employees.

4 Due diligence

4.1 Where the Council is carrying out regulated activities (see 2.1 above), and any of the following apply, then customer due diligence measures must be applied.

- The Council forms a business relationship with a client (which is expected to have an element of duration) – this includes the formation of a company;
- The Council undertakes an occasional transaction amounting to 15,000 Euros (approximately £13,000) or more whether carried out in a single operation or several linked ones;
- The Council suspects money laundering or terrorist financing;
- The Council suspects tax evasion from the UK or a foreign country;

- The Council doubts the veracity or adequacy of information previously obtained for the purposes of client identification or verification.

4.2 Information on customer due diligence procedures is set out in 4.5 below. If due diligence is needed, it must reflect the corporate regulated activity AML risk assessment, and the assessed level of risk in the individual case – taking account of factors such as:

- the purpose of an account, transaction, or business relationship;
- the level of assets to be deposited/size of the transactions undertaken by the client;
- the regularity and duration of the business relationship.

4.3 The customer due diligence procedure set out below must be followed before the establishment of the relationship or carrying out of the transaction (or during, provided that verification is completed as soon as practicable after contact is first established and this is necessary not to interrupt the conduct of business and there is little risk of money laundering).

4.4 The Council is not required to undertake the customer due diligence checks set out below if its customer is another public authority, unless it suspects money laundering or terrorist funding.

4.5 Applying customer due diligence means:

- identifying the client (unless their identity is already known and has been verified) and verifying the client's identity (unless already verified) on the basis of documents or information obtained from a reliable and independent source and assessing (and where appropriate obtaining information on) the purpose and intended nature of the business relationship/occasional transaction:
  - Where the client is acting or appears to be acting for someone else, reasonable steps must also be taken to establish the identity of that other person (although this is unlikely to be relevant to the Council).

- where the client is beneficially owned by another person, identifying the beneficial owner and taking reasonable steps to verify their identity so that the Council can be satisfied that it knows who the beneficial owner is. In the case of a beneficial owner being a legal person, trust, company, foundation or similar legal arrangement, officers must take reasonable measures to understand the ownership and control structure of it. Reliance cannot solely be placed on the statutory register of people with significant control:
  - In terms of clients for whom the Council provides regulated services, "beneficial owner" would include bodies corporate (eg our public

authority clients) and any individual who exercises control over the management of the body (eg Chief Executive Officer).

UNLESS the client is a company which is listed on a regulated market, in which case the above steps are not required.

- where the client is a body corporate:
  - obtaining and verifying its name, company/registration number, registered office address (and if different, its principal place of business address);
  - taking reasonable measures to determine and verify (UNLESS the client is a company which is listed on a regulated market, in which case the steps below are not required):
    - the law to which it is subject;
    - its constitution (whether set out in its articles of association or other governing documents);
    - the full names of the board of directors (or if there is no board, the members of the equivalent management body) and the senior persons responsible for the body's operations;
  - where the client is a body corporate and the beneficial owner cannot be identified or where the individual identified as the beneficial owner cannot be verified as such, despite exhausting all possible means, officers must take reasonable measures to identify and verify the identity of the senior person responsible for managing the body. In these circumstances officers must keep written records of all steps taken to identify the beneficial owner, all action taken, and difficulties encountered.
- where another person purports to act on the client's behalf, officers must verify that they are authorised to so act, identify them and verify their identity from a reliable source, independent of both parties;
- assessing and where appropriate obtaining information on the purpose and intended nature of the business relationship or occasional transaction.

4.6 Where customer due diligence is required, employees in the relevant team must obtain and verify satisfactory evidence of the identity of the prospective client, and full details of the purpose and intended nature of the relationship/transaction, as soon as practicable after instructions are received and before the establishment of the business relationship or carrying out of the occasional transaction. However, the legislation does allow organisations to vary customer due diligence and monitoring

according to the risk of money laundering or terrorist financing which depends on the type of customer, business relationship, product or transaction. This recognises that not all clients present the same risk. Satisfactory evidence of identity is that which:

- is capable of establishing, to the satisfaction of the person receiving it, that the client is who they claim to be, and
- does in fact do so.

4.7 In the Council, details of proposed transactions are usually, as a matter of good case management practice, recorded in writing in any event and proposed ongoing business relationships are usually the subject of Terms of Business Letters, Service Level Agreements or other written record which will record the necessary details.

4.8 Customer due diligence measures must also be applied at other times to existing clients on a risk-based approach and when the Council becomes aware that such existing clients' circumstances have changed, relevant to the risk assessment, taking into account:

- any indication that the identity of the client/its beneficial owner, has changed;
- any transactions which are not reasonably consistent with knowledge of the client;
- any change in the purpose or intended nature of the Council's relationship with the client;
- any other matter which might affect officers' assessment of the money laundering or terrorist financing risk in relation to the client.

Opportunities to do this will differ, however one option is to review these matters as part of the ongoing monitoring of the business arrangements, as is usually provided for in the Terms of Business Letter, Service Level Agreement or other written record.

4.9 Council staff conducting regulated business need to be able to demonstrate that they know their clients and the rationale behind particular instructions and transactions.

4.10 Once instructions to provide regulated business have been received, and it has been established that any of the conditions in paragraph 4.1 above apply, or it is otherwise an appropriate time to apply due diligence measures to an existing client, evidence of identity and its verification and information about the nature of the particular work should be obtained or checked.

4.11 Most of the external clients to whom the Council provides potentially regulated business services are UK public authorities and consequently, as

above, proportionate, simplified customer due diligence measures should be undertaken. Full details about the nature of the proposed transaction should be recorded on the client file or suitable central record (kept by the relevant team), and the identity of such external clients should continue to be checked, along with other external clients (eg designated public bodies). Officers should also then obtain the appropriate additional evidence: appropriate additional evidence of identity will be written instructions on the organisation's official letterhead at the outset of the matter or an email from the organisation's e-communication system. Such correspondence should then be placed on the relevant client file or central record along with a prominent note explaining which correspondence constitutes the evidence and where it is located.

4.12 In some circumstances, however, **enhanced due diligence** (eg obtaining additional evidence of identity or source of funds to be used in the relationship/transaction) and enhanced ongoing monitoring must be carried out, for example where:

- there is an identified high risk of money laundering. Risk factors to be considered include:
  - the type and nature of customers;
  - the countries or geographic areas in which a business operates;
  - where customers are based;
  - customers' behaviour;
  - how customers come to do business with the Council;
  - the products or services to be provided;
  - the nature of transactions;
  - delivery channels and payment processes (eg cash over the counter, cheques, electronic transfers or wire transfers);
  - where customers' funds come from or go to.

- the client is a "politically exposed person" (an individual who at any time in the preceding year has held a prominent public function in the UK, and EU or international institution/body, a family member or known close associate). This is unlikely to ever be relevant to the Council but the provision must be included in local procedures;

- the business relationship or transaction is with a person established in a high-risk third country;

- the client has provided false/stolen identification evidence and the Council wishes to continue to deal with them;

- the transaction is complex or unusually large, or there is an unusual pattern of transactions, or it has no apparent economic or legal purpose;

- the nature of the situation presents a higher risk of money laundering or terrorist financing.

4.13 Enhanced due diligence measures *must* include

- examining the background and purpose of the transaction;
- increasing the degree and nature of the monitoring of the business relationship to determine whether the transaction appears suspicious.

4.14 With instructions from new clients, or further instructions from a client not well known to the Council, officers may wish to seek additional evidence of the identity of key individuals in the organisation and of the organisation itself, for example:

- checking the organisation's website to confirm the identity of key personnel, its business address and any other details;
- conducting an on-line search via Companies House to confirm the nature and business of the client (including any registered office and registration number) and to confirm the identities of any directors;
- where the client is a company, appropriate evidence might be company formation documents or a business rate bill;
- attending the client at their business address
- asking the key contact officer and/ or any individual who exercises control over the management of the body (eg the Chief Executive Officer) to provide evidence of their personal identity and position within the organisation, for example:
  - passport;
  - photocard driving licence;
  - birth certificate;
  - medical card;
  - utility bill;
  - bank/building society statement (but not if used to prove address and no older than 3 months);
  - National Insurance number;
  - signed, written confirmation from their Head of Service or Chair of the relevant organisation that such person works for the organisation.

If such additional evidence is obtained, then copies should be retained on the relevant client file or a suitable central record.

4.15 Relevant persons are still able to rely on the customer due diligence carried out by a third party if that third party is either subject to the Money Laundering Regulations 2017 or an equivalent regime. However, the conditions for doing so are prescriptive. The third party must effectively provide the customer due diligence information it has obtained and enter into a written agreement under which it agrees to immediately provide copies of all customer due diligence documentation in respect of the customer and/or its beneficial owner.

4.16 In all cases, the due diligence evidence should be retained for at least five years from the end of the business relationship or transaction(s). This could be used in any future money laundering investigation. Such personal data should be recorded and stored carefully and in compliance with the Council's information governance requirements.

4.17 If satisfactory evidence of identity is not obtained and verified at the outset of the matter then generally the business relationship or one off transaction(s) cannot proceed any further and any existing business relationship with that client must be terminated (however there are some exceptions).

5 Ongoing monitoring and record keeping

5.1 Each team conducting potentially regulated business must monitor, on an ongoing basis, their business relationships in terms of scrutinising transactions undertaken throughout the course of the relationship (including, where necessary, the source of funds) to ensure that the transactions are consistent with their knowledge of the client, its business and risk profile; and reviewing existing records and keeping due diligence information up-to-date. Particular scrutiny should be given to:

- complex or unusually large transactions;
- unusual patterns of transactions which have no apparent economic or visible lawful purpose;
- any other activity particularly likely by its nature to be related to money laundering, terrorist financing, or tax evasion.

5.2 Teams should also maintain records of:

- client identification/verification evidence obtained (or references to it), and
- details of all regulated business transactions carried out for clients

for at least five years from the end of the transaction/relationship. This is so that they may be used as evidence in any subsequent investigation by the authorities into money laundering.

5.3 The precise nature of the records is not prescribed by law however they must be capable of providing an audit trail during any subsequent investigation, for example distinguishing the client and the relevant transaction and recording the source of, and in what form, any funds were received or paid. In practice, Council teams will be routinely making records of work carried out for clients in the course of normal business and these should suffice in this regard.

Appendix C

Money Laundering Report Officer Disclosure Process

1.1 It is important that the appointed MLRO (and deputy) are aware of the National Crime Agency's (NCA) processes for submitting suspicious activity reports (SARs). SARs should be submitted via the SAR Online platform. On appointment the MLRO (and deputy) should create an account on SAR Online promptly[1].

1.2 Upon receipt of a disclosure report, the MLRO must note the date of receipt on their section of the AML Reporting Form (**Appendix D**) and acknowledge receipt of it.

1.3 The MLRO should consider the report and any other available internal information they think relevant, for example:

- reviewing other transaction patterns and volumes;
- the length of any business relationship involved;
- the number of any one-off transactions and linked one-off transactions;
- any due diligence information held;

and undertake such other reasonable enquiries they think appropriate in order to ensure that all available information is taken into account in deciding whether a report to NCA is required (such enquiries being made in such a way as to avoid any appearance of tipping off those involved).

1.4 The MLRO should consider NCA guidance on how and when to submit a SAR[2] in evaluating the AML Reporting Form and any other relevant information. The MLRO should make a timely determination as to whether:

- there is actual or suspected money laundering taking place;
- there are reasonable grounds to know or suspect that is the case;
- the identity of the money launderer or the whereabouts of the property involved is known, or they could be identified, or the information may assist in such identification;
- whether they should seek consent from NCA for a particular transaction to proceed.

1.5 The MLRO should also consider whether the report indicates suspicions of other crimes that should be reported to the Police, eg a vulnerable person

[1] See NCA SAR Online User Guidance.
[2] See NCA Guidance on submitting better quality Suspicious Activity Reports.

or child at immediate risk of harm, supply of firearms, or modern slavery/human trafficking.

1.6 If the MLRO concludes that the matter should be reported then they should do that as soon as practicable via NCA's Online SAR Portal, unless there is a reasonable excuse for non-disclosure to NCA (for example, if the form has been completed by a lawyer and they wish to claim legal professional privilege[3] for not disclosing the information).

1.7 Where the MLRO suspects money laundering but has a reasonable excuse for non-disclosure, then they must note this on the AML Reporting Form; they can then immediately give their consent for any ongoing or imminent transactions to proceed.

1.8 Where consent is required from NCA for a transaction to proceed, then the transaction(s) in question must not be undertaken or completed until the NCA has specifically given consent, or there is deemed consent through the expiration of the relevant time limits without objection from NCA.

1.9 If the MLRO concludes that there are no reasonable grounds to suspect money laundering then they should record this on the AML Reporting Form and give their consent for any ongoing or imminent transaction(s) to proceed.

1.10 All disclosure reports referred to the MLRO, reports made to NCA, and any subsequent communications from the NCA must be retained by the MLRO in a confidential file kept for that purpose, for a minimum of five years.

[3] In cases where legal professional privilege may apply, the MLRO must liaise with the legal adviser to decide whether there is a reasonable excuse for not reporting the matter to NCA.

Appendix D

Money Laundering Reporting Officer
Suspicious Activity Reporting (SAR) Form
Confidential

To: Money Laundering Reporting Officer, North Yorkshire Council

From: Email:
Job Title: Department:

Note – if no response to a required field, put 'Unknown'.

Main Subject

Is the main subject a person or a legal entity eg a Company?	

Surname		Forename(s)	
Title		Gender	
Date of Birth		Occupation	
Address			
Address Type	Accommodation Address, Foreign Address, Home Address, Other, Previous, Registered Office, Trading Address, UK Address, Unknown		

Current Address?	Yes, No, Unknown

Company Name		Companies House Number	
Company Type		Name of Officer(s) representing Company	
Address			
Address Type	Accommodation Address, Foreign Address, Home Address, Other, Previous, Registered Office, Trading Address, UK Address, Unknown		
Current Address?	Yes, No, Unknown		

Additional Information - fill in any of these, if known

Email address	
Website address	
Car registration	
Mobile number (home or work)	
NHS number	
National Insurance number	
Passport No	
Phone number (home or work)	
Tax Ref number	

Associated Subject – any joint account holders, on the account to be used for the transaction

Subject Status	Victim, Suspect, Unknown		
Surname		Forename(s)	
Title		Gender	
Date of Birth		Occupation	
Address			
Address Type	Accommodation Address, Foreign Address, Home Address, Other, Previous, Registered Office, Trading Address, UK Address, Unknown		
Current Address?	Yes, No, Unknown		

Details of Transaction

Date		Amount	
Credit/Debit		Currency	
Property			
Type	Cash, Property Transaction, Cash/Cheque, Cheque, Credit Card, Currency, Draft, Electronic Transfer, Loan, Mixed, Mortgage, On-Line, Other, Policy, Purchase, Share Transfer, Smart Card, Travellers Cheques, Unknown, Wire Transfer		

Details of the subject's account

Account Holder		Account Number	
Institution Name		Sort Code	
Date Opened		Date Closed	
Account Balance		Balance Date	
Turnover Credit		Turnover Debit	
Turnover Period			

Reason for Suspicion

Please provide as much information as possible, including,

(i) the information or other matter which gives the grounds for your knowledge, suspicion or belief;

(ii) a description of the property that you know, suspect or believe is criminal property; and

(iii) a description of the prohibited act for which you seek a defence (by prohibited act, we mean the proposed activity that you are seeking a defence to undertake).

Enquiries already undertaken

Please answer the questions below and provide as much information as possible, including,

(i) Is the report about an ongoing transaction? What is the current state of the transaction?

(ii) Has the matter been investigated? By whom and what were the findings?

(iii) Have you discussed your suspicions with anyone else? If yes then to whom and why was this necessary?

(iv) Have you consulted any supervisory body guidance eg the Law Society?

(v) Do you feel you have a reasonable explanation for not disclosing this matter to NCA (eg you are a lawyer and wish to claim legal professional privilege?)

To be completed by MLRO

Date report received	Click or tap to enter a date.			
Date receipt of report acknowledged	Click or tap to enter a date.			
Are there reasonable grounds for suspecting money laundering activity?	Yes	☐	No	☐

Do you know the identity of the alleged money launderer, or whereabouts of the property concerned?	Yes	☐	No	☐
Do the circumstances described above meet the NCA's threshold to submit a Suspicious Activity Report (SAR) to obtain a Defence Against Money Laundering (DAML)?	Yes	☐	No	☐
If there are reasonable grounds to suspect money laundering, but you do not intend to report the matter to NCA, or it would not meet their threshold, please set out the reasons for non-disclosure				
Date SAR is sent to the NCA (if applicable)	Click or tap to enter a date.			

Signed ……..…… Date: Click or tap to enter a date.

Signed (MLRO)…….. Date: Click or tap to enter a date.

THIS REPORT TO BE RETAINED FOR AT LEAST FIVE YEARS

AUDIT COMMITTEE

12 December 2022

RISK MANAGEMENT – PROGRESS REPORT

Report of the Corporate Director – Strategic Resources

1.0 **PURPOSE OF THE REPORT**

1.1 To receive details of the updated Corporate Risk Register and the up to date links between Directorate Risk Registers and the Corporate Risk Register .

1.2 To note progress on other Risk Management related matters

2.0 BACKGROUND

2.1 According to the Terms of Reference of the Audit Committee, its role in risk management is:

(i) to assess the effectiveness of the County Council's risk management arrangements and

(ii) to review progress on the implementation of risk management throughout the County Council.

2.2 Regular reports to this Committee therefore cover the implementation of the Policy as well as other related risk management matters in order to fulfill this role.

3.0 CORPORATE RISK REGISTER

3.1 The Corporate Risk Register (CRR) is fully reviewed every year and updated by the Chief Executive and Management Board in October/November. A six monthly review is also carried out in March/May. It has been challenging again this year to sustain the usual timetable for reviewing and updating all risk registers. This is due to the work being undertaken relating to Local Government Reorganisation (LGR).

3.2 Since the last report to this Committee in December 2021, 2 reviews and updates of the Corporate Risk Register have been carried out. There have been changes made at both reviews – see attached at **Appendix A**. The updates involved reviewing the risks, risk controls, risk reductions and risk rankings that had been identified for each of the risks and making amendments to the Register where necessary.

3.3 To assist Members interpret **Appendix A**

- Risks are identified by Management Board during a prep meeting and further discussion
- Each risk has then to be ranked based on the following:

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- existing risk controls in place
- probability of the risk occurring (based on existing controls)
- impact of the risk occurring (based on existing controls)
- further risk controls which may reduce current probability or impact

➢ The prioritisation system follows a fairly traditional risk evaluation approach in that the **probability** and **severity** of risks is measured using High, Medium and Low categories

➢ However, to facilitate the assessment of the severity of each risk this is done in relation to 4 distinct **impact areas**:-

- failure to meet key **service objectives** and standards – reflecting current service plans
- **financial** impact
- **service** delivery
- loss of image or **reputation**

As each risk is ranked with reference to current controls and then future controls, the risk prioritisation system can compute a "score" in the range of 1 to 5

- 1 and 2 being a 'red' risk
- 3 and 4 being an 'amber' risk and
- 5 being a 'green' risk

3.4 The significant amendments that were made to the Register since December 2021 are as follows:

New or Significantly Changed risks

- Opportunities for Devolution and Growth in North Yorkshire – this risk significantly changed following the signing of the proposed devolution agreement for York & North Yorkshire in August this year. The actions relating to this risk have moved on to publishing a draft scheme and the formal public consultation on the proposals. The probability of this risk happening now has reduced and so the ranking has consequently reduced.
- Local Government Reorganisation – since the official Order was approved to create the new Council and elections took place on 5 May 2022, the actions relating to this risk moved forward into the implementation of the transition plan, with numerous workstreams including an ongoing focus on staff communications. These actions are to ensure that the new Council is 'safe and legal' on Day 1.
- Recruitment and Retention – this risk was added at the interim update in May 2022 to reflect the increase in vacancies caused by high levels of staff turnover, and the difficulty in recruiting to vacant posts.

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Deleted risks

- Recovery from Coronavirus – this risk was deleted at the interim update of the register as the position has moved on to business as usual.

With regard to the remaining risks, the rankings stayed the same (as shown on the summary in the left hand column of **Appendix A**). Please see the table at the bottom of **Appendix A** for an explanation of the left hand column.

4.0 LINKS BETWEEN CORPORATE AND DIRECTORATE RISK REGISTERS

4.1 As indicated previously, the Corporate Risk Register is the culmination of the identification of key significant risks that are identified at Directorate and Service levels. For information and out of interest, an exercise is carried out to identify the links between Directorate Risk Registers and the Corporate Risk Register. Please find attached a diagram showing these links at **Appendix B**.

5.0 INSURANCE AND RISK MANAGEMENT FOR NORTH YORKSHIRE COUNCIL

5.1 There is two sub workstreams working as part of the Finance workstream on insurance and risk management issues for the new Council.

- At this point the insurance sub workstream has issued an invitation to tender to the insurance market with a view to awarding the contract at the beginning of March 2023 with insurance cover starting with effect from 1 April 2023.
- The risk management work includes developing a risk management policy, procedures and ensuring that an appropriate system is in place and ready for Vesting Day. The intention is to also have a skeleton corporate risk register in place. This will be built from information including District/Borough/ County corporate risk registers that presently exist. Once the hierarchy of the new Council is known, it will be possible to develop the Directorate and Service risk registers.

6.0 RECOMMENDATIONS

That the Committee:

(i) notes the updated Corporate Risk Register (**Appendix A**) and the links between Directorate Risk Registers and the Corporate Risk Register (**Appendix B**).

(ii) notes the position on other Risk Management related matters

GARY FIELDING
Corporate Director – Strategic Resources

County Hall, Northallerton

December 2022

Author of report: Fiona Sowerby, Head of Insurance and Risk Management
Tel 01609 532400

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Corporate Risk Register

Appendix A

Risk Register: **month 0 (November 2022) – summary**
Next Review due: **May 2023**
Report Date: **23rd November 2022 (fs)**

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
◀▶	**20/194 - Major Failure due to Quality and/or Economic Issues in the Care Market and Workforce Pressures**	Major failure of provider/key providers results in the Directorate being unable to meet the needs of people who use services. 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.	Chief Exec	CD HAS	H	M	H	M	H	1	15	30/11/2022	H	M	H	M	H	1	Y	CD HAS
◀▶	**20/258 - Recruitment and Retention**	Failure to recruit and retain staff across services resulting in inability to deliver services	Chief Exec	CSD ACE BS	H	H	H	H	H	1	10	30/09/2023	H	H	H	H	H	1	Y	Chief Exec
◀▶	**20/187 - Information Governance and Security**	Ineffective information governance arrangements lead to unacceptable levels of unauthorised disclosure of personal and sensitive data, poor quality or delayed responses to FoI requests, and inability to locate key data upon which the Council relies resulting in loss of reputation, poor decision making, fine, etc (including Brierley Group companies) Failure to put in place the appropriate cyber security arrangements could potentially lead to data breach, loss of data, loss of systems, loss of reputation with particular heightened risk due to the change during LGR	Chief Exec	CD SR	H	M	M	M	H	1	13	31/03/2023	H	L	M	L	M	2	Y	CD SR
◀▶	**20/1 - Funding Challenges**	Inadequate funding available to the Council to discharge its statutory responsibilities and to meet public expectation for the medium term resulting in legal challenge, unbalanced budget and public dissatisfaction	Chief Exec	CD SR	H	H	H	H	H	1	13	31/03/2023	M	H	H	M	M	2	Y	All Mgt Board
◀▶	**20/47 - Partnership and Integration with the NHS**	Failure to achieve the best outcomes from working jointly with NHS across the NYCC footprint, a negative impact on the customer experience and the possibility of fragmented care and poor outcomes	Chief Exec	CD HAS	M	M	H	M	M	2	13	31/12/2022	M	M	H	M	M	2	Y	CD HAS
◀▶	**20/189 - Safeguarding Arrangements**	Failure to have a robust Safeguarding service in place results in risk to vulnerable children, adults and families and not protecting them from harm.	Chief Exec	CD HAS CD CYPS	M	H	M	M	H	2	18	31/03/2023	M	H	M	M	H	2	Y	CD CYPS CD HAS
◀▶	**20/244 - Significant Incidents**	Failure to plan, respond to and recover effectively from significant incidents in the community resulting in risk to life and limb, impact on statutory responsibilities, impact on financial stability and reputation	Chief Exec	Chief Exec	M	L	H	L	H	2	8	31/03/2023	L	L	H	L	M	3	Y	Chief Exec
◀▶	**20/247 - Local Government Reorganisation**	Failure to transition effectively to the new North Yorkshire Council by 1 April 2023 and to successfully set out a road map for further transformation over the subsequent years resulting in risk of failing services on Day 1, reputational impacts, member dissatisfaction, reduced performance.	Chief Exec	Chief Exec	M	H	H	H	H	2	10	31/03/2023	L	H	H	H	H	3	Y	Chief Exec
▼	**20/236 - Opportunities for Devolution and Growth in North Yorkshire**	Failure to take advantage of Devolution opportunities and to deliver the ambition of Sustainable Economic Growth, through for example the delivery of the right housing and transport	Chief Exec	CD BES	L	M	H	H	H	3	10	28/02/2023	L	M	M	M	M	5	Y	CD BES Chief Exec

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Corporate Risk Register

Appendix A

Risk Register: **month 0 (November 2022) – summary**
Next Review due: **May 2023**
Report Date: **23rd November 2022 (fs)**

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
		whilst protecting the outstanding environment and heritage, resulting in reduced investment and impact on the growth and jobs, inability to recover from the impact of the Virus, attract, retain and grow businesses and raise living standards across North Yorkshire																		

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

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Corporate Risk Register

Appendix A

Risk Register: **month 0 (November 2022) – detailed**
Next Review due: **May 2022**
Report Date: **23rd November 2022 (fs)**

Phase 1 - Identification							
Risk Number	20/194	**Risk Title**	20/194 - Major Failure due to Quality and/or Economic Issues in the Care Market and Workforce Pressures	**Risk Owner**	Chief Exec	**Manager**	CD HAS
Description	Major failure of provider/key providers results in the Directorate being unable to meet the needs of people who use services. 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**	

Phase 2 - Current Assessment											
Current Control Measures	Regular review and monitoring of contracts in addition to close working relationship with corporate procurement colleagues. Quality Improvement Team now embedded into the service and continuing to work well, with new Head of Service (joint with NHS) joining the service after Easter 22. Market position statement created as an online tool to support commissioning and interventions into the market. Work underway to develop a quality pathway with enhanced market surveillance to ensure market oversight in line with The Care Act. Sustainability process in place to enable financial assistance to the market where value for money and strategic need can be evidenced. Service Development function now created linked to locality working to identify market issues at an early stage and appropriate market support strategies are created. Ongoing rolling programme of audits by Veritau of individual suppliers. Business case being developed further for Intervention into Harrogate market. Enhanced care homes services in place during Coronavirus pandemic to provider wrap around support to the market; worked with ICG to ensure provider BCPs in place and tested. Ethical decision making framework in place and being used and reviewed.										
Probability	H	**Objectives**	M	**Financial**	H	**Services**	M	**Reputation**	H	**Category**	1

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	20/473 - 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 with use of national capacity tracker and contingencies in place	HAS AD PSD (AB)	Sat-30-Sep-23	
Reduction	20/474 - Continue to work with Veritau on audits of individual suppliers (rolling programme in place of focussed work in particular areas)	HAS AD PSD (AB) HAS C&Q Ho Q&M	Sat-30-Sep-23	
Reduction	20/538 - Develop a Quality Pathway, revising processes and procedure and incorporating best practice adopting a risk based / predictive approach; being introduced from Nov 22	HAS AD ASC (RB)	Wed-30-Nov-22	
Reduction	20/539 - Rewriting quality policies as part of Quality Pathway with input from Veritau as part of focussed review	HAS AD ASC (RB)	Wed-30-Nov-22	
Reduction	20/542 - Consideration of market interventions, including development of a provider arm or a proposal to bring organisations together (initial business case approved for intervention into Harrogate market); need to consult and then get agreement for revised costs	HAS AD PSD (AB)	Sat-31-Dec-22	
Reduction	20/798 - Continue to develop and implement the Make Care Matter campaign including a flexible approach to candidate need and availability, to ensure recruitment across the Sector encompassing ideas from people who have lived experience and operational staff (ongoing)	HAS AD ASC (CJK) HAS AD ASC (RB) HAS HoHR	Sat-30-Sep-23	
Reduction	20/803 - Monitor the impact of provider sustainability applications and the procurement of the APL to identify further mitigation	HAS all ASC ADs	Sat-30-Sep-23	
Reduction	20/804 - Consider options relating to recruitment and agency agreements to support the independent and voluntary sector with the ICG and providers (ongoing)	CYPS HoHR	Sat-30-Sep-23	
Reduction	20/822 - Work with market development board to monitor and manage interventions in the care market	HAS AD PSD (AB)	Sat-30-Sep-23	
Reduction	20/893 - Work at a system level (ICS) with partners to mitigate the impact of workplace shortages	HAS all ASC ADs HAS HoHR	Sat-30-Sep-23	

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Risk Register: **month 0 (November 2022) – detailed**
Next Review due: **May 2022**
Report Date: **23rd November 2022 (fs)**

Reduction	20/894 - Complete recommissioning of all approved provider lists; being evaluated	HAS AD PSD (AB)	Wed-30-Nov-22	
Reduction	20/895 - Launch PAMMS to aid early identification of risk and support the quality pathway	HAS AD ASC (RB)	Sat-30-Sep-23	
Reduction	20/896 - Separate quality and contract management to provide additional capacity to contract management	HAS AD ASC (RB) HAS AD PSD (AB)	Sat-30-Sep-23	
Reduction	20/897 - Use the review of the QIT pilot to plan future quality oversight	HAS AD ASC (RB)	Sat-30-Sep-23	
Reduction	20/1188 - Monitor issues caused by the changing landscape of ICS and LGR and raise at HASLT where appropriate - ongoing	HAS AD PSD (AB)	Sat-30-Sep-23	

Phase 4 - Post Risk Reduction Assessment

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

Phase 5 - Fallback Plan

		Action Manager
Fallback Plan	20/548 - Make people 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.	CD HAS

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Corporate Risk Register

Appendix A

Risk Register: **month 0 (November 2022) – detailed**
Next Review due: **May 2022**
Report Date: **23rd November 2022 (fs)**

Phase 1 - Identification							
Risk Number	20/258	**Risk Title**	20/258 - Recruitment and Retention	**Risk Owner**	Chief Exec	**Manager**	CSD ACE BS
Description	Failure to recruit and retain staff across services resulting in inability to deliver services			**Risk Group**	Personnel	**Risk Type**	

Phase 2 - Current Assessment												
Current Control Measures	Recruitment: flexible pay arrangements including market supplements, other payments; good wider benefits package, amended pay structure to take account of posts and grades with particular recruitment and retention challenges; recruitment campaigns and advertising; work with managers to recruit swiftly; social media to promote the organisation and jobs creating a recognisable and attractive employer brand; positively promote the Council as an inclusive employer with good use of diverse images in campaigns to ensure all applicants feel welcome; Retention: Positive and inclusive working environment created; focus on communication and engagement corporately and locally; support and training for managers on good management including engaging and developing their staff; support for staff with health and wellbeing resilience and providing an environment where staff feel they are cared for and supported; providing open access to training and development for employees to enable development in their role and have opportunities to progress internally; staff support networks and staff diversity and inclusion networks which influence policy and practice at work as part of the Council's inclusive workplace approach; good benefits package which encourage retention eg green lease cars, flexible working opportunities so good work life balance available											
Probability	H	**Objectives**	H	**Financial**	H	**Services**	H	**Reputation**	H	**Category**	1	

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	20/735 - Continue with existing mitigations (ongoing)	CSD ACE BS	Sat-30-Sep-23	
Reduction	20/736 - Ensure opportunities and progression through development are provided to staff through internal career pathways	CSD ACE BS	Sat-30-Sep-23	
Reduction	20/737 - Ensure the organisation is a 'good employer' through its actions and practice	CSD ACE BS	Sat-30-Sep-23	
Reduction	20/738 - Enable hybrid working to provide flexibility to employees	CSD ACE BS	Sat-30-Sep-23	
Reduction	20/739 - Ensure work/life balance is available and attainable to all employees	CSD ACE BS	Sat-30-Sep-23	
Reduction	20/740 - Continue to develop and offer good terms and conditions and an innovative package of voluntary benefits	CSD ACE BS	Sat-30-Sep-23	
Reduction	20/741 - Ensure reassurance about job security and information about development opportunities in the new council are an ongoing focus of LGR staff communications	CSD ACE BS	Sat-30-Sep-23	
Reduction	20/742 - Continue to deploy a range of tools and resources to recruit to vacancies adapting the recruitment response to the role type. Continued use of creative recruitment campaigns with good use of social media	CSD ACE BS	Sat-30-Sep-23	
Reduction	20/743 - Develop manager's skills for effective and positive staff management including engagement and support in order to assist retention and successful recruitment (ongoing)	CSD ACE BS	Sat-30-Sep-23	
Reduction	20/744 - Focus on recruitment to entry level posts alongside career pathways (apprentices and trainees where recruitment is more successful)	CSD ACE BS	Sat-30-Sep-23	

Phase 4 - Post Risk Reduction Assessment												
Probability	H	**Objectives**	H	**Financial**	H	**Services**	H	**Reputation**	H	**Category**	1	

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Risk Register: **month 0 (November 2022) – detailed**
Next Review due: **May 2022**
Report Date: **23rd November 2022 (fs)**

Phase 5 - Fallback Plan		
		Action Manager
Fallback Plan		Chief Exec

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Corporate Risk Register

Appendix A

Risk Register: **month 0 (November 2022) – detailed**
Next Review due: **May 2022**
Report Date: **23rd November 2022 (fs)**

Phase 1 - Identification							
Risk Number	20/187	**Risk Title**	20/187 - Information Governance and Security	**Risk Owner**	Chief Exec	**Manager**	CD SR
Description	Ineffective information governance arrangements lead to unacceptable levels of unauthorised disclosure of personal and sensitive data, poor quality or delayed responses to FoI requests, and inability to locate key data upon which the Council relies resulting in loss of reputation, poor decision making, fine, etc (including Brierley Group companies) Failure to put in place the appropriate cyber security arrangements could potentially lead to data breach, loss of data, loss of systems, loss of reputation with particular heightened risk due to the change during LGR			**Risk Group**	Legislative	**Risk Type**	CS 15/161

Phase 2 - Current Assessment												
Current Control Measures			Information Governance Strategy including the associated Policy and Procedure Framework; CIGG Action Plan; data breach process; messages from senior management; on-line training; staff induction; Information Asset Owners identified; information asset registers regularly updated; Internal Data Governance team with an identified representative for each Directorate (replacing DIGCs); Veritau appointed as DPO; posters; intranet information; regular monitoring of electronic communication by T&C; series of unannounced security compliance visits by internal audit; Brierley Group companies' information governance procedures in place; **FoI –** controls include central monitoring of receipt and progress, regular review by Veritau and review of outstanding cases by the Chief Exec on a monthly basis; proactive monitoring of all data; terms of reference reviewed; Veritau investigate significant data breaches; CIGG consider reasons for data breaches and cascade lessons learned; secure physical storage and internal info transfer issues resolved; e learning training packages refreshed; Information Sharing Protocol in place; **SAR -** controls include central monitoring of receipt and progress; refreshed Information Governance page on intranet; Information Governance risk register completed; Data Quality Improvement Action Plan agreed; DPIAs in place; **Cyber Security -** application of all the features of the Information Security Management System (ISMS);cyber prevention tools are kept up to date; security team in place; Non NYCC Network Access Policy produced; e learning training packages refreshed; targeted phishing campaign; Directorates' discussion on the potential outcome of a cyber-attack carried out; regular updates and awareness communications to staff; information sharing agreements in place where required; UK GDPR compliance; robust programme of governance in place to manage all changes taking place in relation to LGR;									
Probability	H	**Objectives**	M	**Financial**	M	**Services**	M	**Reputation**	H	**Category**	1	

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	15/423 - Continue to emphasise personal responsibility of staff for all information in this area and consider disciplinary action in cases of data breaches	CD SR CSD ACE BS	Thu-31-Aug-23	
Reduction	15/424 - Continue to review information asset registers and target training where appropriate (ongoing) (Info Gov)	CSD SR AD T&C Ho Int Audit	Thu-31-Aug-23	
Reduction	15/426 - Continue to ensure individual information sharing agreements completed for each data sharing activity - (ongoing) (Info Gov)	Ho Int Audit	Wed-31-Aug-22	Thu-31-Mar-22
Reduction	15/431 - Continue to work within services in a prioritised order to ensure information (electronic and physical) is secure and transferred securely (ongoing) (linked to Microsoft 365 roll out)	CSD SR AD T&C	Thu-31-Aug-23	
Reduction	15/433 - Put in place a system to ensure regular communications to staff to ensure good Information Governance including messages from Management Board and associated campaigns	CSD SR AD T&C	Thu-31-Aug-23	
Reduction	15/611 - Ensure Data Protection risks are managed to comply with UK GDPR (ongoing)	CSD SR AD T&C	Wed-31-Aug-22	Fri-31-Dec-21

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Reduction	15/612 - Data Quality Improvement - implement an action plan to address the Data Quality issues that are impacting on the accuracy of operational management information, performance reports, transparency publications and statutory returns (Info Gov)	CSD SR AD T&C	Sat-30-Sep-23	
Reduction	15/613 - Documents and Record Management including classification and retention - implement the approach to document and records management and storage with the Council that encompasses both physical and electronic information including classification and retention (linked to Microsoft 365 roll out) (Info Gov)	CSD SR AD T&C	Thu-31-Aug-23	
Reduction	15/636 - Review existing training and continue to develop and implement appropriate training relating to quality and security of information	CSD SR AD T&C Ho Int Audit	Thu-31-Aug-23	
Reduction	15/793 - Review impact on Veritau and the resources required to provide the DPO service, and implement actions required (ongoing)	CD SR	Thu-31-Aug-23	
Reduction	15/1105 - Review and revise Business Continuity Plans with Directorates to take into account actions required following a cyber-attack (Cyber Security); workshops have taken place with T&C and Services, prioritising critical services. County and Districts/Boroughs to review BIA and IMP to reflect Covid, cyber and LGR.	CSD PPC HoR&E	Sat-30-Sep-23	
Reduction	15/1550 - Implement the robust programme of governance to manage all changes taking place in relation to LGR	CSD SR AD T&C	Fri-31-Mar-23	
Reduction	15/1956 - Ensure information governance requirements are in place for wholly owned companies (review Information Governance Procedures in place for each of the Brierley Group companies to ensure they are up to date and fit for purpose)	CSD AD SR (VD)	Fri-31-Mar-23	

Phase 4 - Post Risk Reduction Assessment

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

Phase 5 - Fallback Plan

		Action Manager
Fallback Plan	15/514 - Review Action Plan and new technology and continue to raise awareness. Invite ICO to carry out an audit of NYCC IG systems	CD SR

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Phase 1 - Identification							
Risk Number	20/1	**Risk Title**	20/1 - Funding Challenges	**Risk Owner**	Chief Exec	**Manager**	CD SR
Description	Inadequate funding available to the Council to discharge its statutory responsibilities and to meet public expectation for the medium term resulting in legal challenge, unbalanced budget and public dissatisfaction			**Risk Group**	Resources	**Risk Type**	

Phase 2 - Current Assessment												
Current Control Measures			Existing MTFS and budget monitoring arrangements; Members Budget seminars; LGR challenge sessions to identify initial transformation opportunities from LGR workstreams; LGR transitional savings identified within budget for year 1; LGR and Transformation Programme Governance; modelling on implications of external funding levels (eg Spending Review Settlement); review of NYES overheads completed; review of commercial services and financial action plans developed where required; sustainable additional social care funding; advocacy work including with MPs, CCN and professional networks; Finance LGR workstream charged with producing aggregated budget								
Probability	H	**Objectives**	H	**Financial**	H	**Services**	H	**Reputation**	H	**Category**	1	

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	15/721 - Ensure the Council takes advantage of available central government incentives such as grants and any potential funding is monitored, together with engagement in relevant consultations	CD SR CSD ACE BS CSD AD SR (VD)	Fri-31-Mar-23	
Reduction	20/616 - Ensure active participation in professional networks and LG pressure groups (for example CCN and LGA) to shape activity in relation to advocacy (ongoing)	All Mgt Board	Fri-31-Mar-23	
Reduction	20/617 - Continue to lobby MPs and Govt for additional funding particularly in relation to adults (including hospital discharge funding) and children's social care, High Needs, Schools Capital and rural costs (ongoing)	CD HASCD SR	Fri-31-Mar-23	
Reduction	20/618 - Sweep up Beyond 2020 Change Programme outstanding issues into Transformation Programme/LGR arrangements	All Mgt Board	Fri-31-Mar-23	
Reduction	20/750 - Ensure regular monitoring at management board and CYPS Overview and scrutiny committee of financial challenges for schools to highlight the present financial position to ensure immediate and emerging challenges are addressed. (ongoing)	CD CYPS CSD AD SR (HE)	Mon-31-Jul-23	
Reduction	20/751 - Further develop plans to address significant overspending budgets including high needs/SEN; disabled children; CYPS pooled budgets (ongoing)	CSD AD SR (HE)	Mon-31-Jul-23	
Reduction	20/796 - Lobby for fairer funding review and abolition of business rates retention and part of longer term spending review	CD SR	Fri-31-Mar-23	
Reduction	20/834 - Work with District Councils to address possible future service pressures going forward	CD SR	Fri-31-Mar-23	
Reduction	20/873 - Continue with Supply Chain Resilience Board in order to mitigate and manage supply chain pressures	CD SR	Fri-31-Mar-23	
Reduction	20/888 - Determine financial challenges and opportunities of new Council	CD SR	Fri-31-Mar-23	
Reduction	20/898 - Review reserves and consider all options for maintaining reserve levels to support medium term planning	CD SR	Fri-31-Mar-23	
Reduction	20/899 - Undertake cost activity analysis across all 8 councils to identify workforce structure to shape future transformation	CD SR CSD SR AD T&C	Thu-31-Aug-23	
Reduction	20/1166 - Monitor and review any issues arising from "discharge to assess" requirements post Covid	CD HAS	Mon-31-Jul-23	

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

Phase 5 - Fallback Plan

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		Action Manager
Fallback Plan	20/504 - Further fundamental review in order to discharge statutory responsibilities	All Mgt Board

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Phase 1 - Identification							
Risk Number	20/47	**Risk Title**	20/47 - Partnership and Integration with the NHS	**Risk Owner**	Chief Exec	**Manager**	CD HAS
Description	Failure to achieve the best outcomes from working jointly with NHS 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**	HAS 3/180

Phase 2 - Current Assessment												
Current Control Measures	**HAS:** 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 ICSs; regular finance and commissioning meetings in place (building on Covid response); North Yorkshire Place Board and Silver Command overseeing Covid response and other key interface business; s75 agreements in place for Harrogate and Rural Alliances; investment of IBCF and BCF to protect social care; Joint Health and Well-being Strategy in place (due to be refreshed); extensive hospital discharge arrangements in place; **CYPS:** Healthy Child Programme (HCP) s75 agreement in place; HP2 theme as part of transformation programme; Being Young in North Yorkshire published; Childhood Futures board established; CF scope, vision and priorities reviewed;										
Probability	M	**Objectives**	M	**Financial**	H	**Services**	M	**Reputation**	M	**Category**	2	

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	20/363 - 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) (HAS)	CD HAS	Sat-30-Sep-23	
Reduction	20/451 - Review the Harrogate and Rural Alliance integration of community health and social care services to inform future model and governance arrangements from Apr 22 (HAS)	CD HAS	Thu-31-Mar-22	Thu-31-Mar-22
Reduction	20/734 - Outcome of the review of CHC arrangements for the needs of SEND children with Health, action plan to be developed and implemented (CYPS)	CSD AD SR (HE) CYPS AD Incl	Sat-30-Sep-23	
Reduction	20/805 - Work through the statutory ICS arrangements and the development of the NYY Strategic Partnership; underway (HAS)	CD HAS Dir Public Health	Fri-31-Mar-23	
Reduction	20/806 - Continue to lobby nationally for the continuation of Hospital Discharge funding (ongoing) (HAS)	CD HASCD SR	Fri-31-Mar-23	
Reduction	20/828 - Develop a complex care partnership board for the continuing health care and s117 work (HAS)	HAS AD PSD (AB)	Fri-30-Sep-22	Mon-28-Feb-22
Reduction	20/874 - Some workstreams agreed but still need to develop the full work programme including data matching and understanding of support needs (CYPS)	CYPS Comm Mgr Health	Thu-31-Aug-23	
Reduction	20/877 - Continue pilot of multi agency Quality Improvement Team and plan evaluation (HAS)	HAS AD ASC (RB)	Sat-30-Sep-23	
Reduction	20/916 - Work jointly with CCGs and NHSFTs to develop post-Covid discharge pathways (underpinned by lobbying via LGA/CCN/SCT and others to ensure any changes are funded and with appropriate legislation in place) (HAS)	HAS AD PSD (AB)	Fri-31-Mar-23	
Reduction	20/917 - Working with CCGs and TEWV to commission Emotional Health and Wellbeing services; the s75 is being worked up and consultation will take place through autumn/winter 2021 (CYPS)	CYPS Comm Mgr Health	Thu-31-Mar-22	Thu-31-Mar-22
Reduction	20/1190 - Work closely with NHS partners to triage highest priorities for hospital and community capacity and pressure and undertake LRF exercise to plan for contingencies (HAS)	CD HAS HAS all ASC ADs	Fri-31-Mar-23	
Reduction	20/1197 - Present HARA paper to MB and Exec to provide update and priorities for the next 5 years (HAS)	CD HAS HAS all ASC ADs	Sat-31-Dec-22	
Reduction	20/1397 - Ensure there is a joint plan in place with ICB colleagues to manage winter pressures (HAS)	HAS AD PSD (AB)	Fri-31-Mar-23	

Phase 4 - Post Risk Reduction Assessment

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

Phase 5 - Fallback Plan		
		Action Manager
Fallback Plan	20/210 - Escalation to CMB and Executive Members, further engagement with senior tiers in NHS locally, regionally and nationally.	CD HAS

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Phase 1 - Identification							
Risk Number	20/189	**Risk Title**	20/189 - Safeguarding Arrangements	**Risk Owner**	Chief Exec	**Manager**	CD HAS CD CYPS
Description	Failure to have a robust Safeguarding service in place results in risk to vulnerable children, adults and families and not protecting them from harm.			**Risk Group**	Safeguarding	**Risk Type**	CYPS 24/250 HAS 3/27

Phase 2 - Current Assessment	
Current Control Measures	**CYPS -** North Yorkshire Safeguarding Children Partnership website; regularly reviewed procedures; monthly performance data for monitoring; audit regime; manager authorisation of all assessments; LCS; missing and at risk of exploitation multi-agency procedures and Specialist Social Worker roles to support practitioners; training strategy; clear supervision process which is audited on a regular basis; Multi Agency Screening Team (MAST); Mgt file audit of case files; monitoring and management of performance against agreed targets in the SMT action plan; Front Door Health Check completed by peer authority; Hidden Harm Group; Group Manager and Specialist Social Workers to oversee and support practice in relation to Contextual Safeguarding; daily performance management through dashboards by managers; system BCP in case of failure **HAS -** Detailed action plan; Safeguarding general manager and team; strengthening of Safeguarding policy team; case file audit and review; independent chair to Safeguarding Board in place; risk enablement panel in place and being reviewed; countywide safeguarding general manager in place; testing of initial performance metrics for Safeguarding Board has taken place further developing performance activity; initial safeguarding procedures reviewed linked to consultation in light of the Care Act and are being reviewed again; safeguarding board performance framework; Q&E [protocol for the relationship between Adults Social Care (and Children's Trust) and the Health and Wellbeing Board agreed and implemented;] information framework for serious incident data, eg drug death etc in place; 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 in place with regular meetings of the InterBoard Network; reviewed; training for in house provider; new safeguarding policies and procedures implemented; including a Quality Monitoring Tool, monthly strategic meetings with CQC and Healthwatch; training in respect of latest policies and procedures for elected members, staff and partners in place; safeguarding work to deliver the Transforming Care programme incl. the Care Act role of Principal Social Worker and Safeguarding Board Manager embedded; supervisory body role for DoLS to ensure the system is as effective as possible;

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

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	20/374 - Continue to ensure compliance with Children and Families' and Partnership's procedures [CYPS]	CYPS AD C&F	Sat-30-Sep-23	
Reduction	20/382 - Continue to feed into review of EDT arrangements (adult lead) as required; project group being set up to progress actions from recent review; review progressing and well embedded [CYPS]	CYPS AD C&F	Sat-30-Sep-23	
Reduction	20/384 - Continuation of 'Practice Weeks' where managers will visit locations to observe and review practice; these are now in place and teams will to be involved in the planning to make these more effective; regular QA board reviews this activity and ensures plans are in place where required [CYPS]	CYPS C&F SMT	Sat-30-Sep-23	
Reduction	20/385 - Use and further development of performance dashboards to support individual managers including development of managing upwards reports which support management and ownership of performance; a number of SG dashboards are used by team managers and there is a monthly performance board; a "single view" dashboard is being worked towards [CYPS]	CYPS C&F HoS	Sun-30-Apr-23	
Reduction	20/456 - Continue to report regularly to HASLT, Care and Independence O&S Committee and Health and Wellbeing Board [HAS]	Dir Public Health	Sat-30-Sep-23	
Reduction	20/487 - Continue to work with directorate colleagues 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; new organisational Safeguarding Procedure is mapped against the quality pathway [HAS]	Dir Public Health HAS AD ASC (CJK)	Sat-30-Sep-23	

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Reduction	20/534 - Continue to 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 (LPS guidance and legislation delayed , draft statutory guidance received in 2022, expecting the full guidance early 2023)	Dir Public Health HAS AD ASC (CJK)	Fri-31-Mar-23	
Reduction	20/535 - Continue to ensure Partners are fully engaged with Safeguarding Boards centrally and locally, particularly health and district council partners particularly as we move to LGR [HAS]	Dir Public Health	Sun-30-Apr-23	
Reduction	20/596 - Continue to strengthen Governance arrangements in HAS following consideration of North Yorkshire and national safeguarding adult reviews (ongoing) [HAS]	Dir Public Health HAS AD ASC (CJK)	Sat-30-Sep-23	
Reduction	20/615 - Prepare for implementation of Liberty Protection Safeguards; LPS guidance and legislation delayed due to impact of Coronavirus; draft statutory guidance received in 2022, expecting the full guidance early 2023 [HAS])	HAS AD ASC (CJK)	Fri-31-Mar-23	
Reduction	20/723 - Continue joint work with CYPS and the Community Safety Partnership with quarterly meetings of the InterBoard Network [HAS]	Dir Public Health	Sat-30-Sep-23	
Reduction	20/730 - Put in place governance arrangements reflecting the ethical framework for social care to evidence and record decision making and ensure the best possible solutions for people in the circumstances (Pressures in the care market mean that the best solutions for people are not always available and may lead to safeguarding concerns being raised.); ethical framework considerations complete[HAS]	Dir Public Health HAS AD ASC (CJK)	Fri-30-Sep-22	Fri-30-Sep-22
Reduction	20/829 - Develop contingency plans around the MAST to support should demand increase; contingences were put in place [CYPS]	CYPS C&F HoS	Fri-30-Sep-22	Fri-30-Sep-22
Reduction	20/831 - Manage the risk of children not returning to education post covid; Locality Groups in place for those not in 25 hours of education, targeted support to EHE and visit dashboard in use	CYPS C&F HoS	Sat-30-Sep-23	
Reduction	20/832 - Ensure that service dashboards reflect the criteria for each of the key inspection areas and are monitored on a regular basis; Ed & Skills dashboard being pulled together [CYPS]	CYPS AD C&F CYPS AD E&S CYPS AD Incl	Sat-30-Sep-23	
Reduction	20/833 - Ensure pre inspection readiness within CYPS for the inspections of LA services, and for schools within the inspection window by continual monitoring of performance and identifying areas for further improvement by assessing their impact (ongoing); dashboards will help improve this area [CYPS]	CYPS AD C&F CYPS AD E&S CYPS AD Incl	Thu-31-Aug-23	
Reduction	20/890 - Use a range of tools and resources such as continued rolling recruitment campaigns including international recruitment, development of internal career pathways, providing an attractive employment offer and ensuring that pay is as competitive as possible, to manage the rising demand from increased referrals and greater difficulties in recruitment and retention [CYPS]	CYPS AD C&F	Sat-30-Sep-23	
Reduction	20/900 - Implement an action plan to proactively manage and mitigate risk to people waiting for adult social care (HAS)	HAS AD ASC (CJK)	Sat-30-Sep-23	

Phase 4 - Post Risk Reduction Assessment

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

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Phase 5 - Fallback Plan		
		Action Manager
Fallback Plan	20/545 - Carry out necessary review of approach, target underperforming areas and take on lessons learned from any safeguarding adults reviews	CD CYPS CD HAS

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Phase 1 - Identification							
Risk Number	20/244	**Risk Title**	20/244 - Significant Incidents	**Risk Owner**	Chief Exec	**Manager**	Chief Exec
Description	Failure to plan, respond to and recover effectively from significant incidents in the community resulting in risk to life and limb, impact on statutory responsibilities, impact on financial stability and reputation			**Risk Group**	Performance	**Risk Type**	CS 15/200

Phase 2 - Current Assessment											
Current Control Measures	NYLRF and RMCI; experience and resources of partners; existing plans incl public health (training and exercises); RET; partnership working with District Councils; community resilience; silver response in the County Council major incident plan tested; approach to BCP refreshed to strengthen service resilience; Resilience Direct portal; regional multi agency pandemic exercise held; effectiveness and robustness of resilience plans relating to the public health and social care of the NY population tested; NYCC action plan developed and implemented based on the debrief report recommendations and all multi agency learning (including the flood reporting tool and simplification of information flow); members of national steering group on volunteers; BCP post audit action plan; Multi Agency cyber threat event held; Ready for Anything campaign; provided input to and engaged with national learning and development of best practice following incidents locally, regionally and nationally; use of Office 365 tools to increase engagement and response capability in effective planning and coordination of incidents; increased team to support Covid response and ability to deal with concurrent incidents; LRF workplan through to 2024; partnership work with Directorates, District Councils, Migration Yorkshire and other partners to support refugee resettlement in the County.										
Probability	M	**Objectives**	L	**Financial**	H	**Services**	L	**Reputation**	H	**Category**	2

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	15/614 - Continue to work with our partners in Public Health England, the NHS and the wider North Yorkshire local resilience forum to share the information and messages of reassurance being issued by the lead agencies	Dir Public Health	Fri-30-Jun-23	
Reduction	15/637 - Continue to ensure business continuity plans are reviewed, exercised and kept up to date for County Council services and trading companies	CD SR	Fri-30-Jun-23	
Reduction	15/652 - Continue to work with Directorates, District Councils, Migration Yorkshire and other partners to support refugee resettlement schemes, both into permanent housing in the County and whilst in temporary placements organised by the Home Office in bridging hotels in the County	CSD AD PPC	Fri-30-Jun-23	
Reduction	20/970 - Continue to ensure effective co-ordination and communication with County and District/Borough Council services & NYLRF in light of reduction in resources including LGR (ongoing)	CSD AD PPC	Fri-30-Jun-23	
Reduction	20/971 - Continue to ensure effective and efficient processes are embedded amongst all partners to prioritise work streams (incl. plans, training and exercises) (ongoing)	CSD AD PPC	Fri-30-Jun-23	
Reduction	343/788 - Respond to call to evidence on review of local resilience, National Resilience Strategy and Civil Contingencies Act; responded as required and now waiting for legislative changes	CSD PPC HoR&E	Sat-30-Apr-22	Sat-30-Apr-22
Reduction	343/790 - Continue to embed the recommendations from Covid debrief within practice through the Corp R&E Group	CSD PPC HoR&E	Fri-30-Jun-23	
Reduction	343/854 - Work through the LGR sub work streams to ensure that emergency response and bcp arrangements remain robust throughout the transition and transformation phases (safe and legal)	CSD PPC HoR&E	Fri-31-Mar-23	

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

Phase 5 - Fallback Plan	
	Action Manager

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Fallback Plan	20/207 - Embedded practice based on Response to Major and Critical Incident protocols	Chief Exec

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Phase 1 - Identification							
Risk Number	20/247	**Risk Title**	20/247 - Local Government Reorganisation	**Risk Owner**	Chief Exec	**Manager**	Chief Exec
Description	Failure to transition effectively to the new North Yorkshire Council by 1 April 2023 and to successfully set out a road map for further transformation over the subsequent years resulting in risk of failing services on Day 1, reputational impacts, member dissatisfaction, reduced performance.			**Risk Group**	Change Mgt	**Risk Type**	

Phase 2 - Current Assessment												
Current Control Measures			LGR transition governance created; structural change order in place; work streams identified for transition with nominated sponsors; resources earmarked for costs of transition; LGR transition PMO established; additional capacity secured through management consultancy framework; comms and engagement strategy being developed; programme plans for workstreams in place;									
Probability	M	**Objectives**	H	**Financial**	H	**Services**	H	**Reputation**	H	**Category**	2	

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	15/867 - Continue to review and transform operational service requirements as part of the Programme in order to maximise efficiency	All Mgt Board	Fri-31-Mar-23	
Reduction	20/505 - Transition work streams to produce programme plans	Work Stream Sponsors	Thu-31-Mar-22	Thu-31-Mar-22
Reduction	20/523 - Develop (by Mar 2022 complete) and implement an overall transition plan	LGR Programme Director	Fri-31-Mar-23	
Reduction	20/524 - Continue to engage staff and specialists as appropriate in work streams	Work Stream Sponsors	Fri-31-Mar-23	
Reduction	20/527 - Continue to implement communications and engagement plan	NYCC Chief Exec	Fri-31-Mar-23	
Reduction	20/529 - Carry out regular reporting to Government on progress	LGR Programme Director	Fri-31-Mar-23	
Reduction	20/531 - Continue to identify interdependencies and priorities in work streams	LGR Programme Director	Fri-31-Mar-23	
Reduction	20/536 - Workstreams and sub workstreams to complete implementation of plans to ensure legal and effective services are operating on Vesting Day	Work Stream Sponsors	Fri-31-Mar-23	
Reduction	20/540 - Ensure collaboration, cooperation, dependencies and resources are carried out and coordinated to ensure a successful delivery of workstreams and overall programme	LGR Programme Director	Fri-31-Mar-23	
Reduction	20/541 - Utilise pre procured consultants, open recruitment, HR workstream to ensure sufficient resources	LGR Programme Director	Fri-31-Mar-23	

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

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Phase 5 - Fallback Plan		
		Action Manager
Fallback Plan	20/578 - Work with District Councils on a Local Government Reorganisation solution as set out by Central Government	Chief Exec

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Phase 1 - Identification							
Risk Number	20/236	**Risk Title**	20/236 - Opportunities for Devolution and Growth in North Yorkshire	**Risk Owner**	Chief Exec	**Manager**	CD BES
Description	Failure to take advantage of Devolution opportunities and to deliver the ambition of Sustainable Economic Growth, through for example the delivery of the right housing and transport whilst protecting the outstanding environment and heritage, resulting in reduced investment and impact on the growth and jobs, inability to recover from the impact of the Virus, attract, retain and grow businesses and raise living standards across North Yorkshire			**Risk Group**	Strategic	**Risk Type**	BES 7/174

Phase 2 - Current Assessment													
Current Control Measures			Devolution - Programme management function in place; micro site set up for sharing information with the public; Growth - Direct contribution and support, including through provision of accountable body function, to the YNYER Local Enterprise Partnership; maintenance of an Economic Growth Function within BES; Proactive engagement in LGNYY partnership working including through Directors of Development, Chief Housing Officers, Heads of Planning and Economic Development Officer Groups; Lead role in enabling and further developing YNYERH Spatial Framework; Lead role in supporting and developing the NYCC Growth Plan Steering Group and sub-ordinate arrangements; Lead role in initiating and developing the NYCC Economic Growth Plan and annual Delivery Framework (endorsed by Executive); Devolution deal agreed;									
Probability	L	**Objectives**	M	**Financial**	H	**Services**	H	**Reputation**	H	**Category**	3		

Phase 3 - Risk Reduction Actions				
		Action Manager	**Action by**	**Completed**
Reduction	20/246 - Continue to monitor the Devolution agreement and communication with stakeholders to maximise opportunities (ongoing); the greater York/NY geography is being used in some areas of growth work (ongoing)	BES AD GP&TS	Thu-31-Aug-23	
Reduction	20/550 - Growth - Continue to embed enhanced collaborative working arrangements with District Councils (annual review of progress and developed a pipeline of strategic projects to work together on.) – ongoing with regular review of resources needed to deliver projects	BES AD GP&TS	Fri-31-Mar-23	
Reduction	20/552 - Growth - Maintain good working relationship with the LEP (including work to align LEP funding initiatives with Council Initiatives and with the Directors of Development master planning funding, Coordinated devolution asks. Carbon abatement pathways, local energy action plans) (ongoing)	CD BES	Thu-31-Aug-23	
Reduction	20/553 - Growth - Continue to understand and investigate any impacts of new legislation and funding streams, impacts of change from CAP to ELMS payments in agriculture being monitored; ex EU Funding now becoming UK funding streams eg. CRF, levelling up and Shared Prosperity Fund	BES AD EPU CD BES	Thu-31-Aug-23	
Reduction	20/598 - Growth - Deliver strategic natural capital investment via the Local Nature Partnership (LEP/LNP lead); Taking forward phase 2 implementation options with partners (Local Authorities, DEFRA, Universities, Business) with link to 25 Year Environment plan and government policy changes (planning net gain, agriculture ELMs, Local Industrial Strategy & Natural Capital plans) ongoing; action plan produced; govt legislation through environment act and devolution ask	BES AD GP&TS	Thu-31-Aug-23	
Reduction	20/752 - Devolution - Develop full implementation plan – Part 1 - complete the legal governance procedures to create a combined authority	BES AD EPU CSD ACE LDS	Tue-28-Feb-23	
Reduction	20/753 - Devolution - Develop full implementation plan – Part 2 - implement the content of the devolution deal	BES AD EPU	Fri-31-May-24	
Reduction	20/754 - Devolution - Develop full implementation plan – Part 3 - develop the combined authority organisational structure and associated functions	BES AD EPU		
Reduction	20/755 - Devolution - Create Joint Committee to act as shadow combined authority	BES AD EPU	Fri-30-Sep-22	Mon-31-Oct-22

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Risk Register: **month 0 (November 2022) – detailed**
Next Review due: **May 2022**
Report Date: **23rd November 2022 (fs)**

Reduction	20/892 - Growth - Take part and lead on technical aspects relating to the Natural and Historic Environment and implement necessary strategy and delivery relating to biodiversity, local nature recovery and climate change mitigation	BES AD GP&TS	Thu-31-Aug-23

Phase 4 - Post Risk Reduction Assessment

Probability	L	**Objectives**	M	**Financial**	M	**Services**	M	**Reputation**	M	**Category**	5

Phase 5 - Fallback Plan

		Action Manager
Fallback Plan	20/572 - Carry out further discussions with Central Government if required and review and revise existing arrangements for sustainable economic growth	CD BES Chief Exec

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Linking of Directorate risks to the Corporate risk register November 2022

(Appendix B)

Corporate Risk Register

Major Failure due to Quality &/or Economic Issues in the Care Market and Workforce Pressures (1 1)	Recruitment and Retention (1 1)	Information Governance and Security (1 2)	Funding Challenges (1 2)	Partnership and Integration with the NHS (2 2)	Safeguarding Arrangements (2 2)	Significant Incidents (2 3)	Local Government Reorganisation (2 3)	Opportunities for Devolution and Growth in North Yorkshire (3 5)
Major failure of provider/key providers results in the Directorate being unable to meet the needs of people who use services. 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.	Failure to recruit and retain staff across services resulting in inability to deliver services.	Ineffective information governance arrangements lead to unacceptable levels of unauthorised disclosure of personal and sensitive data, poor quality or delayed responses to FoI requests, and inability to locate key data upon which the Council relies resulting in loss of reputation, poor decision making, fine, etc (including Brierley Group companies) Failure to put in place the appropriate cyber security arrangements could potentially lead to data breach, loss of data, loss of systems, loss of reputation with particular heightened risk due to the change during LGR.	Inadequate funding available to the Council to discharge its statutory responsibilities and to meet public expectation for the medium term resulting in legal challenge, unbalanced budget and public dissatisfaction.	Failure to achieve the best outcomes from working jointly with NHS across the NYCC footprint, a negative impact on the customer experience and the possibility of fragmented care and poor outcomes.	Failure to have a robust Safeguarding service in place results in risk to vulnerable children, adults and families and not protecting them from harm.	Failure to plan, respond to and recover effectively from significant incidents in the community resulting in risk to life and limb, impact on statutory responsibilities, impact on financial stability and reputation.	Failure to transition effectively to the new North Yorkshire Council by 1 April 2023 and to successfully set out a road map for further transformation over the subsequent years resulting in risk of failing services on Day 1, reputational impacts, member dissatisfaction, reduced performance.	Failure to take advantage of Devolution opportunities and to deliver the ambition of Sustainable Economic Growth, through for example the delivery of the right housing and transport whilst protecting the outstanding environment and heritage, resulting in reduced investment and impact on the growth and jobs, inability to recover from the impact of the Virus, attract, retain and grow businesses and raise living standards across North Yorkshire.

Health and Adult Services

Major Failure due to Quality and/or Economic Issues in the Care Market	Major Failure due to Quality and/or Economic Issues in the Care Market Workforce Recruitment and Retention	Information Governance and Health and Safety	Financial Pressures	Partnership and Integration with the NHS	Safeguarding Arrangements

Central Services

Effectiveness, Capacity and Skills of Staff and Workplace Health and Wellbeing (including impact of LGR)	Information Governance and Security	Significant Incidents	North Yorkshire Transformation Programme

Children and Young Peoples Service

Information Governance and Health and Safety	Schools Funding Challenges SEND High Need Budget	Safeguarding Arrangements	Change Programmes

Business and Environmental Service

Statutory Duties	Statutory Duties	Major Incident and Business Continuity	Delivering Change Programmes within BES	Growth Devolution Implementation in North Yorkshire

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NORTH YORKSHIRE COUNTY COUNCIL

AUDIT COMMITTEE

12 DECEMBER 2022

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 30 November 2022, in respect of information technology (IT), corporate themes, and contracts and procurement.

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 respect of IT, corporate themes and contracts, the Committee receives assurance through the work of internal audit (provided by Veritau) as well as relevant update reports from officers.

2.2 This report considers the work carried out by Veritau during the year to 30 November 2022. It should be noted that 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.

3.0 **WORK CARRIED OUT DURING THE YEAR TO 30 NOVEMBER 2022**

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

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

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

- providing advice on corporate governance arrangements and IT related controls;
- providing ongoing advice and support to various corporate / project groups; including the Supply Chain Resilience Board, Contracting Project Board and the LGR Finance Procurement sub-group.
- 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;

- carrying out 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 IT audits detailed in **appendix 1**, there has been coverage of IT related controls and activities as part of general audits where key IT systems are in operation. As part of directorate based plans, audit work has also covered procurement and/or contract related matters.

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**. 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. The work completed and the opinions given following each audit contribute to the annual report and opinion of the Head of Internal Audit.

3.5 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.

4.0 **RECOMMENDATION**

4.1 That Members note the results of internal audit work performed in the period in respect of the Council's information technology, corporate and contract arrangements.

Max Thomas
Head of Internal Audit

Veritau Ltd
County Hall
Northallerton

25 November 2022

BACKGROUND DOCUMENTS

Relevant audit reports kept by Veritau.

Report prepared by Stuart Cutts, Assistant Director – Audit Assurance, Veritau and presented by Max Thomas, Head of Internal Audit, Veritau

APPENDIX 1

INFORMATION TECHNOLOGY - FINAL AUDIT REPORTS ISSUED IN THE YEAR TO 30 NOVEMBER 2022

	System/ Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
A	ICT Capacity Management	Substantial Assurance	ICT Capacity Management is the planning and monitoring of network resources to ensure the Council's network and key systems are always available to end users. The purpose of this audit was to review whether the Council: • has a capacity management plan in line with relevant ISO requirements • monitors and analyses relevant information and data to predict and support future requirements • planning meets the capacity requirements for the Council	June 2022	An ICT Capacity Management Plan is in place and covers all the key areas outlined within ISO 20000 (the international standard for ICT service management). This plan includes assessing the current and future demands of ICT services, the expected impact of agreed requirements for availability and service continuity, and the impact of organisational changes and new technologies. Tools are in place to monitor usage. IT usage can also be monitored at the Councils individual sites. Technology and Change work closely with their suppliers who also monitor internet usage and alert the council to any issues.	**No actions identified.**

	System/ Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
					The Councils internet bandwidth meets the needs of the users.	
B	Symology	Limited Assurance	The Symology system supports the management of highways assets, street lighting and street works. The purpose of this audit was to ensure that: • access to the Symology system was restricted to authorised individuals • the system was secure • the development and maintenance of the system was in line with ISO requirements • the management of the system conformed with performance management set out in ISO 20000.	July 2022	Processes and procedures ensure only authorised users have access to Symology. Access controls are monitored by the system administrator. There is a secure connection to log on to the Symology system. A number of improvements to password requirements and controls were recommended. Symology is a business-critical system for NYCC and NY Highways. However, there was no written strategy for how the system should be developed in the immediate future. The Council has a corporate access control policy in line with ISO 27001. That policy requires each system to have their own access control policy. There is currently no access control policy for Symology.	**Four Priority 2 and Five Priority 3 actions were agreed** **Responsible Officer(s):** Head of Central Systems Team, Corporate Systems Service Owner, and Systems Development Officer (Business) Management and system governance arrangements have been moved to Technology and Change (T&C). A Service Level Agreement is now place with BES. All changes to Symology are now approved by the T&C change management processes. A number of other actions are planned to address the remaining areas for

	System/ Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
					There is a change management policy in place which covers all areas recommended by ISO 27001. However, currently there is no log of changes made to Symology. Consequently, we were unable to confirm that all changes to Symology are authorised, tested, logged and completed within a reasonable timescale. Third party assurances on Symology system security have also not been obtained.	improvement. The current timescale to complete all remaining actions is by the end of April 2023.
C	Cyber Readiness	Substantial Assurance	Cyber security remains a significant risk area for all public bodies. The government has rated 'cyber attacks' as one of the top four risks to UK National Security. The purpose of this audit was to review whether:	November 2022	The Council's disaster recovery planning is up-to-date and includes all key areas as recommended by ISO 27002. Policies are in place setting out the different types of backups required for different network components and systems, as well as frequency and retention periods. Backups were being taken in accordance with the policy. There is also a procedure	**Three P3 actions were agreed** **Responsible Officer:** Various All back-ups are now encrypted and are stored in locations with restricted access. Relevant changes to standing operating procedures have been made.

	System/ Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			• plans are in place to respond to a cyber-attack • key systems and data can be restored following a cyber-attack within the council's recovery point and recovery time objective • Technology & Change provide assistance to service areas to prepare for a cyber-attack.		to monitor and ensure backups are completed successfully. Backups were stored in secure locations at multiple different sites, increasing the security of, and resilience for, restoring data. Backups were not being encrypted; which is recommended by ISO 27002. We noted a small number of instances where the Council's standard operating procedures were not being followed. The Council's business continuity impact assessments and business continuity plans had not been reviewed by Technology and Change (T&C) to verify that the expectations of service areas was in line with T&C capabilities.	T&C are currently reviewing the business continuity requirements (coordinated by the Emergency Planning Team) with backup methods to identify whether there are any gaps. This work is planned to be completed by the end of 2022.

APPENDIX 2

CORPORATE THEMES - FINAL AUDIT REPORTS ISSUED IN THE YEAR TO 30 NOVEMBER 2022

	System/ Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
A	Payroll	Substantial Opinion	The purpose of this audit was to provide assurance that: • the process for posting salaries was working correctly so that salary costs were coded accurately and to the right code in the general ledger • allowances and additional hours paid to staff were appropriate and were authorised, calculated and paid correctly • changes to bank details were carried out appropriately.	May 2022	A suitable process was in place for posting salaries to the correct cost codes and this was working accurately in those cases tested. For the claims tested which were processed either via email to Employment Support Services (ESS) or through MyView, each allowance was in line with the jobs description and had the appropriate authorisation from the employee's line manager. Some claims were being authorised that contained insufficient information to allow for effective checking. There is also limited guidance on the level of detail to include or the areas to check in the Council's policies. We found no issues with the changes to bank details reviewed.	**One P3 actions were agreed** **Responsible Officer:** Assistant Chief Executive (Business Support) Reminder notes were to be sent managers regarding what their teams should be including in forms and what they should be looking for. Additional information and training will be provided to new managers. Officers will also undertake a full refresh of guidance for managers as part preparing for Local Government Reorganisation (LGR).

APPENDIX 3

CONTRACTS - FINAL AUDIT REPORTS ISSUED IN THE YEAR TO 30 NOVEMBER 2022

	System/ Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
A	Contract Waivers	Reasonable Assurance	Contract exemption requests are completed where it is not possible to fully comply with Procurement and Contract Procedure Rules (PCPRs). In these situations, rules can be waived subject to certain criteria and only after suitable challenge and authorisation. The purpose of the audit was to assess whether: • exemption requests were completed and authorised in line with the Procurement and Contract Procedure Rules • best value forms were completed and	November 2022	Clear rules regarding which officers can provide authorisation are in place. However, guidance on how authorisation should be documented and saved is not clearly defined. Consequently, there was a lack of consistency for how/where to document authorisation evidence. There was supporting information indicating that correct authorisation had been obtained in all, but one case tested. Waivers and decision records (DRs) are not being published to Contracts Finder or Contracts Register as required by the PCPRs. The process to complete best value forms appeared appropriate. However, in one instance, contracts were noted	**Three Priority 2 and One Priority 3 actions were agreed** **Responsible Officer:** Head of Procurement and Contract Management A standard procedure will be agreed regarding documenting and saving authorisation emails. An online signing system will also be considered. The Category Procurement Support Officers (CPSOs) will publish waivers and DRs going forward. An escalation process will be introduced for the CPSOs in the event that a best value request is believed to be non-compliant.

System/ Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
		authorised appropriately • adequate arrangements were in place to ensure exemptions were monitored and appropriate records were maintained of exemptions granted.		which were in excess of best value thresholds when combined. Registers are in place to record exemptions and officers have been assigned to oversee this. However, the process is largely reliant on manual input and the use of spreadsheets and forms. We also saw some inaccuracies on the registers.	The Senior Category Managers will be reminded of the importance of accurate record-keeping. Quarterly dip sampling will be undertaken to check the accuracy of recorded information. Various timescales have been agreed for the actions. All are due for completion by September 2023.

APPENDIX 4

AUDIT OPINIONS AND PRIORITIES FOR ACTIONS

Audit Opinions	
Our work is based on using a variety of audit techniques to test the operation of systems. This may include sampling and data analysis of wider populations. It cannot guarantee the elimination of fraud or error. Our opinion relates only to the objectives set out in the audit scope and is based on risks related to those objectives that we identify at the time of audit.	
Opinion	**Assessment of internal control**
Substantial Assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.
Reasonable Assurance	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.
Limited Assurance	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.
No Assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.

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

12 DECEMBER 2022

PROCUREMENT AND CONTRACT MANAGEMENT UPDATE

Report from Corporate Director, Strategic Resources

1. PURPOSE OF THE REPORT

1.1 To provide Members with an update on the work of the Procurement and Contract Management Service, including key achievements, recent activity and the continuing response to supply chain resilience.

2. BACKGROUND

2.1 The Council spends over £515m externally each year across both revenue and capital and it is the Council's responsibility to ensure good value for money is achieved in the delivery or our objectives.

2.2 The Council continues to have good visibility on where money will be spent in the upcoming months / years through the Forward Procurement Plans (FPPs). FPPs allow Directorates (and their corresponding Senior Category Manager) to have an oversight of approaching procurements. As a result, resources and specialist support is deployed appropriately to deliver good procurement and value for money across the Council's external expenditure.

2.3 This report will set out specific work and achievements of the Procurement and Contract Management Service this year, with a focus on supply chain resilience.

3. KEY ACHIEVEMENTS AND RECENT ACTIVITY

Continuing Response to Supply Chain Resilience

3.1 Supply chain resilience arrangements were put in place in response to Covid-19. This included targeted support for the Council supply chains. The intention was, as we transitioned back to life post-COVID the need for supply chain resilience would cease. It soon became apparent that the escalating situation in the Ukraine would result in far reaching repercussions.

3.2 As a country we now face significant cost of living pressures, not seen since the 1970's. Inflation has increased to 11.05%, a 40 year high. This has resulted in our supply chains which were trying to recover from the pandemic being impacted by a number of factors including escalating fuel costs, access to labor, increased raw material costs, pressure in relation to wages etc.

3.3 As a result, the Supply Chain Resilience Board (SCRB), set up in response to triage suppliers at risk due to the pandemic has remained in place. SCRB has been extremely valuable, and it is important it continues as we navigate through the impact of these factors on our supply chains.

3.4 The SCRB provides a decision making and monitoring board made up of the Corporate Director Strategic Resources (Chair), Assistant Chief Executive (Legal), Assistant Directors Strategic Resources, Head of Procurement and Contract Management, and Senior Category Managers. Directorate nominated supply chain contacts and contract managers, including Adult / Children's Social Care, Transport, Social Care, Technology and others attended as and when required.

3.5 The central governance, coordination and challenge provides the opportunity to give complex financial issues proper consideration and colleagues from across the Council collaborate to deliver the right outcomes for the Council and its supply chains.

Wider Supply Chain Support

3.6 The wider resilience issues continue to have an adverse effect on global trade and supply chains. Unsurprisingly the Council has experienced price uncertainty in some supply chains. Within this context, supply chain stability and resilience are key, especially for small and medium sized suppliers (SMEs) and Voluntary, Community, Social Enterprise (VCSEs) in North Yorkshire.

3.7 As a Council we recognise the need to provide more support and guidance for these organisations who find securing contracts in the public sector disproportionately harder than their larger competitors.

3.8 In 2021/22 the councils total spend was £515m, 53% (£274k) of spend was with SMEs and we are committed to supporting more SMEs to do business with the council. Of the 4,797 suppliers the council worked with in 2021/22, 2,527 were SMEs and the ambition is to increase this number.

3.9 The council continues to work with Go4Growth, a local organisation with a programme designed specifically to help smaller organisations in any sector to enter or grow in the public sector marketplace. The programme is funded by the Council and enables businesses to access free support, guidance, tools and resources.

3.10 Recently Go4Growth worked with the social care sector on the re-procurement of the Social Care Approved Provider Lists which deliver support to people in residential settings; their homes or providing day services. The work acknowledged some of the barriers the VCSE and SMEs report when trying to do business with councils. A tailored engagement programme was developed to support Providers through the application process and encourage more VCSE/ SMEs to work with us.

Environmental sustainability

3.11 Targeted work has been undertaken to engage our supply chains around environmental sustainability. 200 suppliers were contacted however the response rate was 3.5% (7). Working with GoForGrowth research and engagement demonstrates that supplier's describe questionnaire fatigue, with a clear preference for engagement through specific tailored market events.

3.12 Work continues with stakeholders within YPO on reducing single use plastics, particularly across the catering and food sectors who supply the Council. Across disposable cutlery and plates in 2021, a third of a tonne of single use plastic has been eliminated from waste by the introduction of sustainable wood alternatives. Rising costs, availability and suitability for purpose of alternatives remain challenges to this sector.

3.13 Working with Eunomia Research and Consulting, a gap analysis was undertaken on current performance across the seven summarised criteria:

- corporate goals on carbon reduction, sustainability and the circular economy
- social value
- environmental impact
- regional alignment
- emissions
- reducing carbon impact
- action plan.

The criteria has been encompassed in the refreshed *Procurement and Contract Management Strategy.*

3.14 Funding has been secured from the Beyond Carbon Budget to support the pilot of a social value platform. This will be available free of charge to suppliers and helps them to understand where they are in relation to delivery of social value through their business activities and where there is scope for additional benefits. The platform offers a sytemised, and bespoke to each supplier, approach to develop an action plan and aid the suppliers when responding to public sector procurement opportunities which often evaluate some form of social value related to the contract. It also provides to the Council insight into it's supply chain's social value maturity identifying the top issues, and developing areas.

Leadership, Regulatory Reform and Skills Development

3.15 The Council continues to play a leading role in procurement and contract management, both regionally and nationally. The Council is the deputy chair for the YorProcure Strategic Procurement Group of twenty-five public sector bodies in the Yorkshire and Humber region and represents the region on the Local Government Association National Advisory Group for Procurement.

3.16 The new Public Contract Regulations will come into force in late 2023. The Procurement and Contract Management Service will lead on appropriate implementation training and awareness building in the lead up to the new regulations becoming law. The proposals outline the government's goal to speed up and simplify procurement processes, leverage support for national and local outcomes for public benefit and drive social, environmental and economic benefits.

Local Government Reorganisation

3.17 Local government reorganisation from April 2023 presents opportunities around bringing together our services and functions and realising efficiencies. Our ultimate priority is to ensure that NYC is safe and legal from day 1.

3.18 Reorganisition to a single unitary Council is likely to result in duplication of contracts with suppliers for the same or similar goods/works/services. With this comes the opportunity to consolidate spend and reduce spend via negotiation.

3.19 Processes have been implemented to support the operational delivery and management in line with the S24 notice, including establishing a consolidated contracts register to identify all the contracts the new Authority will inherit. A combined forward procurement plan has also been created to identify all procurement activity and ensure visibility of capital and revenue spend pre-Vesting day.

3.20 The county council and district/borough councils have unfortunately seen a number of staff leaving their procurement and contracting services over recent months. In NYCC there has been a turnover rate of around 46% (11 FTEs) since September 2021. It is challenging recruiting into vacancies due to the highly competitive labour market and this leaves us facing some capacity issues. We have already seen the shift of some district/borough staff into NYCC which is adding pressure to colleagues. The recruitment of staff through training programmes has proven to be successful for the service and it is therefore intended that further efforts will be made to help bridge any existing gaps post-LGR.

2.1 Future work will include plans to maximise potential cost savings of contractual relationships with suppliers and developing and agreeing a supplier engagement strategy to communicate the future way of working with the new unitary Council and any business opportunities and approaches.

3. PROCUREMENT AND CONTRACT MANAGEMENT STRATEGY PROGRESS

3.1 The current Procurement and Contract Management Strategy has been reviewed in readiness for the new Authority. The strategy focuses on:

- Sustainability issues and market stability
- Supporting SMEs/ VCSE sectors
- Supporting North Yorkshire to have a strong economy
- Dealing with the carbon agenda and other environmental issues.

3.2 The Strategy complements and supports the ongoing transformation work at the Council and helps ensure that commercial arrangements and contracts awarded by the Council provide the very best value for money. We also use our procurement spend to provide the very best social value for our communities.

3.3 The procurement and contract management strategy is monitored through a series of key performance indicators covering the activities detailed in the Strategy Action Plan. The Corporate Procurement Board is accountable for the delivery of the Action Plan and monitors Key Performance Indicators on a quarterly basis. The latest Procurement and Contract Management Strategy Action Plan KPI figures can be found in **Appendix 1.**

4. RECOMMENDATIONS

4.1 The Audit Committee are requested to:-

a) Note progress on key achievements and recent activity.

b) Provide comments in order to further add value to the ongoing work on procurement and contract management, especially in relation to delivering the procurement and contract management strategy.

Gary Fielding
Corporate Director, Strategic Resources

Author of Report –

Rachel Woodward
Head of Procurement and Contract Management
24 November 2022

Appendix 1 – Procurement and Contract Management Strategy Action Plan KPI Figures

Theme group	KPI reference	Measure	2022/23 Target	Q1 Results	Q2 Results	Cumulative Total (Q1 & Q2)
LGR	1.1	Successful transition of service/team into the new council, processes are reviewed, renewed and aligned (cross referenced to KPI refs 4.1, 4.2, 4.3 & 6.5)	N/A	-	-	-
Policy and Governance	2.1	Average days taken to complete above threshold procurements	110 Days	91 Days	90 Days	91 Days
Contract Management	3.1	% contract utilisation	70.00%	79.24% (£102,957,431.37)	83.49% (£110,096,908.13)	81.38% (£213,043,494.50)
Contract Management	3.2	% contract management staff that have or are working towards completing the contract management module	100.00%	100.00%	100.00%	N/A
Value and Savings	4.1	Annual cashable supply chain savings that are delivered	£169,000.00	TBC	TBC	TBC
Value and Savings	4.2	Annual cashable supply chain savings that are secured and not taken	N/A	TBC	TBC	TBC
Value and Savings	4.3	Annual non-cashable supply chain savings	N/A	TBC	TBC	TBC
Sustainability	5.1	% total Council spend with local suppliers	50.00%	54.54% (£70,856,776.32)	55.52% (£73,206,263.92)	55.03% (£144,059,827.50)
Sustainability	5.2	% total Council spend with SME suppliers	50.00%	48.00% (£62,369,373.69)	47.04% (£62,036,278.78)	47.52% (£137,396,221.06)
Sustainability	5.3	% total Council spend with voluntary and community sector	3.00%	4.00% (£5,201,814.05)	2.90% (£3,826,656.83)	3.45% (£9,028,470.88)
Team Development	6.1	% of operational procurement staff with or working towards CIPS accreditation	90.00%	60.00%	73.33%	N/A
Team Development	6.2	% of all Procurement & Contract Management staff with or working towards the Government Commercial Function Foundation Accreditation	100.00%	-	92.31%	N/A
Team Development	6.3	% of contract management staff with or working towards the Government Commercial Function Practitioner Accreditation	100.00%	-	50.00%	N/A
Team Development	6.4	% customer satisfaction rated "fully meets expectation" or above	80.00%	83.33% (5 of 6)	100% (2 of 2)	87.5% (7 of 8)
Team Development	6.5	12 month rolling % staff retention rate and successful TUPE of District staff	75.00%	-	67.26%	N/A
Technology	7.1	% of categorised spend	99.50%	99.81%	99.72%	99.77%

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The below summary relates to performance covering April 2022 – September 2022.

Supporting our local economy

Spend with our local suppliers has increased in quarter 2 compared with quarter 1, currently local supplier spend equates to 55.03% (£144m) of the councils total spend (£261m).

Working with SMEs

The British Chambers of Commerce (BCC) in partnership with Tussell published an SME Procurement Tracker for 2022. Within this report it was found that the proportion of Local Government spend with SMEs was 38% of their overall procurement budgets for 2021. Central government spend was only at 11% and the NHS was at 22%[1]. Although we are not currently meeting our target (50%) it is recognised that our percentage spend (47.52% - £137m) is still above the Local Government average.

Delivery with our VCSEs

We continue to work with our voluntary and community sector organisations to help deliver services across the authority. Based on data from previous financial years, there is typically a drop in spend with VCSEs in quarter 2. It is anticipated that this is in relation to work peaks within particular markets (e.g. health care) occurring outside of the summer period. The Q2 result for this financial year is higher than last year's Q2 spend percentage which was 2.75%. To date we have spent £9m with the VCSEs and are currently exceeding the 3% target (3.45%). Unfortunately there is no central register of VCSE organisations, as such we rely on suppliers informing us that they are a VCSE to ensure this is captured in the payment system to support accurate reporting. This data is currently under reported.

Investing in team development and skills

As a service we are committed to ensuring the team have access to the right training. Over recent months there has been a higher staff turnover within the team due to career progression opportunities within other public sector originations. However, as the winner of the Procurement Team of the Year 2021/22 at the UK National Go Awards we are seen as a desirable employer for those looking for a career in procurement and contracting within the public sector. As a result many of the roles have been successfully recruited to within this period including individuals from the Districts and Borough Councils in North Yorkshire which is supporting the collaborative working linked to LGR. Due to a number of successful recruitments to the team during this period, a couple of staff have not yet started their training. We have also implemented the GCF contract management training, this is a 6 month training course and the first cohort has just commenced. This training will help the authority improve our approach to contract management and our commercial capabilities.

[1] British Chambers of Commerce & Tussell, SME Procurement Tracker 2022
https://www.britishchambers.org.uk/media/get/British%20Chambers%20of%20Commerce%20&%20Tussell%20%20-%20SME%20PROCUREMENT%20TRACKER%202022%20-2.pdf

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North Yorkshire County Council

Audit Committee

12 December 2022

Commercial Governance Review

Report of Corporate Director, Strategic Resources

1.0 Purpose of Report

1.1 To highlight the best practice to commercial governance set out in the Chartered Institute of Public Finance & Accountancy (CIPFA) updated publication "Local Authority Owned Companies – A good practice guide 2022 edition". This report summarises best practice from the CIPFA guide. It is intended that a review of the existing arrangements will take place over the next few months in line with Local Government Reorganisation (LGR), with a report brought back to Committee post LGR detailing the outcome and actions from the review.

2.0 Introduction

2.1 The Brierley Group is made up of Council owned Companies. It is considered to be the trading arm of North Yorkshire County Council (NYCC/the Council). The group was established in 2017 to bring together the companies with the aim of improving customer experience and increasing overall shareholder value. Whilst the Brierley Group is not a legal entity in itself, and the group is not a group of companies in the traditional legal sense (with a holding company) it acts to provide oversight for NYCC. NYCC currently has eight commercial operations within the Brierley Group; Veritau, Align Property Partners, Yorwaste, NYnet, Brierley Homes, First North Law, NYES and NY Highways. Of the seven companies, five are wholly owned by NYCC and the other two are jointly owned with City of York Council. In addition, the Council has historically sold a number of services to schools which it now operates under the branding of "North Yorkshire Education Services" (NYES), but this is not set up as a separate company.

2.2 During the exploratory work of the LGR Commercial work stream a number of district owned commercial companies and commercial interests have been noted which will need to be considered in the future as part of the ongoing review of commercial best practice.

2.3 In June 2022, CIPFA published updated guidance for local authorities to consider in relation to the governance process in place for any local authority owned companies - "Local Authority Owned Companies – A good practice guide 2022 edition". In order to facilitate a review of the commercial environment in which the companies operate, this guidance published by CIPFA will be used as a framework to assess existing arrangements.

2.4 The CIPFA publication is titled as a good practice guide, it is aimed at giving Local Authorities guidance and best practice around establishing and forming trading companies, setting up effective governance and monitoring, ensuring compliance, understanding the risks involved and supporting the enduring success of their business aspirations. The publication highlights the areas where others have pursued commercial goals but have failed, examples include Nottingham City Council failed energy company Robin Hood Energy Limited and London Borough of Croydon Council's Brick By Brick housing company.

3.0 Summary of best practice from the CIPFA guidance

3.1 The guide recognises the increased risk to local authorities and the potential problems that engaging in trading companies and joint ventures can cause. It's stated aim is to assist local authorities by setting out and highlighting existing best practice in terms of ensuring a focus on what the authority wants to achieve and then the process to find the right option to achieve that goal. The guide covers the following areas:

- Set-up – the role of the company and the business case or options appraisal
- Governance – including roles and responsibilities
- Operational practices
- Assurance

3.2 Learning points included in the guide for authorities to consider are:

- Focusing on outcomes to be achieved
- Balancing the freedom for the company to deliver with sufficient oversight from the authority
- Ensuring relationships are robust by developing effective channels of communication between the authority and the company
- Choosing the right delivery model – using a robust options appraisal process
- Engaging effectively with stakeholders
- Seeking expert advice – authorities need support and cannot know everything
- Clarifying roles and responsibilities – obligations must be clear
- Ensuring finance, legal and service delivery functions work closely together throughout the life cycle of the company

3.3 Based on the information contained within the document, the following arrangements are key factors to be considered as part of the review, taking into account the CIPFA guidance:

a) Audit of Brierley group companies
b) Risk Management
c) Conflicts of Interest
d) External Board challenge
e) Business plans
f) Shareholder agreement
g) Post vesting day commercial review

4.0 Key considerations arising from the guidance

a) Audit of Brierley Group Companies

4.1 The guidance highlights that both the internal and the external audit function can provide a range of benefits such as;

- Providing assurance to the Board and wider stakeholders
- Ensuring compliance with policies and regulations
- Determining the adequacy and effectiveness of internal controls
- Identify operational weakness and inefficiencies
- Assess the efficient and responsible use of Council resources
- Pre-empt financial losses

4.2 The current arrangements and appropriate involvement of internal and external audit for each Brierley Group company will be considered as part of the review.

b) Risk Management

4.3 The guidance includes that best practice dictates that the ongoing management of risks is vital to the success of commercial organisations. Operating a successful commercial entity is in being cognisant of the current and emerging risks, creating strategies to document the short and long term risks and how the business is placed to address and mitigate them. Management of risks is also a key element of effective governance and in protecting shareholder and stakeholder interests and in exposing the Council to negative press about its investments.

4.4 Risks facing commercial organisations can (but not limited to) include areas such as technological/obsolescence, financial, interest rate, operational, reputational.

4.5 Technological risk can be due to a lack of forward thinking and innovation, what is currently a marketable product, competitive advantage or unique selling point (USP) today can easily be rendered obsolete.

4.6 Financial and economic risk, trading companies will be set up with an expectation and direction to generate a level of return to ultimately make the venture worthwhile for the authority.

4.7 Operational risk is the risk of losses caused by flawed or failed processes, policies, systems or events. Reputational risk can arise directly through the actions of the company or directly through the actions of an employee or related party. Reputational risk can quickly generate negative press and invite significant challenge to its owners, directors and leadership team.

4.8 The guidance suggests adapting the policies relative to the risk tolerance and risk appetite that each company faces. The approach of each company to risk and the processes and procedures in place will be considered as part of the review.

c) Conflicts of interest

4.9 The CIPFA guidance suggests having a policy for declarations and conflicts of interest within each company's articles of association.

4.10 The guidance notes that Members, officers, Directors and Board attendees can often have a diverse role within the authority and sit on multiple Boards as part of their duties as well as having various outside interests. In a dynamic commercial environment, conflicts of interest can arise and change unexpectedly during formal discussions and throughout the year. Conflicts of interest may arise for a number of reasons; these can include business interests but may also extend to personal relationships and conflicts of loyalty.

4.11 As a company Director, their duty is to the company, and this is the case even if the individual happens to also be a senior officer or elected Member of the Council. Directors also have a statutory duty to avoid conflicts of interest. Directors must have regard to the rules on declaring their interests and any restriction on voting, as may be set out in the company's articles of association.

4.12 When acting as a senior officer or Member of the Council, their duty is foremost to act in the best interests of the Council, subject to confidentiality of information required by the company. This wearing of different hats is clearly a cause of potential conflicts of interest.

4.13 The guidance suggests that Local Authority Members and officers are aware of potential conflicts of interest when performing their role for the Local Authority and their role in respect of the company. In general, if there are any doubts about conflicts of interest arising from an appointment, it is preferable not to make the appointment.

4.14 The guidance also states that there should be a formal policy in place to ensure Members and officers are aware of potential conflicts of interest when performing their role for the Local Authority and the company.

4.15 The review will consider Brierley Group arrangements in relation to conflicts of interest.

d) External challenge to the Board

4.16 Previous failures that have affected Local Authority companies have often included a lack of understanding of roles and responsibilities, a lack of relevant skills and experience and conflict of interests. The CIPFA guidance notes that Non-Executive Directors can play a vital role in holding the executive to account for its performance in fulfilling its responsibilities through constructive challenge and scrutiny. As set out above, the Local Authority should always ensure that the scope for conflicts is minimised with a clear divide between those in such roles, and those responsible for holding them to account or overseeing them.

4.17 Non-Executive Directors make up part of the Board of directors of a company. They can bring vital expertise and different perspectives. Non-Executive Directors can include Members, officers and independent directors (who are external to the authority).

4.18 It is good practice to have some ‘distance’ between key authority decision makers and company decision makers.

4.19 The review will consider arrangements in relation to the involvement of Non-Executive Directors on the Boards of Brierley Group companies.

e) Business Planning

4.20 The success of commercial organisations is reliant in having strong leadership, a commercial culture, establishing a clear strategy and executing on that strategy. The strategy needs to take the form of a commercially focused business plan that details a clear roadmap signalling the companies’ direction and aspirations for the future. Building up a successful company can take many years and requires plans that extend beyond a traditional one year cycle to allow the business to work iteratively towards medium to long term goals, under the guidance and direction of the board.

4.21 The CIPFA guidance explains that the subject of several failed Local Authority companies in case studies and public interest reports is through a lack of ongoing due diligence and weak or flawed business plans. A business case needs to be reviewed to ensure it adapts to the current circumstances or exploit opportunities in the market. Ultimately, the Local Authority need to ensure that the company is generating the intended outcomes, while acting in the public interest at all times.

4.22 The guidance highlights the importance of a strategic plan which brings together some of the key documents and it allows the reader to interpret and understand the current and future position against the business case and provides assurance to the Shareholder that a sound, well thought out and robust plan is in place to protect shareholder interests.

4.23 Current and future business planning arrangements will be considered as part of the review.

f) Shareholder Agreement

4.24 The CIPFA guidance recommends having a shareholder agreement in place for each company.

4.25 A shareholder agreement is a document that supplements the Company's articles of association. It is a contractual agreement between the company and the shareholder and is a private document (unlike the articles which are published). It sets out the rights of the Council as shareholder (or co-shareholder as appropriate). The articles form the overarching constitution for a company and are the legal document required to establish a limited company. However, the articles are a public document, therefore certain matters can be put into the shareholder agreement so that they remain private.

4.26 The shareholder agreement can be used to define the entity's risk management strategy, approve the limits for risk taking, and determining the criteria for internal control. This gives the company certain agreed parameters to work within and allows the company to challenge the level of risk averseness.

4.27 The review will consider arrangements in relation to Shareholder Agreements.

g) Post LGR Company review

4.28 A review of the principles contained within the CIPFA guidance will be carried out as part of the work being carried out by the Local Government Reorganisation (LGR) commercial workstream, it has highlighted a number of commercial interests held within the district and borough councils and districts and borough owned companies. As part of this workstream, a requirement for due diligence and a governance review of these companies has been identified. This shall take place post vesting day, and any such review shall take into account the CIPFA guide.

5.0 Next Steps

5.1 A review of the principles contained within the CIPFA guidance, current arrangements and recommendations for any proposed changes to the commercial governance environment arising from this review will be carried out as part of the work of the LGR Commercial workstream.

6.0 Recommendations

6.1 The Audit Committee is requested to note the contents of the report and agree to receive a further report post LGR.

Author of report: Vicki Dixon, Assistant Director Strategic Resources (BES/CS)

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AUDIT COMMITTEE - PROGRAMME OF WORK 2022/23

	ANNUAL WORKPLAN Audit Committee Agenda Items	MAR 22	JUNE 22	OCT 22	NOV 22	DEC 22	MAR 23
A	Training for Members (as necessary)	4	2	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						
	External Audit Appointments from April 2023						×
	External Audit Progress Update						
C	Statement of Final Accounts including AGS (NYCC + NYPF)				×		
	Letter of Representation						
	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						
	Business Continuity – annual report			×			
	Counter Fraud Policy Framework					×	
	Counter Fraud strategy (inc risk assessment) – annual report		×				×
	Procurement and Contract Management – annual report					×	
	CIPFA FM Code					×	
	Treasury Management – Executive February	×					×
	Commercial Governance Review					×	
	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	21/03	27/06	24/10	28/11	12/12	20/03

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

Meetings to be sorted
1 Governance of External Companies (inc NY Highways) & Commercial Investments
2 LGR Update – MTFS & Governance Issues
3 Pensions Governance
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