Rutland County Council

Catmose, Oakham, Rutland, LE15 6HP.
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Ladies and Gentlemen,

A meeting of the **AUDIT AND RISK COMMITTEE** will be held in the Council Chamber, Catmose, Oakham, Rutland, LE15 6HP on **Tuesday, 30th June, 2015** commencing at 7.00 pm when it is hoped you will be able to attend.

Yours faithfully

Helen Briggs
Chief Executive

Recording of Council Meetings: Any member of the public may film, audio-record, take photographs and use social media to report the proceedings of any meeting that is open to the public. A protocol on this facility is available at www.rutland.gov.uk/haveyoursay

A G E N D A

APOLOGIES FOR ABSENCE

1) MINUTES

To confirm the minutes of the Audit and Risk Committee held on the 20 January 2015 and 7 April 2015

2) DECLARATIONS OF INTEREST

In accordance with the Regulations, Members are invited to declare any disclosable interests under the Code of Conduct and the nature of those interests in respect of items on this Agenda and/or indicate if Section 106 of the Local Government Finance Act 1992 applies to them.

3) PETITIONS, DEPUTATIONS AND QUESTIONS

To receive any petitions, deputations and questions received from Members of the Public in accordance with the provisions of Procedure Rule 217.
The total time allowed for this item shall be 30 minutes. Petitions, declarations and questions shall be dealt with in the order in which they are received. Questions may also be submitted at short notice by giving a written copy to the Committee Administrator 15 minutes before the start of the meeting. The total

time allowed for questions at short notice is 15 minutes out of the total time of 30 minutes. Any petitions, deputations and questions that have been submitted with prior formal notice will take precedence over questions submitted at short notice. Any questions that are not considered within the time limit shall receive a written response after the meeting and be the subject of a report to the next meeting.

4) EXTERNAL AUDIT PLAN

To receive Report No. 62/2015 from the Director of Resources.
(Pages 1 - 28)

5) ANNUAL INTERNAL AUDIT REPORT

To receive Report No. 108/2015 from the Director of Resources.
(Pages 29 - 66)

6) ANNUAL FRAUD REPORT

To receive Report No. 97/2015 from the Director of Resources.
(Pages 67 - 72)

7) REGULATION OF INVESTIGATORY POWERS ACT 2000 (RIPA) ANNUAL REPORT

To receive Report No. 99/2015 from the Director of Resources.
(Pages 73 - 76)

8) LIMITED ASSURANCE UPDATE REPORT

To receive Report No. 106/2015 from the Director of Resources.
(Pages 77 - 90)

9) ANNUAL GOVERNANCE STATEMENT

To receive Report No. 109/2015 from the Director of Resources.
(Pages 91 - 108)

10) INTERNAL AUDIT PLAN

To receive Report No. 73/2015 from the Director of Resources.
(Pages 109 - 116)

11) RISK MANAGEMENT UPDATE

To receive Report No. 122/2015 from the Director of Resources.
(Pages 117 - 120)

12) COMMITTEE TRAINING PROGRAMME

To receive Report No. 107/2015 from the Director of Resources.
(Pages 121 - 124)

13) ANY OTHER URGENT BUSINESS

To receive items of urgent business which have previously been notified to the person presiding.

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DISTRIBUTION
MEMBERS OF THE AUDIT AND RISK COMMITTEE:

Mrs D MacDuff (Chairman)	
Mr J Lammie (Vice-Chair)	
Mr E Baines	Miss G Waller
Mr A Walters	

OTHER MEMBERS FOR INFORMATION

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AUDIT AND RISK COMMITTEE

7 April 2015

EXTERNAL AUDIT – AUDIT PLANNING 2014/15

Report of the Director of Resources

STRATEGIC AIM:	**All**

1. PURPOSE OF THE REPORT

1.1 To inform the Committee of the External Audit plan for 2014/15.

2. RECOMMENDATIONS

2.1 That the Committee notes the plan at Appendix A.

3. REASONS FOR THE RECOMMENDATIONS

3.1 To ensure that the Committee is aware of and understands the approach to the external audit for 2014/15.

4. BACKGROUND

4.1 Each year the External Audit produces and agrees with the Council an Audit Plan setting out its approach to the audit of:

- The Council's Statement of Accounts
- Whole of Government Accounts return
- Value for Money

4.2 The plan for the 2014/15 audit is attached at Appendix A to this report. The plan has been updated following planning work by the external auditors. There are no major risk issues identified by the auditors in their work to date which suggests that additional work will be needed. Members should note that the fee has increased slightly to £87,308 (£86,238 2013/14) because of increases in the Audit Commission's scale fee to reflect work required in relation to local Business Rates following the removal of the certification requirement for the NNDR3 return. For 2015/16 the fee reduces to £70,941. This reduction has been achieved by the Audit Commission re-tendering some of the older audit framework contracts.

5. RISK MANAGEMENT

RISK	IMPACT	COMMENTS
Time	Low	Timescales for the audit work have been agreed with the Audit Manager
Viability	Low	There are no direct implications within this report
Finance	Low	The 2014/15 forecast includes the cost of the external

		audit fee.
Profile	Medium	External assessment of the Council's performance attracts interest locally and nationally.
Equality and Diversity	Low	Equality Impact Assessment completed, there are no particular issues from this report.

Background Papers
None

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A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577.

KPMG

cutting through complexity

External Audit Plan 2014/15

Rutland County Council

February 2015

Contents

The contacts at KPMG in connection with this report are:

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Introduction

This document describes how we will deliver our audit work for Rutland County Council.

Scope of this report

This document supplements our *Audit Fee Letter 2014/15* presented to you in April 2014. It describes how we will deliver our financial statements audit work for Rutland County Council ('the Authority'). It also sets out our approach to value for money (VFM) work for 2014/15.

We are required to satisfy ourselves that your accounts comply with statutory requirements and that proper practices have been observed in compiling them. We use a risk based audit approach.

The audit planning process and risk assessment is an on-going process and the assessment and fees in this plan will be kept under review and updated if necessary.

Statutory responsibilities

Our statutory responsibilities and powers are set out in the *Audit Commission Act 1998* and the Audit Commission's *Code of Audit Practice*.

The Audit Commission will close at 31 March 2015. However our audit responsibilities under the *Audit Commission Act 1998* and the *Code of Audit Practice* in respect of the 2014/15 financial year remain unchanged.

The *Code of Audit Practice* summarises our responsibilities into two objectives, requiring us to audit/review and report on your:

- *financial statements (including the Annual Governance Statement):* providing an opinion on your accounts; and
- *use of resources:* concluding on the arrangements in place for securing economy, efficiency and effectiveness in your use of resources (the value for money conclusion).

The Audit Commission's *Statement of Responsibilities of Auditors and Audited Bodies* sets out the respective responsibilities of the auditor and the Authority.

The Audit Commission will cease to exist on 31 March 2015. Details of the new arrangements are set out in Appendix 4. The Authority can expect further communication from the Audit Commission and its successor bodies as the new arrangements are established. This plan restricts itself to reference to the existing arrangements.

Structure of this report

This report is structured as follows:

- Section 2 includes our headline messages, including any key risks identified this year for the financial statements audit and Value for Money arrangements Conclusion.
- Section 3 describes the approach we take for the audit of the financial statements.
- Section 4 provides further detail on the financial statements audit risks.
- Section 5 explains our approach to VFM arrangements work.
- Section 6 provides information on the audit team, our proposed deliverables, the timescales and fees for our work.

Acknowledgements

We would like to take this opportunity to thank officers and Members for their continuing help and co-operation throughout our audit work.

Headlines

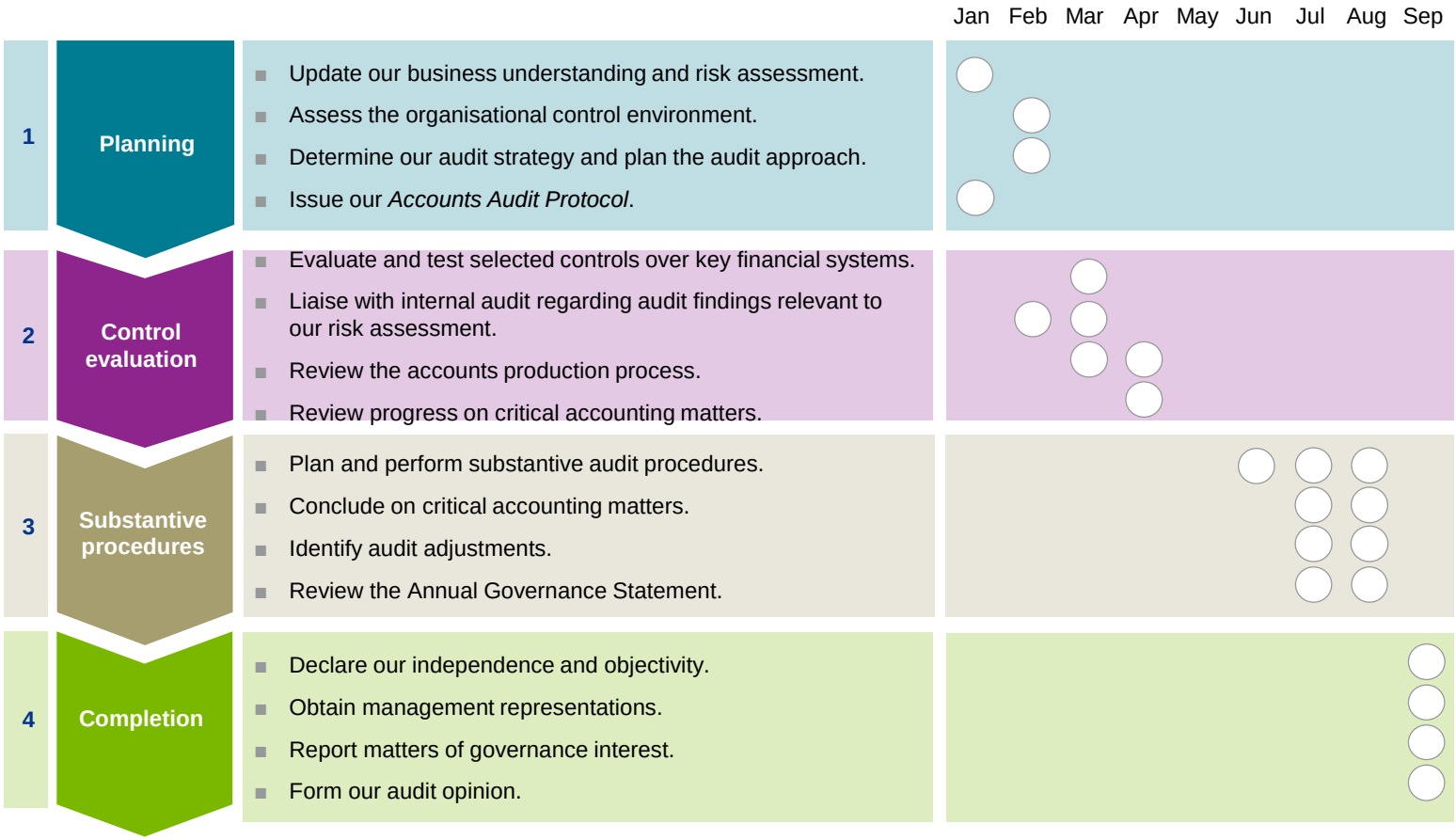
Audit approach	Our overall audit approach remains similar to last year with no fundamental changes . Our work is carried out in four stages and the proposed timings for these are similar to previous years. Our audit strategy and plan remain flexible as risks and issues change throughout the year. We will review the initial assessments presented in this document throughout the year and should any new risks emerge we will evaluate these and respond accordingly.
Key financial statements audit risks	We have completed our initial risk assessment for the financial statements audit and have not identified any significant risks this year.
VFM audit approach	We have completed our initial risk assessment for the VFM conclusion and have not identified any significant risks at this stage.
Audit team, deliverables, timeline and fees	We have made one change to your audit team this year, with David Schofield taking over as Assistant Manager. Our main year end audit is currently planned to start In July 2015. Upon conclusion of our work we will again present our findings to you in our *Report to Those Charged with Governance (ISA 260 Report)*. The planned fee for the 2014/15 audit is £87,308. This is £1,070 more than the fee set out in our *Audit Fee Letter 2014/15* and is due to the increase in the Audit Commission's scale fee to reflect work required in relation to local Business Rates following the removal of the certification requirement for the NNDR3 return.

Our audit approach

We undertake our work on your financial statements in four key stages during 2015:

- **Planning (January to February).**
- **Control Evaluation (February to April).**
- **Substantive Procedures (July to August).**
- **Completion (September).**

We have summarised the four key stages of our financial statements audit process for you below:



Our audit approach – planning (continued)

During January and February 2015 we complete our planning work.

We assess the key risks affecting the Authority's financial statements and discuss these with officers.

We assess if there are any weaknesses in respect of central processes that would impact on our audit.

We will issue our *Accounts audit protocol* following completion of our planning work.

Our planning work takes place in January and February 2015. This involves the following aspects:

Planning

- Update our business understanding and risk assessment including fraud risk.
- Assess the organisational control environment.
- Determine our audit strategy and plan the audit approach.
- Issue our *Accounts Audit Protocol*.

Business understanding and risk assessment

We update our understanding of the Authority's operations and identify any areas that will require particular attention during our audit of the Authority's financial statements.

We identify the key risks including risk of fraud affecting the Authority's financial statements. These are based on our knowledge of the Authority, our sector experience and our ongoing dialogue with Authority staff. Any risks identified to date through our risk assessment process are set out in this document. Our audit strategy and plan will, however, remain flexible as the risks and issues change throughout the year. It is the Authority's responsibility to adequately address these issues. We encourage the Authority to raise any technical issues with us as early as possible so that we can agree the accounting treatment in advance of the audit visit.

We liaise with the finance team on a regular basis to consider issues and how they are addressed during the financial year end closedown and accounts preparation.

Organisational control environment

Controls operated at an organisational level often have an impact on controls at an operational level and if there were weaknesses this would impact on our audit.

In particular risk management, internal control and ethics and conduct have implications for our financial statements audit. The scope of the relevant work of your internal auditors also informs our risk assessment.

Audit strategy and approach to materiality

Our audit is performed in accordance with International Standards on Auditing (ISAs) (UK and Ireland). The Engagement Lead sets the overall direction of the audit and decides the nature and extent of audit activities. We design audit procedures in response to the risk that the financial statements are materially misstated. The materiality level is a matter of professional judgement and is set by the Engagement Lead.

In accordance with ISA 320 (UK&I) '*Audit materiality*', we plan and perform our audit to provide reasonable assurance that the financial statements are free from material misstatement and give a true and fair view. Information is considered material if its omission or misstatement could influence the economic decisions of users taken on the basis of the financial statements.

Further details on assessment of materiality is set out on page 6 of this document.

Accounts audit protocol

At the end of our planning work we will issue our *Accounts Audit Protocol*. This important document sets out our audit approach and timetable. It also summarises the working papers and other evidence we require the Authority to provide during our interim and final accounts visits.

We have met with the Finance Team to discuss mutual learning points from the 2013/14 audit. These will be incorporated into our work plan for 2014/15.

Our audit approach –planning (continued)

When we determine our audit strategy we set a monetary materiality level for planning purposes.

For 2014/15 we have set this at £1.1m.

We will report all audit differences over £55k to the Audit and Risk Committee.

Materiality

The assessment of what is material is a matter of professional judgment and includes consideration of three aspects: materiality by value, nature and context.

- Material errors by value are those which are simply of significant numerical size to distort the reader's perception of the financial statements. Our assessment of the threshold for this depends upon the size of key figures in the financial statements, as well as other factors such as the level of public interest in the financial statements.
- Errors which are material by nature may not be large in value, but may concern accounting disclosures of key importance and sensitivity, for example the salaries of senior staff.
- Errors that are material by context are those that would alter key figures in the financial statements from one result to another – for example, errors that change successful performance against a target to failure.

Materiality for planning purposes has been set at £1.1m which equates to around 2 percent of gross expenditure.

We design our procedures to detect errors in specific accounts at a lower level of precision.

Reporting to the Audit and Risk Committee

Whilst our audit procedures are designed to identify misstatements which are material to our opinion on the financial statements as a whole, we nevertheless report to the Audit and Risk Committee any misstatements of lesser amounts to the extent that these are identified by our audit work.

Under ISA 260(UK&I) *'Communication with those charged with governance'*, we are obliged to report uncorrected omissions or misstatements other than those which are 'clearly trivial' to those charged with governance. ISA 260 (UK&I) defines 'clearly trivial' as matters that are clearly inconsequential, whether taken individually or in aggregate and whether judged by any quantitative or qualitative criteria.

ISA 450 (UK&I), *'Evaluation of misstatements identified during the audit',* requires us to request that uncorrected misstatements are corrected.

In the context of the Authority, we propose that an individual difference could normally be considered to be clearly trivial if it is less than £55k.

If management have corrected material misstatements identified during the course of the audit, we will consider whether those corrections should be communicated to the Audit and Risk Committee to assist it in fulfilling its governance responsibilities.

Our audit approach – control evaluation

In March 2015 we will complete our interim audit work.

We assess if controls over key financial systems were effective during 2014/15.

We work with your finance team to enhance the efficiency of the accounts audit.

We will report any significant findings arising from our work to the Audit and Risk Committee.

Our on site interim visit will be completed during March 2015. During this time we will complete work in the following areas:

Control Evaluation

- Evaluate and test controls over key financial systems identified as part of our risk assessment.
- Liaise with internal audit regarding their controls work relevant to our risk assessment.
- Review the accounts production process.
- Review progress on critical accounting matters.

Controls over key financial systems

We update our understanding of the Authority's key financial processes where our risk assessment has identified that these are relevant to our final accounts audit and where we have determined that this is the most efficient audit approach to take. We confirm our understanding by completing walkthroughs for these systems. We liaise with Internal Audit regarding any relevant controls work they have carried out. We then test selected controls that address key risks within these systems. The strength of the control framework informs the substantive testing we complete during our final accounts visit.

Accounts production process

We raised a small number of recommendations in our *ISA 260 Report 2013/14* relating to the accounts production process. We will discuss the Authority's progress in addressing our recommendations and in preparing for the closedown and accounts preparation.

Critical accounting matters

We will discuss the work completed to address the specific risks we identified at the planning stage. Wherever possible, we seek to review relevant workings and evidence and agree the accounting treatment as part of our interim work.

If there are any significant findings arising from our interim work we will present these to the Audit and Risk Committee.

Our audit approach – substantive procedures

During July to August 2015 we will be on site for our substantive work.

We complete detailed testing of accounts and disclosures and conclude on critical accounting matters, such as specific risk areas. We then agree any audit adjustments required to the financial statements.

We also review the Annual Governance Statement for consistency with our understanding.

We will present our *ISA 260 Report* to the Audit and Risk Committee in September 2015.

Our final accounts visit on site has been provisionally scheduled to start in July 2015. During this time, we will complete the following work:

Substantive Procedures

- Plan and perform substantive audit procedures.
- Conclude on critical accounting matters.
- Identify and assess any audit adjustments.
- Review the Annual Governance Statement.

Substantive audit procedures

We complete detailed testing on significant balances and disclosures. The extent of our work is determined by the Engagement Lead based on various factors such as our overall assessment of the Authority's control environment, the effectiveness of controls over individual systems and the management of specific risk factors.

Critical accounting matters

We conclude our testing of key risk areas identified at the planning stage and any additional issues that may have emerged since.

We will discuss our early findings of the Authority's approach to address the key risk areas with the Assistant Director for Resources prior to reporting to the Audit and Risk Committee in September 2015.

Audit adjustments

During our on site work, we will meet with the finance team on a regular basis to discuss the progress of the audit, any differences found and any other issues emerging.

At the end of our on site work, we will hold a closure meeting, where we will provide a schedule of audit differences and agree a timetable for the completion stage and the accounts sign off.

To comply with auditing standards, we are required to report uncorrected audit differences to the Audit and Risk Committee. We also report any material misstatements which have been corrected and which we believe should be communicated to you to help you meet your governance responsibilities.

Annual Governance Statement

We are also required to satisfy ourselves that your Annual Governance Statement complies with the applicable framework and is consistent with our understanding of your operations. Our review of the work of internal audit and consideration of your risk management and governance arrangements are part of this.

We report the findings of our audit of the financial statements work in our *ISA 260 Report*, which we will issue in September 2015.

Our audit approach – other matters

In addition to the financial statements, we also review the Authority's Whole of Government Accounts pack.

We may need to undertake additional work if we receive objections to the accounts from local electors.

We will communicate with you throughout the year, both formally and informally.

Whole of government accounts (WGA)

We are required to review your WGA consolidation and undertake the work specified under the approach that is agreed with HM Treasury and the National Audit Office. The deadline for the issue of the Statement has not yet been confirmed.

Elector challenge

The Audit Commission Act 1998 gives electors certain rights. These are:

- the right to inspect the accounts;
- the right to ask the auditor questions about the accounts; and
- the right to object to the accounts.

As a result of these rights, in particular the right to object to the accounts, we may need to undertake additional work to form our decision on the elector's objection. The additional work could range from a small piece of work where we interview an officer and review evidence to form our decision, to a more detailed piece of work, where we have to interview a range of officers, review significant amounts of evidence and seek legal representations on the issues raised.

The costs incurred in responding to specific questions or objections raised by electors is not part of the fee. This work will be charged in accordance with the Audit Commission's fee scales.

We have received questions from an elector in relation to the proposals for awarding grants/loans for sports & leisure purposes. We have reviewed the issues and reported our findings to the Chief Executive. We will confirm the fee for this work following confirmation by the Audit Commission.

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Reporting and communication

Reporting is a key part of the audit process, not only in communicating the audit findings for the year, but also in ensuring the audit team are accountable to you in addressing the issues identified as part of the audit strategy. Throughout the year we will communicate with you through meetings with the finance team and the Audit and Risk Committee. Our deliverables are included on page 16.

Independence and objectivity confirmation

Professional standards require auditors to communicate to those charged with governance, at least annually, all relationships that may bear on the firm's independence and the objectivity of the audit engagement partner and audit staff. The standards also place requirements on auditors in relation to integrity, objectivity and independence.

The standards define 'those charged with governance' as 'those persons entrusted with the supervision, control and direction of an entity'. In your case this is the Audit and Risk Committee.

KPMG LLP is committed to being and being seen to be independent. APB Ethical Standard 1 *Integrity, Objectivity and Independence* requires us to communicate to you in writing all significant facts and matters, including those related to the provision of non-audit services and the safeguards put in place, in our professional judgement, may reasonably be thought to bear on KPMG LLP's independence and the objectivity of the Engagement Lead and the audit team.

Appendix 1 provides further detail on auditors' responsibilities regarding independence and objectivity.

Confirmation statement

We confirm that as of February 2015 in our professional judgement, KPMG LLP is independent within the meaning of regulatory and professional requirements and the objectivity of the Engagement Lead and audit team is not impaired.

Section four

Key financial statements audit risks and areas of audit focus

In this section we set out our assessment of the significant risks or other key areas of audit focus of the Authority's financial statements for 2014/15.

We have identified no significant risks or other key areas of audit focus at this stage.

Professional standards require us to consider two standard risks for all organisations. We are not elaborating on these standard risks in this plan but consider them as a matter of course in our audit and will include any findings arising from our work in our *ISA 260 Report*.

- Management override of controls – Management is typically in a powerful position to perpetrate fraud owing to its ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. Our audit methodology incorporates the risk of management override as a default significant risk. In line with our methodology, we carry out appropriate controls testing and substantive procedures, including over journal entries, accounting estimates and significant transactions that are outside the normal course of business, or are otherwise unusual.
- Fraudulent revenue recognition – We do not consider this to be a significant risk for local authorities as there are limited incentives and opportunities to manipulate the way income is recognised. We therefore rebut this risk and do not incorporate specific work into our audit plan in this area over and above our standard fraud procedures.

Appendix 3 covers more details on our assessment of fraud risk.

Our initial assessment has not identified any risks that are specific to the audit of the Authority's financial statements for 2014/15.

We will revisit our assessment throughout the year and should any risks present themselves we will adjust our audit strategy as necessary.

VFM audit approach

Our approach to VFM work follows guidance provided by the Audit Commission.

Background to approach to VFM work

In meeting their statutory responsibilities relating to economy, efficiency and effectiveness, the Commission's *Code of Audit Practice* requires auditors to:

- plan their work based on consideration of the significant risks of giving a wrong conclusion (audit risk); and
- carry out only as much work as is appropriate to enable them to give a safe VFM conclusion.

To provide stability for auditors and audited bodies, the Audit Commission has kept the VFM audit methodology unchanged from last year. There are only relatively minor amendments to reflect the key issues facing the local government sector.

The approach is structured under two themes, as summarised below.

Specified criteria for VFM conclusion	Focus of the criteria	Sub-sections
The organisation has proper arrangements in place for securing **financial resilience**.	The organisation has robust systems and processes to: ■ manage effectively financial risks and opportunities; and ■ secure a stable financial position that enables it to continue to operate for the foreseeable future.	■ Financial governance ■ Financial planning ■ Financial control
The organisation has proper arrangements for challenging how it **secures economy, efficiency and effectiveness**.	The organisation is prioritising its resources within tighter budgets, for example by: ■ achieving cost reductions; and ■ improving efficiency and productivity.	■ Prioritising resources ■ Improving efficiency and productivity

We will report on the results of the VFM audit through our *ISA 260 Report*. This will summarise any specific matters arising, and the basis for our overall conclusion. The key output from the work will be the VFM conclusion (i.e. our opinion on the Authority's arrangements for securing VFM), which forms part of our audit report.

We have considered the VFM risks at the initial planning stage of our audit and have not at this stage highlighted the need for any specific VFM work. We are aware of the financial and operational pressures that you are dealing with. At present, we expect to be able to obtain the assurances that we need to fulfil our responsibilities for the VFM conclusion from our standard programme of work. We will continue to discuss the challenges you face with officers and the update the Audit and Risk Committee if any additional specific significant risks are identified which require us to carry out further audit work.

VFM audit approach (continued)

We will follow a risk based approach to target audit effort on the areas of greatest audit risk.

Overview of the VFM audit approach

The key elements of the VFM audit approach are summarised below.

Each of these stages are summarised further below.

VFM audit stage	Audit approach
VFM audit risk assessment	We consider the relevance and significance of the potential business risks faced by all local authorities, and other risks that apply specifically to the Authority. These are the significant operational and financial risks in achieving statutory functions and objectives, which are relevant to auditors' responsibilities under the *Code of Audit Practice*. In doing so we consider: ■ the Authority's own assessment of the risks it faces, and its arrangements to manage and address its risks; ■ information from the Audit Commission's VFM profile tool ; ■ evidence gained from previous audit work, including the response to that work; and ■ the work of other inspectorates and review agencies.

VFM audit approach (continued)

Our VFM audit will draw heavily on other audit work which is relevant to our VFM responsibilities and the results of last year's VFM audit.

We will then form an assessment of residual audit risk to identify if there are any areas where more detailed VFM audit work is required.

VFM audit stage	Audit approach
Linkages with financial statements and other audit work	There is a degree of overlap between the work we do as part of the VFM audit and our financial statements audit. For example, our financial statements audit includes an assessment and testing of the Authority's organisational control environment, including the Authority's financial management and governance arrangements, many aspects of which are relevant to our VFM audit responsibilities. We have always sought to avoid duplication of audit effort by integrating our financial statements and VFM work, and this will continue. We will therefore draw upon relevant aspects of our financial statements audit work to inform the VFM audit.
Assessment of residual audit risk	It is possible that further audit work may be necessary in some areas to ensure sufficient coverage of the two VFM criteria. Such work may involve interviews with relevant officers and /or the review of documents such as policies, plans and minutes. We may also refer to any self assessment the Authority may prepare against the characteristics. To inform any further work we must draw together an assessment of residual audit risk, taking account of the work undertaken already. This will identify those areas requiring further specific audit work to inform the VFM conclusion. At this stage it is not possible to indicate the number or type of residual audit risks that might require additional audit work, and therefore the overall scale of work cannot be easily predicted. If a significant amount of work is necessary then we will need to review the adequacy of our agreed audit fee.
Identification of specific VFM audit work	If we identify residual audit risks, then we will highlight the risk to the Authority and consider the most appropriate audit response in each case, including: ■ considering the results of work by the Authority, inspectorates and other review agencies; and ■ carrying out local risk-based work to form a view on the adequacy of the Authority's arrangements for securing economy, efficiency and effectiveness in its use of resources.

VFM audit approach (continued)

Where relevant, we may draw upon the range of audit tools and review guides developed by the Audit Commission.

We will report the results of our initial risk assessment and the findings from any further work required to address specific significant risks identified.

We will conclude on the results of the VFM audit through our ISA 260 Report.

VFM audit stage	Audit approach
Delivery of local risk based work	Depending on the nature of the residual audit risk identified, we may be able to draw on audit tools and sources of guidance when undertaking specific local risk-based audit work, such as: ■ local savings review guides based on selected previous Audit Commission national studies; and ■ update briefings for previous Audit Commission studies. The tools and guides will support our work where we have identified a local risk that is relevant to them. For any residual audit risks that relate to issues not covered by one of these tools, we will develop an appropriate audit approach drawing on the detailed VFM guidance and other sources of information.
Concluding on VFM arrangements	At the conclusion of the VFM audit we will consider the results of the work undertaken and assess the assurance obtained against each of the VFM themes regarding the adequacy of the Authority's arrangements for securing economy, efficiency and effectiveness in the use of resources. If any issues are identified that may be significant to this assessment, and in particular if there are issues that indicate we may need to consider qualifying our VFM conclusion, we will discuss these with management as soon as possible. Such issues will also be considered more widely as part of KPMG's quality control processes, to help ensure the consistency of auditors' decisions.
Reporting	We will report on the results of the VFM audit through our *ISA 260 Report*. This will summarise any specific matters arising, and the basis for our overall conclusion. We are aware of the financial and operational pressures that you are dealing with. At present, we consider that we will be able to obtain the assurances that we need to fulfil our responsibilities for the VFM conclusion from our standard programme of work. We will update our assessment throughout the year should any issues present themselves and report against these in our ISA260. The key output from the work will be the VFM conclusion (i.e. our opinion on the Authority's arrangements for securing VFM), which forms part of our audit report.

Audit team

Your audit team has been drawn from our specialist public sector assurance department. Contact details are shown on page 1.

The audit team will be assisted by other KPMG specialists as necessary.

Tony Crawley

Director

"My role is to lead our team and ensure the delivery of a high quality external audit opinion. I will be the main point of contact for the Audit and Risk Committee and Executive Directors."

Mike Norman

Manager

"I am responsible for the management, review and delivery of the whole audit and providing quality assurance for any technical accounting areas. I will work closely with Tony Crawley to ensure we add value. I will liaise with Finance team and Internal Audit.

David Schofield

Assistant Manager

"I will be responsible for the on-site delivery of our work. I will liaise with the finance team and Internal Audit . I will also supervise the work of our audit assistants."

Audit deliverables

At the end of each stage of our audit we issue certain deliverables, including reports and opinions.

Our key deliverables will be delivered to a high standard and on time.

We will discuss and agree each report as appropriate with the Authority's officers prior to publication.

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Deliverable	Purpose	Committee dates
Planning		
External Audit Plan	■ Outlines our audit approach. ■ Identifies areas of audit focus and planned procedures.	**February 2015**
Control evaluation and Substantive procedures		
Report to Those Charged with Governance (ISA 260 Report)	■ Details control and process issues. ■ Details the resolution of key audit issues. ■ Communicates adjusted and unadjusted audit differences. ■ Highlights performance improvement recommendations identified during our audit. ■ Comments on the Authority's value for money arrangements.	**September 2015**
Completion		
Auditor's Report	■ Provides an opinion on your accounts (including the Annual Governance Statement). ■ Concludes on the arrangements in place for securing economy, efficiency and effectiveness in your use of resources (the VFM conclusion).	**September 2015**
Whole of Government Accounts	■ Report to the National Audit Office our findings from the mandated work on the Authority's WGA pack submission.	**September 2015**
Annual Audit Letter	■ Summarises the outcomes and the key issues arising from our audit work for the year.	**November 2015**

Audit timeline

We will be in continuous dialogue with you throughout the audit.

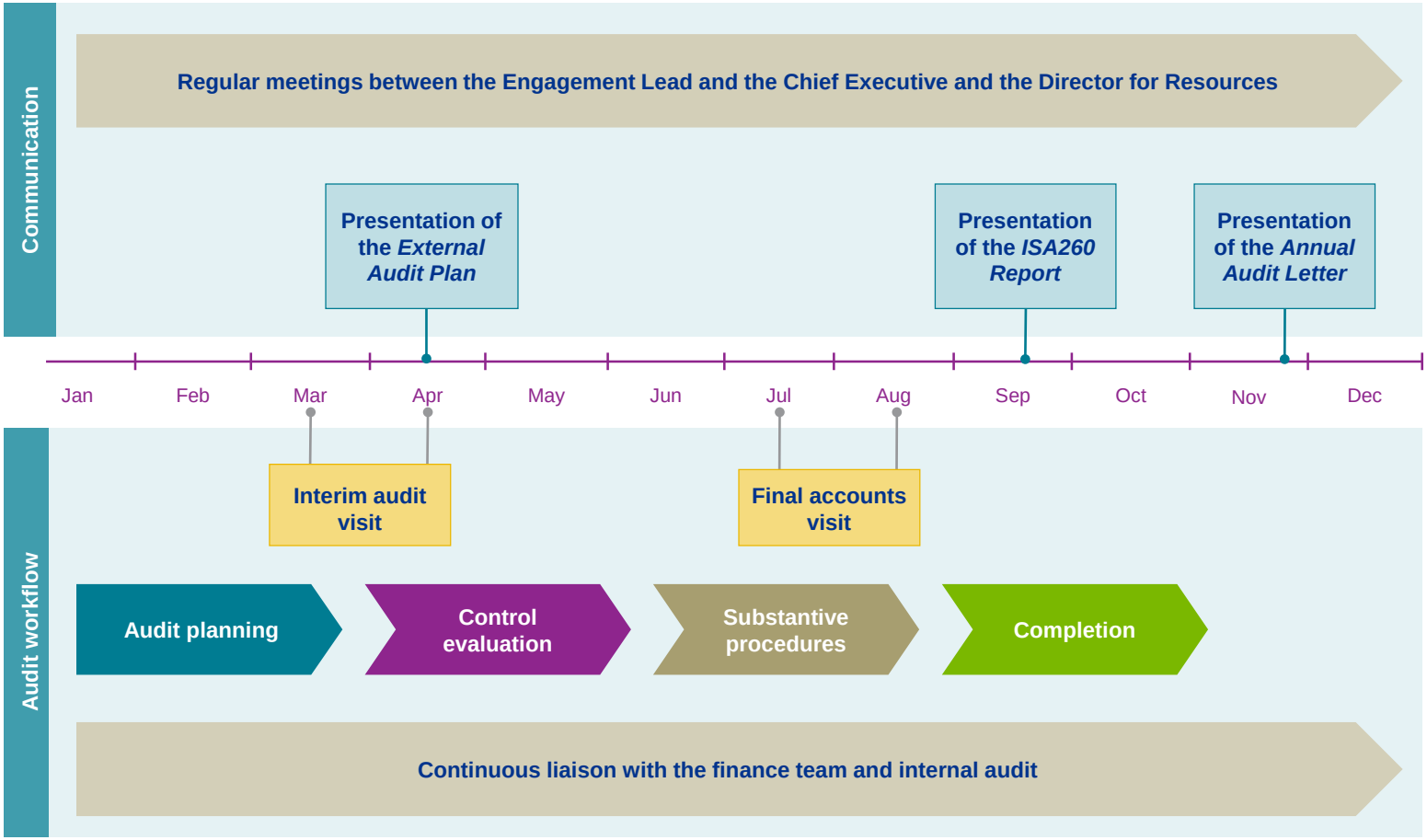
Key formal interactions with the Audit and Risk Committee are:

- February – External Audit Plan;
- September – ISA 260 Report;
- November – Annual Audit Letter.

We work with the finance team and internal audit throughout the year.

Our main work on site will be our:

- Interim audit visits during March.
- Final accounts audit during July.



Key: ● Audit and Risk Committee meetings.

Audit fee

The planned fee for the 2014/15 audit is £87,308.

Our audit fee remains indicative and based on you meeting our expectations of your support.

Meeting these expectations will help the delivery of our audit within the proposed audit fee.

Audit fee

Our *Audit Fee Letter 2014/15* presented to you in April 2014 first set out our fees for the 2014/15 audit.

Our audit fee includes our work on the VFM conclusion and our audit of the Authority's financial statements.

The planned audit fee for 2014/15 is £87,308. This is £1,070 more than the fee set out in our *Audit Fee Letter 2014-15* and is due to the increase in the Audit Commission's scale fee to reflect work required in relation to local Business Rates following the removal of the certification requirement for the NNDR3 return.

Audit fee assumptions

The fee is based on a number of assumptions, including that you will provide us with complete and materially accurate financial statements, with good quality supporting working papers, within agreed timeframes. It is imperative that you achieve this. If this is not the case and we have to complete more work than was envisaged, we will need to charge additional fees for this work. In setting the fee, we have assumed:

- the level of risk in relation to the audit of the financial statements is not significantly different from that identified for 2014/15;
- you will inform us of any significant developments impacting on our audit;
- you will identify and implement any changes required under the *CIPFA Code of Practice on Local Authority Accounting in the UK 2014/15* within your 2014/15 financial statements;
- you will comply with the expectations set out in our *Accounts Audit Protocol*, including:
  - the financial statements are made available for audit in line with the agreed timescales;
  - good quality working papers and records will be provided at the start of the final accounts audit;
  - requested information will be provided within the agreed timescales;
  - prompt responses will be provided to queries and draft reports;
- further additional work will not be required to address questions or objections raised by local government electors or for special investigations such as those arising from disclosures under the Public Interest Disclosure Act 1998.

Meeting these expectations will help ensure the delivery of our audit within the agreed audit fee.

The Audit Commission requires us to inform you of specific actions you could take to keep the audit fee low. Future audit fees can be kept to a minimum if the Authority achieves an efficient and well-controlled financial closedown and accounts production process which complies with good practice and appropriately addresses new accounting developments and risk areas.

Changes to the audit plan

Changes to this plan and the audit fee may be necessary if:

- new significant audit risks emerge;
- additional work is required of us by the Audit Commission or other regulators; and
- additional work is required as a result of changes in legislation, professional standards or financial reporting requirements.

If changes to this plan and the audit fee are required, we will discuss and agree these initially with the Director for Resources..

Appendix 1: Independence and objectivity requirements

This appendix summarises auditors' responsibilities regarding independence and objectivity.

Independence and objectivity

Auditors are required by the Code to:

- carry out their work with independence and objectivity;
- exercise their professional judgement and act independently of both the Commission and the audited body;
- maintain an objective attitude at all times and not act in any way that might give rise to, or be perceived to give rise to, a conflict of interest; and
- resist any improper attempt to influence their judgement in the conduct of the audit.

In addition, the Code specifies that auditors should not carry out work for an audited body that does not relate directly to the discharge of the auditors' functions under the Code. If the Authority invites us to carry out risk-based work in a particular area, which cannot otherwise be justified to support our audit conclusions, it will be clearly differentiated as work carried out under section 35 of the Audit Commission Act 1998.

The Code also states that the Commission issues guidance under its powers to appoint auditors and to determine their terms of appointment. The Standing Guidance for Auditors includes several references to arrangements designed to support and reinforce the requirements relating to independence, which auditors must comply with. These are as follows:

- Auditors and senior members of their staff who are directly involved in the management, supervision or delivery of Commission-related work, and senior members of their audit teams should not take part in political activity.
- No member or employee of the firm should accept or hold an appointment as a member of an audited body whose auditor is, or is proposed to be, from the same firm. In addition, no member or employee of the firm should accept or hold such appointments at related bodies, such as those linked to the audited body through a strategic partnership.
- Audit staff are expected not to accept appointments as Governors at certain types of schools within the local authority.
- Auditors and their staff should not be employed in any capacity (whether paid or unpaid) by an audited body or other organisation providing services to an audited body whilst being employed by the firm.
- Firms are expected to comply with the requirements of the Commission's protocols on provision of personal financial or tax advice to certain senior individuals at audited bodies, independence considerations in relation to procurement of services at audited bodies, and area wide internal audit work.
- Auditors appointed by the Commission should not accept engagements which involve commenting on the performance of other Commission auditors on Commission work without first consulting the Commission.
- Auditors are expected to comply with the Commission's policy for the Engagement Lead to be changed on a periodic basis.
- Audit suppliers are required to obtain the Commission's written approval prior to changing any Engagement Lead in respect of each audited body.
- Certain other staff changes or appointments require positive action to be taken by Firms as set out in the standing guidance.

Appendix 2: KPMG Audit Quality Framework

We continually focus on delivering a high quality audit.

This means building robust quality control procedures into the core audit process rather than bolting them on at the end, and embedding the right attitude and approaches into management and staff.

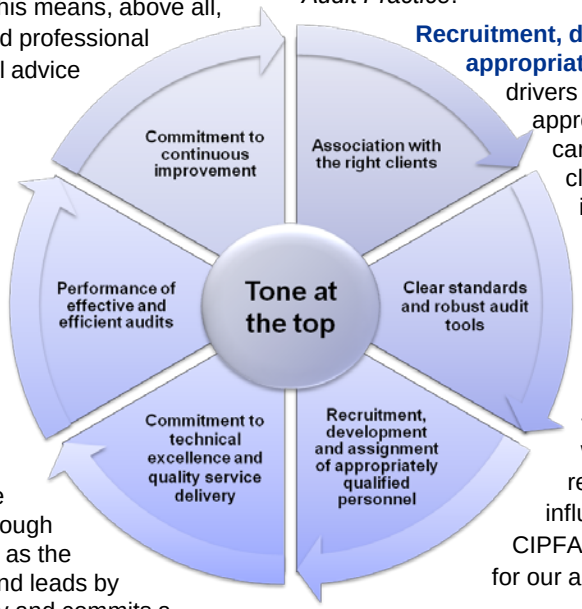
KPMG's Audit Quality Framework consists of seven key drivers combined with the commitment of each individual in KPMG.

The diagram summarises our approach and each level is expanded upon.

At KPMG we consider audit quality is not just about reaching the right opinion, but how we reach that opinion. KPMG views the outcome of a quality audit as the delivery of an appropriate and independent opinion in compliance with the auditing standards. It is about the processes, thought and integrity behind the audit report. This means, above all, being independent, compliant with our legal and professional requirements, and offering insight and impartial advice to you, our client.

KPMG's Audit Quality Framework consists of seven key drivers combined with the commitment of each individual in KPMG. We use our seven drivers of audit quality to articulate what audit quality means to KPMG.

We believe it is important to be transparent about the processes that sit behind a KPMG audit report, so you can have absolute confidence in us and in the quality of our audit.



Tone at the top: We make it clear that audit quality is part of our culture and values and therefore non-negotiable. Tone at the top is the umbrella that covers all the drives of quality through a focused and consistent voice. Tony Crawley as the Engagement Lead sets the tone on the audit and leads by example with a clearly articulated audit strategy and commits a significant proportion of his time throughout the audit directing and supporting the team.

Association with right clients: We undertake rigorous client and engagement acceptance and continuance procedures which are vital to the ability of KPMG to provide high-quality professional services to our clients.

Clear standards and robust audit tools: We expect our audit professionals to adhere to the clear standards we set and we provide a range of tools to support them in meeting these expectations. The global rollout of KPMG's eAudIT application has significantly enhanced existing audit functionality. eAudIT enables KPMG to deliver a highly technically enabled audit. All of our staff have a searchable data base, Accounting Research Online, that includes all published accounting standards, the KPMG Audit Manual Guidance as well as other relevant sector specific publications, such as the Audit Commission's *Code of Audit Practice*.

Recruitment, development and assignment of appropriately qualified personnel: One of the key drivers of audit quality is assigning professionals appropriate to the Authority's risks. We take great care to assign the right people to the right clients based on a number of factors including their skill set, capacity and relevant experience.

We have a well developed technical infrastructure across the firm that puts us in a strong position to deal with any emerging issues. This includes:

- A national public sector technical director who has responsibility for co-ordinating our response to emerging accounting issues, influencing accounting bodies (such as CIPFA) as well as acting as a sounding board for our auditors.

- A national technical network of public sector audit professionals is established that meets on a monthly basis and is chaired by our national technical director.

- All of our staff have a searchable data base, Accounting Research Online, that includes all published accounting standards, the KPMG Audit Manual Guidance as well as other relevant sector specific publications, such as the Audit Commission's *Code of Audit Practice*.

- A dedicated Department of Professional Practice comprised of over 100 staff that provide support to our audit teams and deliver our web-based quarterly technical training.

Appendix 2: KPMG Audit Quality Framework

We continually focus on delivering a high quality audit.

This means building robust quality control procedures into the core audit process rather than bolting them on at the end, and embedding the right attitude and approaches into management and staff.

Quality must build on the foundations of well trained staff and a robust methodology.

Commitment to technical excellence and quality service delivery: Our professionals bring you up- the-minute and accurate technical solutions and together with our specialists are capable of solving complex audit issues and delivering valued insights.

Our audit team draws upon specialist resources including Forensic, Corporate Finance, Transaction Services, Advisory, Taxation, Actuarial and IT. We promote technical excellence and quality service delivery through training and accreditation, developing business understanding and sector knowledge, investment in technical support, development of specialist networks and effective consultation processes.

Performance of effective and efficient audits: We understand that how an audit is conducted is as important as the final result. Our drivers of audit quality maximise the performance of the engagement team during the conduct of every audit. We expect our people to demonstrate certain key behaviors in the performance of effective and efficient audits. The key behaviors that our auditors apply throughout the audit process to deliver effective and efficient audits are outlined below:

- timely Engagement Lead and manager involvement;
- critical assessment of audit evidence;
- exercise of professional judgment and professional scepticism;
- ongoing mentoring and on the job coaching, supervision and review;
- appropriately supported and documented conclusions;
- if relevant, appropriate involvement of the Engagement Quality Control reviewer (EQC review);
- clear reporting of significant findings;
- insightful, open and honest two-way communication with those charged with governance; and
- client confidentiality, information security and data privacy.

Commitment to continuous improvement: We employ a broad range of mechanisms to monitor our performance, respond to feedback and understand our opportunities for improvement.

Our quality review results

We are able to evidence the quality of our audits through the results of Audit Commission reviews. The Audit Commission publishes information on the quality of work provided by KPMG (and all other firms) for audits undertaken on behalf of them (http://www.audit-commission.gov.uk/audit-regime/audit-quality-review-programme/principal-audits/kpmg-audit-quality).

The latest Annual Regulatory Compliance and Quality Report (issued June 2014) showed that we are meeting the Audit Commission's overall audit quality and regularity compliance requirements.

Appendix 3 : Assessment of fraud risk

We are required to consider fraud and the impact that this has on our audit approach.

We will update our risk assessment throughout the audit process and adapt our approach accordingly.

25

Members /Officers responsibilities

- Adopt sound accounting policies.
- With oversight from those charged with governance, establish and maintain internal control, including controls to prevent, deter and detect fraud.
- Establish proper tone/culture/ethics.
- Require periodic confirmation by employees of their responsibilities.
- Take appropriate action in response to actual, suspected or alleged fraud.
- Disclose to Audit and Risk Committee and auditors:
  - any significant deficiencies in internal controls.
  - any fraud involving those with a significant role in internal controls.

KPMG's identification of fraud risk factors

- Review of accounting policies.
- Results of analytical procedures.
- Procedures to identify fraud risk factors.
- Discussion amongst engagement personnel.
- Enquiries of management, Audit and Risk Committee, and others.
- Evaluate controls that prevent, deter, and detect fraud.

KPMG's response to identified fraud risk factors

- Accounting policy assessment.
- Evaluate design of mitigating controls.
- Test effectiveness of controls.
- Address management override of controls.
- Perform substantive audit procedures.
- Evaluate all audit evidence.
- Communicate to Audit and Risk Committee and management/officers

KPMG's identified fraud risk factors

- We will monitor the following areas throughout the year and adapt our audit approach accordingly.
  - Revenue recognition.
  - Management override of controls.

Appendix 4: Transfer of Audit Commission's functions

The Audit Commission will be writing to audited bodies and other stakeholders in the coming months with more information about the transfer of the Commission's regulatory and other functions.

From 1 April 2015 a transitional body, Public Sector Audit Appointments Limited (PSAA), established by the Local Government Association (LGA) as an independent company, will oversee the Commission's audit contracts until they end in 2017 (or 2020 if extended by DCLG). PSAA's responsibilities will include setting fees, appointing auditors and monitoring the quality of auditors' work. The responsibility for making arrangements for publishing the Commission's value for money profiles tool will also transfer to PSAA.

From 1 April 2015, the Commission's other functions will transfer to new organisations:

- responsibility for publishing the statutory Code of Audit Practice and guidance for auditors will transfer to the National Audit Office (NAO) for audits of the accounts from 2015/16;
- the Commission's responsibilities for local value for money studies will also transfer to the NAO; and
- the National Fraud Initiative (NFI) will transfer to the Cabinet Office.

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REPORT NO: 108/2015

AUDIT AND RISK COMMITTEE

30 June 2015

ANNUAL INTERNAL AUDIT REPORT

Report of the Head of Internal Audit

Strategic Aim:	**All**	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor King – Portfolio holder for Places (Development and Economy) and Resources	
Contact Officer(s):	Rachel Ashley-Caunt, Head of Internal Audit	Tel: 07824 537900 rashley-caunt@rutland.gcsx.gov.uk
Ward Councillors	Not Applicable	

DECISION RECOMMENDATIONS
1. That the Committee approve the Annual Report of Internal Audit and the Internal Audit Opinion that it supports.

1. PURPOSE OF THE REPORT

1.1 The Public Sector Internal Audit Standards (The Standards) require the Head of the Internal Audit Consortium to produce an Annual Report of Internal Audit. The report must contain an Internal Audit Opinion on the effectiveness of the Council's internal control arrangements and a statement on the extent of the Consortium's conformance to the Standards.

2. BACKGROUND AND MAIN CONSIDERATIONS

2.1 It is the Opinion of the Head of Consortium that the Council's internal control arrangements provide a Sufficient Level of Assurance. The basis for that Opinion is set out in the Annual Report of Internal Audit shown as Appendix A.

2.2 The Head of Internal Audit has undertaken a self-assessment and concluded that the Consortium now operates in general conformance to the Standards. The basis for that conclusion is also set out in the Annual Report.

2.3 The self-assessment has been reviewed by the Assistant Director – Finance and other Members of the Welland Internal Audit Board. The Board is satisfied that the assessment reasonably reflects how Internal Audit operates.

3. CONSULTATION

3.1 No formal consultation is required as part of this report.

4. ALTERNATIVE OPTIONS

4.1 The Committee could choose not to approve the report if it felt that the overall opinion did not fairly reflect the results of internal audit work.

5. FINANCIAL IMPLICATIONS

5.1 There are no financial implications arising from this report.

6. LEGAL AND GOVERNANCE CONSIDERATIONS

6.1 The Audit and Risk Committee is responsible for oversight of the work of internal audit including approving the annual report and satisfying itself that the conclusions reached is reasonable in light of the work undertaken. It is also responsible for gaining assurance that internal audit is complying with internal audit standards.

6.2 There are no legal implications arising from this report.

7. EQUALITY IMPACT ASSESSMENT

7.1 Equality Impact Assessment (EqIA) screening has been completed and there were no issues arising. A full Impact assessment has not been carried out.

8. COMMUNITY SAFETY IMPLICATIONS

8.1 There are no community safety implications.

9. HEALTH AND WELLBEING IMPLICATIONS

9.1 There are no health and wellbeing implications.

10. CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

10.1 The Committee plays an important role in the oversight of internal audit work. This paper and the views of the Committee will allow a formal programme to be agreed.

11. BACKGROUND PAPERS

None

12. APPENDICES

Appendix A – Annual Internal Audit Report

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577.

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RUTLAND COUNTY COUNCIL

INTERNAL AUDIT ANNUAL REPORT

2014/15

Date: June 2015

1. Background

1.1 The Public Sector Internal Audit Standards (PSIAS) require the Head of Internal Audit to provide an annual Internal Audit opinion and report that can be used by the organisation to inform its governance statement. The Standards specify that the report must contain:

- an Internal Audit opinion on the overall adequacy and effectiveness of the Council's governance, risk and control framework (i.e. the control environment);
- a summary of the audit work from which the opinion is derived and any work by other assurance providers upon which reliance is placed; and
- a statement on the extent of conformance with the Standards including progress against the improvement plan resulting from any external assessments.

2. Head of Internal Audit Opinion 2014/15

2.1 This report provides a summary of the work carried out by the Internal Audit service during the financial year 2014/15 and the results of these assignments. Based upon the work undertaken by Internal Audit during the year, the Head of Internal Audit's overall opinion on the Council's system of internal control is that:

> Sufficient Assurance can be given that there is generally a sound system of internal control, designed to meet the organisation's objectives and that controls are generally being applied consistently. The level of assurance, therefore, remains at a consistent level from 2013/14.
>
> Controls relating to those key financial systems (payroll, debtors, creditors, benefits and local taxation) which were reviewed during the year were concluded to be at a level of at least Sufficient Assurance.
>
> The overall proportion of audit reports giving Limited Assurance has remained approximately consistent with 2013/14, as shown in Table 1.
>
> The implementation of audit recommendations during the year has generally been good, with 71% of those actions from 2014/15 audit reports which were due for implementation being completed in accordance with the agreed timescales.
>
> No systems of controls can provide absolute assurance against material misstatement or loss, nor can Internal Audit give that assurance.

The basis for this opinion is derived from an assessment of the individual opinions arising from assignments from the risk-based Internal Audit plan that have been undertaken throughout the year. This assessment has taken account

of the relative materiality of these areas and management's progress in addressing any control weaknesses. A summary of Audit Opinions is shown in Table 1:

Table 1 – Summary of Audit Opinions 2014/15:

Area	Substantial	Sufficient	Limited	No
Financial Systems	1	5	2	0
IT	0	1	1	0
Counter Fraud	0	2	0	0
Customer Facing	2	5	0	0
Governance & Performance	0	2	1	0
Total	**3**	**15**	**4**	**0**
Summary with 13/14 Comparison	**14% (29%)**	**68% (52%)**	**18% (19%)**	**0% (0%)**

3. Review of Audit Coverage

3.1 Audit Opinion on Individual Audits

The Committee is reminded that the following assurance opinions can be assigned:

Table 2 – Assurance Categories:

Level of Assurance	Definition
Substantial	There is a robust framework of controls making it likely that service objectives will be delivered. Controls are applied continuously and consistently with only infrequent minor lapses.
Sufficient	The control framework includes key controls that promote the delivery of service objectives. Controls are applied but there are lapses and/or inconsistencies.

Level of Assurance	Definition
Limited	There is a risk that objectives will not be achieved due to the absence of key internal controls. There have been significant and extensive breakdowns in the application of key controls.
No	There is an absence of basic controls resulting in inability to deliver service objectives. Fundamental controls are not being operated or complied with.

Audit reports issued in 2014/15, other than those relating to consultancy support, resulted in the provision of one of the above assurance opinions. All individual reports represented in this Annual Report are final reports and, as such, the findings have been agreed with management, together with the accompanying action plans.

3.2 Summary of Audit Work

3.2.1 Table 3 details the assurance levels resulting from all audits undertaken in 2014/15 and the date of the Committee meeting at which a summary of the report was presented.

3.2.2 All assignments have been delivered in accordance with the agreed Audit Planning Records and provide assurance in relation to the areas included in the specified scope.

Table 3 – Summary of Audit Opinions 2014/15:

Audit Area	Audit Opinion	Committee Date
Financial		
Creditors	Sufficient	June 2015
Debtors	Sufficient	June 2015
Local Taxation	Substantial	April 2015
Benefits	Sufficient	June 2015
Payroll	Sufficient	September 2014
Agresso	Limited	January 2015

Audit Area	Audit Opinion	Committee Date
Community Care Finance – Deputyships & Court of Protection	Limited	January 2015
Community Care Finance – Assessments and Fairer Charging	Sufficient	January 2015
IT		
Service Desk & Change Management	Sufficient	June 2015
ICT Asset Management	Limited	June 2015
Fraud Risks		
Recruitment & Payroll Related Fraud	Sufficient	September 2014
NDR Fraud	Sufficient	January 2015
Service Delivery		
Housing Options	Substantial	January 2015
Home to School Transport	Sufficient	January 2015
Early Years Funding	Sufficient	April 2015
Nursery Provision	Sufficient	April 2015
School Improvement Programmes	Sufficient	June 2015
School Admissions Service	Substantial	January 2015
Continuing Health Care Funding	Sufficient	June 2015
Governance & Performance		
Data Management	Sufficient	April 2015
Safe Driving at Work	Limited	September 2014
Contract Management	Sufficient	April 2015

3.2.2 Outlined in Appendix 1 is a summary of each of the audits that has been completed during the year. The Committee should note that the majority of these findings have previously been reported as part of the defined cycle of update reports provided to the Audit and Risk Committee.

3.2.3 At each Audit and Risk Committee meeting, full copies of any reports issued giving a Limited Assurance opinion are provided to Members. Details of actions taken by management to address the findings within these reports are provided.

3.2.4 The Internal Audit Plan for 2015/16 includes 15 days for further review of all areas receiving Limited Assurance opinions during 2014/15 to provide assurance that actions have been taken and risks are being suitably managed.

3.3 Implementation of Internal Audit Recommendations

3.3.1 Internal Audit follow up on progress made against all recommendations arising from completed assignments to ensure these have been fully and promptly implemented. The Head of Internal Audit provides a summary at each Audit and Risk Committee on progress made and actions outstanding. Table 4 provides details of the implementation of recommendations made during 2014/15.

Table 4 - Implementation of Audit Recommendations 2014/15:

	Category 'High' recs	Category 'Medium' recs	Category 'Low' recs	Total
Agreed and Implemented	6	11	3	20 (22%)
Agreed and not yet due for implementation	12	35	16	63 (68%)
Agreed and due within last 3 months, but not implemented	0	0	0	0 (0%)
Agreed and due over 3 months ago, but not implemented	3	3	2	8 (10%)
TOTAL	**21**	**49**	**21**	**91**

3.3.2 In addition to those actions which remain outstanding from the 2014/15 audit reports, a further two actions remain outstanding and overdue from 2013/14 audit reports. A summary of all overdue recommendations is shown in Table 5:

Table 5 - Summary of Overdue Recommendations as at 31st March 2015

		High		Medium		Low	
Audit Title	**Audit year**	**Over 3 months**	**Under 3 months**	**Over 3 months**	**Under 3 months**	**Over 3 months**	**Under 3 months**
Agresso	14/15	1	-	2	-	-	-
Community Care Finance Assessments & Fair Charging	14/15	-	-	-	-	1	-
Safe Driving at Work	14/15	2	-	1	-	-	-
NDR Fraud	14/15	-	-	-	-	1	-
ICT Project Management	13/14	1	-	-	-	-	-
IT Service Desk	13/14	-	-	-	-	1	-
Totals		**4**		**3**	**0**	**3**	**0**

3.3.3 The level of implementation is reported to the Audit and Risk Committee throughout the year. The content of the Progress Reports is also being reviewed for 2015/16 to ensure that these provide members of the Committee with further details on the implementation of actions.

3.4 Internal Audit Contribution

3.4.1 It is important that Internal Audit demonstrates its value to the organisation. The service provides assurance to management and members via its programme of work and also offers support and advice to assist the Council in new areas of work.

3.4.2 Delivery of 2014/15 Audit Plan

The Council commissioned 370 days from the Internal Audit Consortium to deliver the 2014/15 Audit Plan.

The team delivered a total of **397** days to Rutland County Council during 2014/15. This involved delivery of the current year Audit Plan, client liaison, support, reporting and attendance at the Audit and Risk Committee and the completion of a number of assignments which had not been delivered from the 2013/14 Audit Plan.

By the end of April 2015, the team had delivered **100%** of the assignments within the 2014/15 Audit Plan to at least draft report stage.

3.4.3 Internal Audit Contribution in Wider Areas

Key additional areas of Internal Audit contribution to the Council in 2014/15 are set out in Table 6:

Table 6 – Internal Audit Contribution

Area of Activity	Benefit to the Council
Membership of Governance Group and attendance at meetings.	To provide insight into governance arrangements and independent assurance.
Supporting development of Money Laundering Policy.	Shared examples of best practice to ensure policy is robust and compliant with best practice.
Providing advice on the development on a revised Whistleblowing Policy.	To assist in the development of a fit for purpose policy which is compliant with best practice and supports staff in raising any concerns in confidence, including in relation to fraud or safeguarding.
Maintaining good working relationships with External Audit so that Internal Audit work can be relied upon for the purposes of assisting them in forming their opinion on the Annual Accounts.	Reduce audit burden, saving costs.
Review and declaration for the Local Sustainable Transport Fund grant usage.	Compliance with the terms and conditions of the funding and assurance over use of monies.

4. Performance Indicators

4.1 Internal Audit maintains several key performance indicators (KPIs) to enable ongoing monitoring by the Welland Internal Audit Board and Committees. Outturns against these indicators in relation to work delivered for Rutland County Council are provided in Table 7:

Table 7 – Internal Audit KPIs 2014/15

Indicator description	Target	Actual
Delivery of the agreed annual Internal Audit Plan – Audit Days	370	397
Delivery of the agreed annual Internal Audit Plan to at least draft report stage by 31st March 2015	90%	91%
Customer Feedback – rating on a scale of 1 to 4 (average) Where: 1 = Poor, 2 = Satisfactory, 3 = Good and 4 = Outstanding	3.6	3.4

5. Professional Standards

5.1 The Public Sector Internal Audit Standards (PSIAS) were adopted by the Chartered Institute of Public Finance and Accountancy (CIPFA) from April 2013. The standards are intended to promote further improvement in the professionalism, quality, consistency and effectiveness of Internal Audit across the public sector.

5.2 The objectives of the PSIAS are to:

- Define the nature of internal auditing within the UK public sector;
- Set basic principles for carrying out internal audit in the UK public sector;
- Establish a framework for providing internal audit services, which add value to the organisation, leading to improved organisational processes and operations; and
- Establish the basis for the evaluation of internal audit performance and to drive improvement planning.

5.3 A detailed self-assessment against the PSIAS has been completed by the Head of Internal Audit, a copy of which is provided in Appendix 2. The outcome of the assessment was that the Internal Audit service is operating in general **compliance** with the Standards.

5.4 The Head of Internal Audit is keen to drive ongoing, continuous development to ensure the value of the service is maximised. One specific area for further development has been identified from the assessment, in relation to reviewing and strengthening the content of the Progress Reports presented to Audit

Committees to ensure these fully inform members of the key findings of assignments and the performance of the Council services in implementing the agreed actions arising from the finalised reports.

Appendix 1: Summary of Internal Audit Work Undertaken for 2014/15

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
Financial Systems			
Creditors	Sufficient	To provide assurance that adequate controls exist to mitigate the key risks to the Council of the Creditor payment processes. Including: System access, segregation of duties between key tasks, setting up new suppliers, purchase requisitions, purchase order approval, goods receipting, invoice processing, compliance with policies, BACS/Cheque payments, urgent payments, aged creditor reviews and creditor control account reconciliations.	Testing of a sample of invoices paid during the financial year to date confirmed that all were supported by an approved purchase order and all could be matched to the goods receipted on the Agresso financial system. Detective controls had recently been introduced to identify any unauthorised or fraudulent changes to supplier data and all changes to existing supplier details tested had been suitably verified and evidenced. New procedures for verifying details when setting up new suppliers are also due to be implemented which should address the previous weaknesses in the audit trail. Some incidents of inadequate segregation of duties in relation to BACS submissions were identified and the process for BACS approval is to be reviewed. Further work to address the issue of retrospective purchase orders is needed to ensure that this control is consistently applied.
Debtors	Substantial	To provide assurance that the Council's invoicing, debt recovery and income processing systems and procedures are adequately controlled and its Debt Recovery Policy is fit for purpose.	Testing found that there were appropriate system controls operating to ensure sales order requests were complete and appropriately authorised. Debt recovery procedures had been well documented and sample testing on invoices raised across the Council provided assurance that records of all debt recovery actions taken to date were readily available. It was highlighted that a review and analysis of Agresso roles and users with the ability to create, update and delete customer master file data should be conducted. Role profiles should be

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
			amended and/or users removed from roles to ensure that only appropriate members of staff have this functionality.
Local Taxation	Substantial	To provide assurance that the material risks associated with the collection and management of local taxes are sufficiently mitigated. To cover: policies and procedures, system access controls, maintenance of complete and accurate property records, accurate set up of the initial liability, billing controls ensure amounts due are correctly calculated and charged, secure & effective arrangements for collection and posting of income, timely and accurate reconciliations.	Review confirmed that staff in the Revenues and Benefits team were highly experienced with a thorough understanding of the systems, policies and procedures for managing the collection of local taxes. A comprehensive set of procedure notes were identified for key aspects of the system and an effective range of controls were operating to minimise the risk of fraud and error, including appropriate separation of duties where necessary. It was highlighted that arrangements could be strengthened further by improving system access controls, such as promptly revoking access for leavers, and providing further documentary evidence for some aspects of the control framework.
Benefits	Sufficient	To provide assurance that the controls surrounding the processing and payment of benefits are sound. Also that the arrangements for processing and pursuit of overpayments are adequately robust and ensure effective pursuit of the debt.	Procedures were confirmed to be in place for the correct and consistent processing of benefit applications. Testing found that there were adequate procedures to deal with appeals, changes in circumstances and back dated claims. System reconciliations were being completed accurately and controls surrounding the update of system parameters were identified as sound. Procedures were in place to manage the Council's residual responsibilities associated with Benefits Fraud. At the time of testing, there was no separation of duty between the officer setting up benefit payment runs and the officer

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
			completing the BACS payment runs. The level of benefits overpayments subject to recovery action was reviewed and testing determined that recent resourcing issues were affecting the effective review and recovery of this debt.
Payroll	Sufficient	To provide assurance over whether there are adequate processes and controls in place to ensure timely and accurate processing of starter, leavers and payroll changes. To also provide assurance that the requirements of the Local Government Pension Scheme (LGPS) 2014 and auto-enrolment have been fully and accurately implemented.	Arrangements for implementation of LGPS 2014 and auto-enrolment were successful in ensuring that the key requirements of both schemes were implemented fully and accurately for the majority of staff. However, the approach to project implementation was informal and not fully documented, which may have contributed to some of the implementation errors and delays. Controls in respect of starters, leavers, contract changes and non-standard payments were found to be effective in both design and operation, although the policy for payment of honorarium needed further clarification.
Agresso	Limited	To establish whether there are adequate policies, processes and controls in place to ensure that user access privileges are appropriate, including super-user accounts. To provide assurance over how officers ensure that system changes and updates are properly tested and controlled before going 'live'.	Officers asserted that any new or additional access to this system, beyond the minimum access rights, should be subject to formal approval by management to confirm that the access is appropriate and required for the job role. However, the audit found that arrangements for setting up, approving and maintaining user access rights were somewhat informal in practice and controls over super-user access were not fully effective. Some specific access rights were identified as inappropriate. On identifying this issue, prompt action was taken by management. Controls over key financial systems are subject to separate audit reviews and to date Internal Audit had not

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
			identified any misuse of access rights. There were no documented change management procedures, but the team has recently developed a formal change request form and change control form. At the time of audit, preparation of a formal change log was in progress and documentation for all changes was retained on the network drive.
Community Care Finance – Deputyships & Court of Protection	Limited	To examine the arrangements in place to assess clients' proper contributions to their costs of care; arrangements for stewardship of clients' assets; and arrangements to ensure compliance with statutory requirements.	It was confirmed that there were policies in place to enable officers to calculate clients' contributions correctly. Furthermore, there was evidence that responsible officers had been proactive in pursuing clients' financial best interests by ensuring that all relevant benefits are claimed and making use of ISA allowances. Formal policies and procedures did not, however, exist for the management and administration of client finances which had led to inconsistencies in how supporting documentation for each client had been retained. It was recommended that a complete, consistent file of all key financial documentation be retained for each client and these should be subject to independent reviews. This also included maintaining records and assurance over use of monies where lump sums are given to carers/care homes by the Council to spend on the client. Prompt action was taken by the team to revise the policies in this area and the implementation of actions is subject to review.
Community Care Finance – Assessments and Fairer Charging	Sufficient	The review covered the arrangements in place to schedule and deliver financial assessments; to identify clients' assets and to deal with cases	Review confirmed that adequate procedures were in place to identify clients who require a financial assessment, to carry out such assessments accurately and in a timely manner and to communicate the results to the client or their representative and allow for appeals.

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
		where residential property is relevant to the assessment of the clients' liabilities; and to ensure accurate and timely billing of all relevant clients.	Detailed testing confirmed that financial assessments were taking place as described; appeals were resolved in a timely manner and deferred payment agreements were set up, as required. Due to the continued issue of there being no interface between the Abacus and Agresso systems for raising debtor invoices for homecare clients, testing did highlighted some delays in the raising of invoices. It was also recommended that up-to-date policies should be made available on the Council's internet pages to inform service users.
IT			
Service Desk and Change Management	Sufficient	To provide assurance over the Council's incident and problem management processes via the Helpdesk. To review the Council's draft Change Management arrangements (compliance testing not undertaken as it was too early following development of the policy to review this in practice).	Evidence of compliance with good practice for Service Desk management was identified, particularly in relation to the approach to prioritisation of calls and the full audit trail within the eServiceDesk system. A published service level agreement (SLA) for the Service Desk contained key performance targets. It was recommended that performance reporting to senior management should include analysis of the resolution of calls within the SLA targets. It was acknowledged that the functionality to log follow-on calls was not being fully utilised, resulting in some duplicate calls being logged on the system. Procedures for change management, modification and alteration of system functionalities had been documented in the draft Change Management policy. Review of the draft policy concluded that it contained appropriate guidance and, if fully implemented, should provide a basis for well managed change.

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
ICT Asset Management	Limited	To provide assurance that the ICT asset management arrangements are fit for purpose and registers relating to hardware; software; and data storage media are complete and accurate.	The IT management team were aware of the need to revise the procedures for maintaining ICT asset records and plans were in place, including the potential replacement of the service desk and asset management software. The ICT asset management database contained appropriate data-fields to assist ICT in locating items or identifying the age or value of assets; however, Internal Audit testing identified significant gaps in record keeping. The Council did not hold a software application register listing details of all applications used across the authority. Reconciliations between the licences held and usage should be conducted and evidenced for all applications to provide assurance over compliance with the license terms.
Fraud Risks			
Recruitment & Payroll Related Fraud	Sufficient	To provide assurance that the Council has put in place arrangements to mitigate the risks of employee-related fraud including: recruitment of individuals who misrepresent themselves; false claims for overtime; false claims for expenses; falsification of flexitime records; and false claims relating to sickness.	Testing highlighted that line managers were able to demonstrate a good level of controls regarding checks of flexi time and overtime worked. Review also confirmed that expense claims were subject to management authorisation. Requirements for clearer narratives and acceptable evidence were to be included in the new Expenses Policy. Whilst testing identified some small delays in checking recruitment documentation, responsible managers received reminders from HR. The new Safer Recruitment Processes require all documentary evidence to be checked at interview stages.

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
NDR Fraud	Sufficient	To examine the arrangements to manage the risks of fraud relating to failures to declare rateable hereditaments; misrepresentation to obtain reliefs; and withholding of information to retain reliefs after period of entitlement ends.	Based upon the testing completed, a satisfactory framework of controls had been identified to address the risks associated with NDR fraud. This included an embedded programme of property inspections to identify instances of potential fraud, a clear procedure in place for reporting and investigating any suspicions that changes of use of properties had not been reported, and evidence of close monitoring of NDR relief end dates. Testing did not identify any instances of fraud or money laundering. The review highlighted that the Council did not have an approved and cascaded Money Laundering Policy; however a draft policy was being prepared for approval and finalisation. It was also identified that the current processes in place for paying NDR refunds could be further improved to reduce the risk of money laundering by implementing approval limits for any such refunds over £5,000.
Service Delivery			
Housing Options	Substantial	To establish whether there are adequate processes and controls in place to ensure that housing and homelessness applications are treated in accordance with established local policies and national legislation.	The audit found that appropriate controls were in place for ensuring housing applications and homelessness cases were treated in accordance established policies and the relevant legislative framework. Testing confirmed that all applications for housing and homelessness within the selected samples had been consistently processed in accordance with these policies, thereby demonstrating the effectiveness of these controls. There was evidence that standards of record keeping could be improved in some cases and some scope to strengthen further the existing arrangements by developing operational guidance for certain aspects of the allocations policy.

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
Home to School Transport	Sufficient	To provide assurance over the arrangement to assess risks to children and to identify, evaluate and record all incidents that might require a reassessment of those risk; arrangements in place to mitigate acknowledged risks; and arrangements to record and evidence those mitigations. To examine the arrangements in place to ensure that the best price is obtained for transport required; and that spare capacity can be – and is managed out of the service.	Evidence was provided to demonstrate that safety responsibilities had been appropriately set out in contractual terms and conditions and that all vehicles used by the Council's contractors had appropriate insurance and MOT certification. Some of the documentation was not readily available at the time of audit testing and it was recommended that such evidence be obtained from all contractors on a regular basis and securely retained. The Council had policies and procedures in place to manage the risks involved in the transport service such as a Passenger Code of Conduct and operational risk assessments. However, at the time of the audit, assurance could not be provided that all individual routes had been appropriately risk assessed. It was recommended that all remaining routes be assessed to provide evidence that each had been suitably reviewed and any additional training and/or safety measures had been provided where necessary.
Early Years Funding	Sufficient	To provide assurance over the management and allocation of direct funding from the Department of Education and to provide assurance that the controls over early years funding claims are robust.	The governance arrangements for the Early Years Service were found to be well designed and mechanisms were in place to review and monitor performance. Evidence was provided that the budget had been allocated based on statutory requirements and any remaining budget had been appropriately used on a needs basis. During sample testing, Internal Audit identified some errors resulting in overpayments of funding; the majority of these

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
			inaccuracies were caused by human error and were subsequently detected by the Council. Claims from providers were reviewed to ensure that all supporting evidence was available. Some cases were identified where evidence was incomplete. Furthermore, there was no formal programme for checking the eligibility of funding claims. The introduction of spot checks would enable the Council to identify areas of concern and ensure accuracy.
Nursery Provision	Sufficient	To provide assurance that the Council has established and maintains an appropriate framework of controls to ensure that relationships between schools and pre-school providers do not compromise safeguarding arrangements or the financial interests of schools; that the respective duties, rights and responsibilities of schools and pre-school providers are appropriately defined; and that those governance requirements are satisfied.	Internal Audit found that although the Council no longer had direct responsibility for ensuring schools and settings comply with safeguarding requirements, an appropriate framework of support had been developed to help schools and other early years providers ensure proper standards are in place. For the five nurseries operating on school sites, local arrangements had been established for recharging costs and there was evidence of appropriate operational policies and procedures in some cases. However, financial and governance arrangements were not formalised into legally enforceable contracts or agreements. This increased the risk of misunderstandings about roles and responsibilities and any financial disputes or disagreements may be more difficult to resolve.
School Improvement Programmes	Sufficient	To provide assurance that the local authority has appropriate processes and controls in place	A performance dashboard had been produced and a detailed data analysis had been conducted to allow the Council to identify any underperforming schools. This information was used

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
		for supporting school improvement. Including review of the strategy and plans, policies and procedures relating to school improvement, compliance with statutory guidance from Ofsted, funding and resource allocations, budget monitoring, school performance data, performance monitoring, contract management and service capacity.	to channel support to areas of greatest need through school visits and strategy meetings. Appropriate mechanisms to monitor the performance of the School Improvement Team were found to be in place; however on occasions, evidence of review and recording of outcomes and actions taken were not fully evidenced. The Council's definition, arrangements and criteria for monitoring, challenging, intervention and support were identified as clear and comprehensive. The service was continuing to develop and implement their control framework. Key documents such as the School Improvement Policy and Schools Causing Concern Policy were in consultation and not finalised at the time of reporting.
School Admissions Service	Substantial	To provide assurance over the effective management of the Schools Admissions service including compliance with statutory procedures and admissions guidance, operation in accordance with deadlines, ability to place all children applying for places and ability to demonstrate that appealed decisions have been based upon a proper application of	The audit confirmed that there was a clear process for receiving and responding to appeals which is defined by the statutory School Admissions Appeals Code and explained in outline on the Council's website. Refusal letters sent to parents provided details on how to submit an appeal. The Council had developed standard appeals forms and an independent appeal panel. The clerk to the panel was responsible for checking that all relevant documentation was provided by the Council, including a statement to defend the schools decision. A standard template was used for this purpose. Testing of a sample of appeals did not identify any evidence of failure to apply proper processes or

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
		policy informed by all necessary and relevant information.	policy requirements. Testing of a sample of 2014/15 admissions confirmed that all deadlines had been met and the Council had complied with all requirements of the national School Admission Code.
Continuing Health Care (CHC) Funding	Sufficient	To provide assurance over the processes in place to support eligible service users in accessing CHC Funding and that costs are suitably recovered and accounted for by the Council.	The audit found that reliance was placed primarily on the professional judgement of individual social workers to identify and assess potentially eligible cases, supported by appropriate training and supervision arrangements. Invoices for recovery of NHS contributions were being raised promptly and accurately, although recharges in respect of transport and community equipment costs were not always included. Actions have been agreed to address this. Debt recovery from Clinical Commissioning Groups was identified as difficult and time consuming but officers asserted that all invoices were paid eventually and appropriate debt recovery processes were being followed to pursue these monies. Budget reporting was generally sound and revisions to the budget monitoring reports to be introduced for the 2015/16 financial year should strengthen this further.
Governance			
Data Management	Sufficient	To provide assurance that the identified risks associated with compliance with Data Protection and Freedom of Information (FoI) legislation have been	The audit confirmed that much had been achieved within in the last year to develop appropriate systems and procedures and to raise staff awareness of their roles and responsibilities. Clear operating procedures had been developed supported by a number of standard forms and templates. There was also

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
		suitably mitigated. Effective data management supports the delivery of the Council's strategic objectives. The audit did not cover arrangements related to data collection, retention, disposal or sharing, where further work was already underway within the Council.	evidence of senior officer commitment within the Council and various training and awareness initiatives in place and planned. Testing of a sample of FoI cases confirmed that all requests had been promptly acknowledged and processed in accordance with established procedures. Review of rejected cases confirmed that the grounds for rejection were reasonable and compliant with the legislation. There was evidence, however, that record keeping could be improved. Furthermore, there was a lack of audit trail from the FoI register to quarterly performance reports.
Safe Driving at Work	Limited	To cover the arrangements that have been put in place (and any others that are in development) to ensure that compliance with legislation related to safe driving at work can be ensured and demonstrated; and to promote the safe driving of employees whilst at work.	The Council's safe driving at work control framework was under development at the time of the audit and was not sufficient to demonstrate full compliance with health and safety legislation. During testing limited evidence was provided that driver and vehicle documentation was being examined before staff could use vehicles for business use. A draft Travel & Subsistence Policy had been developed which, if approved, would require such checks to be carried out. Testing also demonstrated that operational risk assessments were not being consistently carried out for employees driving at work. A further review in 2015/16 will confirm whether all risks are now being suitably mitigated.

Audit Assignment	Assurance Rating	Area Reviewed	Basis for Assurance Opinion
Contract Management	Sufficient	To provide assurance over contract management arrangements in the Council's Places Directorate. To cover: arrangements for developing a strategic approach to contracting/procurement, ensuring continuity of services, managing contractor performance and compliance with statutory obligations.	Testing confirmed that most areas of major and regular spending were subject to formal contracts awarded through a competitive process. In order to identify any further opportunities to maximise value for money, it was recommended that the department would benefit from undertaking periodic strategic procurement reviews of non-contractual departmental spending. A range of performance information was being used to manage contracts but arrangements for recording performance information, contractor meetings and inspections were found to be inconsistent across the department and sometimes informal. It was recommended that the approach to procurement adopted by Property Services, as specified in the Construction Procurement Policy, be reviewed to consider whether the use of closed tender lists remained appropriate. This was not being consistently applied in practice and procurement advice indicated that if followed it could increase the risk of legal challenge.

Appendix 2: Self-Assessment against the Public Sector Internal Audit Standards (PSIAS)

Standard	Ref	Conformance with Standard	Yes	Partial	No	Evidence
1000 – Purpose, Authority & Responsibility	1010	Recognition of the Definition of Internal Auditing, the Code of Ethics and the Standards in the Internal Audit Charter	✓			The Internal Audit Charter reflects the mandatory nature of the relevant Standards.
1100 – Independence and Objectivity	1100	Organisational Independence	✓			Head of Internal Audit reports directly to the Audit Committee and has unfettered access to the Chief Executive, Chair of the Audit Committee and Section 151 Officer.
	1111	Direct Interaction with the Board	✓			Head of Internal Audit reports directly to the Audit Committee.
	1120	Individual Objectivity	✓			All members of the Internal Audit team are required to complete a Declaration of Interest form at the start of the financial year and any conflicts of interest are avoided in work allocations.
	1130	Impairment to Independence or Objectivity	✓			Approval sought from Audit Committees before undertaking any significant consulting services not already included in Audit Plans.
1200 – Proficiency and Professional Care	1210	Proficiency	✓			Head of Internal Audit is CCAB qualified and all Audit Managers hold professional qualifications and are suitably experienced for the role. Auditor is completing Institute of Internal Audit qualification.
	1220	Due Professional Care	✓			Experienced Audit staff exercise due professional care when planning and undertaking assignments. Scope of assignment is clarified within detailed audit planning record and the limitations to the scope and assurance provided are documented within audit planning records, audit reports and progress reports. All audit planning records are approved by the Head

Standard	Ref	Conformance with Standard	Yes	Partial	No	Evidence
						of Internal Audit before work commences.
	1230	Continuing Professional Development	✓			Staff attendance at training and development opportunities. All Audit Managers must satisfy professional body CPD requirements.
1300 – Quality Assurance & Improvement Programme	1310	Requirements of the Quality Assurance and Improvement Programme	✓			External assessment completed in 2013 and annual internal self-assessment conducted by Head of Internal Audit, which is included in the Annual Report.
	1311	Internal Assessments	✓			Ongoing monitoring of performance at monthly individual supervision meetings, team meetings and post audit completion discussions. Customer Satisfaction Questionnaires (CSQs) requested from clients for each assignment and responses summarised for Audit Committees. Head of Internal Audit meets with senior management on regular basis and seeks feedback on value of the Internal Audit service and areas for development.
	1312	External Assessments	✓			External assessment conducted in 2013 by independent, professional company to assess against compliance with PSIAS.
	1320	Reporting on Quality Assurance and Improvement Programme	✓			The outcome of the external assessment and progress against the resulting improvement plan were reported to the Welland Board (where all Welland S151 officers are members) and to Audit Committees. All actions from the improvement plan were signed off by the Welland Board. Annual self-assessment against PSIAS included within Head of Internal Audit's Annual Report – to be presented to the Welland Board and Audit

Standard	Ref	Conformance with Standard	Yes	Partial	No	Evidence
						Committees.
	1321	Use of 'Conforms with the International Standards for the Professional Practice of Internal Auditing'	✓			Based upon completion of improvement plan and ongoing assessment and quality assurance processes, results support compliance with Standards and Code of Ethics.
	1322	Disclosure of Non-conformance	✓			Instances of non-conformance were reported to the Board and Committees following the external assessment. Progress against the improvement plan to address all areas of non-conformance was reported to Committees and management until all actions were signed off.
2000 – Managing the Internal Audit Activity	2010	Planning	✓			Process for development of risk based audit plans was presented to each Audit Committee for approval. Plans were developed with input from senior management and Committee members. Audit planning process is documented in Internal Audit Charter.
	2020	Communication and Approval	✓			Any changes to the approved Audit Plans during the financial year are communicated to the Audit Committee and subject to agreed approval mechanisms in accordance with the delegated decision making arrangements.
	2030	Resource Management	✓			Resources reviewed on an ongoing basis to ensure these are appropriate, sufficient and effectively deployed. Team includes four professionally qualified, experienced Audit Mangers. Any concerns on adverse impact on provision of the audit opinion would be raised by the Head of Internal Audit in Annual Report.
	2040	Policies and Procedures	✓			Audit manual, charter and practice notes revised as part of improvement plan to ensure compliance with

Standard	Ref	Conformance with Standard	Yes	Partial	No	Evidence
						Standards.
	2050	Coordination	✓			Other sources of assurance are considered and reviewed as part of the Audit Planning process to avoid any duplication with other assurance providers.
	2060	Reporting to Senior Management and the Board	✓			The Head of Internal Audit attends meetings with senior management and Audit Committees on a regular basis. Progress reports are presented at every Audit Committee meeting and details of assurance levels are provided with focus upon those of Limited Assurance opinions. The content of the progress reports has been agreed with the existing committees but is subject to constant review to ensure this meets the needs of members and supports effective decision making. The content of the progress reports is to be reviewed at the start of 2015/16 with proposals for amendments presented to the Welland Board and discussed with Audit Committees. *** Area for further development – Action 1**
2100 – Nature of Work	2110	Governance	✓			Audit team provides independent advice on drafting of governance related policies and attends governance groups, where applicable. Audit findings on risks and controls are presented to the Audit Committee and senior management with recommendations on areas for improvement. As appropriate, the Internal Audit team contributes to the development of the Annual Governance Statement.

Standard	Ref	Conformance with Standard	Yes	Partial	No	Evidence
						IT Governance reviews included in rolling IT Audit plan.
	2120	Risk Management	✓			Internal Audit refer to the organisation's risk registers during Annual Planning exercises and provide training to committee members on risk management and the 'three lines of defence' to support effective review. Risks relating to the organisation's governance, operations and information systems, as well as fraud risks, form part of individual audit assignments, as stated in the audit planning records and audit reports. The Internal Audit plans for 2015/16 include review of risk management systems and procedures at two of the five Councils within the consortium. For those remaining Councils, as stated in the PSIAS 'Internal Audit gather the information to support this assessment during multiple engagements The results of these engagements, when viewed together, provide an understanding of the organisation's risk management processes and their effectiveness'. As such, the outcome of the various risk based assignments within the Audit Plans provide an understanding of the effectiveness of the Council's risk management procedures which can be raised with senior management and the Committee. Auditors are alert to other significant risks when undertaking any consulting engagements and give advice and make recommendations but it is the

Standard	Ref	Conformance with Standard	Yes	Partial	No	Evidence
						responsibility of management to implement these actions.
	2130	Control	✓			In accordance with the risk based approach to Internal Audit assignments, the adequacy and effectiveness of controls are evaluated and reported upon on each audit assignment. The audit report template clearly provides an assurance rating for both design and compliance for each control.
2200 – Engagement Planning	2201	Planning Considerations	✓			An audit planning record is issued and subject to formal approval for all audits. This outlines the scope, objectives, timescales, resource allocations, access requirements and limitations to scope for the assignment. This is reviewed and approved by the Head of Internal Audit before issuing to the client. Any consultancy engagement is also subject to documented, agreed scope, objectives and respective responsibilities of the auditor and the client.
	2210	Engagement Objectives	✓			Audit planning records are agreed for each engagement following preliminary discussions on risks with the audit clients and with input and review from Head of Internal Audit. Value for money considerations are included in the scope as appropriate.
	2220	Engagement Scope	✓			Detailed audit planning records are provided for all assignments establish the objectives, resources and access to systems, records, personnel and premises, as appropriate.
	2230	Engagement Resource Allocation	✓			Audit planning records state the number of audit days allocated to the assignment and the Audit Manager should agree a scope which is achievable within the

Standard	Ref	Conformance with Standard	Yes	Partial	No	Evidence
						resource available. The Head of Internal Audit reviews and approves all audit planning records before issuing to clients to ensure scope is appropriate and consistent with resource allocation.
2300 – Performing the Engagement	2310	Identifying Information	✓			Audit Managers ensure that sufficient, reliable and relevant information is used for audit assignments. File reviews conducted by Head of Internal Audit to confirm quality of evidence and basis for conclusions.
	2320	Analysis and Evaluation	✓			File reviews conducted by Head of Internal Audit to confirm quality of evidence and basis for conclusions. Clearance meetings held with clients to discuss findings and basis for conclusions and provide opportunity to confirm accuracy of findings.
	2330	Documenting Information	✓			Retention of evidence to support conclusions and engagement results is saved on the audit software and network folders, where access is limited to Audit staff. Any hard copy evidence is scanned onto the network and software and destroyed via confidential waste. Practice note states 'Rutland County Council is the Consortium's employing body and the Consortium operates in line with the Council's Document Retention Policy'.
	2340	Engagement Supervision	✓			Monthly supervision meetings held with each member of Audit team to discuss progress made with each assignment, any issues encountered, workload and priorities for the month ahead. All audit reports are reviewed by the Head of Internal

Standard	Ref	Conformance with Standard	Yes	Partial	No	Evidence
						Audit and evidence is retained on file. All working papers are reviewed by the Head of Internal Audit (unless completed by an Auditor and fully reviewed by Audit Manager). Evidence of the review is held on the audit software with full audit trail.
2400 – Communicating Results	2410	Criteria for Communicating	✓			Internal Audit reports state the objectives, scope, conclusions, recommendations and agreed action plans.
	2420	Quality of Communications	✓			Head of Internal Audit review of reports ensures these are accurate, objective, clear, concise, constructive, complete and timely.
	2421	Errors and Omissions	✓			No incidents recalled of any significant errors or omissions in reports. Any such incidents would be suitably escalated for resolution.
	2430	Use of 'Conducted in Conformance with the International Standards for the Professional Practice of Internal Auditing'	✓			Based upon completion of the improvement plan arising from the external assessment and the internal self-assessment, results support this statement.
	2431	Engagement Disclosure of Non-conformance	✓			Not applicable.
	2440	Disseminating Results	✓			The final reports issued on all assignments are provided to all individuals named on the circulation list, approved at the commencement of the audit. Any circulation to parties in addition to those listed on the audit planning record will be agreed with the Head of Internal Audit and senior management. Copies of all finalised audit reports are available to Committee members by requesting from the Head of Internal Audit or Section 151 Officer. Copies are

Standard	Ref	Conformance with Standard	Yes	Partial	No	Evidence
						provided to the Chair of the Audit Committee where agreed with the specific committee. The progress reports presented at each committee meeting include the outcome of each assignment, in relation to the assurance rating. In order to provide members of the committee with sufficient detail in relation to the findings, the content of the progress report is currently under review by the Head of Internal Audit and will consistently include a summary of each assignment completed during the period for all members of the consortium. *** Area for further development – Action 1**
	2450	Overall Opinions	✓			The Head of Internal Audit provides an annual Internal Audit opinion which can be used to inform the Council's governance statement. This report includes an opinion, a summary of work that supports that opinion and a statement on conformance with PSIAS.
	2500	Monitoring Progress	✓			There is an established process in place at each of the councils within the Consortium for the follow-up of progress made by management in implementing the agreed actions arising from audit reports. Internal Audit monitor and report to the Committee on the progress made. The Head of Internal Audit is currently reviewing the level of detail provided to Audit Committees on the implementation of actions to ensure these can be suitably reviewed and challenged, as necessary.

Standard	Ref	Conformance with Standard	Yes	Partial	No	Evidence
						*** Area for further development – Action 1**
	2600	Communicating the Acceptance of Risks	✓			Where an identified risk is accepted by management this is reflected in the audit report. Where the risk is subsequently accepted because the agreed action is no longer feasible this would be discussed with senior management and details and context would be reported to the Committee. If the Head of Internal Audit had concerns about the level of risk accepted by management this would be reported to the Committee.

Conclusion

Based upon the self-assessment completed by the Head of Internal Audit on 23rd April 2015, the Welland Internal Audit Consortium is compliant with the Public Sector Internal Audit Standards (PSIAS). One action for further development has been highlighted as follows:

Action	Details	Owner	Timescale
1	Whilst the current Progress Reports presented to the Councils' Audit Committees include details of delivery of the Audit Plan and Assurance Opinions assigned to completed assignments, there is scope to further review and develop the content of these reports. In particular: • To ensure all progress reports include a summary of the key findings of audits completed during the period. • Any limited assurance opinions are suitably highlighted to the Committee's attention, with assurances over actions underway to address the issues raised. • Members should be provided with more details on the implementation of actions arising from audit reports including the nature of the actions, priority levels and timescales. This should enable Members to exercise their role in challenging any failure in implementing actions to address high risks to the Council. Focus should be upon actions assessed as High or Medium priority. The format and content of the Progress Report will be reviewed and strengthened to ensure Members are provided with all information required to effectively exercise their roles and responsibilities.	Head of Internal Audit	To present proposed format to Welland Board for approval by June 2015.

REPORT NO: 97/2015

AUDIT AND RISK COMMITTEE

30 June 2015

ANNUAL FRAUD REPORT 2014-2015

Report of the Director for Resources

Strategic Aim:	**All**	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor King, Portfolio Holder for Places (Development and Economy) and Resources	
Contact Officer(s):	Debbie Mogg, Director for Resources	Tel: 01572 758358 dmogg@rutland.gov.uk
	Diane Baker, Head of Corporate Governance	Tel: 01572 720941 dbaker@rutland.gov.uk
Ward Councillors	Not Applicable	

DECISION RECOMMENDATIONS
That the Audit and Risk Committee: 1. Endorses the content of this annual fraud report and 2. Notes the control mechanisms in place to mitigate the risk of fraud against Rutland County Council

1. PURPOSE OF THE REPORT

1.1 This report provides an overview of any fraud related activity, which has affected Rutland County Council during the period 2014-2015. The report also seeks to provide an assurance regarding the Council's resilience against the risk of fraud. This is in accordance with the Committee's Terms of Reference to provide assurance of the adequacy of the risk management framework and control environment.

2. HOW DO WE DEFINE FRAUD AND HOW PREVALENT IS IT?

2.1 Fraud is defined as a deception deliberately practiced in order to secure a gain (or cause a loss). Under the Fraud Act 2006, there are three main ways to commit fraud:

- Fraud by false representation
- Fraud by failing to disclose information
- Fraud by abuse of position

2.2 These categories can be applied to any fraudulent activity that the Council may, at times, be subjected to. For example, false representation may occur during the recruitment [process, failing to disclose information may arise during the register of interest process and abuse of position could occur in a social care setting.

2.3 The latest government statistics show the UK economy lost £52bn to fraud in 2013. Fraud against the public sector is estimated to cost around £20.6bn; more than £2bn of this is attributable to local government.

2.4 In the Audit Commission's latest annual report 'Protecting the Public Purse 2013: Fighting Fraud against Local Government' it is highlighted that fraud amounting to £178 million was detected by local government in 2013. This can be broken down further to 107,000 cases of detected fraud. Housing Benefit and Council Tax Benefit fraud accounted for over two-thirds of the total fraud loss value.

3. WHAT IS THE COUNCIL'S COUNTER FRAUD STRATEGY?

3.1 Councillors and Officers continue to have a crucial role in supporting the right approach to deter and detect fraud. For example:

- Ensuring the Council understands local fraud risks;
- Comparing the Council's performance against countering fraud with similar Councils;
- Ensuring counter-fraud resources are proportionate to risk and local harm;
- Encouraging the Council to focus on deterrence, by widely publicising action against fraudsters; and
- Increasing staff confidence in the Council's whistleblowing arrangements through corporate leadership and support for those who report concerns.

3.2 The Council's Counter Fraud Strategy forms part of the Constitution. It was last fully reviewed in 2012 and is scheduled for a further full review in 2016.

3.3 The Strategy is made up of five key areas with a clear theme of individual responsibility placed upon Councillors and Officers for their own conduct:

- Prevention
- Detection
- Investigation
- Retribution and restitution
- Use of deterrents

4. HOW HAS THE COUNCIL WORKED TO TACKLE FRAUD IN THE YEAR?

4.1 **Fraud Risk Register:** As part of the Council's proactive approach in identifying fraud risks it decided to establish a specific Fraud Risk Register. The Register includes a list of areas where officers believe the Council could be susceptible to fraud. The Register was initially presented to Audit and Risk Committee in April 2014. Further enhancements were made and it was again presented to Audit and Risk Committee in January 2015, where it was agreed that the Committee would continue to review this process as the Register continues to develop. The development of this Register did not identify any issues of concern.

4.2 **Joint Working Arrangements**: In order to obtain national funding for fighting fraud, the Council joined a group of 10 local authorities (in Leicestershire and Rutland) to bid for funding to support a project to share best practice, namely providing a central Intelligence Hub, the development of an Application for residents to report fraud and the provision of a resource to consider insurance fraud. The bid was successful resulting in an award of £470,109 to Leicester City Council as the lead authority. This project is in the early stages of implementation and will be reported back to Audit and Risk Committee as it develops.

4.3 **Training and Awareness:** The Council continues to deliver Fraud Awareness training to all new Officers during the induction process. More targeted training will be delivering during 2015-2016 as part of a wider corporate governance initiative entitled 'Focus on Fraud'.

4.4 **Whistleblowing –** Reporting Concerns: The Council's Whistleblowing Policy is a key element in its arrangements to promote good governance and to guard against fraud, corruption or other types of improbity. The Policy is undergoing a full review with the outcome being presented to Audit and Risk Committee in July 2015.

5. HOW DO WE MEASURE THE LEVEL OF FRAUD EACH YEAR?

5.1 **Fraud Survey:** Each year, the Council participates in a national fraud survey, which until recently, was administered by the Audit Commission. During the last survey, the Audit Commission received responses from 493 local government bodies: a response rate of 100 per cent. These results map the volume and value of different types of fraud detected, providing information about emerging and changing fraud risks and help identify good practice in tackling fraud. Although Rutland County Council was not identified as having any particular risks, it is important to see where other Councils are suffering through fraudulent activity. The Council has just completed its Fraud Survey submission for 2015. Benefit fraud activity has been included alongside one other procurement issue, which occurred in 2014. This matter has already been reported to Audit and Risk Committee.

5.2 **Benefit Related Fraud**: As identified earlier in this report, the biggest challenge for any Council continues to be the management of benefit-related fraud. During the summer of 2014, the Government introduced its Single Fraud Investigation Service, which is hosted by the Department for Work and Pensions (DWP) as part of the Government's Welfare Reform agenda. Under previous arrangements, Rutland County Council operated a shared service with Corby Council whereby Corby investigated all cases of benefit-related fraud affecting Rutland. All staff previously engaged on local authority benefit investigations, have now transferred across to the DWP to investigate *all* types of benefit fraud. Therefore, all cases affecting Rutland will now be handled by the DWP as part of their wider strategy. During the period of this report 10 cases of Housing and/or Council Tax Benefit fraud were detected; the value of which was £56,844. The usual steps were taken to recover overpaid benefit.

5.3 **Blue Badges:** There were no issues concerning the fraudulent use of a Blue Badge in the period of this report. However, one issue of note concerned a Rutland resident, who applied for a Blue Badge on line *via* a bogus website. This resulted in the resident being defrauded of a £48 fee. When the Council became aware of this matter, they immediately reported it to Action Fraud, which is the UK's national fraud and internet crime reporting centre.

5.4 **Single Person Discount:** The Revenues and Benefits team undertake various checks as a means of preventing and detecting fraud and corruption. One annual check involves verifying the eligibility of single person discount claims. The Council engages a specialist company to carry out this work. The outcome involves informing those who may no longer be entitled that the discount will be removed. During the period of this report, the Council identified savings of approximately £40,000 in this area.

5.5 **National Fraud Initiative (NFI):** The NFI places a mandatory requirement on local authorities to annually upload selected datasets to a secure website. The data is then matched against other collected data and a number of matches are produced for each participating authority. The NFI has recently provided the Council with 1,234 matches to review. They include Blue Badge registrations, concessionary parking anomalies and Pension data. The results of the reviews will be reported to Audit and Risk Committee at a future date.

6. CONSULTATION

6.1 There is no requirement to consult on this subject; the report focusses on internal arrangements to counter fraud.

7. ALTERNATIVE OPTIONS

7.1 The alternative option is to fail to implement any measures to address the risk of fraud. This would leave the Council vulnerable therefore it is not an option that should be considered.

8. FINANCIAL IMPLICATIONS

8.1 The financial implications of failing to protect the Council could be substantial. These measures provide an assurance that public funds are being protected from abuse.

9. LEGAL AND GOVERNANCE CONSIDERATIONS

9.1 The Council has an ongoing obligation to detect and investigate localised fraud. To prevent reoccurrence by risk management and the continuance of good governance including best practice and by following evolving anti-fraud initiatives".

10. EQUALITY IMPACT ASSESSMENT

10.1 An Equality Impact Assessment (EqIA) has not been completed as the report concerns internal administrative processes.

11. COMMUNITY SAFETY IMPLICATIONS

11.1 None

12 HEALTH AND WELLBEING IMPLICATIONS

12.1 Good governance arrangements promote the financial wellbeing of the local community.

13 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

13.1 This report seeks to demonstrate that Rutland County Council continues to have a robust counter-fraud culture and effective counter-fraud arrangements in place. Fraud risks are managed effectively therefore preventing harm to the local community. It should, however, be noted that although the Council will make vigorous efforts to protect itself; fraud is recognised as a growing area of concern and the Council is not immune to these increased levels of risks. Therefore a vigilant approach is required at all times.

14 BACKGROUND PAPERS

Protecting the Public Purse: fighting fraud against local government. Audit Commission

15 APPENDICES

None

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577.

REPORT NO: 99/2015

AUDIT AND RISK COMMITTEE

30 June 2015

REGULATION OF INVESTIGATORY POWERS ACT 2000 (RIPA) ANNUAL REPORT

Report of the Director for Resources

Strategic Aim:	**All**	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor King, Portfolio Holder for Places (Development and Economy) and Resources	
Contact Officer(s):	Debbie Mogg, Director for Resources	Tel: 01572 758358 dmogg@rutland.gov.uk
	Diane Baker, Head of Corporate Governance	Tel: 01572 720941 dbaker@rutland.gov.uk
Ward Councillors	Not Applicable	

DECISION RECOMMENDATIONS
That the Audit and Risk Committee: 1. Notes the content of this annual report, which covers all RIPA activity during 2014/2015. No further action is required.

1. PURPOSE OF THE REPORT

1.1 To provide an overview of the Regulation of Investigatory Powers Act 2000 (RIPA) and a summary of the Council's use of RIPA during 2014/2015.

1.2 The Regulation of Investigatory Powers Act 2000 (RIPA) was enacted to provide a framework within which a public authority may use covert investigation for the purpose of preventing and detecting crime or of preventing disorder.

1.3 The codes of practice issued by the Home Office in relation to Part II of RIPA recommend that elected members have oversight of the Council's use of these provisions. The Audit and Risk Committee's terms of reference enable the Committee to receive reports on the Council's use of covert investigations under RIPA. Update reports are presented to each Audit and Risk Committee meeting on a quarterly basis in order to comply with regulatory requirements

2. WHAT IS RIPA AND HOW CAN IT BE USED BY A LOCAL AUTHORITY?

2.1 RIPA sets out a regulatory framework for the use of covert investigatory techniques by public authorities. Local Authorities are limited to using three covert techniques for the purpose of preventing or detecting crime or preventing disorder

2.2 Use of these techniques has to be authorised internally by a trained authorising officer and can only be used where it is considered necessary, proportionate and as a last resort, when other overt techniques have proved to be unsuccessful. The three techniques are:

- Directed covert surveillance;
- The use of Covert Human Intelligence Source (CHIS) i.e. undercover officers and public informants;
- Access to communications data i.e. mobile telephone or internet subscriber checks but not the content of any communication.

2.3 Following the introduction of the Protection of Freedoms Act 2012, certain changes have been made to the way in which Local Authorities approve the use of RIPA. This Act introduced a requirement for Local Authorities to seek approval from a Justice of the Peace (JP) before any application under RIPA can commence.

2.4 In addition to the above change, there is a further requirement that Local Authorities only grant Directed Surveillance authorisations where the Local Authority is investigating particular types of criminal offences. These are criminal offences which attract a maximum custodial sentence of six months or more or criminal offences relating to underage sale of alcohol.

2.5 The Council has an approved policy, which governs the use of RIPA. This was approved by Cabinet in 2014.

2.6 It is also a requirement of RIPA to ensure Members within the authority review the use of RIPA and set the policy at least once a year. Members should also consider internal reports on the use of RIPA at least on a quarterly basis to ensure it is being used consistently with the Council's policy and that the policy remains fit for purpose. Members should not, however, be involved in making decisions on specific authorisations.

3. HOW HAS THE COUNCIL DEVELOPED ARRANGEMENTS TO ENSURE COMPLIANCE?

3.1 Members should be assured that in addition to a review of the current policy, a number of other enhancements have been made in order to strengthen the Council's position when considering the use of RIPA. These include the creation of a Rutland RIPA Group, where RIPA matters are discussed between officers who have expertise in this field. A central log of RIPA activity has been introduced and the Constitution has been updated (via Full Council) to reflect responsibilities and delegations under RIPA.

3.2 In May 2014, the Council was inspected in its use of RIPA by the Office of Surveillance Commissioner (OSC) - this inspection forms part of the OSC's overall regulatory approach and involves a visit to every Public Authority who is able to use RIPA. The purpose of the inspection was to examine policies, procedures, operations and administration in relation to RIPA. The Inspection Report was extremely positive with no recommendations for improvement being made. This outcome recognised the work that had been undertaken during the previous year to ensure the Council fully complied with the legislation.

3.3 Although the Council is robust in its approach to RIPA; it must be noted that the techniques mentioned within this report are rarely used. Enforcement action can be progressed using open source information and the requirement to use covert techniques is rare. The Council has not needed to rely on RIPA at any time during 2014/2015 and will continue to apply this sensible approach when dealing with enforcement matters. However, any future use of RIPA will be reported to the Audit and Risk Committee on a quarterly basis

4. CONSULTATION

4.1 No consultation required.

5. ALTERNATIVE OPTIONS

5.1 Not applicable; there is no recommendation to take any action. Failure to adhere to RIPA would place the Council at legal and reputational risk.

6. FINANCIAL IMPLICATIONS

6.1 There are no financial implications arising from this report.

7. LEGAL AND GOVERNANCE CONSIDERATIONS

7.1 These are mainly detailed within the body of the report. The Investigatory Powers Tribunal (IPT) would investigate any complaint by an individual about the use of RIPA techniques by the Council. If, following a complaint to them, the IPT does find fault with a RIPA authorisation or notice it has the power to quash the order of the Justice of the Peace, which approved the grant or renewal of the authorisation or notice. This may nullify any subsequent criminal proceeding relying on that authorisation or notice.

8. EQUALITY IMPACT ASSESSMENT

8.1 An Equality Impact Assessment (EqIA) has not been completed at this stage. However, if the Council does need to consider any future applications under RIPA, a full assessment will be carried out as part of the individual circumstances.

9. COMMUNITY SAFETY IMPLICATIONS

9.1 As above. There are no direct implications but this will be considered as part of any future individual application.

10. HEALTH AND WELLBEING IMPLICATIONS

10.1 As above.

11. CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

11.1 RIPA sets out a regulatory framework in which the Council must operate in order to comply with the law. The Council has a robust approach to RIPA; this has been endorsed by the OSC during their inspection of arrangements in 2014. The Council will continue to use the Act infrequently, instead relying on open sources methods of investigation. However, the Council will consider future use of the Act in the appropriate circumstances.

12. BACKGROUND PAPERS

None.

13. APPENDICES

None

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577.

REPORT NO: 106/2015

AUDIT AND RISK COMMITTEE

30 June 2015

UPDATE ON AUDIT REPORTS GIVING LIMITED ASSURANCE

Report of the Head of Welland Internal Audit Consortium

Strategic Aim:	**All**	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor King, Portfolio Holder for Places (Development and Economy) and Resources	
Contact Officer(s):	Rachel Ashley-Caunt, Head of Internal Audit	Tel: 07824 537900 rashley-caunt@rutland.gcsx.gov.uk
Ward Councillors	Not Applicable	

DECISION RECOMMENDATIONS

That Members:

1. Note that there has been one report: ICT Asset Management 2014/15 giving rise to a limited assurance rating since the last Committee meeting.
2. Note the action being taken by Officers to address issues raised.
3. Agree that further updates should be provided in October 2015.

1. PURPOSE OF THE REPORT

1.1 When audit assignments give rise to Limited (or No) Assurance ratings, the Committee requires assurance that Officers have taken appropriate and effective steps to address the areas of concern identified by the audit. This report provides Members with an update any assignments which have resulted in Limited Assurance ratings since the last Committee meeting.

2. BACKGROUND AND MAIN CONSIDERATIONS

2.1 One of the seven assignments which has been finalised since the last Committee meeting resulted in a Limited Assurance rating. This related to ICT Asset Management. This audit was requested by the Council in order to support the review of the Council's ICT strategy and operations and the development work which is already planned to strengthen the asset management operations.

2.2 The findings of this review are summarised within this report, including any updates on the current status of the agreed management actions. Appendix A provides the Executive Summary for the audit assignment, including details of all recommendations and the agreed management actions**.**

2.3 In relation to ICT asset management, the audit review concluded that control arrangements needed to be improved to ensure the accuracy and completeness of the Council's ICT asset database. Whilst the database contained appropriate data-fields to assist the IT service in locating items or identifying the age or value of asset, Internal Audit testing identified significant gaps in record keeping, these issues have been summarised in Appendix A.

2.4 Although there is a formal process in place for Human Resources (HR) to notify the IT team of starters and leavers, it was established that the ICT asset database had not been periodically reconciled to current HR or Member records to confirm that ICT asset records remained correct. The absence of periodic reconciliations to HR or Member records also increased the risk of failing to identify any stock that had not been returned to the Council by leavers. The 'Asset Database Procedures' document states that an annual stock take audit will take place but it was confirmed at the time of testing that due to staff changes this has not been completed for 2014/15. In response to these findings, the IT service will be reviewing the current database and conducting a full site audit to provide assurance over the records before implementing new procedures for maintaining these.

2.5 At the time of the review, the Council did not hold a software application register listing details of all applications used across the authority. A complete record of all applications should be maintained and should also include details of licenses held to support reconciliations and identification of under or over use. The Head of IT has confirmed that the software management system is to be included as part of the wider IT service review.

2.6 All agreed actions to address the findings from the report are due to be completed by September 2015 and will be subject to formal review by Internal Audit as part of the standard audit process and reported to Members in the regular progress report.

3. CONSULTATION

3.1 No formal consultation was required as part of this report.

4. ALTERNATIVE OPTIONS

4.1 This Committee has oversight of internal audit reports. The audit of areas rated as 'limited' is part of the 2015/16 internal audit plan. Members could wait for the results of this follow up review rather than ask for an update in October.

5. FINANCIAL IMPLICATIONS

5.1 There are no financial implications arising from this report.

6. LEGAL AND GOVERNANCE CONSIDERATIONS

6.1 The Audit and Risk Committee is responsible for oversight of internal audit work and ensuring that officers are taking action to ensure that the control environment is robust.

6.2 There are no legal implications arising from this report.

7. EQUALITY IMPACT ASSESSMENT

7.1 Equality Impact Assessment (EqIA) screening has been completed and there were no issues arising. A full Impact assessment has not been carried out.

8. COMMUNITY SAFETY IMPLICATIONS

8.1 There are no community safety implications.

9. HEALTH AND WELLBEING IMPLICATIONS

9.1 There are no health and wellbeing implications.

10. CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

10.1 As the Council is required to ensure that the control environment is robust, it is important that all areas reviewed receive, as a minimum, a sufficient assurance audit opinion.

10.2 In the area of ICT Asset Management, the audit has highlighted that the control environment was not adequate and further action is required. The Committee has a role to play in assessing the adequacy of management's response to recommendations and assessing, at a future date, whether actions have been taken.

11. BACKGROUND PAPERS

None

12. APPENDICES

Appendix 1: ICT Asset Management Internal Audit Report 2014/15

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577.

WELLAND INTERNAL AUDIT CONSORTIUM
Rutland County Council

INTERNAL AUDIT REPORT

ICT Asset Management

2014-15

Issue Date:	26th May 2015	***Issued to:***	Jason Haynes	Performance and Applications Support Team Manager
Author:	Lucy Fernandez		Mark Poole	Head of IT
		Agreed draft	Debbie Mogg	Director of Resources
		Final report	Helen Briggs	Chief Executive
		Final report	Saverio Della Rocca	Assistant Director – Finance

WELLAND INTERNAL AUDIT CONSORTIUM
Rutland County Council

ICT Asset Management 2014/15

EXECUTIVE SUMMARY

1. INTERNAL AUDIT OPINION

Rutland County Council's (RCC) ICT assets are managed by the in-house IT service. Effective ICT asset management is important in enabling the IT team to exercise control over IT equipment owned by the Council. This should include complete and accurate records of hardware and software. The audit was requested by the client in order to support the review of the Council's ICT strategy and operations and the development work which is already planned to strengthen the asset management arrangements.

The ICT asset management database contains appropriate data-fields to assist IT in locating items or identifying the age or value of assets; however, Internal Audit testing identified significant gaps in record keeping, these issues have been summarised in section 2 and in the action plan of this report.

Although there is a formal process in place for Human Resources (HR) to notify the IT team of starters and leavers, it was established that the ICT asset database is not periodically reconciled to current HR or Member records to confirm that ICT asset records are correct. The absence of periodic reconciliations to HR or Member records also increases the risk of failing to identify any stock that is not returned to the Council by leavers. The 'Asset Database Procedures' document states that an annual stock take audit will take place. It was confirmed that due to staff changes this has not been completed for 2014/15.

The IT team are responsible for arranging the disposal of redundant ICT assets with the selected third party organisation. The Internal Audit review confirmed that arrangements are appropriate and a review of documentation for the two most recent destruction visits confirmed compliance with the agreed process. The procurement of assets, including software, is controlled through the Council's financial procedures which have been tested in the financial audits undertaken during 2014/15. It was also confirmed that IT access controls only enable the installation of software to be completed by members of the IT team, thereby addressing the risk of installation of unauthorised software applications.

The Council does not currently hold a software application register listing details of all applications used across the authority. A complete record of all applications should be maintained and should also include details of licenses held. Reconciliations between the number of licences held and usage should also be conducted and evidenced to provide assurance over compliance with the license terms and highlight any under or over usage. Evidence was provided of such reconciliations undertaken for Microsoft software, however, this was not available for the Council's other applications.

The IT management team are aware of the need to revise the procedures for maintaining ICT asset records and it is understood that plans are in place to address this including the potential replacement of the service desk and asset management software.

Based upon the testing completed, it is the Auditor's Opinion that the current design and operation of controls provides Limited Assurance. The audit was carried out in line with the scope set out in the approved Audit Planning Record. The Opinion is based upon testing of the design of controls to manage the two risks about which the Client sought assurance.

WELLAND INTERNAL AUDIT CONSORTIUM
Rutland County Council

Internal Audit Assurance Opinion	Direction of Travel				
Limited Assurance	N/A				
Risk	**Design**	**Comply**	**Recommendations**		
			H	**M**	**L**
Risk 1: Theft, loss and misuse of Council ICT equipment and data.	**Sufficient assurance**	**Limited assurance**	1	1	0
Risk 2: Failure to manage the software in use on ICT equipment across the Council.	**Limited assurance**	**Limited assurance**	1	0	0
Total Number of Recommendations			**2**	**1**	**0**

2. SUMMARY OF FINDINGS

Risk 1: Theft, loss and misuse of Council ICT equipment and data

The Council has appropriate directive guidance available to IT staff in order to support the effective management of assets; including the safe and secure disposal of redundant assets. The 'Asset Database Procedures' document was prepared in December 2012 and last revised in September 2013.

At present all IT officers have access to the database and are responsible for updating it at each stage of an asset's lifecycle. Assets should be physically tagged and allocated a unique number; however a review of the database confirmed that seven items on the ICT asset database did not contain details of a tag. During a review of fixed assets it was noted that the council's printers had not been tagged or recorded on the ICT Asset Database. The database contains appropriate data-fields to assist ICT in locating items or identifying the age or value of assets. Details of the assets are also entered onto the 'Land Desk' Management system which enables the IT team to locate or view details of devices connected to the RCC Corporate network. Internal Audit testing did, however, identify significant gaps in record keeping.

A review of records established that as part of a project to upgrade machines, at the time of audit, the IT team were trying to trace the location of 9 PCs and 12 laptops.

Internal Audit testing also identified inaccuracies in the asset database as follows:

- Of a sample of 30 portable devices selected, 10% could not be verified as user details had not been recorded on the asset database.
- Of the 18 responses received from portable device users, 28% did not agree to details regarding status and allocated users as recorded on the database.
- Of a sample of 40 fixed assets reviewed, 17.5% of the sample had not been recorded on the asset database (consisting of telephones and printers), a further 20% of items had been recorded on the database however an inaccurate location or status was specified (items included a PC, a storage area network device, servers and monitors). The remaining 62.5% of items reviewed were found to be accurately recorded.

The structure and content of the database was comprehensive. A review of the content, however, identified 20 duplicate tag numbers, of which 9 were assigned to multiple items and 11 were double entries.

There are 326 'deployed' assets recorded with unspecified locations (e.g. laptop user/remote user/blank cell) of which 32 did not have a specific user assigned to the asset. Of the 2880 items recorded, 2078 (91%) of the items did not contain an asset value.

There is a formal process in place for HR to notify the IT team of starters and leavers; however the ICT asset database is not periodically reconciled to current HR or Member records. The absence of periodic reconciliations

to HR or Member records increases the risk of failing to identify any stock is not returned to the Council. The 'Asset Database Procedures' document states that an annual stock take audit will take place but it was confirmed that, due to staff changes, this has not been completed for 2014/15.

The IT Support Officer interviewed during the audit was aware of the procedures to be followed for purchasing assets including software; these procedures have also been formally documented in the ICT Security Policy which all staff must review as part of their induction to the Council. The procurement of assets, including software, is controlled through the Council's financial procedures which have been tested in the financial audits undertaken during 2014/15.

Risk 2: Failure to manage the software in use on ICT equipment across the Council

The Council's arrangements to effectively manage software usage are currently limited. IT management are aware of this and are intending to review the process as part of the IT service and strategy review.

It was asserted that an annual Microsoft reconciliation takes place in order to confirm that the number of users complies with the terms of the software licence. A review of documentation confirmed that this is currently taking place for 2014/15, with a completion date of May 2015. The Council does not currently maintain a software applications register which contains details of the application and its corresponding licence details (e.g. expiry dates, usage restrictions). It was therefore not known at the time of audit, without viewing actual licence documentation, whether any of the Council's other software applications have usage restrictions.

It was also confirmed that with the exception of Microsoft, use of software applications is not periodically checked by IT and reconciled to the license terms in order to monitor over or under-usage.

ACTION PLAN

Risk 1: Theft, loss and misuse of Council ICT equipment and data							
Rec No.	ISSUE	RECOMMENDATION	Management Comments	Category	Officer Responsible	Due date	WP Ref
1	Internal Audit testing identified inaccuracies in the asset database, as follows: • Of a sample of 30 portable devices selected, the details and location of10% could not be verified as user details had not been recorded on the asset database. • Of18 responses received from portable device users, the status, location or user details for 28% did not agree to details recorded on the database. • Of a sample of 40 fixed assets reviewed, 18% had not been recorded on the asset database (consisting of telephones and printers), a further 20% of items had been recorded on the database however an inaccurate location or status was specified (items included a PC, a SAN, servers and monitors). • During a review of fixed assets it was noted that the council's printers had not been tagged or recorded on the ICT Asset Within the asset database, 20 duplicate tags were identified, 9 of which had been assigned to multiple items and the remaining 11 appeared to be double entries. There are 326 'deployed' assets recorded with unspecific locations (e.g. laptop user/remote user/blank cell) of which 32 did not have a specific user assigned to the asset. Of the 2,880 items recorded, 2,078 (91%) of the items did not contain an asset value.	IT staff should be reminded of the importance of updating the database correctly as and when there are changes made. IT Management should review the database to confirm whether this is being fully completed. The errors and missing details highlighted during the testing should be investigated and resolved. In future, the value of any assets acquired should also be recorded.	Database will be reviewed in the near future with the team to highlight where this is being kept up to date and the implications of this. The intention is then for a full site audit to be conducted to ensure this is up to date before a new process is put in place so it will be kept up to date.	H	Interim Head of ICT and Performance & Applications Support Team Manager	30 Sept 2015	01.01.02 & 01.01.03

Risk 1: Theft, loss and misuse of Council ICT equipment and data							
Rec No.	ISSUE	RECOMMENDATION	Management Comments	Category	Officer Responsible	Due date	WP Ref
2	The ICT Asset database is not periodically reconciled to current HR or Member records. The 'Asset Database Procedures' document states that an annual stock take audit will take place. It was confirmed that, due to staff changes, this has not been completed for 2014/15.	IT to ensure that annual stock-checks and reconciliations to current staff and member records are undertaken.	Full audit of assets will be completed during Q2.	M	Interim Head of ICT and Performance & Applications Support Team Manager	30 Sept 2015	01.01.01

Risk 2: Failure to manage the software in use on ICT equipment across the Council.							
Rec No.	ISSUE	RECOMMENDATION	Management Comments	Category	Officer Responsible	Due date	WP Ref
3	The Council does not currently maintain a software applications register which contains details of all software applications and their corresponding licence details (e.g. expiry dates, usage restrictions). It was therefore not known at the time of audit, without viewing actual licence documentation, whether any of the Council's software applications, other than Microsoft, have usage restrictions. With the exception of Microsoft, usage of software applications and licence details is not periodically reconciled to licence information in order to monitor over or under-usage.	A software applications register should be established and maintained which clearly details software installed and corresponding licensing details and restrictions. Checks should also be conducted at the appropriate frequency to monitor over and under-usage, and to mitigate the risk that software terms and conditions are breached. Evidence of such reconciliations must be retained on file.	Agreed, currently software management system is being reviewed as part of ongoing IT review.	H	Interim Head of ICT and Performance & Applications Support Team Manager	30 Sept 2015	02.04.06 &02.04.07

GLOSSARY

The Auditor's Opinion

The Auditor's Opinion for the assignment is based on the fieldwork carried out to evaluate the design of the controls upon which management relay and to establish the extent to which controls are being complied with. The table below explains what the opinions mean.

Level	Design of Control Framework	Compliance with Controls
SUBSTANTIAL	There is a robust framework of controls making it likely that service objectives will be delivered.	Controls are applied continuously and consistently with only infrequent minor lapses.
SUFFICIENT	The control framework includes key controls that promote the delivery of service objectives.	Controls are applied but there are lapses and/or inconsistencies.
LIMITED	There is a risk that objectives will not be achieved due to the absence of key internal controls.	There have been significant and extensive breakdowns in the application of key controls.
NO	There is an absence of basic controls which results in inability to deliver service objectives.	The fundamental controls are not being operated or complied with.

Category of Recommendation

The Auditor categorises recommendations to give management an indication of their importance and how urgent it is that they be implemented. By implementing recommendations made managers can mitigate risks to the achievement of service objectives for the area(s) covered by the assignment.

Category	Impact & Timescale
HIGH	Management action is imperative to ensure that the objectives for the area under review are met.
MEDIUM	Management action is required to avoid significant risks to the achievement of objectives.
LOW	Management action will enhance controls or improve operational efficiency.

Limitations to the scope of the audit

The Auditor's work does not provide any guarantee against material errors, loss or fraud. It does not provide absolute assurance that material error; loss or fraud does not exist.

AUDIT PLANNING RECORD

Client	Debbie Mogg - Director of Resources
Assignment	ICT Asset Management

OBJECTIVES, BACKGROUND, RISKS AND CONTROLS

Critical Objectives for the area under review	An accurate and complete ICT Asset Register allows the ICT Team to exercise effective control over ICT equipment owned by the Council. This should include complete and accurate records of ICT equipment and software applications.
Background Information	The IT Audit Plan for 2014/15 has been developed to support the review of the Council's IT service and the development of an IT strategy. Responsibility for maintaining the Council's ICT assets lies with the in-house ICT team.

RISK 1	Theft, loss and misuse of Council ICT equipment and data.
Risk Description	The Council does not maintain an up to date record of ICT equipment so it is not known what ICT equipment is owned and its location. The Council is unaware of loss or theft of ICT equipment. ICT equipment is not suitably maintained. There is no procedure for procurement, disposal and disabling of ICT equipment. The Council is not able to respond to FOI requests about the Council's ICT assets.
Risk Source	Internal Audit
Sources of Assurance	Central record of each piece of ICT equipment held which includes all purchases and disposals, policy on central purchasing, financial controls to promote central spending of ICT budgets, periodic reconciliation of central record with actual equipment, controls to identify assets in need of updating/replacing.
	Preventive and Detective controls

RISK 2	Failure to manage the software in use on ICT equipment across the Council.
Risk Description	There are no procedures for procuring and installing software on the Councils network. The Council does not maintain records of software installed or details of software licences purchased. Terms and conditions of software licences are breached because an annual software to software licence reconciliation exercise is not undertaken to check under/over usage. The Council is unable to respond to FOI requests about the Council's software arrangements.
Risk Source	Internal Audit
Sources of Assurance	Software applications register and licensing information, annual reconciliation of licenses to number of users, Council procedures for procuring and installing software applications, controls to prevent unauthorised software installations on Council equipment.
	Preventive and Detective controls
Risk Source	Internal Audit

SCOPE OF ASSIGNMENT

Areas to be covered	The assignment will cover the completeness and accuracy of records relating to hardware; software; and data storage media.
Audit objective	To provide assurance that the ICT asset management arrangements are fit for purpose and registers are complete and accurate.
Audit approach	The Auditor will identify the controls in place to ensure that the Asset Register is maintained as an accurate document and carry out testing (on a sample basis where appropriate) sufficient to confirm the effectiveness of those controls. Accuracy and completeness of the controls for the management of software licenses will also be reviewed.
Benchmarking	N/A
Joint Reviews	N/A
Limitations to the scope	The Consortium's work does not provide absolute assurance that material error; loss or fraud does not exist.
Additional Client Comments	

REQUIRED DOCUMENTS & RECORDS

To enable us to commence our fieldwork we will require has access to the following information or records.
Access to or a copy of the asset register and software applications register.

MANAGING THE ASSIGNMENT

Client Sponsor	Debbie Mogg – Director of Resources
Distribution of ToR	Debbie Mogg – Director of Resources Mark Poole – Head of IT Jason Haynes – Performance and Application Support Team Manager Sav Della Rocca – Assistant Director of Finance and s151 Officer
Auditors	Lucy Fernandez – Internal Auditor
Audit Start Date	March 2015
Fieldwork Completion Date	March 2015
Draft Report Due	March 2015
Final Report Due	March 2015
Budget	**15 days**

CLEARING THE AUDIT REPORT

Distribution of Draft Report	Mark Poole – Interim Head of IT Jason Haynes – Performance and Application Support Team Manager
Discussion Window	1 week
Issue Executive Report to Client Sponsor	Within 1 week of draft report being agreed.
Agreed Circulation of Executive Report	Debbie Mogg – Director of Resources Sav Della Rocca – Assistant Director of Finance and s151 Officer Mark Poole – Head of IT Jason Haynes – Performance and Application Support Team Manager

QUALITY ASSURANCE

Document prepared by	L. Fernandez – Internal Auditor
Date	02/03/15
Document Reviewed by	R Ashley-Caunt – Interim Head of Internal Audit
Date	02/03/15
Agreed by (Client Sponsor)	D Mogg (email)
Date	16/03/15

REPORT NO: 109/2015

AUDIT AND RISK COMMITTEE

30 June 2015

ANNUAL GOVERNANCE STATEMENT

Report of the Director for Resources

Strategic Aim:	**All**	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor King – Portfolio holder for Places (Development and Economy) and Resources	
Contact Officer(s):	Debbie Mogg, Director for Resources	Tel: 01572 758358 dmogg@rutland.gov.uk
	Saverio Della Rocca, Assistant Director - Finance	Tel: 01572 758159 sdrocca@rutland.gov.uk
Ward Councillors	Not Applicable	

DECISION RECOMMENDATIONS
1. That the Committee considers whether the Annual Governance Statement (AGS) fairly represents the governance framework at place in the Council and advises on whether there are any issues it would wish to see addressed or expanded upon in the Annual Governance Statement.

1. PURPOSE OF THE REPORT

1.1 To meet the statutory requirement for the Council to approve an AGS for inclusion in its published Statement of Accounts for 2014/15. In advance of formal approval in September, the Committee is invited to consider an early draft.

2. BACKGROUND AND MAIN CONSIDERATIONS

2.1 When publishing its statement of accounts (SoA), the Council is required by regulation 4(3) of the Accounts and Audit Regulations 2011 to consider and approve an AGS. The function is delegated to this Committee. CIPFA guidance suggests that the Committee considers a version of the Statement in advance.

2.2 The draft is (attached as Appendix A) sets out the Council's responsibilities, the purpose of the governance framework, a description of the governance

framework itself, illustrated by examples, and its effectiveness.

2.3 The governance framework is designed to facilitate the achievement of the Council's aims and objectives and policies, identifying and managing any risks to a reasonable level. The framework is embedded in the Constitution and the policies, procedures, operations and systems in place.

2.4 The review of the effectiveness of the governance environment is informed by a number of methods, including internal and external audit, and consideration by Council, Cabinet and Scrutiny Panels, and assurance statements given by service managers in respect of their areas of responsibility. As part of the review of effectiveness, the Council must disclose the actions any significant governance issues in relation to the Council achieving its vision.

2.5 While it is for individual authorities to judge whether a matter is significant, the following tests might indicate a significant issue:

- Might the issues seriously prejudice or prevent achievement of a corporate target?
- Could the issue have a material impact on the accounts?
- Could the issue divert resources from another important aspect of the business?
- Does the Audit and Risk Committee advise it is significant?
- Does internal or external audit regard it as significant?
- Could the issue, or its impact, attract significant public interest, or seriously damage the reputation of the organisation?

2.6 Whilst Internal Audit and other reviewers have indicated that there are areas where internal controls must be improved, there are no significant areas of weakness identified that fall into any of the above categories. The Internal Auditors themselves have given a positive opinion on the internal control framework. The Committee should consider, based on its knowledge, whether there are any significant areas of the governance framework which it believes are not working appropriately.

2.7 The AGS needs to be submitted to the external auditor with the Statement of Accounts by 30 June 2015 and needs to be approved with the accounts by this Committee before 30 September 2015. The Section 151 Officer is responsible for preparing the Statement of Accounts for submission, but the AGS is signed by the Leader and the Chief Executive following the approval of this Committee. The external auditor will check the format of the AGS and whether its content is consistent with his understanding of the authority.

2.8 Should any issues come to light before the date of sign off, the AGS will be amended accordingly.

3. CONSULTATION

3.1 The Annual Governance Statement has been reviewed by Senior Management team and the Governance Group. Other officers have contributed to parts of the Statement.

4. ALTERNATIVE OPTIONS

4.1 At this stage the Committee is being asked to provide comment so alternative options are not appropriate.

5. FINANCIAL IMPLICATIONS

5.1 There are no financial implications arising from this report.

6. LEGAL AND GOVERNANCE CONSIDERATIONS

6.1 The Audit and Risk Committee is responsible for reviewing the Annual Governance Statement.

6.2 There are no legal implications arising from this report.

7. EQUALITY IMPACT ASSESSMENT

7.1 Equality Impact Assessment (EqIA) screening has been completed and there were no issues arising. A full Impact assessment has not been carried out.

8. COMMUNITY SAFETY IMPLICATIONS

8.1 There are no community safety implications.

9. HEALTH AND WELLBEING IMPLICATIONS

9.1 There are no health and wellbeing implications.

10. CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

10.1 The Committee plays an important role in the oversight of the corporate governance framework. Its review of the Annual Governance Statement on behalf of the Council provides an independent assurance to the Chief Executive and Leader.

11. BACKGROUND PAPERS

None

12. APPENDICES

Appendix A – Draft Annual Governance Statement

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577.

APPENDIX A DRAFT ANNUAL GOVERNANCE STATEMENT

1. Scope of Responsibility

Rutland County Council ("the Council") is responsible for ensuring that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively. The Council also has a duty under the Local Government Act 1999 to make arrangements to secure continuous improvement in the way its functions are exercised, having regard to a combination of economy, efficiency and effectiveness.

In discharging this overall responsibility, the Council is responsible for putting in place proper arrangements for the governance of its affairs, facilitating the effective exercise of its functions, which includes the arrangements for the management of risk.

The elements of the CIPFA/SOLACE Framework Delivering Good Governance in Local Government are embedded throughout the Council's Constitution and other strategies. This statement explains how the Council has complied with the framework and also meets the requirements of regulation 4(3) of the Accounts and Audit (England) Regulations 2011 in relation to the publication of an Annual Governance Statement.

2. The Purpose of the Governance Framework

The governance framework comprises the systems, processes, culture and values by which the Council is managed and controlled and its activities through which it accounts to, engages with and leads the community. It enables the Council to monitor the achievement of its strategic objectives and to consider whether those objectives have led to the delivery of appropriate, cost-effective services.

The system of internal control is a significant part of that framework and is designed to manage risk to a reasonable level. It cannot eliminate all risk of failure to achieve policies, aims and objectives and can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the Council's policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically by identifying and implementing measures to reduce the likelihood of the risks being realised and to negate or mitigate their potential impact.

The governance framework has been in place at Rutland County Council for the year ended 31 March 2015 and up to the date of approval of the statement of accounts.

3. The Governance Framework

Vision, Aims and Objectives

A clear statement of the Council's purpose and vision is set out in its Sustainable Community Strategy, the most recent revision of which was approved in July 2010. The Strategy was developed with Rutland Together, the local strategic partnership, and involved consultation with key stakeholders and the wider community.

The Council's strategic aims, which are reviewed and refreshed by Cabinet and Council generally on an annual basis, provide a clear set of priorities against which the Council can allocate resources and are supported by clear accountability for delivery. A revised set of strategic aims and objectives was approved by the Council in April 2012. The financial implications of implementing the agreed priorities were incorporated in the Medium Term Financial Plan ("MTFP") approved in February 2013 and then kept under review. The MTFP was updated in February 2015. Appropriate provision for continuing to implement the Council's priorities has been included in the budget for 2015/16.

The key priorities for 2014/15 included:

- Delivering a balanced MTFP;
- Undertaking a comprehensive review of the People Directorate with a view to resetting priorities and reshaping service provision in light of continued financial challenges;
- Planning for the implementation of the Care Act from 1 April 2015;
- Working with East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG) through the Health and Well Being Board to develop a Better Care Fund plan for integrating social and health care services;
- Targeting steps to achieve local economic growth;
- Developing a Learning Strategy for the new Education environment; and
- Continuing to implement capital projects, in particular Oakham Enterprise Park and Digital Rutland.

These priorities have been addressed against a backdrop of other significant changes affecting the Council and the county.

Constitutional Arrangements

The Constitution defines the roles and responsibilities of the Council, Cabinet, Committees and Scrutiny Panels and provides for extensive delegation to officers. Policy and decision making are facilitated by a clear framework of delegation set out in the Council's Constitution. Delegation arrangements were renewed at the Annual Council Meeting in May 2013. The exercising of delegated powers is regulated by Financial Procedure Rules, Contract Procedure Rules and other policies and procedures.

The Constitution is kept under review by a working group of members appointed by the Council. The working group recommends amendments to the Constitution to the Council as and when it considers it appropriate.

During 2014/15 the work included:

- A rewrite of the Financial Procedure Rules which were approved by Full Council in March 2015;
- Amendments to planning delegations which were approved in October 2014;
- Amending the constitution so that only the members of the Strategic Management Team are subject to appointment by the Chief Officer Appointment Committee;
- Revisions to the model planning code which were approved in February 2015; and
- Recommending an increase to the quorum of Development Control and Licensing Committee from three members to five members which was approved in February 2015.

The working group also contributed to the Community Governance Review regarding the future of the Parish of Horn. The Terms of Reference were produced and presented to the Group in

December 2014 and formal consultation then began. The key recommendation of the community governance review was to amalgamate both parishes into a new parish called Exton and Horn.

The Audit and Risk Committee undertakes the core functions of an audit committee, in accordance with CIPFA's Audit Committees – Practical Guidance for Local Authorities and this is set out in the Committee's terms of reference, which include the Council to act as those charged with governance on behalf of the Council.

Decision Making Arrangements

The officer structure of the Council operates with a Chief Executive and three Directorates, titled People, Places and Resources.

The usual course taken by a matter which requires a decision to be made by members is that it is considered by the relevant Directorate Management Team which will make a recommendation to the Strategic Management Team, which comprises the Chief Executive, Directors and Assistant Directors, and before the matter is reported, with a recommendation, to the Cabinet or other appropriate body.

The Director of Resources is designated as the Council's Monitoring Officer under the Local Government and Housing Act 1989. All reports to a decision making body must be considered by the Head of Legal (under a shared service arrangement with Peterborough City Council) before they are submitted. This is to ensure compliance with relevant laws and regulations, internal policies and procedures and that expenditure is lawful.

In accordance with the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012, decisions made by officers following express delegation by the Cabinet are recorded in writing.

Governance

In 2014/15, the Council established a Governance Group to provide a forum for officers of the Council to discuss and develop a coordinated approach to:

1. Risk management;
2. Corporate governance;
3. Statutory and constitutional compliance;
4. Decision-making and accountability;
5. Audit, inspection and control systems; and
6. Corporate policy and procedures

The focus of the Group is upon the Council and also the partnership bodies on which it serves as a member. The group works under the broad direction of the Strategic Management Team and comprises officers from across the Council. To date, the Group has focused on raising awareness of changes in legislation affecting governance matters and promoting compliance with existing policies and procedures in areas like data management, changes to the transparency code etc.

Performance Management

The Council has a performance management framework through which quality of service and use of resources is measured. Financial and non-financial performance is monitored by Directorate Management Teams and Strategic Management Team on a regular basis and is formally reported to Scrutiny Panels and Cabinet on a quarterly basis. Progress against the strategic aims is measured in milestones and this is included in quarterly monitoring reports. The performance management framework flows through the Council, down to an individual employee level. All officers have a Performance Development Review with their manager during each year. This process includes reviewing progress against objectives and targets.

Cabinet takes the lead role in improving the performance management framework and maintaining comprehensive quarterly reporting that includes financial performance, progress against non-financial targets and milestones, and risk management. The framework changed for 2014/15 in two aspects: a new key project list with progress updates was added to each report as was a public health performance dashboard.

Financial Management

The Assistant Director - Finance is designated as the responsible officer for the administration of the Council's financial affairs under section 151 of the Local Government Act 1972.

The CIPFA Statement on the Role of The Chief Financial Officer in Local Government sets out the five principles that need to be met to ensure that the Chief Financial Officer can carry out the role effectively. The principles are that the Chief Financial Officer:

- Is a key member of the leadership team;
- Must be actively involved in all material business decisions;
- Must lead the promotion and delivery of good financial management;
- Must lead and direct a finance function that is resourced to be fit for purpose; and
- Must be professionally qualified and suitably experienced.

The Assistant Director - Finance is a member the Council's Strategic Management Team and is actively involved in the key business decisions of the Council. The Assistant Director oversees the development and work of the financial management function at the Council and is the Council's proper officer for matters of financial administration. The post holder is professionally qualified as a CIPFA Accountant with suitable experience. It is therefore confirmed that the Council is fully compliant with the requirements set out in the CIPFA statement (at 3.17 above).

The Council's MTFP covers a five year period. Such an approach to financial planning provides the platform by which the Council can look to deliver public services in accordance with local priorities. Moreover, through 'scanning the horizon' and anticipating necessary change at the earliest opportunity, the Council can plan and react accordingly to not only secure its financial position but to protect services.

The MTFP was updated throughout 2014/15 and periodically reported to Cabinet. The updated MTFP, following the Local Government Settlement, was presented to each Scrutiny Panel by the Leader and to Council on 17 February 2014 as part of the budget setting process for 2014/15. Members have up-to-date financial information about not only the current but also the medium term outlook for decision making purposes.

In their Annual Governance report issued in September 2014, the external auditors concluded that the Council has made proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

The Council has a set of Financial Procedure Rules and Contract Procedure Rules within its Constitution which govern the way in which financial matters are conducted. The Contract Procedure Rules were reviewed during 2013/14 and the Financial Procedure Rules have been reviewed, updated and will be implemented from 1 April 2015. To support the new rules and financial governance in general, the Council has run training sessions and developed an e-learning module for those involved in financial management.

Risk Management

Risk Management is embedded in the Council through the Risk Management Strategy. The Council maintains a Strategic Risk Register, linking risks to strategic aims and assigning ownership to each risk. The Deputy Leader is the lead member for risk management. The Strategic Management Team is responsible for maintaining an up-to-date register of strategic risks and monitoring the actions taken to mitigate them. Risk Management reports are occasionally presented to Audit and Risk Committee or Scrutiny Panels.

The key development in 2014/15 was the development of a new fraud risk register which was reported to Audit and Risk in January 2015. This set out a list of potential fraud risks and details of how the Council seeks to mitigate them. This will be kept up-to-date and reported to Audit and Risk Committee.

Risk Management is an integral part of the Council's decision making processes. All Council papers include reference to risk and set out an impact analysis that helps members and officers understand the impact of decision-making. In late March 2015, the Council developed a new reporting template which requires more explicit reference and commentary in relation to how specific risk issues related to decisions. This template was accompanied by a report writers guide for Officers.

In relation to overall risk management arrangements, the Council has been in dialogue with its insurance advisors to review existing arrangements, refresh its strategy and update undertake risk management awareness training.

Standards of Conduct

The behaviour of elected members is regulated through a Code of Conduct. The Code changed in July 2012 as a result of provisions in the Localism Act 2011. The previous ethical standards regime was set up by the Local Government Act 2000 and required all members to sign up to a model code of conduct upon election to the Council. This was a national code, approved by Parliament. The Localism Act required councils to adopt their own code of conduct and establish local arrangements for dealing with complaints of a member breaching the code.

The Council adopted a Code of Conduct and local arrangements which came into effect on 1 July 2012. A Conduct Committee has been set up in place of the former Standards Committee. Two Independent Persons have been appointed by the Council to provide independent support to members and the Monitoring Officer. Training is provided to members periodically to ensure that they are fully aware of their responsibilities. In particular, such training is included as a mandatory element in the induction programme for newly-elected members.

The Conduct Committee reviewed and made recommendations (which were agreed) to March Council to revise the Code of Conduct to ensure that it met the revised definitions of the general principles of conduct (the Nolan principles) provided by the Committee for Standards in Public Life.

A register of members' interests is maintained and published on the Council's website. The requirements in this regard also changed in July 2012. Members continue to register and amend their declarable interests as appropriate.

Employees are also subject to a Code of Conduct and a number of specific policies (such as Harassment, Discrimination and Bullying) set out in the Corporate Induction Portfolio. All new members of staff receive one to one induction training with their line manager and attend an induction training session.

The Officer Code of Conduct was updated in 2013/14 and required no changes in 2014/15. . All new members of staff are required to sign up to the new code and it is covered as part of the induction process.

Information Governance

The Council has introduced a number of safeguards to ensure the appropriate use of information it holds. All employees have undertaken mandatory training to ensure they are compliant with data protection legislation and good practice.

Enhancements to current processes such as Subject Access Requests have been made to ensure customers are able to access the information they are legally entitled to. A Governance Coordinator post has been introduced to review current processes and develop strategies for improvement in corporate Privacy Notices and Data Sharing arrangements. The Council has also implemented a Data Incident Response Protocol. This document provides a clear framework in which Members and Officers should operate in the event of a data incident.

Data Retention is the next key area to be reviewed as part of the overall Information Governance strategy.

Counter-fraud, Whistleblowing and Complaints

The Council has arrangements in place for receiving allegations of fraud or misconduct through its whistle-blowing policy. All members of staff are made aware of this policy through the induction programme and it is publicised through the staff bulletin and intranet.

The Council was the victim of a fraud in the year. The Council received a fraudulent letter asking for a genuine suppliers bank details to be updated. The letter was not deemed to be suspicious and was processed. This resulted in a number of payments being made to a false account. A report was taken to Audit and Risk Committee setting out how the Council has strengthened procedures in response to this issue. The Council also developed a fraud risk register as part its wider response to mitigating fraud and corruption.

The Council recognises the importance of customer complaints and welcomes complaints as a valuable form of feedback about its services. There is a formal compliments and complaints procedure which enables the Council to respond to complaints but also to use the information it receives effectively, to help drive forward improvements. A new process came into effect on 1st January 2015. The Council also developed a Children's and Adults Social Care protocol which

sits under the corporate complaints policy and provides further detail on responding to matters in these areas.

Developing Effectiveness

Individual officers have a Performance Development Review annually with opportunities for interim reviews. This process includes identifying training and development needs. In addition, members of staff have regular, planned, one-to-one meetings with their manager.

The Council has developed a Corporate Training Programme that is driven by the Performance Framework. The programme has three strands:

- Mandatory/priority training – essential in order to perform role/deliver service;
- Organisational Development/Corporate Improvement – key themes linked to Leadership Behaviours and Values; and
- Core Skills – Finance, Governance, IT, Health and Safety

Members are provided with development opportunities through in-house and external training and briefings. There is mandatory training on the Code of Conduct, development control, licensing and appeals. Members are encouraged to express an interest in receiving training on specific topics.

In 2014/15 Member training was provided on:

- The Care Act
- Safeguarding/Corporate Parenting
- Standards & Conduct
- Conduct & Ethics
- Childhood Sexual Exploitation
- Plus other regulatory training prior to committees such as Audit & Risk.

Budget provision is made for training and development of members and officers.

Service Delivery

The Council uses a variety of service delivery models. It has a number of key services such as refuse collection and highways which are outsourced. It is also part of many successful partnerships, including a pooled budget with Leicester City Council, Leicestershire County Council and the three Clinical Commissioning Groups covering Rutland and Leicestershire for Adult Social Care service and the Children's Trust. Along with other authorities in the Welland Partnership, the Council has a shared Internal Audit Service (for which it is the lead Council) and joint Procurement Unit. Further shared services arrangements have been implemented, covering public protection services, legal services and benefit fraud investigations. The Council works in partnership with other local authorities and public agencies through the Leicester, Leicestershire and Rutland Local Resilience Forum to prepare for, and respond to, civil emergencies.

The cost of the Council's services continues to be relatively low as evidenced by cost profiles produced by the Audit Commission. Nevertheless, the Council continues to review how services should be delivered and this was a key part of its budget deliberation for 2015/16.

One of the Council's key projects in 2014/15 was the review of the People Directorate called **PeopleFirst** which was originally commissioned by Council in January 2014. The objectives of the review were to:

- put in place a vision for the future of service delivery for the Directorate within the over-arching One Council Vision
- propose a commissioning strategy to support the vision
- recommend a structure to support the commissioning strategy
- undertake the appropriate consultation
- deliver on-going savings on the cost base of the People Directorate

The review included a detailed look at all services provided by the People Directorate and considered the rationale for the provision of services, options for delivering services differently and improving performance/reducing cost. The review also included significant stakeholder engagement for 7 weeks from 28th April – 13th June.

The conclusions of the review were presented to Council in September 2014 and identified a number of recommendations/lines of enquiry that could save the Council in the region of £1.5m over the term of the Medium Term Financial Plan (3-5 years). This included restructuring the Directorate, working up opportunities to integrate services with health, redirecting Public Health monies, focusing service provision on those in greatest need and exploring the opportunity to charge for some services.

Community Engagement, Partnership working and Reporting

Rutland Together

The Council engages with the local community in different ways. Rutland Together is the Local Strategic Partnership (LSP) for Rutland. The Partnership was established to bring together all of those people and bodies whose work impacts on the lives of local people.

The partnership has gone through radical changes since its beginning; this is due to political changes over the years which have affected the partnerships direction of travel. Rutland Together is made up of over 50 partners from the public, private and voluntary sectors. Rutland Together allows different organisations in the community to support each other and work together on different initiatives and services to address local issues.

Better Care Together and the Better Care Fund

Better Care Together (BCT) is a significant programme of work which will transform the health and social care system in Leicester, Leicestershire and Rutland (LLR) by 2019. BCT brings together partners in Health and Local Government, including the Council, to ensure that services change to meet the needs of local people. The programme is also working closely with public and patient involvement (PPI) representatives to develop plans for change.

Two of the key issues we need to address relate to the ever increasing demand on social and health care services and the fact too many people find themselves in hospital and residential care. This is often because we have not done enough to keep them well and supported in the community before hospital and/or residential care becomes the only option.

The BCT vision is for a local health and social care system that supports our community through every stage of life. More information can be found at:

http://www.bettercareleicester.nhs.uk/EasysiteWeb/getresource.axd?AssetID=32078

Officers and Members of the Council are working across LLR to integrate reform and transform services. As part of this work, the government has set up the Better Care Fund – this is a budget to improve the ways health services and social care services work together, starting with services for older people and people with long term conditions. The Council and ELRCCG have submitted a Better Care Fund plan; this has now been fully approved by NHS England. The two organisations' are working closely to develop implementation plans for integrating health and social care services.

We report to the Health and Wellbeing Board on a regular basis to present our developing project plans, and report on expenditure and progress against the performance metrics as set out by government. More information can be found here

Other engagement

The Council undertakes public engagement and consultation on a range of matters. In 2014/15 this included:

- consultation in relation to PeopleFirst as described above;
- a business summit held in partnership with the Local Enterprise Partnership to raise awareness of the support available locally;
- annual budget consultation about future levels of council tax. In respect of the budget, public consultation took place through the Council website, was promoted through Twitter, and a small display at Rutland libraries. Presentations were also made to local businesses and council employees;
- a statutory review of the polling districts, places and stations was undertaken starting on 17 November 2014 until 12 December 2014 with final recommendations being presented to full Council on 31 January 2015; and
- a Community Governance Review was undertaken in December 2014 to February 2015 with a final report to full Council in March 2015 in order to determine the future of the parish area of Horn. All residents of Horn were contacted via letter along with the neighbouring parish council, ward councillors and council officers. The resulting decision merged the parish area of Horn with that of the Exton parish area.

Reporting

All formal meetings are held in public, and the reports and minutes of those meetings are published on the Council's website, unless there are legal reasons for confidentiality. There are opportunities for members of the public to make deputations to, or ask questions at, meetings of the Council, Committees and Scrutiny Panels.

The Council publishes information relating to all of its expenditure on its website and also complies with the Local Government Transparency Code 2015 which sets out the minimum data that local authorities should be publishing and the frequency it should be published and how it should be published. The information published can be found here.

http://www.rutland.gov.uk/council_and_democracy/transparency_code_2014-15.aspx

4. Review of Effectiveness

The Council has responsibility for conducting, at least annually, a review of the effectiveness of its governance framework including the system of internal control. The review of its effectiveness is informed by the work of the senior managers within the Council who have responsibility for the development and maintenance of the governance environment, the Head of Internal Audit's annual report, and also comments made by the external auditors and other review agencies and inspectorates.

Internal and Management assurance

Internal Audit

The responsibility for maintaining an effective Internal Audit function is set out in Regulation 6 of the Accounts and Audit (England) Regulations 2011. This responsibility is delegated to the Assistant Director - Finance. The Internal Audit service operates in accordance with best practice professional standards and guidelines. The service independently and objectively reviews, on a continuous basis, the extent to which the internal control environment supports and promotes the achievement of the Council's objectives, and contributes to the proper, economic, efficient and effective use of resources.

The Internal Audit service is provided by the Welland Internal Audit Consortium. The former Head of Consortium retired in August 2014 having implemented an improvement plan following an independent external review undertaken in 2013/14. From August 2014, the Consortium has been working with Local Government Shared Services (LGSS) to manage the Internal Audit service.

In 2014/15 the Consortium completed 22 assurance assignments, each providing an assurance opinion over the design and effectiveness of the control framework in place – 18 of these were rated as 'Substantial' or 'Sufficient' assurance and 4 as 'Limited' assurance. The reports providing an opinion of Limited Assurance related to the Agresso system, Safe Driving at Work, ICT Asset Management and Client Finances – Court of Protection and Deputyships. Each Limited assurance report is presented to the Audit and Risk Committee with separate follow up on actions taken by management to address the areas of concern.

Members receive an annual report of Internal Audit activity and approve the Audit Plan for the forthcoming year. For the year 2014/15, it is the opinion of the Head of the Welland Internal Audit Consortium that Sufficient Assurance can be taken from the Council's control environment. At least Sufficient assurance was provided over audits of the key financial system controls for Payroll, Creditors, Debtors, Local Taxation and Benefits.

Scrutiny

During 2014/15 the Scrutiny Panels have considered a number of issues of particular concern to satisfy members that there are robust governance arrangements in place as far as the Council's own services are concerned. These include: development of the People First Review, implications of the Care Act and Better Care Fund, CQC Inspection reports, Safeguarding Children and Adults, Corporate Parenting; Learning and Skills Strategy, School Improvement Plan, Parking Review, Community Infrastructure Levy, Economic Growth Strategy; Legal Services, ICT Services, Corporate Support Team, Complaints Policy and Discretionary Relief Policy.

Each Scrutiny Panel has produced an annual scrutiny report presented to Council in March.

The Scrutiny Commission conducted a review of the work that scrutiny carries out and a number changes were identified which will improve the reporting pathway to Cabinet and Council, the support provided to Chairs and working groups and the presentation of officer reports to Panels. Further suggestions will be considered by the new Scrutiny Commission.

Performance

The end of year report was presented to Cabinet in June 2015. In summary, the report states that 94% of KPI targets were on target and 6% were below target.

Business Continuity Exercise

Specific recovery plans are in place for the 5 key threats listed below.

- loss of key staff (skills/knowledge);
- loss of telephone system;
- loss of buildings;
- loss of ICT; and
- loss of utilities.

An exercise was carried out on 9th October 2014 with senior managers across the authority to test the plans. This exercise was successful but highlighted some areas for improvement. Officers have reviewed and revise the recovery plans following the exercise. The business continuity documents have been uploaded to a secure website (Resilience Direct) to ensure they can be accessed from any site in the event of an incident. The revised business impact assessment and recovery plans will be approved in June 2015.

Management Assurance

Senior managers make annual individual written assurance statements relating to any internal control weaknesses they have identified. The outcome of this work has not highlighted any significant control issues.

External Audit, Inspections and Reviews

External Audit

The Audit and Risk Committee has received and formally debated the Annual Audit and Inspection Letter and External Audit Annual Plan. KPMG in their Annual Governance Report for 2014/15 gave the Council an unqualified audit opinion on the financial statements and value for money conclusion.

Peer Challenge Review– Adults

The Peer Challenge Team Review (PCTR) is part of the East Midlands Sector-Led Improvement Programme for Adults Services. This was a 3-day visit that took place 9th February 2015 focussing on Adult Safeguarding. The review identified strong political and strategic engagement and that front-line practice appears to have improved significantly. The reviewers felt that the Council has knowledgeable, informed and committed staff and feedback from service users and carers was positive. They identified the need to support priority and

capacity of managers, as well as improving stability of managers and leadership. There was a need for greater clarity and consistency around policy, procedures shared across L&R with questions about the structure of the adults safeguarding board. Overall there was a strong message about the need to maintain the pace of improvement. The recommendations are now being progressed through the peer review action plan.

Data Incidents

Following the introduction of a Data Incident Response Protocol, a small number of incidents were reported and subsequently managed in accordance with the Protocol.

Between May 2014 and February 2015 10 reports were made. All were investigated to satisfactory conclusion with no outstanding risks identified. Incidents ranged from the loss of files containing personal information to Council Tax information being incorrectly disclosed to a number of customers. Officers involved were disciplined as a result of various breaches. The Information Commissioner's Office (ICO) was notified of two incidents; which resulted in their decision to take no further action.

Office of the Surveillance Commissioner (OSC)

A planned inspection of the Council's arrangements in respect of the Regulation of Investigatory Powers Act (RIPA) took place in November 2013. A number of recommendations were made and a follow up visit was undertaken in May 2014. The follow up visit generated excellent feedback on the Council's arrangements around the use of RIPA; no formal recommendations were made by the Surveillance Inspector

Public Services Network compliance

The Council must demonstrate compliance with the Public Services Network (PSN) Code of Connection (CoCo) on an annual basis. The CoCo is an Information Assurance mechanism to support the connection of a network to another accredited network, without increasing or substantially changing the risks to the already accredited network. The Council undertake a CoCo Security Health-Check annually (carried out by accredited third party) to identify any weak compliance positions. Once these have been addressed, the Council complete and return the CoCo for the PSNA (PSN Authority) to assess eligibility to connect.

The Council has had its compliance verification activity reviewed and may act and operate as a PSN Customer during 9th March 2015 and 9th March 2016. The Certificate is valid until 9th March 2016. It may be withdrawn at any time in instances of non-compliance are identified.

Better Care Fund review

The final Better Care Fund plan was approved by the Rutland Health and Wellbeing board on the 17th September and submitted to the Department of Health on the 19th September 2014, with a couple of tweaks required in November 2014 (As requested by NHS England).

Local Government Ombudsman (LGO) Diane

The Ombudsman's report for the year ended 31 March 2014 showed that eighteen complaints (there were 7 in 2012/13) had been made during the year. The nature and outcome of these complaints are detailed in the table below.

Detailed investigations carried out						
Upheld	Not upheld	Advice given	Closed after initial enquiries	Incomplete/Invalid	Referred back for local resolution	Total
1	1	0	9	1	6	18

5. Summary

This statement has been considered by the Audit and Risk Committee, who were satisfied that it is an accurate reflection of the governance framework and that the arrangements continue to be regarded as fit for purpose in accordance with the governance framework. The areas already addressed and those to be specifically addressed with new actions planned are outlined below.

Significant Governance Issues

The Council is satisfied that the governance framework provides a reasonable assurance of effectiveness. Any action plans contained in audit reports will be implemented and monitored during 2015/16.

Certification

As Leader and Chief Executive, we have been advised on the implications of the results of the review of effectiveness of the Council's governance framework, by the Audit Committee and Cabinet.

Our overall assessment is that the Annual Governance Statement is a balanced reflection of the governance environment and that an adequate framework exists within Rutland County Council to ensure effective internal control is maintained. We are also satisfied that there are appropriate plans in place to address any significant governance issues and will monitor their implementation and operations as part of our next annual review.

Signed: _____ Signed: _____

Helen Briggs, Chief Executive Roger Begy, Leader of the Council

Date: _____ Date:: _____

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REPORT NO: 73/2015

AUDIT & RISK COMMITTEE

7 April 2015

INTERNAL AUDIT PLAN 2015/16

Report of the Head of Welland Internal Audit Consortium

STRATEGIC AIM	**All**

1. PURPOSE OF THE REPORT

1.1 To present the draft Internal Audit Plan for 2015/16 for Members' review, refinement and formal approval.

2. RECOMMENDATIONS

2.1 That Members review and approve the Internal Audit Plan for 2015/16.

2.2 That Members give authority to the Assistant Director – Finance to make changes to the audit plan in consultation with the Chair of the Audit and Risk Committee and to report any changes at the next available Committee.

3. KEY ISSUES

3.1 The Welland Internal Audit Consortium provides the Internal Audit service for Rutland County Council and is commissioned to provide 370 days to deliver the Annual Audit Plan.

3.2 The Public Sector Internal Audit Standards require the annual Audit Plan to be reviewed and approved by the 'Audit Committee'. The Audit Plan should be developed based upon key risks identified through consultation with Senior Management and members of the committee.

3.3 At the last Audit and Risk Committee meeting, Members reviewed an initial list of potential topics which were generally supported in particular the audit of the Better Care Fund. These assignments have been built into the audit plan with the exception of:

- New expenses policy – placed on a 'reserve' list based on a risk assessment should other items be deferred;
- PeopleFirst review – other assurance mechanisms are in place over implementation progress; and
- Supplier account maintenance – included in fraud risk review.

3.4 Appendix A to this report provides further detail on the development of the 2015/16 Audit Plan and a copy of the draft Internal Audit Plan.

4. RISK MANAGEMENT

RISK	IMPACT	COMMENTS
Time	**Low**	The report does not prompt or require any time-bound response.
Viability	**Low**	There are no resourcing issues arising directly from this report.
Finance	**Low**	There are no financial issues arising directly from this report. The audit plan is based upon the number of days commissioned from the Council on an annual basis.
Profile	**Medium**	The report demonstrates that the Consortium and the Committee operates in conformance with the Standards.
Equality and Diversity	**Low**	EIA screening indicates no issues arising therefore full Impact Assessment has not been carried out.

Background Papers
None

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e-mail: enquiries@rutland.gov.uk

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577.

Report 73/2015 Appendix A

Internal Audit Plan 2015 / 2016

RUTLAND COUNTY COUNCIL

Head of Internal Audit

INTERNAL AUDIT PLAN 2015/16

1. Introduction

1.1 This report sets out the proposed Internal Audit Plan for 2015/16 for approval by the Audit & Risk Committee.

1.2 In August 2014, LGSS was commissioned to manage the Welland Internal Audit Consortium. As part of this role, LGSS has been given responsibility for developing the Audit Plans for 2015/16. This has provided an opportunity to 'refresh' the approach to Audit Planning and ensure that the Plans are of optimum value to the Council and provide Members with the necessary assurances to exercise their roles and responsibilities.

1.3 In setting the Annual Audit Plan, the Public Sector Internal Audit Standards require:

- The Audit Plan should be developed reflecting the Council's key risks as identified through consultation with senior management and the Audit Committee; and
- The Audit Plan should be reviewed and approved by an effective and engaged Audit Committee to confirm that the plan addresses their assurance requirements for the year ahead.

2. The Audit Plan

2.1 The Audit Plan is designed to support the provision of an annual Head of Internal Audit Opinion. The basis for forming this opinion is as follows:

- An assessment of the design and operation of the underpinning Governance, Assurance and Risk Frameworks and supporting processes; and

- An assessment of the range of individual opinions arising from the risk based assignments, which will be reported throughout the year.

Planning Process

2.2 During February 2015, Individual meetings have been held with the Council's Senior Management Team to identify the key potential risk areas for audit coverage.

2.3 Members of the Audit & Risk Committee were provided with an opportunity to raise any areas where they require assurance during 2015/16 at the January 2015 Committee meeting.

2.4 Internal Audit also draw upon an "audit universe" (a list of potential areas for Internal Audit review) to highlight a list of further potential audit review areas for consideration.

2.5 The process has also incorporated consideration of potential audits which can be undertaken by drawing upon similar emerging themes from the Councils within the Welland Internal Audit Consortium.

2.6 The Audit Plan covers the two key component roles of Internal Audit:

- The provision of an independent and objective opinion to the Section 151 Officer/ and the Governance and Audit Committee on the degree to which risk management, control and governance support the achievement of Council objectives;

- The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

2.7 Following this consultation, a Draft Internal Audit Plan has been compiled. The Draft Internal Audit Plan is provided in Appendix A.

2.8 Also provided as Appendix B, is a schedule of other potential areas for audit coverage. These have been considered in discussions with Senior Management but have been assessed as lower risk or of lower value at this time. The Audit Plan will be subject to ongoing review during the year to ensure it continues to address the key risks to the Council, however, any changes would be subject to formal approval. The additional potential audits within Appendix B will be considered where any other assignments within the plan are deferred or amended. Members could also consider whether any of these assignments should be incorporated within the draft Plan in place of any of the planned assignments.

Appendix A
Draft Internal Audit Plan 2015/16

Assurance Area	Audit Assignment and Potential Coverage	Proposed days
Finance	**Key Financial Controls** Annual review of the Council's key financial controls.	55
	Financial Governance / Transparency This review can be conducted at multiple Councils across the Welland consortium to compare approaches to transparency around the budget setting and budget monitoring processes and compliance with the Transparency Code.	7
Counter Fraud	**Fraud Risk Review** In 2014/15 the Council has put together a fraud risk register. The review will select a sample of areas from the register and assess whether controls noted are working as intended. This will include controls over supplier account maintenance which were further developed following a fraud in 2014/15.	15
Service Delivery	**Better Care Fund (BCF) Monitoring** The BCF pooled fund comes into effect from 1st April 2015. Each BCF project needs to demonstrate its impact against BCF targets and show how much has been spent. This review will focus on a sample of schemes and verify reported performance and spend.	15
	Data Retention and Disposal To review procedures in place for data management and disposal, including IT specific controls and procedures. Work is currently underway within the Council to improve these areas and a review in 2015/16 will provide assurance over the robustness of these arrangements once complete.	15
	Recruitment of Interims and Agency staff The Council has agreed a revised procedure for recruitment of Interims and Agency staff to ensure that all employment regulations are complied with and value for money is achieved. The review will consider how these procedures are being applied.	15
	Contract Procedure Rules (CPR) compliance In 2013/14 the Council updated its CPR's. New procurement rules are also likely to come into force early in the new year which will require CPR's to be updated again. This review will assess how officers are complying with these procedures but also identify any practical difficulties in applying the rules to inform future revisions.	15
	Capital Allocations Programme Board To review the Terms of Reference for this group and whether funding is allocated to schools in accordance with this. To provide assurance over the decision making processes and the approach adopted for academies. This is a priority area for 2015/16 and facing additional pressures due to new primary schools and increased places.	20

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Assurance Area	Audit Assignment and Potential Coverage	Proposed days
31	**Digital Broadband** To deliver support to this project and provide assurance over the billing arrangements and quality assurance processes.	15
	Kerbside Collections To review compliance with TEEP (technically, environmentally and economically practicable) requirements following EU ruling, to provide assurance that procedures would withstand challenge. This audit is planned at other Councils within the Consortium and will share best practice.	15
	Demand Led Budgets To review procedures in place for managing and monitoring demand led budgets in the Council's People Directorate.	20
	External Placements (Care Packages) To review the Council's procedures around purchasing external social care placements. To provide assurance over the processes in place to ensure value for money is achieved, and subject to ongoing assessment, and that contract management is robust.	15
	Care Act Implementation To review the implementation and embedding of the revised policies and procedures following the introduction of the Care Act in April 2015. This could include consistent application of revised eligibility criteria, newly introduced eligibility criteria for carers, staff training effectiveness etc.	20
	Public Health Budgets To review budget arrangements in place for the use of Rutland Public Health funding.	15
	Limited Assurance Reports There were a number of audits in 2014/15 which resulted in 'Limited' opinions. In all cases action plans were agreed to resolve issues raised. This review will report on the updated status of those action plans.	15
ICT	IT Audit Plan to be developed in consultation with Head of IT and specialist LGSS IT Auditor.	30
Client Support	Committee attendance and preparation, client liaison, follow up of audit actions, committee training, audit planning, annual Head of Internal Audit reporting, Annual Governance Statement/National Fraud Initiative support and advice and assistance.	34
Welland Internal Audit Management	Management of the Welland Internal Audit Consortium.	34
	Total days commissioned	**370**

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Appendix B
Other Potential Audit Areas for Consideration

Audit Assignment and Potential Coverage
Oakham Enterprise Park To review the leasing and rent review arrangements in place and provide assurance as to compliance with best practice and whether these are being accounted for correctly.
New Expenses Policy Following a review of the expenses policy further to a tax review by KPMG and acceptance by HMRC of the Council's P11D dispensation, a new policy will be in place for 2015/16. This review will assess compliance with the P11D dispensation and the new policy.
Data Quality To provide assurance over the data quality procedures in place for the Council's performance data.
Community Infrastructure Levy / s.106 Agreements To review processes in place to maximise income potential from s.106 / CIL agreements for the Council. However, it is understood that this audit assignment would not be of utmost value until the end of 2015/16 and can be reviewed in depth as part of the 2016/17 Audit Plan.

REPORT NO: 122/2015

AUDIT AND RISK COMMITTEE

30 June 2015

Risk Management Update

Report of the Director for Resources

Strategic Aim:	**All**	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor King, Portfolio holder for Places (Development and Economy) and Resources	
Contact Officer(s):	Debbie Mogg, Director for Resources	Tel: 01572 758358 dmogg@rutland.gov.uk
Ward Councillor(s)	Not applicable	

DECISION RECOMMENDATIONS
1. That the Audit and Risk Committee comments on the contents of this report, including the next steps set out in section 3.

1. PURPOSE OF THE REPORT

1.1 To update the Committee and seek comment on the work planned in respect of the Council's risk management arrangements.

2. CURRENT POSITION

2.1 The Council has an approved Risk Management Strategy and Policy in place which sets out the Council's approach to managing risk along with the roles and responsibilities of various individuals, groups and elected members.

2.2 This strategy and policy has been in place for a number of years and is due for a refresh to ensure it represents and promotes best practice.

2.3 The strategic risk register is owned and maintained by the Strategic Management Team (SMT). Each risk is allocated to a member of SMT as the 'risk owner,' who takes responsibility for overseeing any action plans arising from the register and monitoring any change in the likelihood or impact of the risk.

2.4 The risk registers have previously been reported on a regular basis to this committee and to each of the scrutiny panels.

2.5 Whilst it right and proper that SMT are the owners of the strategic risk register, there is a need to ensure that senior managers fully understand their role within the risk management framework and how they contribute to effective risk

management across the organisation. There have been several changes at the senior manager level over recent months so now is considered an opportune time to do this.

3. PLANNED PROGRAMME OF WORK

3.1 Included within the Council's insurance contract with Zurich Municipal, is an annual provision of support for risk management. This is effectively a block of consultancy time which the Council can access to for any work that falls under the umbrella of risk management.

3.2 Based on the situation as outlined above, we have been in discussion with Zurich Municipal about the work programme for 2015/16. The detail and timetable is yet to be finalised but the proposal is for the following work to be delivered.

Project	**Activity**
Risk Management Health Check	A review of the existing policies, procedures, risk registers and governance arrangements currently in operation. This assessment will identify areas for enhancement and development. Output: 1) Summary report highlighting the work performed along with the findings and suggested areas of improvement 2) Development Action Plan
Risk Management Strategy and Policy refresh	Best practice review of the Risk Strategy and the accompanying procedures. Following this, a refresh will be completed along with the addition of any necessary amendments to ensure compliance and best practice Output: 1) Revised Risk Management Strategy and Procedures
Risk Register Redesign	Implementation of a new risk register format and the transferring of all current risks into the new format. Output: 1) New Risk Register format, fit for purpose and in line with recommendations 2) Transfer of all existing risks 'as is' into new format
Risk Management – Insight sessions (training) for Senior Managers' Forum	Two sessions of risk management training/awareness. These sessions will be completed in order to 'relaunch' the new risk management strategy, policy and procedures. Output: 1) 2 x 2 hr sessions – approx. 15 attendees for each 2) Summary evaluation capturing issues and feedback from the sessions

3.3 The refreshed policy and procedures will be presented to a future meeting of this committee, as will the risk register once a thorough review and update is complete.

4. CONSULTATION

4.1 The purpose of this paper is to consult with the Committee and gain feedback on the proposals

5. ALTERNATIVE OPTIONS

5.1 The Council could undertake this review without the support of Zurich Municipal but their expertise and experience of best practice in other organisations is considered a significant benefit to the Council.

5.2 Other areas of work were considered for this year, such as a review of business continuity arrangements but it is considered that the review of the risk management framework is of higher priority.

6. FINANCIAL IMPLICATIONS

6.1 There are no additional costs arising from this work. The allowance forms part of our insurance contract.

7. LEGAL AND GOVERNANCE CONSIDERATIONS

7.1 As set out in its terms of reference within the constitution, this committee has responsibility to provide assurance of the adequacy of the risk management framework and control environment.

7.2 There are no legal implications arising from this report.

8. EQUALITY IMPACT ASSESSMENT

8.1 An Equality Impact Assessment (EqIA) has not been completed at this stage. I screening exercise will be undertaken when the revised policy and procedures are considered.

9. COMMUNITY SAFETY IMPLICATIONS

9.1 There are no community safety implications.

10. HEALTH AND WELLBEING IMPLICATIONS

10.1 There are no health and wellbeing implications.

11. CONCLUSION & SUMMARY OF REASONS FOR THE RECOMMENDATIONS

11.1 The Committee's role is to monitor the effective development and operation of risk management and corporate governance. The proposals within this paper are

intended to further improve and enhance the arrangements the Council has in place.

12. BACKGROUND PAPERS

12.1 There are no additional background papers to the report

13. APPENDICES

13.1 None

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REPORT NO: 107/2015

AUDIT AND RISK COMMITTEE

30 June 2015

COMMITTEE TRAINING PROGRAMME

Report of the Director of Resources

Strategic Aim:	**All**	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor King – Portfolio Holder for Places (Development and Economy) and Resources	
Contact Officer(s):	Debbie Mogg, Director for Resources	Tel: 01572 758358 dmogg@rutland.gov.uk
	Saverio Della Rocca, Assistant Director - Finance	Tel: 01572 758159 sdellarocca@rutland.gov.uk
Ward Councillors	Not Applicable	

DECISION RECOMMENDATIONS
1. That the Committee provide feedback on their training requirements and their preferred option for the delivery and scheduling of training.

1. PURPOSE OF THE REPORT

1.1 To provide Members with an opportunity to assess their training requirements and to agree a schedule of training to be delivered over the coming year and beyond.

2. BACKGROUND AND MAIN CONSIDERATIONS

2.1 The Constitution sets out a number of core functions for which the Audit and Risk Committee is responsible:

1. Approve (but not direct) internal audit's strategy, plan and monitor performance.
2. Review summary internal audit reports and the main issues arising, and seek assurance that action has been taken where necessary.
3. Receive the annual report of the head of internal audit.
4. Consider the reports of external audit and inspection agencies.
5. Consider the effectiveness of the authority's risk management arrangements, the control environment and associated anti-fraud and anti-

corruption arrangements. Seek assurances that action is being taken on risk related issues identified by auditors and inspectors.

6. Be satisfied that the authority's assurance statements, including the Annual Governance Statement, properly reflect the risk environment and any actions required to improve it.
7. Ensure that there are effective relationships between external and internal audit, inspection agencies and other relevant bodies, and that the value of the audit process is actively promoted.
8. Review the financial statements, external auditor's opinion and reports to members, and monitor management action in response to the issues raised by external audit.

2.2 It is therefore beneficial for the Audit Committee members to have certain skills or knowledge to carry out their role. The extent to which members of the Committee are familiar with the above areas will depend on their professional background, experience, interests etc. In any event, the Council is committed to providing training to Members (internally or externally) to equip them with the necessary skills and knowledge to carry out their roles effectively. CIPFA guidance also states that regardless of the knowledge and skills a member has when joining the committee, there needs to be a commitment to participate in training and development to ensure knowledge is kept up to date.

2.3 Officers have put together a suggested list of training topic areas below and invite the Committee to consider:

- In which areas would it like to receive training? This may depend on the background of the Committee members.
- How might this training be scheduled and over what time period? Training has been delivered in the past as part of Audit and Risk meetings, although there have also been separate sessions outside of formal meetings. Members may wish to consider a priority order for training and assess over what time period it wishes to cover all topics.
- How might training be delivered? Training has been delivered in-house and through external bodies. Both the Director of Resources and Assistant Director have worked for a professional services firm and delivered training in most of the areas listed. Members may have their own preferences.

Area	**Detail (for sessions say 1 – 2hrs)**	**Options**
Internal Audit	There are various areas that could be covered: • Audit planning • Internal Audit process • Reporting • Public Sector Internal Audit Standards	The Local Government Shared Service (LGSS) provide our Head of Internal Audit and delivery IA training to their clients.
Risk Management	Session on the risk management process and how it works at the	Internally or through Zurich Municipal who

Area	Detail (for sessions say 1 – 2hrs)	Options
	Council	are our Insurance advisors and are undertaking a review of our risk processes
Fraud	Session on fraud in the public sector, who is the typical fraudster, fraud risk areas and what local authorities should do to protect themselves	LGSS have fraud officers who could deliver this training. External firms can also provide this free of charge.
External audit	Session on their role and responsibilities and how they work with the Council	KPMG, our external auditors
Financial accounts	Session on the financial statements, how they are put together, what the key statements are and how they differ to the private sector	Internally or externally via KPMG.
Control environment and assurance	Session on internal controls, different types of controls, how these are applied and how the Council assures itself that they work	Internal Audit or Assistant Director – Finance

2.4 Officers will put together a training programme and schedule further to comments and suggestions from the Committee. Where training is scheduled then the Committee may wish to invite all Members to attend if they wish – this has been normal practice in the past.

3. CONSULTATION

3.1 The purpose of this paper is to consult with members of the Committee and gain feedback on training requirements.

4. ALTERNATIVE OPTIONS

4.1 The report does not prescribe a specific course of action or an exhaustive list of topics that Members may wish to consider for training purposes. Members are able to determine whether training is required and how it might be delivered.

5. FINANCIAL IMPLICATIONS

5.1 There may be financial implications should the Committee wish to bring in external bodies to deliver training or attend external events. There is a Members training budget which allows for some external support. The impact on this budget will be assessed when the training programme is agreed.

6. LEGAL AND GOVERNANCE CONSIDERATIONS

6.1 The Audit and Risk Committee is responsible for delivering on its functions and should consider what training or support it needs to fulfil its role.

6.2 There are no legal implications arising from this report.

7. EQUALITY IMPACT ASSESSMENT

7.1 Equality Impact Assessment (EqIA) screening has been completed and there were no issues arising. A full Impact assessment has not been carried out.

8. COMMUNITY SAFETY IMPLICATIONS

8.1 There are no community safety implications.

9. HEALTH AND WELLBEING IMPLICATIONS

9.1 There are no health and wellbeing implications.

10. CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

10.1 The Committee plays an important role in the Council's governance framework and it is important that Members of the Committee have the right skills and knowledge to execute this role effectively. This paper and the views of the Committee will allow a formal programme to be agreed.

11. BACKGROUND PAPERS

None

12. APPENDICES

None

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