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Rutland County Council

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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, 26th January, 2016** 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 22 September 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) RISK MANAGEMENT UPDATE

To receive Report No. 32/2016 from the Director for Resources
(Pages 5 - 22)

5) WHISTLE BLOWING POLICY AND PROCEDURES REVIEW

To receive Report No. 18/2016 form the Director for Resources
(Pages 23 - 36)

6) REGULATION OF INVESTIGATORY POWERS ACT 2000 QUARTERLY UPDATES

To receive Report No.17/2016 from the Director for Resources.
(Pages 37 - 40)

7) INTERNAL AUDIT UPDATE REPORT

To receive Report No. 28/2016 from the Assistant Director for Finance.
(Pages 41 - 102)

8) INTERNAL AUDIT PLAN REPORT 2016/17

To receive Report No. 29/2016 from the Assistant Director for Finance.
(Pages 103 - 110)

9) EXTERNAL AUDIT PROGRESS REPORT

To receive Report No. 30/2016 from the Assistant Director for Finance.
(Pages 111 - 140)

10) ACCOUNT CLOSURE PLANNING 2015/16

To receive Report No.20/2016 from the Assistant Director for Finance.
(Pages 141 - 148)

11) 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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Report No: 32/2016
PUBLIC REPORT

AUDIT AND RISK COMMITTEE

26 January 2016

STRATEGIC RISK REGISTER

Report of the Director for Resources

Strategic Aim:	All	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor Terry King, Deputy Leader and Portfolio Holder for Places (Development and Economy) and Resources	
Contact Officer(s):	Debbie Mogg, Director for Resources	01572 758358 dmogg@rutland.gov.uk
Ward Councillors	N/A	

DECISION RECOMMENDATIONS
1. That the Committee notes the contents of the risk register and the actions underway to address the risks

1 PURPOSE OF THE REPORT

1.1 To present the Committee with a revised Strategic Risk Register and provide assurance that strategic risks are being adequately managed.

1.2 To provide an update to the Committee on review of the Council's risk management arrangements.

2 UPDATE SINCE LAST MEETING

2.1 Since September a number of actions have taken place. A consultant from Zurich Municipal has been working with the Council to:

a) Undertake a risk management health check – this involved a review of existing policies, procedures and risk registers plus interviews with senior managers. The output from this work will be a report which sets out the findings and suggested areas of improvements along with a development action plan.

b) Review the Risk Management Strategy and Policy – taking into account the findings of the health check and in line with best practice

c) Risk register redesign and review of all strategic risks – a workshop was held with the Strategic Management Team (SMT) to discuss the strategic risks

the council is facing and populate the redesigned risk register. This is described further in the next section.

3 STRATEGIC RISK REGISTER

3.1 Attached at **Appendix A** is the Council's Strategic Risk Register as at January 2016. The risk register is now more focussed on the strategic risks i.e. those that may prevent the Council from meeting its Strategic Aims and Objectives or statutory responsibilities.

3.2 The redesigned risk register covers the following:

- A description of the risk – a well-defined risk will have a cause (the situation or fact that gives rise to the unwanted event), an event (the unwanted event that could happen) and an impact (the effect or result of the event happening).

- SMT owner – the strategic risk register is owned and maintained by SMT. Each risk is allocated to a member of SMT who takes responsibility for overseeing any action plans arising from the register and monitoring any change in the likelihood or impact of the risk.

- A description of the existing controls in place to mitigate the risk and a risk score based on those controls.

- A description (summary) of the actions required to manage the risk score to an acceptable level, along with the target risk score. Where appropriate, more detailed actions plans will be in place, summarised in the risk register.

- Any other relevant information on current activity or movement in the risk.

3.3 A summary of the risks, plotted on the risk matrix has been prepared. This is shown at **Appendix B** and highlights how the risks are spread across the matrix.

4 CONSULTATION

4.1 No consultation is necessary; the purpose of this report is to present the risk register to the Committee.

5 FINANCIAL IMPLICATIONS

5.1 There are no direct financial implications arising from this report but the Committee should note that failure to manage risks effectively can have a financial impact on the Council.

6 LEGAL AND GOVERNANCE CONSIDERATIONS

6.1 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.

6.2 There are no legal implications arising from this report.

7 EQUALITY IMPACT ASSESSMENT

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

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's role is to monitor the effective development and operation of risk management and corporate governance. The risk register sets out the strategic risks facing the Council and demonstrates how they are being managed.

11 BACKGROUND PAPERS

11.1 There are no additional background papers

12 APPENDICES

Appendix A: Strategic Risk Register
Appendix B: Risk Matrix

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Risk No.	Description of the risk	SMT Owner	Current Controls	Current Risk Score			Actions to Achieve Target	Target Risk Score			Current status
				I	L	Score		I	L	Score	
1 **6**	Failure to recruit and retain sufficient skilled staff to ensure safe and effective service delivery Causes: • Ineffective recruitment procedures • Less favourable pay terms and conditions compared to the market • Ineffective management • Lack of opportunities for development and progression Consequences: • Increased cost of recruiting interims to cover vacancies • Failure to deliver services • Poor staff morale	D Mogg	• Specific recruitment plans in place for teams experiencing difficulties with recruitment. Innovative approaches being taken. • Maximum alignment to national terms and conditions • Health and Wellbeing programme in place for staff which continues to expand • Corporate training programme in place along with a Leadership Development programme. • Workforce Development Strategy approved in January 2016. • Part of regional and national pay networks • Regular market comparison of pay levels through epay check. • Exit interview analysis and monitoring of turnover	2	4	8	• Working groups in place to address the issues identified from the 2015 staff survey in respect of communication, wellbeing, environmental factors and mental health. • Staff survey to be undertaken again early 2017 • Action plans required, to deliver the workforce development strategy which include specific actions around recruitment • Development of improved marketing and recruitment strategies • Completion of Senior pay review to evaluate all senior roles and review the pay policy	2	3	6	Further action required and this is built into the relevant work plans.

Risk No.	Description of the risk	SMT Owner	Current Controls	Current Risk Score			Actions to Achieve Target	Target Risk Score			Current status
				I	L	Score		I	L	Score	
2	There is a risk that the Council cannot meet its statutory requirement to produce a robust and balanced budget now or in the medium term Causes: • further losses of government funding • failure to identify or deliver savings programmes • unanticipated demand • unforeseen event • unwillingness to use our revenue generating powers (fees, council tax, precept etc) • failure to deliver growth Consequences: • Breach of statutory requirement • Erosion of reserves below recommended levels • Drastic action needed to rectify the positions e.g. cuts	S Della Rocca	• Lobbying of Government (done individually and with LGA/SPARSE) • Key savings programmes monitored by Directorate team, SMT and through quarterly monitoring • New saving programme to be developed in 16-17 for Places directorate • Maintenance of a 5-year MTFP with funding and other risks detailed in Budget and Quarterly reports • Risks quantified as far as possible and build into MTFP e.g. Living Wage, Contracts • Overall financial context discussed and shared with SMT/Cabinet formally and informally including sensitivity analysis over key variables • Economic development plan in place and key growth project (OEP)	4	2	8	• Agree by June 2016 a savings programme process for Places Directorate (HB)	4	2	8	Process has been discussed and a formal process has now to be agreed

Risk No.	Description of the risk	SMT Owner	Current Controls	Current Risk Score			Actions to Achieve Target	Target Risk Score			Current status
				I	L	Score		I	L	Score	
3	Failure to deliver key services should a significant business interruption occur, include supplier failure. Causes: • Natural disasters • Fire • ITC system failure • Restricted access to premises • Loss of utilities • Outbreak of disease or infection • Terrorist attack • Theft or vandalism • Failure of key suppliers or contractors Consequences: • Failure to deliver key services • Breach of statutory duty Reputational damage	D Brown	• A Business Impact Assessment (BIA) has been carried out to determine which services are critical, how quickly they must be restored and the minimum resources required. • A Major Incident Plan has been prepared which defines a structure to: ○ Confirm the nature and extent of any incident; ○ Take control of the situation; ○ Contain the incident; and ○ Communicate with stakeholders. • Specific recovery plans are in place for the 5 key threats: ○ loss of key staff (skills/knowledge); ○ loss of telephone system; ○ loss of buildings; ○ loss of ICT; and ○ loss of utilities. • SMT approved a revised BIA and	4	3	12	• An SMT exercise is planned to test of the Major Incident Plan in January 2016. • Recovery plans will be reviewed in March 2016. • Checks required to ensure contracts are being risk assessed and appropriate mitigation is in place. • An additional recovery plan required for the supported living service.	3	3	9	Further action required.

Risk No.	Description of the risk	SMT Owner	Current Controls	Current Risk Score			Actions to Achieve Target	Target Risk Score			Current status
				I	L	Score		I	L	Score	
			recovery plans in June 2015. • 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. • Contract procedure rules include the requirement for contract managers to consider the impact of contractor failure and mitigate the risks appropriately.								
4	Failure to Safeguard (Children) and a child is significantly abused, badly hurt or dies. Causes: • Case not being known • Failing to identify risk after referral • Failing to effectively assess risk at the correct level • Failure to put relevant safeguards in place • Poor information	TON	• Processes and procedures in place to protect the most vulnerable. • Scrutiny and overview from the Safeguarding Boards. • Monthly performance and financial monitoring by senior officers and update reports to Cabinet. • High quality, timely information contained within case files. • High quality, timely management oversight.	3	3	9	• Service Improvement Plan delivered phase 1 – March 16; phase 2 – March 17. • Phase 1 includes: • Introduction of new quality assurance process • Introduction of new performance management framework • Implement new recruitment approach including retention payments for social workers	2	3	6	• Significant issues of interim staff have been addressed in part by the Recruitment/retention strategy. Residual risk remains on certain significant posts.

Risk No.	Description of the risk	SMT Owner	Current Controls	Current Risk Score			Actions to Achieve Target	Target Risk Score			Current status
				I	L	Score		I	L	Score	
13	sharing Consequences: • Intensive scrutiny by Public and Press • Reputation damage • Potential loss of frontline staff • Potential external intervention • Requirement to undertake and publish a serious case review • Potentially high legal costs		• Revised supervision process to ensure early information. • Ensuring we have sufficient competent staff to safeguard children and there is no unallocated work. • Case auditing to identify any shortfalls in practice and to identify where further action is required to keep children safe. • Development of clear practice standards so staff know what is expected of them. • Case tracker to ensure visits are being undertaken. • Management oversight recorded on file. • Effective Staff training • Strict application of the panel process.								
5	Failure to Safeguard (Adult's) and an adult is significantly abused, badly hurt or dies. Causes: • Case not being known • Failing to identify risk after referral	TON	• Processes and procedures in place to protect the most vulnerable. • Scrutiny and overview from the Safeguarding Boards. • Monthly performance	3	3	9	• Implement new recruitment approach including retention payments for social workers – Jan 16 • Development and embedding of Prevention &	2	3	6	• Significant issues of interim staff have been addressed in part by the Recruitment/retention strategy. Residual risk remains on certain significant

Risk No.	Description of the risk	SMT Owner	Current Controls	Current Risk Score			Actions to Achieve Target	Target Risk Score			Current status
				I	L	Score		I	L	Score	
14	• Failing to effectively assess risk at the correct level • Failure to put relevant safeguards in place • Poor information sharing Consequences: • Intensive scrutiny by Public and Press • Reputation damage • Potential loss of frontline staff • Potential external intervention • Requirement to undertake and publish a serious case review • Potentially high legal costs		and financial monitoring by senior officers and update reports to Cabinet. • High quality, timely information contained within case files. • High quality, timely management oversight by DASM. • Ensuring we have sufficient expert and competent staff • Case auditing to identify any shortfalls in practice and to identify where further action is required • Development of clear practice standards so staff know what is expected of them. • Management oversight recorded on file alongside regular supervision. • Effective Training of				Safeguarding team – March 16 • Implementation and embedding MSP now incorporated in the Care Act – March 16				posts.

Risk No.	Description of the risk	SMT Owner	Current Controls	Current Risk Score			Actions to Achieve Target	Target Risk Score			Current Status
				I	L	Score		I	L	Score	
6	Long term failure to achieve educational attainment.		• Monitoring by officers • Education	4	3	12	• Implementation of year 1 of the learning and	4	2	8	• Positive one academic year

	Causes: • Poor quality teaching, learning and governance in schools. • Poorer family engagement in the home. Consequences: • Reputation damage • Reputation damage • Potential external intervention		Performance Board to review schools. • Increased scrutiny and intervention in schools causing concern. • Regular liaison with DfE and Ofsted • Effective early help support				skill strategy, particularly in relation to categorisation and monitoring of school outcomes – August 16 • Implementation of year 1 of the early help strategy – March 16				improvement across all Key Stages not yet sustained over longer period • Developing strong partnership schools and academies again this needs to be sustained

Risk	Description of the risk	SMT	Current Controls	Current Risk Score	Actions to Achieve	Target Risk Score	Current Status

No.		Owner		I	L	Score	Target	I	L	Score	
7	Failure to put in place the infrastructure to support growth Causes: • Development occurs at a faster pace than anticipated • Infrastructure needs are not identified and provided for Consequences: • Complaints from community and potential risk of legal challenge	H Briggs	• Infrastructure requirements fully identified linked to CIL and the 123 list • Regularly reviewed • Key infrastructure requirements are monitored on a regular basis e.g. School Places • Specific projects in place to meet specific need including:- Digital Rutland – Broadband OEP – employment and business growth Schools Programme – School and Learning places • Medium Term financial plan and level of balances would facilitate urgent action to be taken if required	2	2	4	• Continue to review the 123 list and prioritise the most significant requirements • Ensure CIL implemented and receipts are collected and targeted at need • Review key areas as at present	2	2	4	• Actions are in place to deliver against current demand and need

Risk No.	Description of the risk	SMT Owner	Current Controls	Current Risk Score	Actions to Achieve Target	Target Risk Score	Current Status

				I	L	Score		I	L	Score	
8	Failure to secure delivery of change required within Health & Social Care Causes: • Insufficient funding • Demand exceeds expectations • Challenge to changes slows the process down Consequences: • Ineffective service delivery and on-going cost pressure and impact on MTFP	H Briggs	• Risk highlighted and an allowance made within our MTFP • Playing a key role in the LLR BCT Project • Working directly with ELRCCG to achieve improved care pathways and focus on 'Left Shift' and its impact • Focussing on early intervention and prevention • ASC strategy being revised • New commissioning framework being developed • Better Care Fund evolving and initial outcomes are positive	3	4	12	• Need to remain engaged in BCT project • Quantify and risk assess the impact on Social Care of BCT changes • Continue with Care Pathway reviews and changes • Expand BCF to accommodate the impact of Left Shift • Continue to make adequate and appropriate provision within our MTFP • Ensure our commissioning framework is sufficiently flexible to accommodate pressure from spikes in demand	2	2	4	• Although significant work is on-going this is still at an early stage and requires a sustained focus

Risk No.	Description of the risk	SMT Owner	Current Controls	Current Risk Score	Actions to Achieve Target	Target Risk Score	Current Status

				I	L	Score		I	L	Score	
9	Failure to manage the public's perception of the Council Causes: • A significant failing in service provision Consequences: • Loss of confidence and significant resource required to improve thus distracting from service delivery	H Briggs	• The Council works hard and proactively to present a positive image through a number of channels including:- Web Site Local press through PR's Social Media Rutland Radio • The Council's Strategic Communication Advisor provides advice and training where required for Officers and Members • If additional support is required this is available and has been used during 2015 to good effect • SMT monitor current issues and assess the likely impact positive and negative. Where required communication strategies are developed customised to the event etc?	2	2	4	• Continue current actions as outlined • Media training being refreshed in 2016 • Expanding Social Media presence • Web site being redeveloped • Customer Services being reviewed • Plan in place for responses to events as they occur e.g. Resilience Issues	2	2	4	• Recent experience has tested current plans and they have met the test. Active learning will feed into on-going review of plans.
Risk	**Description of the risk**	**SMT**	**Current Controls**	**Current Risk**			**Actions to Achieve**	**Target Risk**			**Current Status**

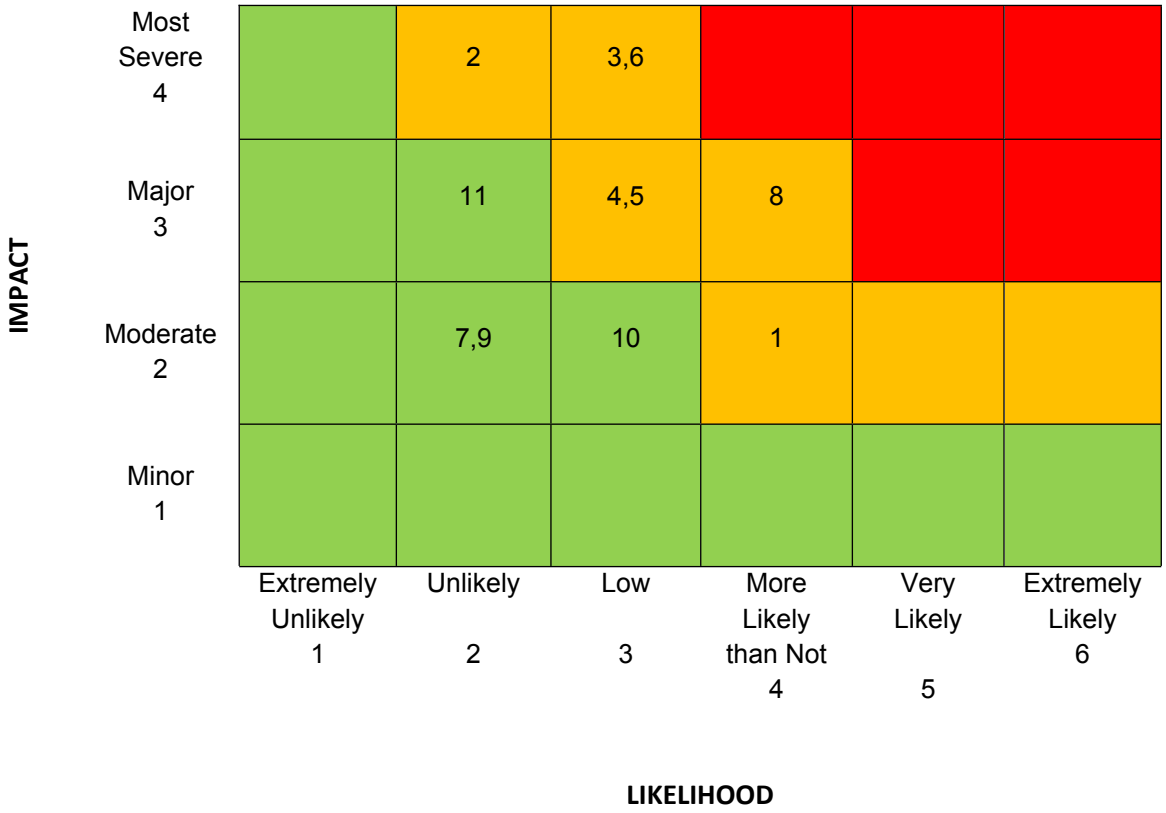
No.		Owner		Score			Target	Score			
				I	L	Score		I	L	Score	
10	Failure to protect the health and safety of employees and members of the public Causes: • Non-compliance with health and safety legislation Consequences: • Employee or customer injury • Regulatory fine • Reputational damage	P Phillipson	• Full time health and safety advisor employed who reviews health and safety implications of all policies and contracts. • Joint safety committee in place that reviews all internal risk reports such as RIDOR forms. • Contract procedure rules require contract managers to take due regard of health and safety when procuring contracts. • Managers complete risk assessments for service activities and review annually. • Mandatory health and safety training for all staff as part of induction process.	2	3	6	• Corporate health and safety risk assessment template required. • Central register of risk assessments.	2	3	6	Live

Risk No.	Description of the risk	SMT Owner	Current Controls	Current Risk Score			Actions to Achieve Target	Target Risk Score			Current Status
				I	L	Score		I	L	Score	

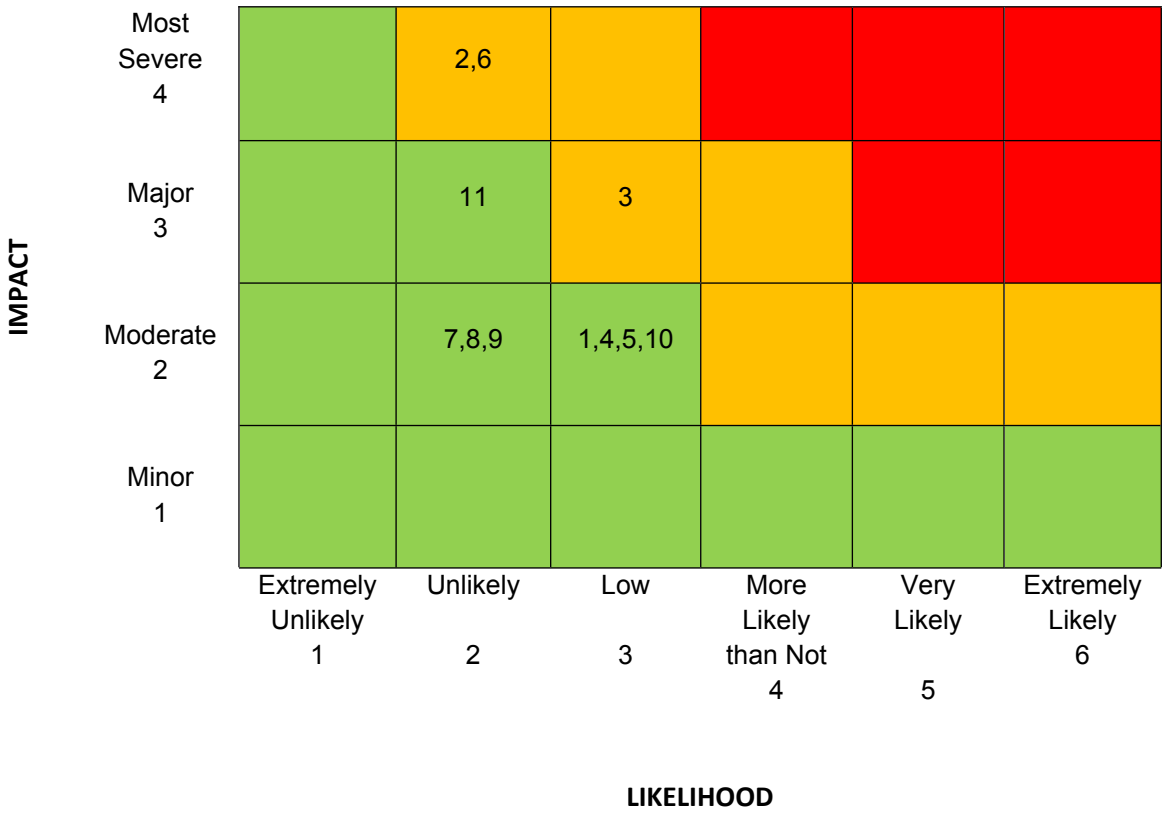
11	Failure of corporate governance (incl data governance) with service, financial or reputational consequences Causes: • Serious data breach • Breakdown in internal control • Decision taken without the proper authority • Fraud Consequences: • Non-achievement of objectives • Reputational damage • Financial loss or fine	D Mogg	• Constitution, including scheme of delegation • Annual Governance Statement • Corporate compliments, comments and complaints scheme • Member and Officer Codes of Conduct • Member Training Programme • Policies in place re Bribery, Whistleblowing, Anti-fraud and corruption • Clear management structure • Data Protection Policy and Procedures supported by training • IT security policy • Track ICO guidance • Proactive internal audit service	3	2	6	• Complete review of scheme of delegation to take place by March 2016 • Further development of the Members training programme • IT security policies to be reviewed	3	2	6	Ongoing

Summary of Risks plotted on the risk matrix

1. Current Scores



2. Target Scores



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Report No: 18/2016
PUBLIC REPORT

AUDIT AND RISK COMMITTEE

26th January 2016

REVIEW OF THE COUNCIL'S WHISTLE BLOWING POLICY AND PROCEDURES

Report of the Director for Resources

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

DECISION RECOMMENDATIONS

That the Committee:

1. Considers the revised Whistle Blowing Policy at **Appendix A** and recommends that it be presented to Cabinet for approval.

2. Notes that the revised procedures will be introduced to all employees as part of a re-launch of the Whistle Blowing process, following approval of the Policy.

1 INTRODUCTION

1.1 Rutland County Council is committed to ensuring that it, and the people working for it, complies with the highest standards of openness, honesty and accountability.

1.2 The term Whistle Blowing has a specific legal definition i.e. a disclosure or allegation of serious wrongdoing made by an employee and a wider public definition i.e. any disclosure or allegation of serious wrongdoing made by anyone. UK Whistle Blowing legislation was introduced by the Public Interest Disclosure Act 1998, which sets out to protect individuals who make certain disclosures of information in the public interest, to allow such individuals to bring action in respect

of associated victimisation and/or for other detriment.

1.3 The attached Policy **(Appendix A)**, which has been reviewed to ensure it encompasses recent changes to legislation (see 5.2 below), seeks to cover both disclosures and allegations of serious wrongdoing made by employees and members of the public, and to demonstrate the Council's commitment to the protection of employees who raise concerns in what they reasonably believe to be in the public interest.

Examples of wrongdoing are:

- Breach of a legal obligation;
- Any criminal activity, including incitement to commit a criminal act;
- Corruption or fraud
- A miscarriage of justice
- A danger to the health or safety of an individual or damage to the environment
- Abuse of power or authority

1.4 This Policy makes it clear that in appropriate circumstances, any employee can raise concerns without fear of victimisation, subsequent discrimination or disadvantage. It is intended to encourage and enable employees to raise serious concerns within the Council rather than overlooking a problem or 'blowing the whistle' outside.

1.5 These procedures are in addition to the Council's Compliments, Comments and Complaints Policy and Procedures and other statutory reporting procedures applying to some departments. The Council will proactively publish these procedures to ensure all stakeholders are aware of its existence; it is also the individual responsibility of each employee to ensure customers and members of the public are aware of the existence of these procedures.

1.6 A flowchart has been developed to guide you through the process; this can be found at the end of the policy at **Appendix A.**

2 CONSULTATION

2.1 When the original Whistle Blowing Policy was introduced, unions were consulted and supportive of the Policy. As this review has focussed primarily on legislative updates, extensive consultation has not been required however, the content has been discussed with the relevant trade unions and has their support.

3 ALTERNATIVE OPTIONS

3.1 As an employer and public body, it is good practice to create an open, transparent and safe working environment where employees and service users feel able to speak up. To this end, it is essential that the Council continues to ensure all policies and procedures are legal and current. An alternative option would be not to update the original Policy therefore failing to recognise the changes in legislation, which are fundamental to creating a culture of openness and support.

4 FINANCIAL IMPLICATIONS

4.1 There are no financial implications arising from this report. However, if the Council fails to follow the correct legal procedure when dealing with a whistleblowing disclosure, it could be open to legal, financial and reputational challenge.

5 LEGAL AND GOVERNANCE CONSIDERATIONS

5.1 Although the law does not require employers to have a whistleblowing policy in place, the existence of such shows an employer's commitment to listen and act upon the concerns of workers and other stake-holders. The two main barriers to whistleblowing are fear of reprisal and that no action will be taken; this policy serves to demonstrate that the Council has considered these issues and has introduced measures to properly deal with these concerns. Also, if an employer has taken all reasonable steps to prevent their employees suffering or subjecting others to unlawful detriment, it can avoid vicarious liability. Examples of reasonable steps include appropriate policies and training for employees on how to manage a whistleblowing disclosure.

5.2 In terms of legislative updates, the changes affect those making a disclosure in that they must now reasonably believe it to be in the public interest; the previous requirement for disclosures to be made in good faith has been removed. The other change relates to the introduction of personal liability for whistleblowing detriments.

6 EQUALITY IMPACT ASSESSMENT

6.1 An Equality Impact Assessment (EqIA) has not been completed because the report does not represent the introduction of a new policy or service or a significant review to an existing policy or service.

7 COMMUNITY SAFETY IMPLICATIONS

7.1 There are no Community Safety Implications.

8 HEALTH AND WELLBEING IMPLICATIONS

8.1 The Council is committed to ensuring its employees are protected from detriment and other unlawful actions; this policy sets out how anyone who needs to make a whistleblowing disclosure can do so without fear of reprisal.

9 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

9.1 The Council's Whistleblowing Policy has been reviewed and updated to take account of significant changes to process for raising concerns at work. Although anyone can make a whistleblowing disclosure, only employees are protected from detriment. It is essential that the Council updates its procedures in this regard in order to provide assurance to employees, and the general public, that wrongdoing will not be tolerated.

9.2 It is therefore recommended that this Policy is approved and implemented immediately. A relaunch of the Council's whistleblowing procedures is planned to ensure employees are aware of recent changes in legislation and understand how

their concerns will be managed as part of this process.

10 BACKGROUND PAPERS

10.1 There are no additional papers.

11 APPENDICES

11.1 Appendix A – Draft Whistleblowing Policy including flow chart

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

Rutland County Council

WHISTLEBLOWING POLICY

Version & Policy Number	Version 2 : Whistleblowing
Guardian	Head of Corporate Governance
Date Produced	November 2012
Review Date	November 2015
Next Review Date	November 2018

Approved by Audit and Risk Committee	September 2012
Approved by Full Council	November 2012
Approved by LJC	May 2013
Revisions discussed at DMT	30 November 2015
Revisions discussed at SMT	22 December 2015
Revisions approved by Cabinet	

Contents

1. Introduction

1.1 Rutland County Council is committed to ensuring that it, and the people working for it, complies with the highest standards of openness, honesty and accountability.

1.2 The term Whistle Blowing has a specific legal definition i.e. a disclosure or allegation of serious wrongdoing made by an employee and a wider public definition i.e. any disclosure or allegation of serious wrongdoing made by anyone. UK Whistle Blowing legislation was introduced by the Public Interest Disclosure Act 1998, which sets out to protect individuals who make certain disclosures of information in the public interest, to allow such individuals to bring action in respect of victimisation and for connected purposes.

1.3 This Policy seeks to cover both disclosures and allegations of serious wrongdoing made by employees and members of the public, and to demonstrate the Council's commitment to the protection of those who raise concerns in what they reasonably believe to be in the public interest. To this end, where this policy makes reference to a whistle blower; it refers to any individual (including Rutland County Council employees and/or members of the public) who is making a disclosure or allegation of serious wrongdoing. Examples of wrongdoing are:

- Breach of a legal obligation;
- Any criminal activity, including incitement to commit a criminal act;
- Corruption or fraud
- A miscarriage of justice
- A danger to the health or safety of an individual or damage to the environment
- Abuse of power or authority

1.4 Failure to comply with professional standards, Council policies or codes of practice/conduct. Committed by or related to the actions of:

- Rutland County Council employees;
- County Councillors; and/or
- Contractors, agency staff, suppliers or consultants of Rutland County Council in the course of their work for the Council.

1.5 The Council will investigate such allegations and, where appropriate, take action. The Council is also committed to preventing any harassment, victimisation or unfair treatment of any person arising from their whistle blowing, and where appropriate, will take disciplinary action against any member of staff responsible for such harassment, victimisation or unfair treatment against a whistle blower.

1.6 The Council is committed to the highest possible standards of openness, probity and accountability. In line with that commitment we expect employees, and others that we deal with, who have serious concerns about any aspect of the Council's work to come forward and voice those concerns. It is recognised that most cases will have to proceed on a confidential basis.

1,7 Employees are often the first to realise that there may be something seriously wrong within the Council. However, they may not express their concerns because they feel that speaking up would be disloyal to their colleagues or to the Council. They may also fear harassment or victimisation. In these circumstances it may seem easier to ignore the concern rather than report what may just be a suspicion of malpractice.

1.8 This Whistleblowing Policy makes it clear that any employee can do so without fear of victimisation, subsequent discrimination or disadvantage. This Policy is intended to encourage and enable employees to raise serious concerns within the Council rather than overlooking a problem or 'blowing the whistle' outside.

1.9 These procedures are in addition to the Council's Compliments, Comments and Complaints Policy and Procedures and other statutory reporting procedures applying to some departments. The Council will proactively publish these procedures to ensure all stakeholders are aware of its existence; It is also the individual responsibility of each stakeholder to ensure customers and members of the public are aware of the existence of these procedures.

1.10 The Policy has been discussed with the relevant trade unions and has their support.

1.11 A flowchart has been developed to guide you through the process; this can be found at Appendix A.

2. Aims and Scope of the Policy

2.1 The Policy aims to:

- encourage anyone to feel confident in raising serious concerns and to question and act upon concerns about practice;
- provide avenues to raise those concerns and receive feedback on any action taken;
- ensure that anyone making a disclosure receives a response to their concerns and knows how to pursue them if unsatisfied;
- reassure employees making a disclosure that they will be protected from possible reprisals or victimisation either from colleagues or the Council, as their employer, if they make a disclosure in what they believe is to be the public interest.

2.2 There are existing procedures in place to enable employees to lodge a grievance relating to their own employment contract. Anyone wishing to raise a matter under this subject should refer to the Council's Grievance Policy. The Whistleblowing Policy is intended to cover major concerns that fall outside the scope of other procedures and are outlined at section 1. above.

2.3 Thus, any serious concerns that anyone has about any aspect of service provision or the conduct of officers or Councillors or others acting on behalf of the Council can be reported under the Whistleblowing Policy. This may be about something that:

- makes someone feel uncomfortable in terms of known standards, own experience or the standards we believe the Council subscribes to; or
- is against the Council's Constitution and policies; or
- falls below established standards of practice; or
- amounts to improper conduct.

3. Safeguards

3.1 The Council is committed to good practice and high standards and wants to be supportive of anyone with legitimate concerns.

3.2 The Council recognises that the decision to report a concern can be a difficult one for anyone to make. If a disclosure is made in the public interest, in reasonable belief, there should be nothing to fear from acting to protect the interests of the Council and the people that it serves.

3.3 A whistle blower is protected from victimisation if they are:

- A worker
- Revealing information as set out at section 1. Above thus making what is known as a ‘qualifying disclosure’. This means that they are eligible for protection against detriment if they disclose under the employer’s recognised procedure.
- Revealing it to the right person, and in the right way making it a ‘protected disclosure’. (See section 7).

3.4 The Council will not tolerate any harassment or victimisation (including informal pressures) and will take appropriate action to protect any individual who raises a concern in accordance with this Policy.

3.5 Any investigation into allegations of potential malpractice will not influence or be influenced by any disciplinary or redundancy procedures that might already be in place.

4. Confidentiality

4.1 All concerns will be treated in confidence and every effort will be made not to reveal the identity of anyone reporting a concern if they so wish. At the appropriate time, however, they may need to come forward as a witness, to allow an investigation to proceed.

5. Anonymous Allegations

5.1 This Policy encourages everyone to put their name to their allegation whenever possible.

5.2 Concerns expressed anonymously are much less powerful but will be considered at the discretion of the Council.

5.3 In exercising this discretion the factors to be taken into account would include:

- the seriousness of the issues raised;
- the credibility of the concern; and
- the likelihood of confirming the allegation from attributable sources.

6. Untrue Allegations

6.1 If allegations are made frivolously, maliciously or for personal gain, appropriate and proportionate action may be taken against the individual making them.

7. How to Raise a Concern

7.1 As a first step, employees should normally raise concerns verbally or in writing to their immediate manager or their superior. This depends, however, on the seriousness and sensitivity of the issues involved and who is suspected of the malpractice. For example, if an employee believes that management is involved, an approach should be made to the nominated officers below. The telephone contacts for these senior officers are provided below.

- the Head of Corporate Governance (Deputy Monitoring Officer) - Diane Baker 01572 720941
- the Director for Resources (Monitoring Officer) – Debbie Mogg 01572 758358
- the Chief Executive – Helen Briggs - 01572 758201

7.2 Anyone else wishing to raise a concern can also contact the nominated officers above. Contact can be via the Council's dedicated email address whistleblowing@rutland.gov.uk or verbally to a nominated officer.

7.3 If the concern is about a child or vulnerable adult and is considered to be a safeguarding issue, the matter should be referred immediately to the Director of People.

- The Director of People – Dr. Tim O'Neil 01572 758402

7.4 Concerns should set out:

- the background and history of the concern (giving relevant dates);
- the reason why there is particular concern about the situation.

7.5 Although anyone making a disclosure is not expected to prove beyond doubt the truth of an allegation, there is a requirement to demonstrate to the person contacted that there are reasonable grounds for concern and that they believe there is a public interest in the matter.

7.6 If the person making the disclosure is an employee, they may invite a trade union or professional association representative or a friend to be present during any meetings or interviews in connection with the concerns raised.

8. How the Council will respond

8.1 Where appropriate, the matters raised may:

- be investigated by management (including the use of external investigators), internal audit, or through the disciplinary process;
- be referred to the police;
- be referred to the external auditor;
- form the subject of an independent inquiry.

8.2 In order to protect individuals and those accused of misdeeds or possible malpractice, initial enquiries will be made to decide whether an investigation is appropriate and, if so, what form it should take. The overriding principle which the Council will have in mind is the public interest.

8.3 Some concerns may be resolved by agreed action without the need for investigation. If urgent action is required this will be taken before any investigation is conducted.

8.4 Within **ten working days** of a concern being raised, the person with lead responsibility for managing the concern will write to you:

- acknowledging that the concern has been received;
- indicating how the Council proposes to deal with the matter;
- giving an estimate of how long it will take to provide a final response;
- advising whether any initial enquiries have been made;
- supplying information on support mechanisms, and
- advising whether further investigations will take place and if not, why not.

8.5 The amount of contact between the Officers considering the issues and those making a disclosure will depend on the nature of the matters raised, the potential difficulties involved and the clarity of the information provided.

8.6 Where any meeting is arranged, an employee can be accompanied by a union or professional association representative or a friend. A member of the public, or any other party, may be accompanied by a friend.

8.7 The Council will take steps to minimise any difficulties which an individual might experience as a result of raising a concern. For instance, if the person making the disclosure is required to give evidence in criminal or disciplinary

proceedings the Council will arrange for that person to receive advice about the procedure.

8.8 The Council accepts that anyone making a disclosure will need to be assured that the matter has been properly addressed. Thus, subject to legal constraints, the Council will inform the person making the disclosure of the outcome of any investigation.

9. The Responsible Officer

9.1 The Chief Executive has overall responsibility for the maintenance and operation of the Policy. The Head of Corporate Governance maintains a record of concerns raised and the outcomes (but in a form which does not endanger confidentiality), on behalf of the Chief Executive, and will assist in reporting as necessary to the Council.

10. How the Matter can be taken further

10.1 The Policy is intended to provide an avenue within the Council to raise concerns. The Council hopes that anyone wishing to raise a concern will be satisfied with any action taken. If not the following are possible contact points:

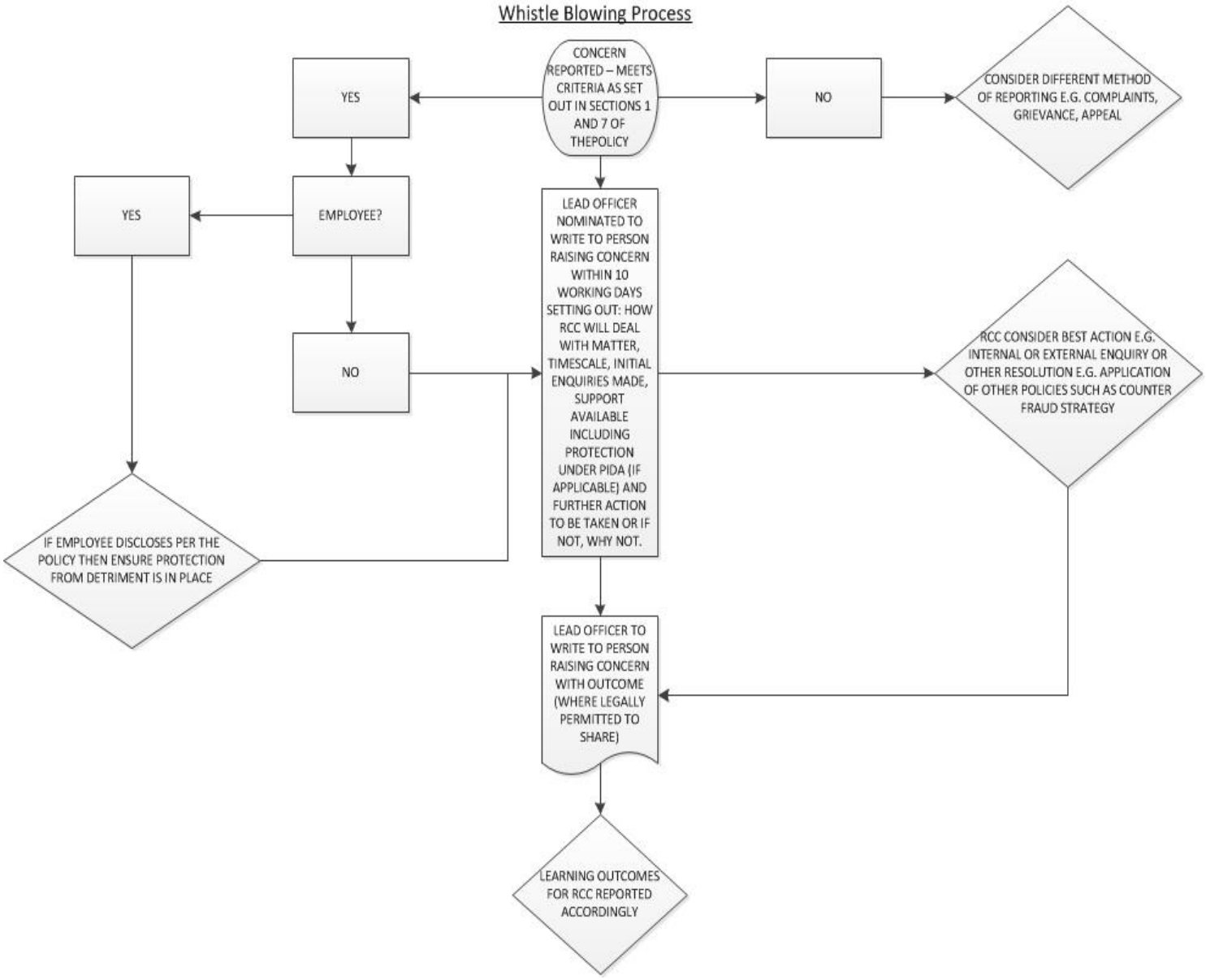
- the Council's Internal Audit team
- the Council's External Auditor;
- Public Concern at Work.
- the Police; or, for employees
- A trade union

10.2 If anyone decides to take the matter outside the Council, they should ensure that they do not disclose confidential information.

11. Maintaining the Policy

11.1 The Policy will be reviewed by the Audit and Risk Committee on a regular basis to ensure that it continues to be fit for purpose.

APPENDIX A



A large print version of this document is available on request

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County Council

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Report No: 17/2016
PUBLIC REPORT

AUDIT AND RISK COMMITTEE

26 January 2016

REGULATION OF INVESTIGATORY POWERS ACT 2000 (RIPA) QUARTERLY REPORT COVERING TWO QUARTERS JULY – SEPTEMBER 2015 AND OCTOBER – DECEMBER 2015

Report of the Director for Resources

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

DECISION RECOMMENDATIONS
That the Committee: 1. Notes the content of this quarterly report, which covers all RIPA activity during the period 1st July to 31 December 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 the period 1 July to 31 December 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 Audit and Risk Committee each quarter, or

thereabouts, 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 COMPLAINCE?

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 the period of this report 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 is required

5 ALTERNATIVE OPTIONS

5.1 Not applicable; there are no recommendations in this instance. 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

12.1 There are no background papers.

13 APPENDICES

13.1 There are no appendices.

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

Report No: 28/2016
PUBLIC REPORT

AUDIT AND RISK COMMITTEE

26 January 2016

INTERNAL AUDIT UPDATE

Report of the Head of Internal Audit

Strategic Aim:	All	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor Terry 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	N/A	

DECISION RECOMMENDATIONS
1. That Members note the Internal Audit update report (Appendix A) including the proposed timing for follow up reporting on "limited" assurance audit reports finalised since the last Committee meeting.

1 PURPOSE OF THE REPORT

1.1 To update Members on the progress made in delivering the 2015/16 Annual Audit Plan and key findings arising from audit assignments completed since the last Committee meeting.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 Update on Delivery of Internal Audit Plan

The progress made to date in delivering the 2015/16 audit plan is set out in Appendix A. At the time of reporting, ten assignments have been finalised, two reports are at draft report stage, and fieldwork and planning is underway on a further six assignments.

2.2 Implementation of Recommendations

Internal Audit require Officers to provide updates on all open audit actions on a monthly basis. Since the last Committee meeting, 16 recommendations have

been implemented. At the date of reporting, there are 28 actions which are overdue for implementation. Three of the overdue recommendations (as outlined in Appendix I) are classified as high priority and were due over 3 months ago. The Director of Resources and Assistant Director – Finance have reviewed the issues outstanding and do not consider the current risk to be high for following reasons:

- A suite of IT project documentation has been developed and is currently being applied to the key Liquid Logic (social care management system) project. This suite of documentation will be rolled out for all new projects commencing 1st April 2016 once reviewed for any lessons learnt or areas for improvement.

- The recommendation re Agresso is concerned with the setting up of new accounts rather than addressing weaknesses in the existing set up which compromise the integrity of transaction processing.

- The issue re the segregation of duties on the BACS system has been resolved following technical support.

2.3 **Limited Audit reports**

2.3.1 The Committee previously agreed that where audit work resulted in a "limited" opinion, it would receive the report in full and subsequently receive updates to satisfy itself that issues are being addressed. Limited assurance opinions have been given in the following areas:

- IT Systems Administration (Appendix B);

- External Placements (Appendix C); and

- Oakham Enterprise Park (Appendix D).

2.3.2 Unless the Committee specify otherwise, updates will be provided in September 2016.

3 CONSULTATION

3.1 No formal consultation is required.

4 ALTERNATIVE OPTIONS

4.1 The Committee is asked to note the report but may wish to receive an earlier update on limited assurance reports.

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 are 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 There are no equality implications.

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 latest update report, provided in Appendix A, details the findings of recent Internal Audit work and any weaknesses in the control environment highlighted by these reviews, and provides an overview of the performance of the Internal Audit team and the implementation of actions by management. The Committee plays an important role in the oversight of Internal Audit work.

11 BACKGROUND PAPERS

11.1 There are no additional background papers to the report.

12 APPENDICES

12.1 Appendix A: Internal Audit Update Report

12.2 Appendix B: System Administration 201516 Final Audit Report

12.3 Appendix C: External Placements 201516 Final Audit Report

12.4 Appendix D: Oakham Enterprise Park 201516 Final Audit Report

12.5 Appendix E: Internal Audit reports finalised since last Committee Meeting – Executive Summaries

12.6 Appendix F: IT Updates

12.7 Appendix G: Customer Satisfaction Statistics

12.8 Appendix H: Implementation of Audit Recommendations

12.9 Appendix I: ‘High’ and ‘Medium’ Priority actions overdue for more than three months

12.10 Appendix J: Limitations and responsibilities

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

Appendix A

RUTLAND COUNTY COUNCIL

INTERNAL AUDIT UPDATE

JANUARY 2016

Date: 26th January 2016

Introduction

1.1 The Welland Internal Audit Consortium provides the internal audit service for Rutland County Council and has been commissioned to provide 370 audit days to deliver the 2015/16 annual audit plan and undertake other work commissioned by the client.

1.2 The Public Sector Internal Audit Standards (the Standards) require the Audit and Risk Committee to scrutinise the performance of the internal audit team and – of equal significance – to satisfy itself that it is receiving appropriate assurance about the controls put in place by management to address identified risks to the Council. This report aims to provide the committee with the information, on progress in delivering planned work and on performance of the consortium, which it requires to engage in effective scrutiny.

Performance

2.1 **Will the Internal Audit Plan for 2015/16 be delivered?**

The Welland Internal Audit Consortium is currently under the management of LGSS. The Welland Board has set LGSS the objective of delivering at least 90% of the Internal Audit plans for 2015/16 to draft report stage by the end of March 2016.

At the date of writing, ten final reports have been issued, two reports are at draft report stage, and work is in progress on a further six assignments. Progress on individual assignments is shown in Table 1. By the end of January 2016, it is estimated that 71% of the audit plan will be completed to draft report stage and a further 10% of the assignments will be in advanced delivery stages.

2.2 **Are audits being delivered to budget?**

Internal Audit is on target to deliver the audit plan within the commissioned days. Any overruns on individual assignments are managed within the overall budget.

2.3 **Is the Internal Audit team achieving the expected level of productivity?**

The most recent information available (week 40) shows that the Internal Audit team are spending 92% of time on chargeable activities against a target of 90%.

2.4 **Are clients satisfied with the quality of the Internal Audit assignments?**

Customer satisfaction questionnaires are issued on completion of audits. At the time of reporting, five questionnaires had been returned (of nine issued) with an average score of 'Good'. See Appendix G for further details.

2.5 **Based upon recent Internal Audit work, are there any emerging issues that impact on the Internal Audit opinion of the Council's Control Framework?**

Since the last Committee meeting, seven audit reports have been finalised. Three of the reports in relation to **IT Systems Administration, External Placements** and **Oakham Enterprise Park** have resulted in Limited Assurance opinions. Copies of the full reports are provided in Appendices B, C and D.

Reviews of **Demand Led Budgets** and **Public Health Budgets** have provided Sufficient Assurance opinions and a review of **Payroll** resulted in a Substantial Assurance opinion. A review of **Financial Transparency** was completed which was a consultancy style, benchmarking review and this concluded that Rutland County Council demonstrated a high level of transparency in relation to its budget setting and monitoring and the Transparency Code when compared with other local authorities. Copies of the Executive Summaries from all four reports are provided in Appendix E.

Based upon the findings and the actions agreed with management to address any identified weaknesses in the control environment, these would not currently reduce the Internal Audit Assurance opinion of the Council's overall Control Framework.

In addition, the **Capital Allocation Programme Board** report has been reviewed since the last Committee meeting and management comments have been updated.

2.6 Has progress been made in addressing the weaknesses identified in recent IT audits?

During 2014/15 and 2015/16 a number of IT audits have been performed which have resulted in Limited Assurance opinions and high priority recommendations. As such, it was agreed at the September 2015 Audit and Risk Committee meeting that full updates would be provided on progress made in addressing the areas of weakness identified by recent IT audits.

Appendix F provides details of the key actions taken to address the findings of the IT Asset Management (Limited Assurance) and IT Service Desk and Change Management (Sufficient Assurance) audits from 2014/15 and progress made in addressing the recommendations made in the recently issued IT Systems Administration report (Limited Assurance). Internal Audit have confirmed with the Head of IT that all recommendations in all three reports have been actioned, including those from the IT Systems Administration report issued in December 2015. A number of improvements have been made to the controls in all three areas and action has been taken to ensure these are consistently enforced.

In order to provide assurance that the controls implemented are fully embedded and operate effectively in practice, Internal Audit will review these again as part of the follow up on Limited Assurance reports.

2.7 **Are clients progressing audit recommendations with appropriate urgency?**

Outstanding audit recommendations now form part of the Quarterly Performance Report considered by Cabinet. Since the last Committee meeting, 16 actions arising from audit reports have been implemented.

At the date of reporting, there are 28 actions which are overdue for implementation. Three of the overdue recommendations are classified as high priority and were due for implementation over three months ago. See Appendices H and I for further details.

Table 1: Progressing the annual audit plan

KEY
Current status of assignments is shown by ●

Assignment	Budget	Actual	Not Started	Planning	Field Work Underway	Field Work Complete	Draft Report	Final Report	Assurance Rating	Comments
Financial Risks										
Creditors	10	0		●						Quarter 4
Debtors	10	19.5					●			
Local Taxes	14	18.3				●				
Benefits	10	15.1				●				
Payroll	11	14.2						●	Substantial	Final
Financial Governance & Transparency	7	5.8						●	n/a	Final
Fraud Risks										
Fraud Risk Review	15	4.1			●					Quarter 4
Service Delivery Risks										
Better Care Fund Monitoring	15	2.2			●					Quarter 4
Recruitment of Interim and Agency Staff	15	15.7						●	Sufficient	Final

Assignment	Budget	Actual	Not Started	Planning	Field Work Underway	Field Work Complete	Draft Report	Final Report	Assurance Rating	Comments
Contract Procedure Rules Compliances	15	13.5					●			
Capital Allocations Programme Board	20	18.5						●	Sufficient	Final
Digital Broadband	15	1.7			●					
Kerbside Collections	15	13.9						●	Sufficient	Final
Oakham Enterprise Park	15	12.3						●	Limited	Final
Demand Led Budgets	20	16						●	Sufficient	Final
External Placements (Care Packages)	15	24.5						●	Limited	Final Budget overrun due to complexity of testing required and issues identified.
Care Act Implementation	20	8.3			●					Fieldwork 50% complete
Public Health Budgets	15	11.9						●	Sufficient	Final
Limited Assurance Reports	15	0.7		●						Quarter 4
IT										

Assignment	Budget	Actual	Not Started	Planning	Field Work Underway	Field Work Complete	Draft Report	Final Report	Assurance Rating	Comments
System Administration	15	18.9						●	Limited	Final
Contingency	15	0	●							Quarter 4
Client Support (Committee support, training, client liaison)	34	12.4								
Consortium Management	34	19.45								
TOTAL	370	266.95								

Notes

At the completion of each assignment the Auditor will report on the level of assurance that can be taken from the work undertaken and the findings of that work. The table below provides an explanation of the various assurance statements that Members might expect to receive.

Substantial	There is a sound control framework designed to manage or mitigate risks to the achievement of defined objectives. Testing confirms that the controls are being applied consistently.
Sufficient	The control framework is basically sound but either • there are minor gaps or weaknesses which mean that some risks are not fully managed or mitigated; or • testing provides evidence of non-compliance sufficient to weaken the effect of some controls.
Limited	There are significant weaknesses in key elements of the control framework which mean that significant risks are not managed or mitigated. Testing demonstrates significant levels of non-compliance with prescribed processes and procedures
No	The controls identified are not sufficient to manage/mitigate identified risks to the achievement of defined objectives. Testing demonstrates high levels of non-compliance with prescribed processes and procedures.

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Rutland County Council

Appendix B

INTERNAL AUDIT REPORT

the Welland Internal Audit Consortium

IT SYSTEM ADMINISTRATION 2015/16

Issue Date:	10th December 2015	***Issued to:***	Andy Nix – Head of IT
Author:	Nicola Scott		Jason Haynes – Performance & Application Support Team Manager
			Debbie Mogg – Director for Resources
			Helen Briggs – Chief Executive
			Sav Della Rocca – Assistant Director (Finance)
			Cllr King – Portfolio Holder for Place, Finance and Resources (final report only)
			Cllr MacDuff – Chair of Audit & Risk Committee (final report only)

IT SYSTEM ADMINISTRATION 2015/16

EXECUTIVE SUMMARY

1. INTRODUCTION & OVERALL OPINION

The annual Internal Audit Plan contains a number of days to cover ICT audits and is subject to approval by the Audit & Risk Committee. Potential risk areas and areas of concern are then discussed with and agreed by the Director for Resources as scope for audits in the current audit year. IT System Administration was selected as an area for review during the 2015/16 Audit Plan as it is important that the Council has effective IT System Administration of both the network and the business critical / sensitive applications. Whilst members of the IT team act as network administrators, some system administrators are based in service areas, outside of the IT team.

As all members of the IT team act as network administrators, there is sufficient cover for service users. All administrators within the IT team have their own admin accounts and any generic passwords required to access specific systems or routers are stored securely. Adequate back up procedures were found to be in place for all servers and the Council is subject to annual Public Sector Network Code of Connection compliance reviews which include a review of the adequacy of network parameters. New network users must be authorised and sample testing confirmed that these are being set up in a timely manner and with appropriate access rights. A procedure is also in place to notify the IT team of leavers so access can be promptly revoked.

Some controls were highlighted which require improvement to ensure the effective administration of the network. In areas, the testing conducted and assurances which could be given were limited due to restrictions in the availability of key information. It was identified that there are no regular reviews conducted of network users to identify any redundant user accounts and Internal Audit could not be provided with a report of all current network user accounts at the time of testing in order to verify the validity of all network access. It should be noted that if a Council leaver was to remain as an active IT user; their network access would be restricted by not having physical access to Council buildings and equipment. Review of remote access users however, did identify three leavers which still had live access to the Council's network resulting in a risk that Council records could be reviewed and altered from remote locations.

Currently the Council also does not have an IT Change Management methodology and event logs of actions by network administrators are not available. Network performance is also not recorded, monitored or reported. Internal Audit have been assured that there are already plans to address the issues identified and an action plan has been agreed with the newly appointed Head of IT.

Testing of three Council systems determined that System Administrators were aware of their responsibilities and that they have access to assistance from the IT team when required. Processes to request new users were however in some cases informal, despite relating to systems containing some sensitive data. It was noted that System Administrators are not notified of leavers from the Council resulting in a risk that access is not revoked in a timely manner. The access rights to each system were not subject to periodic review and incidences were identified where former staff retained access rights. These have since been revoked.
These issues are addressed by the recommendations in the Action Plan of the report. The audit was carried out in accordance with the agreed Audit Planning Record (APR), which outlined the scope, terms and limitations to the audit. It is the Auditor's Opinion that the current overall design and operation of controls provides **Limited Assurance**, as summarised below:

Internal Audit Assurance Opinion	Direction of Travel				
Limited Assurance	N/A				
Risk	**Design**	**Comply**	**Recommendations**		
			H	**M**	**L**
01 - The Council does not have an effective and controlled 'system administration' of its network.	**Limited Assurance**	**Sufficient Assurance**	0	2	1
02 - The Council does not have an effective 'system administration' of its business critical / sensitive applications.	**Limited Assurance**	**Sufficient Assurance**	0	2	0
Total Number of Recommendations			**0**	**4**	**1**

2. SUMMARY OF FINDINGS

Risk 1: The Council does not have an effective and controlled 'system administration' of its network.

All officers within the Council's IT team act as network administrators. The team is structured into different officer levels that in turn provide different levels of support to network users. A team calendar is in place and officer leave is managed to ensure appropriate cover. Network administration is conducted through separate, named administrator accounts set up for each member of the IT team. Whilst the use of generic user names and passwords should be avoided wherever possible, the IT team have stated that these are required in certain incidences, such as accessing routers. In these cases, the generic passwords are being saved in a secure application to which access is only given when officers have been working with the team for a period of time and a level of experience and trust has been established.

Appropriate back up procedures for all servers were found to be in place. Backups are taken at frequent intervals to hard drive and to tape, with tapes being stored securely off site. An example of successful recovery of back up data was also provided.

The Council is subject to stringent annual Public Sector Network Code of Connection compliance reviews which include the review of some network parameters such as password length and complexity.

New network users must be authorised by a line manager and testing confirmed that the users reviewed were authorised, set up in a timely manner and with appropriate access levels. New user testing was restricted, however, to only the most recent requests from the ICT helpdesk inbox as due to system limitations it was not possible to test and verify a sample independently selected by Internal Audit. The IT team are notified of leavers by an email alert from the HR Team and a diary note is created to help ensure the access is revoked in a timely manner. If the team are notified of any user who has been missed and should no longer have access to the system, the access is revoked with immediate effect.

Areas for improvements were also identified. Currently no audit trail is available of actions taken by systems administrators to network access and settings. This would result in an inability to trace and evidence the cause of an issue in the event of error or impropriety.

The Council also has no IT Change Management methodology in place and currently required network changes are recorded as help desk calls or if deemed significant classified as a project, however there is currently no guidance or

templates to outline requirements or to provide consistency. Introduction of a methodology would allow effective recording and monitoring of required IT changes and their associated authorisation, testing and implementation. An Internal Audit recommendation was made surrounding this issue in the Service Desk & Change Management Audit Report 2014/15 and discussion with the newly appointed Head of IT determined that plans are in place to address this issue.

There are no periodic reviews of all network users resulting in a risk that those no longer requiring access to the network remain as active users. As no periodic review was available and a report of all current network user accounts could not be provided to Internal Audit at the time of testing it could not be independently verified that all access related to current, bona-fide employees. It should be noted however, that if a Council leaver was to remain as an active IT user; their network access would be restricted by not having physical access to Council buildings and equipment. The Head of IT has plans to introduce monthly reports of inactive users which will identify any user accounts that need to be revoked, see Action Plan below.
The list of 359 remote access users was reviewed. Whilst the majority of users were found to be legitimate staff, Member or ICT access accounts, 19 could not be easily identified and attributed to a staff or IT user and require further scrutiny by the ICT team. A further 23 were found to be leavers, although their network access had been disabled or revoked, preventing access to Council systems. Three leavers were found to be both on the remote access list and have live network access network resulting in a risk that Council records could be reviewed and altered from remote locations. One of the leavers was also found to be an active user on one of the sub systems covered in the scope of this audit review. A summary of the remote access testing has been provided to the IT team to ensure the leavers were immediately revoked and all queries are investigated.

Performance of the network is not currently monitored or reported. Such exercises would be beneficial to both create a benchmark of 'normal' performance and allow potential problems to be proactively avoided, but also allow any issues to be detected, isolated and resolved in a timely manner.

Risk 2: The Council does not have an effective 'system administration' of its business critical / sensitive applications.

The audit reviewed the system administration of the RAISE (Adult & Children Social Care) system, FLARE (licensing) system and ELREG (Elections) system. The System Administrators sit outside of the core IT team, either within the Performance, Application & Support team or in individual service areas. The System Administrators interviewed were clear on the responsibilities which were outlined in their job descriptions and could describe arrangements to cover absences.

Testing determined that named rather than generic administrator accounts are in place and that when required administrators will contact the core IT team for support, for instance in the event that an update or patch is required. System Administrators have also developed procedures to clone the access of an equivalent user when creating a new account on their system to ensure that the access level given is appropriate to the user's need.

Some areas for improvement were identified however. Whilst the core IT team are notified of all Council leavers, currently system administrators do not receive such notification and so there is no prompt to revoke the access of such users from individual systems. This could be improved by IT forwarding the notifications they receive to a defined list of System Administrators.

Some controls were also found to be weak. For one of the systems reviewed, forms had been created to record the request for a new user to the system including authorisation of the request by line management, however in the case

of the other systems, procedures were more informal and in some cases requests were made verbally with no records available of the request or associated authorisation. This authorisation should be consistently required and evidenced when providing access to a system holding sensitive data.

It was confirmed that system event logs were available for the three systems tested, however it was also confirmed that system users were not periodically reviewed. In one case a System Administrator had carried out an ad hoc review of system users, but when this system was reconciled to HR records during audit testing some Council leavers were identified as still having current accounts on the system. These were reported and have now been revoked. System Administrators would benefit from some advice in best practice in terms of network administration, see Action Plan below.

3. ACTION PLAN

The following Action Plan provides a number of recommendations to address the findings identified by the audit. If accepted and implemented, these should positively improve the control environment and aid the Council in effectively managing its risks.

4. LIMITATIONS TO THE SCOPE OF THE AUDIT

This is an assurance piece of work and an opinion is provided on the effectiveness of arrangements for managing only the risks specified in the Audit Planning Record.

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.

Rutland County Council

the Welland Internal Audit Consortium

ACTION PLAN

Rec No.	ISSUE	RECOMMENDATION	Management Comments	Priority	Officer Responsible	Due date
1	There are no audit reports or event logs available of changes to network access and settings. This would result in an inability to trace and evidence the cause of an issue in the event of error or impropriety.	The Head of IT introduces a mechanism to record changes to network access and settings (such as changes to standing data/parameters) by network administrators, including the details of the action, time and date of the action and officer responsible.	A change control process will be introduced that will document significant changes to the ICT infrastructure. Automatic Audit logging will be investigated to see how this can help reduce risks of the inability to trace cause of issues.	Medium	Head of IT	End Jan 2016 End Feb 2016
2	There are no periodic reviews of all network users resulting in a risk that those no longer requiring access to the system remain as active users. Audit testing could not verify that all users were current employees as a report of all current network accounts was not available at the time of audit testing.	The Head of IT introduces monthly reports of inactive users to allow identification of any users whose access should be revoked. Any inactive users should be queried with HR and user access revoked if required. Such periodic reviews should also include the remote access list to ensure that leavers' remote access rights are also removed.	Monthly meetings have now been introduced to provide reports of inactive users on the network. These will be investigated with HR to establish if the access should be revoked.	Medium	Head of IT	Complete
3	Performance of the network is not currently monitored or reported.	The Head of IT should introduce a means to record, monitor and report network performance.	Where possible the performance of the network will be monitored – however this is likely to be in specific areas of concern and therefore reactive in nature	Low	Head of IT	Ongoing
4	Whilst the core IT team are notified of all Council leavers, currently system	The Head of IT introduces a system to ensure that leaver notifications are	The process for leavers will be reviewed to ensure that system	Med	Head of IT	End Jan 2016

Rec No.	ISSUE	RECOMMENDATION	Management Comments	Priority	Officer Responsible	Due date
	administrators do not receive such notification and as such there is no prompt to revoke the access of such users.	forwarded to a defined list of System Administrators.	administrators are aware of leavers.			
5	Some system administration controls, particularly in relation to system access, were found to be weak in systems that sat outside of the remit of the core IT team.	Head of IT develops and distributes best practice guidance to all System Administrators outside of the core IT team. Such guidance should include, but may not be limited to; • Authorisation and recording of user access requests and set up, especially in regards to systems containing sensitive data; • Periodic user access reviews; • Ensuring audit log functionalities are activated on all systems.	A best practice guide will be produced and system administrators asked to complete a questionnaire regarding system administration.	Med	Head of IT	End Feb 2016

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 Recommendations

The Auditor prioritises 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.

Priority	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.

Rutland County Council

Appendix C

INTERNAL AUDIT REPORT

the Welland Internal Audit Consortium

External Placements
2015-16

Issue Date:	04 December 2015	***Issued to:***	Tim O'Neill, Director for People
Author:	Trevor Croote		Mark Andrews, Deputy Director for People
			John Morley, Head of Adult Social Care
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			Emma Jane Perkins, Service Manager (Adult Social Care)
			Karen Kibblewhite, Head of Commissioning
			Helen Briggs, Chief Executive (final report only)
			Sav Della Rocca, Assistant Director (Finance) (final report only)
			Cllr Clifton – Portfolio Holder for Adult Social Care and Health (final report only)
			Cllr Willby – Portfolio Holder for Lifelong Learning (final report only)
			Cllr King – Portfolio Holder for Place, Finance and Resources (final report only)
			Cllr MacDuff – Chair of Audit & Risk Committee (final report only)

External Placements 2015-16
Executive Summary

1. Introduction and overall opinion

The People Directorate accounts for over 45% of all money spent by the Council and provides services to some of the most vulnerable local residents. A significant proportion of these services are delivered by external providers and it is important to ensure that the Council has a robust framework of controls to ensure services are being delivered to the required standard and achieve value for money. Based on discussions with management and analytical review, the audit focused on special educational needs (SEN) placements, disabled children residential care, learning disability residential care and older people residential care.

A Head of Commissioning has been appointed and has been tasked with developing a strategic approach to all commissioning activity within the department. At the time of audit, this work was in the early stages of development with plans in place to establish a project group and appropriate governance arrangements.

An Individual Placements policy has been drafted. At the time of audit testing, the policy was yet to be finalised, formally adopted and fully implemented. The draft policy includes a requirement for specialist procurement input into the commissioning process which, if implemented, will help to ensure value for money and provide additional safeguards through separation of duties. Evidence to demonstrate the achievement of value for money (VFM) needs to be better documented in most cases and sample testing found a majority of placements were not supported by a valid signed contract. The approach to contract management also needs to be clarified and strengthened, particularly in relation to out-of-county and educational placements. It was highlighted that there are well established processes in place for dealing with any safeguarding concerns in external placements. Testing identified, however, that the processes for undertaking checks at the pre-contract stage could be improved to ensure all checks are consistently evidenced.

Based on these findings, the framework of controls currently in place provide ***Limited Assurance*** that the identified risks have been appropriately mitigated. Detailed findings are set out in section 2 below. The audit was carried out in line with the scope set out in the approved audit planning record (APR). The assurance opinion is based upon testing of the design of controls to manage the identified risks and testing to confirm the extent of compliance with those controls, as summarised in Table 1 below.

Table 1 – Assurance opinion

Internal audit assurance opinion	Direction of travel				
Limited Assurance	N/A				
Risk	**Design**	**Comply**	**Recommendations**		
			H	**M**	**L**
Risk 1 - Weak or ineffective arrangements for procuring external placements with limited challenge or negotiation of costs leading to poor value for money.	Limited assurance	Limited assurance	2	7	0
Risk 2 - Inadequate arrangements for ensuring compliance with contracts, including service quality (e.g. safeguarding) and financial management.	Limited assurance	Sufficient assurance	3	3	1
Total number of recommendations			**5**	**10**	**1**

Summary of findings

Risk 1 – Weak or ineffective arrangements for procuring external placements with limited challenge or negotiation of costs leading to poor value for money.

Management asserted that the lack of a formal departmental commissioning strategy has been a long-standing issue within the directorate. Positive action was taken to address this last year with the appointment of a new Head of Commissioning tasked with developing a strategic approach to all commissioning activity within the department. At the time of audit, due to other workload pressures and limited capacity, development of the strategy was inevitably still in the early stages with intentions to establish a project group and appropriate governance arrangements still at the planning stage.

Officers stated that opportunities to improve value for money through greater use of block and framework contracts will be considered as part of development of the departmental commissioning strategy. At present, limited use is made of such agreements. Whilst there is no evidence that this has had a detrimental effect on value for money, the size of the Council means it has limited purchasing power or capacity to negotiate preferential rates when making spot purchases. There may, therefore, be merit in considering working collaboratively with other councils or NHS bodies to develop framework agreements or other joint commissioning arrangements.

The approach to individual placements is set out in a draft policy dated September 2013, although the policy has not yet been finalised or formally adopted by the Council. Consequently, some aspects of the policy have not been fully implemented or embedded into current procedures. For example, the draft policy specifies that the Contracts and Procurement Team should be involved in the commissioning process, including negotiation of costs to help ensure value for money. In practice, due to limited capacity in the contracts and procurement team, the commissioning process is largely led by social workers with little specialist procurement input. Social workers are inevitably focused on addressing the needs of the service user and do not necessarily have the skills or experience to manage the commissioning process most effectively. The involvement of specialist procurement staff in the commissioning process as set out in the draft policy is more likely to maximise value for money and would provide additional safeguards through separation of duties.

Placements are exempt from the competition requirements of Contract Procedure Rules (CPRs), subject to approval by the relevant Chief Officer, Head of Legal, Director of Resources and portfolio holder. However, there is a lack of clarity amongst some staff about whether an approval is required for all individual placements or just those with new providers.

Given that placements are exempt from contract procedure rules it is important that alternative arrangements are in place to demonstrate how value for money has been achieved. For older people residential care services the Council negotiates and sets annual standard banded rates. The standard rates are applied whenever possible although some flexibility is necessary based on needs and availability of places. For other services officers asserted that value for money is achieved primarily through obtaining costings from a minimum of three potential providers, although this is not always possible in cases involving specialist or complex care. Negotiation of cost is particularly difficult in cases where there are few or only one provider willing and able to meet the assessed needs. Nevertheless, CPRs require

the basis for selection of providers to be clearly documented and officers asserted that this is usually set out in the relevant funding panel referral form.

Officers stated that arrangements are in place to ensure that a formal contract with appropriate terms and conditions is in place for all placements and that all contracts have been reviewed and approved by legal services. A record of all contracts is maintained and a system is in place to provide an early warning of contracts that are due to expire. CPRs require the relevant Chief Officer to be satisfied that any contract extension achieves value for money and must record the basis of this conclusion. All extensions have to be approved by the relevant Chief Officer, Head of Legal, Director of Resources and relevant portfolio holder and are recorded using a standard form.

CPRs require the Chief Officer to ensure that the provider meets the relevant national minimum standards (for example those set out in relevant legislation). It is also good practice to ensure that providers are fit for purpose prior to making a placement by checking relevant policies, procedures (such as safeguarding arrangements, health and safety, business continuity etc.), insurances and financial standing. Officers asserted that basic checks are always undertaken (e.g. CQC registration) to ensure that service users are not placed at risk. However, there was a lack of clarity over the extent of the expected checks, who was responsible for undertaking them or how they should be documented. Consequently there is a lack of consistency in how these checks are undertaken and evidenced; which could result in the Council finding it difficult to demonstrate the exercise of appropriate due diligence if challenged.

The draft Individual Placements policy includes a Core Process Checklist with a specific section to demonstrate how value for money has been achieved, for example through benchmarking, negotiation of costs and use of various costing tools. Officers asserted that the checklist is not regularly used in practice and that documentation to demonstrate value for money could be more robust. Furthermore, access to tools such as the national care funding calculator is no longer available as the Council has not renewed its subscription to these services.

Based upon these findings, the assurance rating for the design of controls in respect of this risk is ***limited assurance***.

A sample of 20 placements was tested and found:

- there was no valid current contract in place for 13 (65%) of the placements and nine of these (45%) also had no Individual Placement Agreement (IPA);
- four cases related to SEN placements and officers asserted that current procedures do not require contracts in respect of maintained schools;
- where contracts were in place all included relevant clauses and provisions;
- the basis for shortlisting and selection of providers was not clearly documented in many cases;
- there was no clear evidence of any pre-contract checks in 11 cases (55%) and checks in respect of the other nine were variable in nature and coverage;
- there was no evidence of pre-contract checks of policies, procedures or insurance in any of the cases tested;
- financial checks were evidenced in seven cases, although some providers were classified as high risk and it was not clear how the information influenced the placement decision or any subsequent actions;
- CPR exemption approval forms were seen in only one of the cases tested, although officers asserted that some cases pre-date the approval requirement and, as stated above, there was a lack of clarity over whether an exemption was required for all placements or just those with new providers;

- the Core Process Checklist was seen in only two cases and there was limited evidence available of consideration of value for money, although older people residential placements were consistent with agreed banded rates in most cases; and
- funding panel approval forms were not available in three cases and a further three were unsigned.

Based upon these findings, the assurance rating for compliance with controls in respect of this risk is ***limited assurance***.

Risk 2 – Inadequate arrangements for ensuring compliance with contracts, including service quality (e.g. safeguarding) and financial management.

The Council has clear and well established arrangements for dealing with safeguarding concerns, including those related to external providers. There are designated safeguarding managers and internal meetings are held every two weeks to discuss any relevant issues and concerns. Safeguarding concerns can be raised through a number of sources and are initially routed through the Duty Team. As well as contractual requirements to notify the Council, all external providers have a 'duty of candour' meaning they are legally required to record and inform the Council and CQC of all safeguarding incidents.

The response to safeguarding reports depends on the nature and seriousness of the incident. However, officers asserted that any serious safeguarding issues related to external providers are likely to result in the suspension of future placements pending investigation. A full and detailed review of safeguarding procedures was outside of the scope of this audit although adult safeguarding arrangements have recently been subject to peer review by the Association of Directors of Adult Social Services (ADASS).

It is the responsibility of individual providers to ensure that their staff are properly trained to deal effectively and appropriately with all safeguarding issues. However, it is good practice for councils to support safeguarding training for external providers, particularly for smaller providers that may not have the necessary infrastructure to deliver in-house training. In the past, the Council used to facilitate safeguarding training for external providers through a subscription to the Leicestershire Social Care Development Group (LSCDG) although this was ended some time ago as part of departmental efficiency savings.

Contract Procedure Rules state that all contracts should have a named contract manager who must monitor the overall performance of the contract. There are, however, no documented procedures for contract management and the draft Individual Placements Policy does not clearly specify roles, responsibilities or procedures for contract management. In practice, the relevant budget holder is regarded as the nominated contract manager and responsibilities are shared between the contracts and procurement team and relevant case worker. The contracts and procurement team monitor in-county residential contracts to ensure compliance with overall contractual terms and quality requirements whilst the relevant case worker is responsible for ensuring the needs of individual service users are being met and are regularly reviewed and updated when necessary.

Monitoring by the contracts and procurement team includes the following.

- Quarterly monitoring returns – gathering information from each provider on occupancy, staffing levels, safety incidents, safeguarding concerns etc. This information is shared with the Duty Team and used to determine whether a targeted inspection or other follow-up action is necessary.
- Annual inspections – covering most aspects of contractual requirements such as staffing levels, training, policies, insurances, health and safety, communications etc.

- Targeted inspections – focused on a specific area

or areas of concern arising from quarterly monitoring information, Care Quality Commission (CQC) reports, previous inspections etc.

Officers asserted that inspections are recorded using standard forms and any issues or recommendations are followed up by the most appropriate means.

For out-of-county placements reliance is placed on the contract and performance monitoring arrangements of the relevant 'host' council. Officers liaise closely and meet regularly with neighbouring councils through various forums and share intelligence and any concerns about providers, although there is no routine mechanism for sharing and recording specific performance monitoring information between authorities. The Council also works closely and meets regularly with the CQC and contracts compel all providers to inform the Council of any safeguarding incidents or other significant issues and events. Nevertheless, the current system is largely reactive and relies on third parties informing the Council of issues and concerns. Without a programme of proactive monitoring of out-of-county providers there is an increased risk that poor service quality or non-compliance with contractual obligations could go undetected.

For SEN placements reliance is placed on the annual review process which is focused on assessing the progress and needs of the service user. It is the school's responsibility to arrange and manage annual reviews and to involve the Council by sharing relevant information and reports and inviting the Council to attend the review meeting. The school also leads the process of setting personal objectives and targets for the service user but the Council has an opportunity to review and challenge these targets. Officers asserted that review meetings are attended whenever possible but that the current caseload and limited resources means that it is not possible to attend them all. There is currently no process in place for monitoring compliance with overall contractual obligations in respect of SEN placements.

The Care Act introduced a responsibility on councils to manage failure of providers in their area, even if the provider has no local authority funded residents. In response to this requirement the Head of Commissioning has drafted a policy for managing provider failure which follows national guidance. The CQC undertake national monitoring of certain 'hard to replace' providers, of which three operate within Rutland. For other Rutland providers officers asserted that financial failure is relatively low risk as there are few large national providers in the area and a relatively high proportion of self-funders. However, there is currently no evidence of formal risk assessment or periodic refresh of financial checks in respect of individual providers. A corporate review of financial assessment processes is currently being carried out by a working group led by the Procurement and Contracts Team Manager which should address this issue.

Payments to residential care providers are managed by the Community Care Finance team. The team is informed of all placements by way of a signed Notice of Placement (NoP) which sets out the details of the placement and agreed payment rates. The finance team makes regular payments to the provider based on the rates set out in the NoP. For SEN placements a purchase order is raised on Agresso and approved by the Head of Service. Termly invoices are checked to the placements budget spreadsheet (which records all placements, agreed rates and dates) before being approved for payment by the SEN Operations and Finance Officer.

Based primarily on the lack of contract monitoring in respect of out-of-county and SEN placements, the assurance rating for the design of controls is ***limited assurance***.

Testing of a sample of 20 placements found that 14 (70%) were out-of-county and therefore not subject to in-house inspections. Of the six in-county placements:

- one related to an SEN placement and was therefore not subject to any contract monitoring activity;

- evidence of some form of inspection was seen for all of the remaining five cases. It was noted that one inspection was over two years old and the other four were all targeted inspections focused on specific areas or follow-up of previous issues. There was no evidence of a routine annual inspection in any of these cases but officers asserted that all inspections tend to be targeted in this way as there is insufficient capacity to carry out a full annual inspection of every in-county provider; and
- in one case the inspection report included recommendations that were classified as 'immediate actions required'. Officers asserted that they believed the actions were followed up at the time of the inspection but were unable to locate the evidence.

Testing confirmed that an annual review had been conducted in 17 of the 20 cases in the sample (85%). Of the remaining three, one review was planned but overdue due to a backlog of work. One related to an educational exclusion placement in which there was evidence of review by the school but no evidence of council involvement in the review process. One case related to an SEN placement in which details of the review had been requested by the Council but not provided by the school at the time of audit.

Testing of a sample of 19 payments found that 18 (95%) were supported by an approved Notice of Placement or official purchase order. Payment rates were agreed to contract documents in 14 out of 15 cases (93%): one SEN payment was lower than the rate in the contract but was consistent with the initial quote provided by the school.

Although monitoring of compliance with overall contractual obligations needs to be improved, there is clear evidence that individual placements are being regularly reviewed to ensure service users' needs are being met. Based upon these findings, the assurance rating for the operation of controls is ***sufficient assurance***.

The Action Plan at appendix 1 provides a number of recommendations to address the findings identified by the audit. If accepted and implemented, these should positively improve the control environment and aid the Council in effectively managing its risks.

2. Limitations to the scope of the audit

This is an assurance piece of work and an opinion is provided on the effectiveness of arrangements for managing only the risks specified in the Audit Planning Record. 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.

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Appendix 1

Action plan

Rec no.	Issue	Recommendation	Management comments	Priority	Officer responsible	Due date
Risk 1: Weak or ineffective arrangements for procuring external placements with limited challenge or negotiation of costs leading to poor value for money.						
1	A placements policy exists but has not been finalised, formally adopted or fully implemented in practice.	The draft Individual Placements Policy should be reviewed, updated, approved and fully implemented. It should include detailed process maps for all placement types and examples of completed documents.	The placements policy will be reviewed in line with the recommendations and implemented with the agreement of the three service heads.	H	Head of Commissioning / Head of Adult Social Care) / Head of Lifelong Learning	31 January 2016
2	The commissioning process is led by social workers with limited specialist procurement input. The involvement of specialist procurement and contract compliance staff would represent a better use of relevant skills and experience and help to ensure value for money and improve probity safeguards through separation of duties.	Prepare a business case with cost/benefit analysis to determine the options and viability of using specialist procurement and contract compliance staff in the identification and short-listing of providers and negotiation of costs in respect of all placements.	A business case was previously prepared for this but was not progressed for reasons unknown as this pre-dates the current Heads of Service. Consideration will be given to reviewing this and taking it forward.	M	Head of Commissioning	31 January 2016
3	Lack of a departmental commissioning strategy has been a long-standing issue. Positive action has been taken to appoint a Head of Commissioning to prepare a strategy, which is currently in the early stages of development	A project plan and appropriate governance arrangements should be established to support preparation of a detailed commissioning strategy for the People Directorate.	The governance arrangements for developing a strategy are already in place. The need to review and effectively commission placements is not reliant on such a strategy, and therefore the prioritisation will be of the policy and placement process rather than of an overarching strategy per se.	M	Head of Commissioning	31 March 2016

Rec no.	Issue	Recommendation	Management comments	Priority	Officer responsible	Due date
4	There is currently limited use of framework and block contracts or joint commissioning as a means of improving value for money.	The commissioning strategy should include proposals to seek opportunities to improve value for money through greater use of framework agreements, block contracts and joint commissioning where appropriate.	This work has very recently begun and will be taken forward over the next 9-12 months for the various placement types.	M	Head of Commissioning	30 June 2016
5	There is a lack of clarity over the nature and responsibility for undertaking pre-contract checks. Officers asserted that basic checks are always carried out to ensure service users are not placed at risk, although testing found that this had not been fully and consistently evidenced in 55% of cases.	The Individual Placement Policy and supporting procedures should specify the pre-contract checks that are expected to be carried out before making a placement. This should include clarification of roles and responsibilities for carrying out the checks and details of how they are to be evidenced and documented.	This will be undertaken as part of Recommendation 1.	M	Head of Commissioning / Head of Adult Social Care) / Head of Lifelong Learning	31 January 2016
6	The Individual Placements Policy requires completion and presentation of a Core Process Checklist as part of the panel approval process for all placements. In practice the checklist is rarely completed and, whilst there is no direct evidence of poor value for money, testing found that evidence of how value for money has been achieved could be better documented in many cases.	The Core Process Checklist in the draft Individual Placements Policy should be completed and retained in all cases, or some other means developed to clearly demonstrate how value for money has been assured. Consideration should be given to what tools and information would be useful to support this process (e.g. the Care Funding Calculator). Funding panels should ensure that the checklist or other evidence of value for money is presented as part of the panel's consideration and approval of the placement.	Agreed (Head of Learning & Skills). This will be undertaken as part of Recommendation 1. Please note that there is no funding panel for Adult Social Care in line with Care Act guidance.	M	Head of Adult Social Care) / Head of Lifelong Learning	31 January 2016

Rec no.	Issue	Recommendation	Management comments	Priority	Officer responsible	Due date
7	Testing found that 65% of placements in the sample did not have a valid signed contract at the time of audit. This increases the risk of difficulties in resolving any disputes or disagreements over the obligations of both parties.	All current placements should be reviewed and arrangements made to ensure that an up-to-date signed contract and Individual Placement Agreement is in place for them all. This should include SEN placements in all except RCC maintained schools.	Work has begun and is focusing on ensuring correct processes and contracts are in place going forward and are put in place at point of review.	H	Head of Commissioning	31 December 2015
8	Testing found that signed panel approvals were not retained in six cases and a further two cases did not go to panel as costs were below £10k. Officers asserted that panel approval is not required below £10k but this was not formally specified. There was also a lack of clarity over when a CPR exemption form was required and testing found only one case with an approved exemption.	The Individual Placement Policy and any supporting guidance notes and procedures should clarify exactly when a panel approval is required for each type of placement and when completion of the CPR exemption form is expected.	Agreed, Head of Learning and Skills. This will be undertaken as part of Recommendation 1.	M	Head of Lifelong Learning	31 January 2016
9	Testing found that signed panel approvals were not available in six cases and the basis for shortlisting and selection of providers was not clearly documented in most cases.	The basis for shortlisting and selection of providers should be clearly documented in all cases and signed panel approval forms or other evidence of formal management approval of the placement should be retained.	Agreed, Head of Learning and Skills. This will be undertaken as part of Recommendation 1	M	Head of Lifelong Learning	31 December 2015
Risk 2: Inadequate arrangements for ensuring compliance with contracts, including service quality (e.g. safeguarding) and financial management.						
10	Roles and responsibilities for contract monitoring are not clearly documented.	The Individual Placements Policy should be updated to include details of roles, responsibilities and procedures in respect of contract management for each type of placement.	Agreed, Head of Learning and Skills. This will be undertaken as part of Recommendation 1.	M	Head of Commissioning / Head of Adult Social Care) / Head of Lifelong Learning	31 January 2016

Rec no.	Issue	Recommendation	Management comments	Priority	Officer responsible	Due date
11	Although individual placements are being regularly reviewed, there is currently no proactive monitoring of overall contractual obligations in respect of out-of-county placements. Reliance is placed on the host council and CQC for monitoring provider performance and notifying the Council of any issues or concerns.	Develop more formal proactive arrangements for monitoring overall contractual obligations in respect of out-of-county placements either through extension of the existing monitoring and inspection regime or obtaining formal periodic assurances from the relevant 'host' council.	This work has started.	H	Head of Commissioning	29 February 2016
12	Again, although individual placements are being regularly reviewed, there is currently no contract monitoring of in-county or out-of-county SEN placements.	Contract monitoring should include all placement contracts, including SEN.	This is the responsibility of the individual budget holders as well as the Procurement and Contracts Team. This will be undertaken as part of Recommendation 1.	H	Head of Commissioning	29 February 2016

Rec no.	Issue	Recommendation	Management comments	Priority	Officer responsible	Due date
13	Officers asserted that contract monitoring includes quarterly information returns, annual inspections and targeted inspections. In practice, limited resources mean that most inspections are focused on a specific area or concern. However, the basis for determining the focus of each inspection is not clearly documented and there are no mandatory aspects. Testing found evidence that follow-up of recommendations arising from inspections is not always evidenced.	The overall approach to contract monitoring and inspections should be clarified and documented, including: • the basis for determining the type of inspection to be undertaken each year (e.g. full, targeted, follow-up etc); • any areas that should be subject to mandatory annual inspection (e.g. insurance certificates, safeguarding policies etc); • justification for the focus of targeted inspections and/or the areas not covered by the inspection should be clearly documented in inspection reports; and • retention of evidence of follow-up of recommendations / actions arising from inspections.	This will be undertaken as part of Recommendation 1	H	Head of Commissioning	31 March 2016

Rec no.	Issue	Recommendation	Management comments	Priority	Officer responsible	Due date
14	Testing found that most placements (85%) had been subject to an annual review except: • one case (older person residential) was overdue; • one case (educational exclusion) had no evidence of council involvement; and • one case (SEN) had no evidence of review.	Ensure that an annual review has been carried out or is planned for all individual placements.	ASC has recruited two designated review officers whose job is to carry out all ASC reviews. The cases described are surprising; this will be reviewed, Head of Learning and Skills.	M	Head of Adult Social Care) / Head of Lifelong Learning	31 December 2015
15	The council no longer facilitates safeguarding training for residential care providers.	Consider reinstating training provision for external providers via the LSCDG.	This provision has already been reinstated.	L	Head of Adult Social Care)	31 March 2016
16	There is no periodic refresh of the financial standing of care providers in order to provide an early warning of any potential failure and timely initiation of contingency plans.	Introduce periodic refresh of financial monitoring checks, particularly in respect of any high-risk providers.	A Financial Due Diligence policy is currently being developed in line with Financial Procedure Rules and Contract Procedure Rules.	M	Head of Commissioning	29 February 2016

Rutland County Council

the Welland Internal Audit Consortium

Appendix 2

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 recommendations

The Auditor prioritises 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.

Priority	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.

Rutland County Council

Appendix D

INTERNAL AUDIT REPORT

the Welland Internal Audit Consortium

OAKHAM ENTERPRISE PARK
2015/16

Issue Date:	12th January 2016	***Issued to:***	Paul Phillipson – Director for Places
Author:	Kelly Epps		Andrew Edwards – Property Manager
			James Frieland – Oakham Enterprise Park – Business Manager
			Saverio Della Rocca – Assistant Director (Finance) *(final copy only)*
			Councillor Terry King - Portfolio Holder - Places (Development) and Finance *(final copy only)*
			Councillor Diana MacDuff - Chair of Audit & Risk Committee *(final copy only)*
			Helen Briggs – Chief Executive *(final copy only)*

OAKHAM ENTERPRISE PARK
EXECUTIVE SUMMARY

1. INTRODUCTION & OVERALL OPINION

Oakham Enterprise Park (OEP) is a 25 acre business park that offers businesses affordable office, storage and industrial premises for rent. The Council purchased the site in December 2012 and put in place a business plan which anticipated that by April 2015 it would be generating rental income of £190,500. The main project targets were to have 103,000 sqft of business space made available to market, to have let 77,000 sqft of remediated business space, to have created or safeguarded 250 new jobs and supported 35 businesses all by 2018/19. Currently around 96,000 sqft has been let which excludes external areas and the Events Zone. More than 90 tenants currently have leases at OEP and progress towards other targets are good with 24 start-up businesses being supported to date and an estimated 150 jobs created or safeguarded at the site. An accurate employment survey is proposed early 2016 now that the site is approaching capacity.

Since opening for business, the demand for the site has been exceeded expectations with existing local businesses and new businesses to Rutland requiring units, often even before they were finished. In September 2013, the Council appointed an OEP business manager and the park is currently at more than 98% capacity and continues to expand with a total revenue projection of £404k in 2015/16 increasing to over £530k total budgeted income for 2016/17 and these figures exclude any additional income from business rates. The wider economy, especially the tourism sector has benefitted from side-line activities such as filming at the site and it's financial success has led to the Council being shortlisted for an LGC award for 'Entrepreneurial Council of The Year'.

The pace of change has been such that the systems underpinning its operation have been developed alongside ongoing activity. The Council recognises that robust systems need to be put in place and in this context, the Director requested a review which was supported by the Audit & Risk Committee. Assurance was sought from the Audit review that lease agreements are commercially viable, subject to a robust tenancy application process and that income due from tenants is suitably recovered.

Internal Audit recognises that the Council has taken positive steps to improve the controls over the tenancy application process for prospective tenants at Oakham Enterprise Park. Tenants' credit, trade reference, age (to ensure they are over 18 and thus legally entitled to hold a lease) & citizenship checks have recently been introduced and any new lease agreements are now independently reviewed by an Estates Surveyor to ensure they are accurate and commercially viable prior to them being forwarded to Legal Services.

An internal audit review of a sample of ten units highlighted that controls over the administration of tenancy applications and pre-tenancy checks were found to be limited in places and not fully embedded. Credit checks, trade reference checks and identification verification did not take place for all tenants within the audit sample and 50% of tenants did not complete a tenancy application form.

Lease agreements were available for 90% of the sample and included key areas such as rent charged, details of any break clauses, length of term, renewal rights, service charges, repair obligations and subletting arrangements. However rent review arrangements and rent deposit information were inconsistently documented and lacking suitable audit trails. In addition, lease agreements could not be located for one tenant, who occupies two units.

Tenants were found to be invoiced accurately and timely in accordance with the terms agreed in the lease and market rental values. Rental income is recovered in a structured, timely manner and payments plans have been put into place where required. However, on occasions it was noted that cash payments are received directly at the OEP site rather

than through customer services. This handling of cash and an insufficient audit trail could potentially expose the Council to an increased risk of fraud and should be avoided in future. This has already been addressed and rent is only accepted by cheque or BACS with most tenants now paying by standing order.

The audit was carried out in accordance with the agreed Audit Planning Record (APR). It is the Auditor's Opinion that the current overall design and operation of controls provides **Limited Assurance**, as summarised below:

Internal Audit Assurance Opinion	Direction of Travel				
Limited Assurance	**N/A**				
Risk	**Design**	**Comply**	**Recommendations**		
			H	**M**	**L**
Risk 1: Lease agreements are not commercially viable, possibly leading to financial losses and reputational damage.	Sufficient Assurance	Limited Assurance	1	0	3
Risk 2: Inadequate tenancy application process, leading to potential fraud and financial losses.	Sufficient Assurance	Limited Assurance	2	0	2
Risk 3: Increase in bad debt due to insufficient income monitoring and recovery.	Substantial Assurance	Sufficient Assurance	1	0	0
Total Number of Recommendations			**4**	**0**	**5**

2. SUMMARY OF FINDINGS

Risk 1: Lease agreements are not commercially viable, possibly leading to financial losses and reputational damage.

Chartered Surveyors (Innes England) carried out valuations on Oakham Enterprise Park in March 2013 and were asked to provide open market rental values for the units proposed to be offered as business units. The council was provided with an open market rental figure and a marketing figure. For office spaces a price of £7-£8 per square foot was recommended and for a workshop/studio a rate of £3-£4 per square meter was recommended. All ten units sampled by Internal Audit had been given a rental price that was within the guidelines provided by Innes England. Further analysis highlighted on occasions that units may be charged lower than the recommend rates due to market conditions and the condition of the unit, in examples reviewed this was suitably justified.

A Heads of Terms letter or document sets out the key commercial terms that parties intend to incorporate in a binding agreement. The Heads of Terms set out the basis for negotiating a subsequent longer form agreement and are often useful in establishing what will and will not be included in any future agreement. Just one unit from a sample of ten had a heads of term document, highlighting that the requirements for a Heads of Terms document have not yet been established or are unclear. **Recommendation 2 addresses this issue.**

A process has recently been introduced whereby an Estates Surveyor independently reviews all lease agreements prior to finalising. It was noted that none of the ten leases included in sample testing during the audit had been independently reviewed. Furthermore, fully signed certified copies of leases could only be found for 60% of the sample. Of leases reviewed, 30% had not been signed by the Council or signed copies were not available for review and a lease agreement could not be located for Unit 11a and Unit 1, both of which are occupied by the same tenant. **Recommendations 1 and 3 address these issues.**

Of the nine leases reviewed by Internal Audit, key details such as the rent charged, details of any break clauses, length of term, renewal rights, service charges, repair obligations and subletting arrangements were all documented and included in the agreements. Details relating to rent review arrangements and rent deposits were not always documented in leases. **Recommendation 4 addresses this issue.**

Risk 2: Inadequate tenancy application process, leading to potential fraud and financial losses.

Positive steps have been taken to develop and document procedures for the tenancy application process. Process maps covering applications for tenancy and the payment recovery process have been developed, however they could be further enhanced by including responsible officers and including more detailed steps such as lease approvals, identification verification, Heads of Terms and rent deposits. **Recommendation 5 addresses this issue.**

All potential tenants are required to complete and sign a tenancy application form. Of the ten units sampled by Internal Audit, only 50% had completed and signed an application form. Should there be more than one applicant for a vacant unit, the tenancy would be offered by the OEP Manager based on his judgement, taking into account that the Council is encouraging new/start-up businesses. If an unsuccessful tenant was to raise a dispute over a tenancy application, the Council would not have a sufficient audit trail to justify their decision**. Recommendation 6 addresses this issue.**

Pre-tenancy checks such as the verification of tenant identity, performing credit checks and checking trade references had not been conducted for any of the ten units in the selected sample. Internal Audit recognise that steps have been put in place to ensure that credit checks and trade references are carried out going forward, however it is also important to confirm the identity of all tenants to reduce the risk of money laundering and potential fraud. **Recommendation 7 addresses this issue.**

It is considered best practice for Officers involved in the management of commercial lettings to be suitably training in fraud awareness as well as bribery and corruption and money laundering. Counter fraud awareness has been covered in the Corporate Induction since 2013; however the OEP Business Manager has not received this training. Whilst the Council has a documented money laundering protocol, it is currently not mandatory to read the document and there has been no awareness training on money laundering or bribery and corruption in recent years. **Recommendation 8 addresses this issue.**

Risk 3: Increase in bad debt due to insufficient income monitoring and recovery.

OEP tenants are invoiced one month in advance for rental and service charge payments. Nine units within a sample of ten were invoiced accurately for the 2015/16 rental period and in accordance with lease agreements. A lease agreement could not be provided for one unit in the sample (Unit 11a) and therefore Internal Audit was unable to verify that the rent charged was accurate.

The recovery of rental income is carried out in accordance with the Council's Financial Procedure Rules. Overdue debt is discussed monthly between the Exchequer Team Leader and the OEP Business Manager. At the time of the audit, fifteen accounts were overdue, totalling £22,421. Appropriate action is being taken to recover the debt and payment plans have been put into place where appropriate.

Suitable segregation of duties exists between the setting of rent, creation of leases and collection of income, however it was highlighted during the audit that on rare occasions, cash is accepted by staff at the OEP site office rather than the customer taking the cash directly to customer services. This practice together with the lack of audit trail for rent deposits creates a significant fraud risk to the Council. Internal Audit note that where it could be seen that cash was accepted on site, a receipt was later emailed to the tenant and cash was posted to the correct tenant account. **Recommendation 9 addresses this issue.**

Rental deposits were not consistently requested from earlier tenants, however this is now considered to be a requirement going forward. Of the ten units sampled by Internal Audit, eight units were charged a deposit according to an electronic record held by the OEP Business Manager. Receipts could be found for seven deposits and six payments were correctly charged to the Council's holding account (BZ534) within the Council's finance system (Agresso). One payment for £1,000 had been incorrectly posted to account R9322 and has now been transferred to the correct account. A receipt or finance entry could not be found for a deposit payment of £521 for unit 11a. In this instance there was also no lease agreement or rental deposit deed available for review, therefore it is unclear as to whether a deposit was actually charged or received. Such lack of audit trail puts the Council at greater risk of potential fraud. **Recommendation 4 addresses this issue.**

3. LIMITATIONS TO THE SCOPE OF THE AUDIT

This is an assurance piece of work and an opinion is provided on the effectiveness of arrangements for managing only the risks specified in the Audit Planning Record. 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.

This audit did not include a review of the management and funding of the OEP project or health and safety legislation compliance for commercial properties and communal areas.

ACTION PLAN

Rec No.	ISSUE	RECOMMENDATION	Management Comments	Priority	Officer Responsible	Due date
1	A clear audit trail for lease review and approvals could not be found for all units within the audit sample.	The Property Manager should ensure that all lease agreements for the Oakham Enterprise Park are independently reviewed by the Estates Surveyor prior to signing to ensure there are no errors and they are commercially viable. A suitable audit trail for the review process should be kept on file.	In place	Low	Director - Places (D & E)	Complete
2	Of the units reviewed during the audit, 90% did not have a Heads of Terms document. Whilst heads of terms are not a legal requirement, they set out the key commercial terms for a lease and could minimise the risk of errors and disputes, particularly for longer lease agreements.	The Council should determine under what circumstances a Heads of Terms should be required depending on the size/type of unit that is being let This should be documented within the OEP process maps. Copies of all Heads of Terms should be saved in the appropriate unit folder on the shared network for reference and audit purposes.	In place	Low	Director - Places (D & E)	Complete

Rec No.	ISSUE	RECOMMENDATION	Management Comments	Priority	Officer Responsible	Due date
3	From a sample of ten units, internal audit identified the following: - 30% of the leases were not signed and sealed by the Council or copies were not available for review. - One lease agreement (Unit 11a) was not available for review during the audit. Further review highlighted that a lease was also not available for Unit 1 which is occupied by the same tenant. Without a signed lease it could be more difficult to resolve any tenant/landlord disputes.	The OEP Business Manager should work with the legal department to ensure that there is a signed lease agreement on file for all currently let units within the Oakham Enterprise Park. Originals should be held in the Council safe and certified copies scanned on to the Council network and saved in the appropriate folder.	In place	Low	Director - Places (D & E)	Complete
4	Rent review arrangements and rent deposits are not clearly stated in lease agreements. From a sample of ten units, the following was highlighted: - Two leases referred to a schedule 5 for rent reviews, however a schedule 5 did not exist and one lease did not state any rent review arrangements. - Five leases did not state arrangements for rent deposits, despite the tenant being charged a deposit. - It was unclear whether one deposit with a value of £521 had been charged or received due to an insufficient audit trail. Unclear landlord and tenant roles and responsibilities, can lead to potential disputes, reputational damage and a lack of audit trail leaves the process open to abuse and risk of fraud.	Rental deposits and rent review arrangements should be detailed in all lease agreements. A rent deposit deed should be completed for all deposits and evidence should be retained on file. The Council should consider developing a checklist to ensure that all tenancy documentation has been obtained and saved on file.	All future leases will have a clear statement and/or procedure regarding rent reviews A checklist will be developed to ensure that all relevant documentation is included within the property file	High	Director - Places (D & E)	01/11/15 31/03/16

Rec No.	ISSUE	RECOMMENDATION	Management Comments	Priority	Officer Responsible	Due date
5	Whilst current process maps outline the steps the Council will take regarding tenancy applications and income collection, it does not provide details on who will carry out these tasks and some key steps in the processes are missing. There is a risk that key controls are not followed and staff do not know how to perform their roles and responsibilities leading to non-compliance and inconsistences in working practices.	The current process maps for the tenancy application process and payment recovery should be revised to include details of responsible officers and also to include controls over lease reviews, ID checks and Heads of Terms.	Process map to be developed	Low	Director - Places (D & E)	31/03/16
6	A Tenancy Application Form was not completed for 50% of tenants in the audit sample. Furthermore, a formal, documented, transparent selection process for multiple tenants does not currently exist. The Council would not be able to demonstrate how a tenant was selected if a tenancy was disputed.	Formal criteria for receiving, assessing and selecting tenancy applications should be determined. A signed application form must be completed for all prospective tenants as it gives the tenant's consent for the Council to carry out credit searches and records permanently the tenant's declaration as to identity, accommodation, references and personal details	A process will be developed	High	Director - Places (D & E)	31/3/16
7	Current processes outline that credit checks and trade references should be carried out on new tenants however out of the ten units reviewed by Internal audit, none of the tenants had been subject to such checks. Furthermore, it is not current procedure to verify identification of the tenants. Without the processes in place to carry out appropriate tenant checks, the Council is at risk of potential fraudulent activities which could result in financial and/or reputational damage.	Pre tenancy checks should be carried out on all prospective tenants at the OEP. Checks should include but not be limited to the following: • ID verification • Credit checks • Trade references Documentary evidence of these checks should be retained on file.	This will be introduced as part of the standard procedure	High	Director - Places (D & E)	29/1/16

Rec No.	ISSUE	RECOMMENDATION	Management Comments	Priority	Officer Responsible	Due date
8	The Business Manager for OEP has not received awareness training on fraud, bribery and corruption or money laundering in recent years. Staff involved in the management of commercial lettings may not have the skills and information to detect and prevent potential fraudulent activities.	Awareness training on fraud, bribery, corruption and money laundering should be considered for all employees involved in the management of commercial lettings. .	The Council's HR team have advised this training is not yet available. However, the Governance team are working on some online training to be available soon.	Low	Director - Places (D & E)	31/3/16

Rec No.	ISSUE	RECOMMENDATION	Management Comments	Priority	Officer Responsible	Due date
9	It was identified during the audit that occasionally cash or cheque payments from tenants are received at the Oakham Enterprise Park site and taken to customer services by the OEP Manager. This leaves the Council vulnerable to fraud risk and open to abuse.	Cash or cheques should not be accepted at the Oakham Enterprise Park. Tenants should be advised to take all cash and cheque payments to Customer Services. If the Council chose to accept cash and cheque payments on site the following controls must be implemented: - Policies and procedures for the handling of cash should be documented, - All cash should be held in a secure safe with restricted access, - The maximum amount of cash held on site must be covered by the Council's insurance policy, - All income received must be recorded and reconciled to the income received, - The person receiving income must not be the OEP Business Manager, - Receipts should be issued for all income received and a suitable audit trail retained.	No cash payments will be taken for rent going forwards. However, it is reasonable to be expected to accept cash for sundry item sales via the Council's EBAY account (the Council cannot accept PayPal payments which is the default & preferred EBAY payment method). Due to the long distances often travelled by buyers, items are often collected out of hours or at weekends when the Council offices are not open. A numbered cash receipt book is now located within the site office and will be used going forwards.	High	Director - Places (D & E)	Complete

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 Recommendations

The Auditor prioritises 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.

Priority	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.

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Appendix E: Internal Audit reports finalised since last Committee Meeting – Executive Summaries

DEMAND LED BUDGETS 2015-16

EXECUTIVE SUMMARY

INTRODUCTION & OVERALL OPINION

Expenditure on social care is demand led in a number of areas and, as such, can be very difficult to accurately predict. The Council has set a total budget for demand led social care expenditure of £8.7 million for 2015/16. In year expenditure projections are set, taking into account known changes in commitments.

The audit was designed to provide assurance that the Council has put in place appropriate controls to ensure that the Council is doing all it reasonably can to control, monitor and predict demand led social care expenditure, whilst balancing the risks and resources required. The key risks upon which the audit was focussed related to failure to control demand led social care expenditure and failure to monitor and predict demand led social care expenditure.

The audit review highlighted good practice in a number of areas. Based upon a review of 20 areas of expenditure, there is a high level of compliance with the Council's established budget monitoring procedures. There are clear communication channels in place to highlight emerging pressures. Quarterly finance reports are submitted to Cabinet and provide appropriate commentary on emerging issues related to demand led budgets. Commitment records are in place for a number of the services examined, including Day Opportunities Services, Aiming High and Learning Disabilities. The Council is currently developing processes to ensure correlation between the services provided, commitment records and budgets, although this is work in progress. A review of financial reports published by five larger authorities was carried out to identify any notable good practice in the area of demand led expenditure budget setting and forecasting; this review did not identify any best practice which has not already been considered by the Council.

The audit review also identified a number of areas in which further improvements can be made to improve the reliability of demand led budget setting and expenditure forecasting. There are currently some inaccuracies within expenditure commitment records, particularly in relation to Adult Social Care, whereby the forecast expenditure is not consistent with the latest approved care package. Furthermore, there is scope to improve the budget setting process by adopting a 'zero based' approach, rather than setting the budget based on the previous year. It is acknowledged that management have already initiated actions to address some of these issues.

The audit was carried out in accordance with the agreed Audit Planning Record (APR), which outlined the scope, terms and limitations to the audit. It is the Auditor's Opinion that the current overall design and operation of controls provides **Sufficient Assurance**, as summarised below:

Internal Audit Assurance Opinion	Direction of Travel				
Sufficient Assurance	Not Applicable				
Risk	**Design**	**Comply**	**Recommendations**		
			H	**M**	**L**
01 – Failure to control demand led social care expenditure	**Sufficient Assurance**	**Sufficient Assurance**	0	3	2
02 – Failure to monitor and predict demand led social care expenditure	**Sufficient Assurance**	**Sufficient Assurance**	0	2	1
Total Number of Recommendations			**0**	**5**	**3**

Appendix E: Internal Audit reports finalised since last Committee Meeting – Executive Summaries

PUBLIC HEALTH BUDGETS 2015-16

EXECUTIVE SUMMARY

INTRODUCTION & OVERALL OPINION

Public health is about helping people to stay healthy and protecting them from threats to their health. Public health activities include protecting the public's health from hazards and infectious diseases, encouraging healthier lifestyles, reducing the large health inequalities across England and promoting health as part of healthcare services. Improving health and wellbeing creates a more economically and socially active population and reduces the burden on the NHS and the economy. The Public Health function transferred over from the former Leicestershire County and Rutland Primary Care Trust to Rutland County Council (RCC) in April 2013. Service delivery for Leicestershire and Rutland is led by Leicestershire County Council (LCC).

The Council receives ring fenced grant funding for use in accordance with the Public Health grant conditions; in 2015/16 this funding amounts to £1,078,500. The key risks upon which the audit was focussed related to failure to achieve public health outcomes and deliver value for money for Rutland, and failure to demonstrate that the public health budget is being spent in accordance with grant terms and conditions.

The audit review highlighted a number of examples of good governance. Contracts for provision of Public Health services are entered into only on approval of RCC. There is a Public Health Steering Group in place, attended by representatives of RCC and the LCC Public Health department, and LCC Public Health representatives attend RCC People Directorate Departmental Management Team (DMT) meetings. Appropriate contract and performance management frameworks are in place. Sample testing of 20 Public Health transactions confirmed that in 19 cases the expenditure was in accordance with the Public Health grant terms and conditions. The remaining case has since been discussed with officers and resolved.

The audit review also identified a number of areas in which further improvements can be made to ensure that future commissioning activity meets the needs of Rutland. It is acknowledged that management have already initiated action to address this issue. Furthermore, there is scope to further improve accountability by obtaining assurances that the amounts paid to the LCC Public Health department reflect the level of support received by RCC.

The audit was carried out in accordance with the agreed Audit Planning Record (APR), which outlined the scope, terms and limitations to the audit. It is the Auditor's Opinion that the current overall design and operation of controls provides **Sufficient Assurance**, as summarised below:

Internal Audit Assurance Opinion	Direction of Travel				
Sufficient Assurance	Not Applicable				
Risk	**Design**	**Comply**	**Recommendations**		
			H	**M**	**L**
01 – Failure to achieve public health outcomes and deliver value for money for Rutland	**Sufficient Assurance**	**Sufficient Assurance**	1	1	0
02 – Failure to demonstrate that the public health budget is being spent in accordance with grant terms and conditions	**Sufficient Assurance**	**Sufficient Assurance**	0	1	0
Total Number of Recommendations			**1**	**2**	**0**

Appendix E: Internal Audit reports finalised since last Committee Meeting – Executive Summaries

PAYROLL 2015/16

EXECUTIVE SUMMARY

INTRODUCTION & OVERALL OPINION

Accurate and timely payroll payments and deductions are required on a monthly basis and should be appropriately evidenced and authorised. The Council's Payroll function is administered by Exchequer Services whilst the Human Resources team administer establishment records.

The audit determined that both the HR and Payroll team have adequately documented procedures in place which include appropriate separation of duties and secondary checks. A full review of user accounts and permissions on the payroll system was already underway at the time of testing and is due to be completed by the end of November 2015. Whilst the Internal Audit testing of payroll system user access highlighted examples of temporary Payroll staff for who access rights had not been revoked, all issues highlighted have been promptly addressed by management and the ongoing, full review should ensure all permissions are up-to-date and appropriate.

Processes for monthly payroll payments, pension payments and payment to HMRC were found to be adequate and testing confirmed that the payments reviewed were made in a correct and timely manner. Variable and temporary payments were found to be accurate and suitably authorised and both mandatory and voluntary deductions were also tested and confirmed to have been processed correctly. Monthly reconciliations of the Payroll control account are in place and payroll payments are also included in the Council's full payment bank reconciliation. Establishment records are subject to review each time a request to amend a post is received and all changes are subject to review by the Head of Human Resources prior to any amendment on the HR system.

Starter testing confirmed adequate procedures to be in place to ensure all appropriate checks are carried out, records are updated and officers are notified. Leavers testing confirmed appropriate HR procedures are in place to identify leavers, update all records and to notify payroll that a final payment needs to be calculated and processed. Testing of the accuracy of payments did not identify any significant issues. Full details of testing are provided in Section 2.
The audit was carried out in accordance with the agreed Audit Planning Record (APR). It is the Auditor's Opinion that the current overall design and operation of controls provides **Substantial Assurance**, as summarised below:

Internal Audit Assurance Opinion	Direction of Travel				
Substantial Assurance	⇧				
Risk	**Design**	**Comply**	**Recommendations**		
			H	**M**	**L**
01 - Inappropriate and/or inadequate staff access and procedures	**Substantial Assurance**	**Sufficient Assurance**	0	0	0
02 - Accuracy and timeliness of payroll payments	**Substantial Assurance**	**Substantial Assurance**	0	0	0
03 - Inappropriate and/or inadequate procedures for processing new starters	**Substantial Assurance**	**Substantial Assurance**	0	0	0
04 - Inappropriate and/or inadequate procedures for processing leavers	**Substantial Assurance**	**Substantial Assurance**	0	0	0
05 - Inaccurate financial records	**Substantial Assurance**	**Substantial Assurance**	0	0	0
Total Number of Recommendations			**0**	**0**	**0**

FINANCIAL TRANSPARENCY 2015-16
EXECUTIVE SUMMARY

1. INTRODUCTION & CONCLUSIONS

The Local Government Transparency Code was introduced in 2014 in order to meet the Government's objective to increase democratic accountability and make it easier for local people to contribute to local decision making processes and help shape public services. The Transparency Code sets out the information which local authorities must publish, and details of further information which local authorities are recommended to publish. The purpose of this review was to provide assurance that the mandatory requirements of the Transparency Code are being complied with and that best practice is also followed when publishing information on budget setting, budget monitoring and financial performance. By publishing this information and ensuring it is easily accessible, the Councils should also reduce the number of Freedom of Information requests they receive and the pressure this can place on resources.

This was a joint benchmarking review which was delivered concurrently to Rutland County Council, Melton Borough Council and East Northamptonshire District Council (participating Councils). The data published by the five Welland authorities, plus an additional five authorities, was reviewed to provide meaningful comparative information.

The review confirmed that budget setting and budget monitoring reporting is highly transparent for all three participating Councils. Furthermore, all three Councils were found to be at least generally compliant with the mandatory requirements, and partially compliant with the recommended elements, of the Transparency Code. All three Councils have arrangements in place to ensure that the requirements of the Transparency Code are fully understood, that officer responsibilities and reporting timescales have been established, and to ensure that responsibilities have been allocated in respect of data validation. There were no significant differences between the Schemes of Publication adopted by each Council. The conclusion for Rutland County Council is provided below.

Conclusion – Rutland County Council

The Council publishes extensive information relating to its budget setting and monitoring, in addition to setting out its funding, statutory and constitutional requirements. The Council transparently sets out its financial plans and the pressures and risks related to those plans. Budget monitoring reports are published quarterly and provide extensive coverage and commentary on financial developments across the Council. All expected sources of information relating to the setting and monitoring of budgets had been published by the Council and were found to be easily accessible and up to date. For these reasons, Internal Audit has assessed the Council as providing a **High** level of transparency relating to its budget setting and monitoring.

The Council demonstrates **Full** compliance with all mandatory elements of the Transparency Code. In addition, Rutland County Council publishes 56% of the voluntary data as recommended by the Code. In the benchmarking exercise, this was found to be the same, or a higher, level of voluntary publication of additional information than seven other Councils in the group of ten. The highest percentage of additional information published across the remainder of the whole group was 67% and included expenditure on procurement cards (which is not applicable to Rutland County Council) and grants to voluntary organisations. All information provided was published on time and was noted as particularly easy to locate on Rutland's website in comparison with other authorities.

Implementation of actions from IT Audit Reports issued in 2014/15 and 2015/16

IT Asset Management	Issued May 2015 Limited Assurance	HIGH Priority Recommendations		MEDIUM Priority Recommendations	
		Made	Actioned	Made	Actioned
		2	**2**	1	**1**

Key Actions

Staff have been reminded of the importance of asset management. This has been discussed in a team meeting and also by email. A new asset database has been developed as the master and included as a task on the set-up process checklist. A monthly meeting is scheduled to review reports such as machines not logged on for 30 days and this is being matched to the asset database.

A matching exercise between the HR list and the ICT asset list has been carried out to ensure the quality of the asset database.

A document detailing the current software applications and licence details has been created. This is being reviewed and updated as new information is provided (e.g. currently awaiting MS Project and Visio licence information). A meeting is planned with a supplier at the end of January 2016 to explore a full software asset management program and whether there is a business case for the implementation.

All recommendations have now been implemented and will be subject to a further follow up review in March 2016 to ensure controls are embedded and operating as expected.

Service Desk & Change Management	Issued April 2015 Sufficient Assurance	HIGH Priority Recommendations		MEDIUM Priority Recommendations	
		Made	Actioned	Made	Actioned
		2	**2**	4	**4**

Key Actions

Staff in IT have been reminded by email that the eServiceDesk can link calls and that where possible this should be used. A review of the helpdesk software is being carried out and it is very likely that new software will be introduced, therefore no further action is planned until this is implemented.

It was recommended that procedures be introduced to proactively collate and review cases to identify any areas of persistent concern and reduce future workloads. A weekly team meeting now allows for persistent concerns to be raised. A review of the helpdesk software is being carried out and it is likely that reports from the new software will be used to identify trends, therefore a formal procedure will not be developed in the short term.

A new Change Control policy has been developed and implemented from January 2016.

A report on the feedback from staff via questionnaires has been presented to the Director of Resources.

All recommendations have now been implemented.

IT System Administration	Issued December 2015 Limited Assurance	HIGH Priority Recommendations		MEDIUM Priority Recommendations	
		Made	Actioned	Made	Actioned
		0	**0**	4	**4**

Key Actions

A Change Control policy and procedure have been developed and introduced in January 2016. Software has been procured to enable audit reports to be produced detailing any changes to the Active Directory.

A comparison of the HR staff list and the IT directory of users has commenced to ensure that only current members of staff remain on the network.

Monthly meetings now take place to identify any machines that have not been on the network for 30 days and any users that have not logged on to the network for 30 days.

The remote access list has been reviewed to ensure all with remote access rights are valid employees and a further review of the leavers process is planned for January 2016.

The leavers form has been modified to include a reference to any application access that requires revoking to ensure access to Council systems is suitably removed.

Where possible, the performance of the network will be monitored on an ongoing basis – however this will be in relation to specific areas of concern and therefore reactive in nature. There have been no specific instances where network performance needs monitoring since the report was issued in December 2015.

A document has been created by the IT service entitled 'ICT System Review'. This identifies best practice in system administration and has been provided to service managers for completion – it is likely that further actions will take place once reviews have been completed as this will identify areas of weakness for investigation.

All recommendations have now been implemented and will be subject to a further follow up review to ensure controls are embedded and operating as expected, as part of the 2016/17 Audit Plan.

Appendix G: Customer Satisfaction

At the completion of each assignment, the Auditor issues a Customer Satisfaction Questionnaire to each client with whom there was a significant engagement during the assignment. The Head of Service and the Line Manager receive a CSQ for all assignments within their areas of responsibility. The standard CSQ asks for the client's opinion of four key aspects of the assignment. The five responses received in the year to date are set out below.

Aspects of Audit Assignments	N/A	Outstanding	Good	Satisfactory	Poor
Design of Assignment	1	0	4	0	0
Communication during Assignments	0	2	3	0	0
Quality of Reporting	0	1	4	0	0
Quality of Recommendations	0	1	3	1	0
Total	**1**	**4**	**14**	**1**	**0**

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Appendix H: Implementation of Audit Recommendations

	'High' priority recommendations		'Medium' priority recommendations		'Low' priority recommendations		Total	
	Number	**% of total**	**Number**	**% of total**	**Number**	**% of total**	**Number**	**% of total**
Actions due and **implemented** since last Committee meeting	3	33%	9	39%	4	33%	16	**36%**
Actions due within last 3 months, but **not implemented**	3	33%	7	30%	6	50%	16	**36%**
Actions due **over 3 months** ago, but **not implemented**	3	33%	7	30%	2	17%	12	**27%**
Totals	9	100%	23	100%	12	100%	44	100%

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Appendix I: 'High' and 'Medium' Priority actions overdue for more than three months

Audit Title and Year	Service Area	Outstanding Action	Status Update	Officer Responsible	Original Date	Revised Date (if provided)
High Priority						
Agresso 2014/15	Resources	Internal Audit recommends controls are improved for setting up new user accounts and for ensuring they remain appropriate over time. In particular: a) Any new users and changes to user access privileges should be made on an agreed form and signed off by the line manager and Finance Manager (to ensure non-finance staff are not given inappropriate access to finance only functions). b) Managers should be asked to periodically confirm user access rights.	This is being addressed as part of the upgrade of Agresso. Based on existing IT controls and subsidiary controls in place, the inherent risk is not considered to be high.	P&A Support Team Manager	November 2014	August 2016
ICT Project Management 2013/14	Resources	A corporate approach to managing projects should be considered. ICT should be notified of all projects and expected outcomes so that ICT implications can be considered, even if project teams do not immediately think there are implications for infrastructure or ongoing support.	A suite of documentation has been developed and has been used for the delivery of the Liquidlogic project. The success of this first use of the documentation will be reviewed before full roll out to ensure any lessons learnt are incorporated, It is intended that the new approach will roll out for all new projects commencing from 1st April 2016.	Director for Resources	November 2014	April 2016
Benefits 2014/15	Resources	The Revenues & Benefits Manager working with the Assistant Director (Finance), if required, resolve the BACS compatibility issue with the service's laptops to	Some technical issues have been resolved and IT is now in position to	Assistant Director (S151	July 2015	February 2016

Audit Title and Year	Service Area	Outstanding Action	Status Update	Officer Responsible	Original Date	Revised Date (if provided)
		ensure that separation of duties can be re-established in payment runs. In addition, all BACS payment information should be retained on file in the future.	deliver this in the next month. Additional manual checks are in place in the interim period.	Officer)		
Medium Risk						
Agresso 2014/15	Resources	P&AS Team Manager to review and rationalise the number of 'roles' within the Agresso system, in particular: a) consider deleting the 1,830 roles that are not currently used; and b) review roles allocated to staff with access to aggregated cost centres and remove individual cost-centre roles to avoid duplication where necessary.	This is being addressed as part of the upgrade of Agresso.	P&A Support Team Manager	December 2014	August 2016
Agresso 2014/15	Resources	The audit identified a number of actions for which there was no audit trail retained on the system in the form of an audit log. Due to lack of information available on the affected items there was uncertainty over whether these represented a risk. It was agreed that the IT team would explore this further to confirm whether action logs should be switched on in these areas.	This is being addressed as part of the upgrade of Agresso.	P&A Support Team Manager	December 2014	August 2016
Disaster Recovery & Business Continuity 2013/14	Resources	Head of Business Support to ensure, in conjunction with the Director of Places (Development & Economy), that the ICT Disaster Recovery Plan is finalised, approved, cascaded and tested.	The newly appointed Head of IT will be undertaking a full review of the Disaster Recovery Plan to ensure it fully meets the needs of the organisation.	Head of IT	March 2015	September 2016

Audit Title and Year	Service Area	Outstanding Action	Status Update	Officer Responsible	Original Date	Revised Date (if provided)
Recruitment of Interims and Agency staff 2015/16	Resources	HR should review the list of current agency providers with Comensura and work together to extend the range of providers currently using the framework.	The Comensura framework is due for review in September 2016. Where Comensura is not used officers are expected to comply with Contract Procedure Rules (there are separate audits on this).	Head of Human Resources	August 2015	September 2016
Early Years Performance Management and Funding 2014/15	People	1) The code of practice should be updated to ensure that it has the most up to date information. 2) Once updated, the code of practice should be sent to all early year providers with a revised contract which should be signed and returned	1)The code of practice is no longer required; it was replaced by national statutory guidance. 2) New contracts were sent to all providers, were signed and returned. Small number outstanding.	Interim Head of Lifelong Learning	April 2015	March 2016
Early Years Performance Management and Funding 2014/15	People	A cyclical programme of spot checks should be designed and implemented for early years providers to check the accuracy of their funding claims for two, three and four years olds. This should be risk based so that high risk settings are checked annually and low risk settings at least once every three years. Once designed, all providers should be informed that a spot check programme is in place.	A spot check programme is being devised and is shortly to be put into operation. This will fully reflect the recommendation.	Interim Head of Lifelong Learning	April 2015	Jan 2016
Early Years Performance Management and Funding 2014/15	People	The Accountant for Early Years should issue all early year providers with an indicative budget at the beginning of each financial year which broadly reflects anticipated participation for 3-4 year old funding.	This is in hand for 16/17 and will be done by mid Feb for the 16/17 allocation.	Interim Head of Lifelong Learning	April 2015	Feb 16

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Appendix J: Limitations and responsibilities

Limitations inherent to the internal auditor's work

The consortium is undertaking a programme of work agreed by the Council's senior managers and approved by the Audit & Risk Committee subject to the limitations outlined below.

Opinion

Each audit assignment undertaken addresses the control objectives agreed with the relevant, responsible managers.

There might be weaknesses in the system of internal control that the consortium are not aware of because they did not form part of the programme of work; were excluded from the scope of individual internal assignments; or were not brought to the consortium's attention. As a consequence, the Audit & Risk Committee should be aware that the audit opinion for each assignment might have differed if the scope of individual assignments was extended or other relevant matters were brought to the consortium's attention.

Internal control

Internal control systems identified during audit assignments, no matter how well designed and operated, are affected by inherent limitations. These include the possibility of poor judgement in decision making; human error; control processes being deliberately circumvented by employees and others; management overriding controls; and unforeseeable circumstances.

Future periods

The assessment of each audit area is relevant to the time that the audit was completed in. In other words, it is a snapshot of the control environment at that time. This evaluation of effectiveness may not be relevant to future periods due to the risk that:

- the design of controls may become inadequate because of changes in operating environment, law, regulatory requirements or other factors; or
- the degree of compliance with policies and procedures may deteriorate.

Responsibilities of management and internal auditors

It is management's responsibility to develop and maintain sound systems of risk management; internal control and governance; and for the prevention or detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

The consortium endeavours to plan its work so that there is a reasonable expectation that significant control weaknesses will be detected. If weaknesses are detected additional work is undertaken to identify any consequent fraud or irregularities. However, Internal Audit procedures alone, even when carried out with due professional care, do not guarantee that fraud will be detected, and its work should not be relied upon to disclose all fraud or other irregularities that might exist.

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Report No: 29/2016
PUBLIC REPORT

AUDIT AND RISK COMMITTEE

26 January 2016

INTERNAL AUDIT PLAN 2016/17

Report of the Head of Internal Audit

Strategic Aim:	All	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor Terry 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	N/A	

DECISION RECOMMENDATIONS
1. That Members note the process being followed to develop the risk based Audit Plan for 2016/17. 2. That Members note the initial areas highlighted for potential coverage in the Internal Audit Plan 2016/17 (listed in Appendix A) and advise on any areas where the committee seeks assurance from the Internal Audit team during 2016/17.

1 PURPOSE OF THE REPORT

1.1 To advise Members on the process being followed to develop the Internal Audit Plan for 2016/17 and the initial areas proposed for inclusion in the Plan, subject to further risk assessment and prioritisation. The report also invites Members to highlight any areas where they require assurance from the Internal Audit team during the next financial year.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 Internal Audit Plan

The Internal Audit Plan sets out the assignments that will be delivered by the Internal Audit team during the financial year. In accordance with the Public Sector Internal Audit Standards (PSIAS), the Audit Plan should be risk based and developed with input from senior management and the Audit Committee.

2.2 In order to ensure that the Audit Plan for 2016/17 addresses the Council's key risks and adds value, the Head of Internal Audit is identifying and prioritising the areas for coverage by:

- Reviewing the Council's Risk Registers and Corporate Plan;
- Identifying any other sources of assurance for each of the Council's key risks, which may reduce the added value of an Internal Audit review;
- Analysing coverage of Internal Audit reviews over the last four years and the assurance opinions provided following each review, to identify any gaps or areas where follow up work would be of value;
- Identifying any areas of the Audit Universe which have not been subject to Internal Audit review during the last four years; and
- Meetings with Senior Management to discuss key risks and emerging risk areas for the year ahead and also any areas where Internal Audit support would be beneficial either in an assurance or consultancy role.

2.3 Following this process, a number of potential audit assignments have been identified and will be prioritised and refined based on risk and added value. A list of areas highlighted during the planning process to date has been provided in Appendix A.

2.4 Members of the Audit and Risk Committee are invited to raise any areas where assurance from Internal Audit is sought during 2016/17 for inclusion and prioritisation in the development of the Audit Plan. As the full list in Appendix A is unlikely to be covered in 2016/17 the Committee is also asked to identify those areas which they believe should be a priority for this year. A reserve list of topics will be maintained and presented with the draft Audit Plan.

2.5 The draft Audit Plan will be presented to the Audit and Risk Committee on 26th April 2016 for final refinement and formal approval.

3 CONSULTATION

3.1 No external consultation is required but, as noted above, senior management have been involved in developing audit proposals. The Audit and Risk Committee are being consulted as part this process.

4 ALTERNATIVE OPTIONS

4.1 This report is for noting only but when the Audit Plan is formally presented in April Members will be able to approve the plan or approve it with amendments.

5 FINANCIAL IMPLICATIONS

5.1 There are no financial implications arising from this report. The Audit Plan will be based upon the number of days commissioned by the Council on an annual basis.

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 Audit Plan and satisfying itself that the conclusions reached in the annual audit report are reasonable in light of the work undertaken. It is also responsible for gaining assurance that the internal audit

service is complying with Internal Audit Standards.

6.2 There are no legal implications arising from this report

7 EQUALITY IMPACT ASSESSMENT

7.1 There are no equality implications

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 Audit Plan for 2016/17 is being developed using a risk based approach, with input from Senior Management and the Audit Committee. The potential areas for coverage highlighted during the planning process to date will be refined and prioritised based on associated risk and potential value added by an Internal Audit review at this time. The draft Audit Plan will be presented to the Audit and Risk Committee in April 2016 for final refinement and formal approval.

11 BACKGROUND PAPERS

11.1 There are no additional background papers to the report.

12 APPENDICES

12.1 Appendix A: Internal Audit Plan 2016/17 – Initial Areas Highlighted

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

Appendix A: Internal Audit Plan 2016/17 – Initial Areas Highlighted

Topic	Assurance provided and reason for inclusion
Corporate / Cross Cutting	
Data Retention and Disposal	To provide assurance over the Council's procedures and controls to ensure data is held and disposed of in a secure manner and in compliance with the Data Protection Act. This audit was deferred from the 2015/16 Audit Plan.
Contract Procedure Rules (CPR) compliance	To provide assurance over compliance with the Council's procurement rules across the organisation. To review a sample of procurements for evidence of compliance. The full Procurement audit in 2015/16 has identified some areas for improvement to ensure consistent compliance with the new rules and it is key that these are fully embedded and enforced.
Agresso upgrade	To provide consultancy support during design phase, to ensure controls are suitably enforced in new system, changes to access rights are appropriate and identify potential flaws before sign off. This is a high risk area and audit involvement upfront is a key control in ensuring new systems are fit for purpose.
Agresso System Administration	To provide assurance over the administration of the Agresso system following the upgrade. Will also follow up on issues highlighted by Limited Assurance report on Agresso issued in 2014/15. This poses a risk due to the changes in responsibility (transferring from IT to Finance) and in the upgrade process.
Financial Systems	All financial systems to be reviewed in full following the Agresso upgrade.
'Limited' audits follow up	There have been a number of audits in 2015/16 which have 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.
Absence Management	To provide assurance over procedures for managing absence and compliance with these across the Council. Given the changes proposed to the sick policy, it would be of value to ensure these have been suitably communicated and applied and levels of sickness are reducing/stable.
Customer Services	To provide assurance over performance of customer services and compliance with good practice, including complaints management. Would take place in Q4 of 2016/17 to allow for changes in staffing.

Topic	Assurance provided and reason for inclusion
Counter Fraud	
Council Tax/NDR Fraud	To provide assurance over controls in place to prevent and detect Council Tax and NDR fraud, including pro-active measures and recovery. An area of ongoing fraud nationally.
Blue Badges	To provide assurance over controls in place to prevent and detect fraudulent abuse of blue badges. Area of ongoing fraud nationally. Responsibility for this area has recently transferred from People to Resources.
Service Specific	
Safeguarding (Children and Adults)	To provide assurance that controls are being exercised consistently and in accordance with Council procedures, including case audits and escalation processes. Possible follow up of actions arising from Ofsted report and Peer Review.
LiquidLogic	To provide assurance over the new system including its administration and a post implementation review of the project.
Taxi Licensing	To provide assurance that licences are granted to applicants that satisfy the relevant conditions and in accordance with Council policy and procedures. An audit was performed in 2013/14 which resulted in Limited Assurance over the controls in place. There has also been an update to legislation since the last audit.
S106 Agreements	To provide assurance over the controls in place for collection of income, legal agreements, monitoring of existing agreements and clawbacks. This area has not been subject to Internal Audit review in the last four years.
Highway Maintenance Contract	To provide assurance over the effective management of this key, high value contract. Potential to undertake an open book review. Contract in place since 2013 and valued at £3m per year.
Development Control	To provide assurance over compliance with statutory requirements, regulations and best practice, timely collection of fee income and that planning applications are suitably processed and evaluated. This area has not been subject to audit review in the last four years and may benefit from a review to identify areas for improvements/efficiencies.

Topic	Assurance provided and reason for inclusion
Total Transport Project	To provide embedded assurance over the project reviewing transport arrangements. The project will include a review of value for money and ensuring transport provision is fair and transparent. Internal Audit support has been requested to provide independent challenge and advice to the project board.
Registration Services	To provide assurance over the management of the registration service, including controls over the register of births, deaths and marriages, associated fraud risks, collection of income and compliance with legislation and good practice. No Internal Audit review has been conducted in this area. The service has recently moved from People services to Places.
Digital Broadband	To continue to provide embedded assurance support to the Digital Rutland programme and provide assurance over the project management arrangements and milestone to cash process. A key project for the Council where learning and good practice from other authorities involved in the national roll-out can be shared by the Internal Audit team.
Impact of Early Help	To provide assurance over the arrangements in place to demonstrate the value of the preventative work delivered by the Early Help services. This has been subject to recent work by the service and there may be value in sharing of guidance and good practice.
Fostering service	To provide assurance over the controls in place to support the robust management of the Council's fostering service including payments to foster carers and quality service provision. No Internal Audit review in the last five years.
Special Educational Needs Placements	To provide assurance over the arrangements with the health service for education health and care plans to support the provision of appropriate and effective placements and support for health needs. To provide assurance over the effectiveness and value achieved by these care plans. Highlighted as an area for a review of efficiency and effectiveness.
Deprivation of Liberty safeguards (DoLS)	Subject to discussions with Leicestershire County Council (providers of the service), to seek assurance over the effective management of the DOLs service. No Internal Audit review in last five years.

Topic	Assurance provided and reason for inclusion
IT	
IT Asset Management	To provide assurance over the Council's management of its IT assets, including maintaining full and accurate records, recovering assets from leavers and monitoring use of software licenses. An audit was performed in 2014/15 and resulted in Limited Assurance. The new Head of IT has advised that a great deal of work has been undertaken to address this. A further audit would provide assurance that these new processes are embedded and operating effectively.
IT Policies and Procedures	To review new and revised IT policies to ensure all key policies are in place, fit for purpose, communicated and compliant with good practice.

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Report No: 30/2016
PUBLIC REPORT

AUDIT AND RISK COMMITTEE

26 January 2016

EXTERNAL AUDIT UPDATE

Report of the Director for Resources

Strategic Aim:	All	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor Terry King, Portfolio Holder for 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	N/A	

DECISION RECOMMENDATIONS
That the Committee notes the update from the external auditors, KPMG LLP

1 PURPOSE OF THE REPORT (MANDATORY)

1.1 To update the Committee on various technical matters and report progress on the external audit of the Statement of Accounts for 2014/15 and 2015/16.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 The report in Appendix 1 includes a progress update on the audit for 2014/15 and 2015/16.

2.2 The auditors have completed the audit of the 2014/15 accounts and issued the audit opinion. The Annual Audit Letter (AAL) was also issued in late October. The AAL did not highlight any issues to be addressed by this Committee. External audit have not yet issued the audit certificate for 2014/15 as they were looking into matters raised regarding the Oakham North position. The auditors will update the Committee at the meeting itself.

2.3 The auditors have also recently issued an Annual Report on Grants and Return work for 2014/15. This is included in Appendix 2. There are no issues to note.

2.4 The progress report also updates on progress with the 2015/16 audit and the key point to note is that an audit plan will be issued shortly. The auditors have also highlighted changes to the Value for Money conclusion they are required to make. Officers view is that these changes will not have any substantial impact on the work of the Council.

2.5 The report also includes various technical updates on matters relevant to the remit of the Council and this Committee, including:

- The Local Government Finance Settlement – the impact on Rutland is worked through in detail in the Council's 16/17 budget report;

- The new local audit framework – this will allow local councils to appoint their own external auditors from 2018/19. Officers are not supportive of this change. Officers recognise the value of the Council having external auditors appointed and regulated by an independent body and believe that there is little benefit to be gained from the Council undertaking a costly procurement process led by Council Members to appoint an audit firm. The Sector is looking at whether existing arrangements can continue in some form and the Council will monitor developments with interest; and

- Changes to the Code of Practice on Local Authority Accounting including the reporting of Infrastructure Assets – there is a separate report on this matter on the agenda.

3 CONSULTATION

3.1 No formal consultation is required.

4 ALTERNATIVE OPTIONS

4.1 The Committee is asked to note the report. There are no alternatives.

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 receiving the reports of external audit, acting on any relevant matters and approving of the Statement of Accounts.

7 EQUALITY IMPACT ASSESSMENT

7.1 An Equality Impact Assessment (EqIA) has not been completed as this report does not impact on Council policies and procedures.

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 It is important that the Committee understand the progress of external audit work and any changes to the scope of that work.

11 BACKGROUND PAPERS

11.1 There are no additional background papers to the report.

12 APPENDICES

Appendix 1 – External Audit progress report

Appendix 2 – Annual Report on grants and returns

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

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Appendix 1

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External audit progress report and technical update

Rutland County Council -Audit And Risk Committee

January 2016

External audit progress report and technical update – January 2016

This report provides the Audit and Risk Committee with an overview on progress in delivering our responsibilities as your external auditors.

The report also highlights for your attention some of the technical issues which are currently having an impact in local government.

If you require any additional information regarding the issues included within this report, please contact a member of the audit team.

We have flagged the articles that we believe will have an impact at the Authority and given our perspective on the issue:

- **High impact**
- **Medium impact**
- **Low impact**
- **For info**

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Progress report

External audit progress report – January 2016

This document provides the Audit and Risk Committee with a high level overview on progress in delivering our responsibilities as your external auditors.

At the end of each stage of the audit we issue certain deliverables, including reports and opinions. A summary of progress against these deliverable is provided in Appendix 1 of this report.

Area of responsibility	Commentary
Audit Certificate 2014/15	We informed the Committee in September 2015 that we planned to withhold the audit certificate for the 2014/15 audit. This was to allow us more time to consider the issues connected with the Oakham North S106 Agreement, in the context of our responsibilities under the Act, and gather any necessary additional information before deciding what action, if any, we were required to take. We expect to share our draft report with the Chief Executive before the end of January 2016 and will provide the Committee with a verbal update at the meeting.
2015/16 Audit	We are updating our risk assessments and completing our detailed planning to determine our audit plan. We expect to issue the draft detailed audit plan to officers before the end of January 2016 and in line with auditing standards, we will present it to the next meeting of the Committee. **Financial statements audit** A significant area of focus will continue to be the work required to give the audit opinion on the accounts. Our plan will include our response to any issues identified through our risk assessment regarding: • the accounting requirements for 2015/16, including relevant changes to the CIPFA guidance; and • the closure of accounts process generally and our working paper requirements. In March 2016 we expect to carry out our interim visit to assess the adequacy of processes and systems in operation for the generation of the financial statements. **Value for Money Conclusion** We will also carry out our VFM conclusion risk assessment and assess your arrangements against the new criterion specified by the National Audit Office (issued in November 2015) for 2015/16 onwards. The assessment will now require us to conclude whether *in all significant respects, the Council had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people*. The NAO's guidance sets out sub-criteria that we need to consider in forming our conclusion. The sub-criteria cover the Council's arrangements for: • *Informed decision making* • *Sustainable resources deployment; and* • *Working with partners and other third parties.* We have included a link to the new guidance in our technical update included with this report. We will discuss this new criterion, and the additional information required, with managers as part of the detailed audit planning work.

External audit progress report – January 2016 (continued)

Area of responsibility	Commentary
2015/16 Audit (continued)	**Other work** We will continue to liaise with Internal Audit, and consider your assurance frameworks and your response to issues you identify throughout the year. We will review your 2015/16 Annual Governance Statement for consistency with our understanding of your arrangements and issues identified. There are no significant audit concerns that we need to raise with the Audit and Risk Committee at this stage in relation to the audit of the accounts or the VFM conclusion from the planning work we have carried out to date.
Certification of claims and returns	We have issued our Annual Grant Claims and Returns Report for 2014/15 and there are no significant points that we need to bring to the Audit and Risk Committee's attention in this report. No additional grant certification work has been mandated for 2015/16 and we expect the programme of work to again focus on the Housing Benefit claim and the Teacher's Pension return. These returns will be certified by the November 2016 deadline..

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Technical update

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Technical update

Area	Level of Impact	Comments	KPMG perspective
CIPFA Survey of Chief Financial Officers	For information	Confidence in councils' ability to keep delivering services amid ongoing government budget cuts has continued to fall sharply among chief financial officers (CFOs), according to a survey by the CIPFA published in November 2015. The survey found that: • 49% were less confident in their ability to deliver services for 2016/17 than a year ago. The proportion of respondents who were less confident has increased from 41% of CFOs last year for 2015/16 and 27% for 2014/15. • 56% were less confident over their organisation's overall financial position for the next financial year (2016/17) – up from 44% for 2015/16 and 20% for 2014/15. • the services under the biggest pressure were considered to be adult social care (95% of respondents), children's social care (94%), environment and regulatory services (44%) and housing (37%).	***The Committee should note the survey findings.***
Provisional Local Government Finance Settlement 2016/17	High	The provisional local government finance settlement for 2016/17 was issued on 17 December 2015, and sets out the distribution of centrally allocated resources for local authorities in England. Responses to the consultation are due by 15 January 2015, and the final settlement will be issued in February 2016. The key points are: • Local authorities will see an average cut in funding of 2.8% in 2016/17, and a real terms cut of 6.7% over the spending review period. • The government will also offer any council that wishes to take this up a four-year funding settlement to 2019/20. This can provide funding certainty to enable longer term planning. • The referendum threshold for council tax increases is being set at 2%. As announced in the November 2015 spending review, the government is also giving authorities with social care responsibilities the flexibility to raise council tax in their area by up to 2% above the referendum threshold for each year between 2016/17 and 2019/20, to fund adult social care services. • A technical consultation on reforms to the New Homes Bonus is being published alongside the provisional local government finance settlement. • As announced in the spending review, by the end of the current Parliament local government will retain 100% of business rate revenues to fund local services. The system of tariffs and top-ups will be retained, and the main local government grant will be phased out and additional responsibilities devolved to local authorities. These changes will require legislation. The government will set up systems to involve councils, businesses and others in the process, and will consult on the implementation of the 100% business rates retention proposals in summer 2016.	***The Committee may wish to enquire of officers how the Council is to respond to the provisional settlement.***

Technical update

Area	Level of impact	Comments	KPMG perspective
Reporting developments – Code of Practice on Local Authority Accounting 2015/16	**Medium**	The key accounting changes in this edition of the Code which impact on the council's accounts include: • Amendments to chapter one to underline CIPFA/LASAAC's view of the importance of the consideration of materiality when preparing disclosures for local authority financial statements. • The introduction of a new section on fair value measurement in chapter two (Concepts and Principles) to reflect the adoption of IFRS 13 *Fair Value Measurement*. • Clarification of the reporting requirements for disclosures that support the Movement in Reserves Statement. • Clarification of the current adaptation of the measurement requirements for property, plant and equipment following the adoption of IFRS 13 and the introduction of the concept of current value. The 2015/16 Code has changed the measurement requirements for assets classified as surplus assets, which are now to be measured at fair value in accordance with the definition in IFRS 13. • Following adoption of the amendments in the Update to the 2014/15 Code, minor clarifications of the reporting requirements in Appendix E (Accounting for Schools in Local Authorities in England and Wales).	***The 2015/16 Code includes few changes or clarifications of significance but the Committee may wish officers to confirm that the relevant changes will be reflected in the financial statements.***
Reporting developments – Infrastructure assets	**Medium**	CIPFA/LASAAC, the group that produce the *Code of Practice for Local Authority Accounting*, have confirmed that transport infrastructure assets owned by local authorities will be required to be included in the accounts from 2016/17. This would require prior period adjustments for 2015/16, including the opening position at 1 April 2015. The changes require local authorities to recognise the value of all transport infrastructure assets using the depreciated replacement cost method, i.e. the cost required to replace the asset with a new replacement depreciated over the life of the existing asset. Transport infrastructure assets include: • roads, bridges, roundabouts and traffic calming measures; • footways, footpaths and cycle tracks; • tunnels and underpasses; and • water supplies and drainage systems, as they support the assets identified above. CIPFA have issued a *Code of Practice on Transport Infrastructure Assets* which contains the requirements to be included in the Local Authority Code. Local authorities should have developed a project plan to identify all of the relevant transport infrastructure they own and a timetable for valuing these. CIPFA expects authorities to have undertaken the 1 April 2015 valuations by 31 December 2015.	***The Committee may wish to enquire of officers whether a project plan has been developed to address the requirements and review progress against this on a regular basis.***

Area	Level of impact	Comments	KPMG perspective
New local audit framework 123	Medium	The Local Audit and Accountability Act 2014 included transitional arrangements covering the audit contracts originally let by the Audit Commission in 2012 and 2014. These contracts covered the audit of accounts up to 2016/17, and gave the Department for Communities and Local Government (DCLG) the power to extend these contracts to 2019/20. DCLG have now announced that the audit contracts for large local government bodies (including district, unitary and county councils, police and fire bodies, transport bodies, combined authorities and national parks) will be extended to include the audit of the 2017/18 financial statements. From 2018/19, local government bodies will need to appoint their own auditors; it is not yet clear whether there will be a sector-led body that is able to undertake this role on behalf of bodies. NHS and smaller local government bodies (town and parish councils, and internal drainage boards), will not have their contracts extended, and will have to appoint their own auditors for 2017/18, one year earlier than for larger local government bodies.	***We understand guidance is being prepared by CIPFA on the request of the NAO.*** ***We will also be preparing a briefing note for clients.***

Technical update

Area	Level of impact	Comments	KPMG perspective
National Audit Office Value for Money Conclusion guidance	● **Medium**	The Local Audit and Accountability Act 2014 provides the Comptroller and Auditor General with the power to issue guidance to auditors which may explain or supplement the provisions of the Code of Audit Practice. The Act requires auditors to have regard to such guidance. In November 2015 the NAO published Auditor Guidance Note 03 covering auditors work on audited bodies arrangements for Value for Money. The guidance sets out: • The general framework for the auditor's assessment, within the Act and the Code of Audit Practice • The expected areas of focus in determining whether the audited bodies' arrangements are adequate • The expected risk based audit approach and the reporting arrangements • Sector specific guidance for NHS and Foundation Trusts, CCGs, local government, police, fire and rescue and other bodies. The guidance also provides illustrative examples of the types of developments that auditors would be likely to consider to be 'significant risks' and sets out the actions they would be expected to take. We will discuss the guidance with managers and report our findings to the Audit and Risk Committee. https://www.nao.org.uk/code-audit-practice/guidance-and-information-for-auditors/	***We will discuss the guidance with managers and report our findings to the Audit and Risk Committee.***

Area	Level of Impact	Comments	KPMG perspective
Local Audit and Accountability Act 2014 – provisions affecting auditors' work from 1 April 2015	● **Low**	With effect from 1 April 2015, certain provisions of the *Local Audit and Accountability Act 2014* (LAAA 2014) came into force and are applicable to auditors' work for the year 2015/16. Whilst the *Audit Commission Act 1998* is transitionally saved for audit work on 2014/15, insofar as auditors are engaged in planning work for 2015/16, or possibly considering public interest reports (PIRs) to be made during 2015/16, they need to be aware of the provisions of LAAA 2014 that are already in force. Provisions affecting auditors' work with effect from 1 April 2015 are: ***1) New duty to publish PIRs on audited bodies' websites*** Under the new audit regime, there is an emphasis on the publication of relevant information on the relevant authority's website. The following provisions are relevant to auditors carrying out work on 2015/16 if they decide to issue a public interest report during the audit. Under Schedule 7 LAAA 2014, the following matters must be published on the relevant authority's website (if it has one): ■ PIRs (relating to the relevant authority or a connected entity); ■ notice of a meeting to consider a PIR/written recommendation; and ■ notice summarising those decisions approved by the auditor as a result of consideration of the PIR/recommendation. Where the relevant authority does not have a website, it is instead generally required to make the relevant publication "in such manner as it thinks is likely to bring the notice or report to the attention of persons who live in its area". This could be, for example, in a local newspaper (as was required in certain cases under the previous legislation).	***The Committee need to be aware of the provisions that are in place from 1 April 2015***

Area	Level of Impact	Comments	KPMG perspective
Local Audit and Accountability Act 2014 – provisions affecting auditors' work from 1 April 2015 (continued)	● Low	***2) Prohibition on disclosure*** The prohibition against disclosure that was previously to be found in section 49 of the *Audit Commission Act 1998* has been repealed and replaced by provisions in Schedule 11 of LAAA 2014. This change has not been transitionally introduced and auditors and local authority bodies need to be aware that this applies to all audits, irrespective of the year. Thus, any reference to the prohibition against disclosure needs to be to Schedule 11 and not section 49. There are no material differences between the two sets of provisions. ***3) Connected entities*** LAAA 2014 introduces a new concept into the audit regime, "connected entities". Connected entities are bodies that are separate to the relevant authority, but are associated with the authority in such a manner that requires the authority to record financial information relating to the entity in its accounts. The full definition of "connect entities" is set out in paragraph 8 of Schedule 4 LAAA 2014. For the purposes of this Act, an entity ("E") is connected with a relevant authority at any time if E is an entity other than the relevant authority and the relevant authority considers that, in accordance with proper practices in force at that time: ■ the financial transactions, reserves, assets and liabilities of E are to be consolidated into the relevant authority's statement of accounts1 for the financial year in which that time falls; ■ the relevant authority's share of the financial transactions, reserves, assets and liabilities of E is to be consolidated into the relevant authority's statement of accounts for that financial year; or ■ the relevant authority's share of the net assets or net liabilities of E, and of the profit or loss of E, are to be brought into the relevant authority's statement of accounts for that financial year.	***The Committee need to be aware of the provisions that are in place from 1 April 2015***

Area	Level of Impact	Comments	KPMG perspective
Local Audit and Accountability Act 2014 – provisions affecting auditors' work from 1 April 2015 (continued)	● **Low**	***3) Connected entities (continued)*** Authorities have a number of duties in relation to their connected entities under LAAA 2014 beyond those which are expanded on below: ■ Auditors have a right to access documents (at all reasonable times) relating to connected entities, as well as those relating to the "parent" relevant authority. The auditor can inspect, copy or take away documents. The auditor can also require people who are in possession or are accountable for the document (or have been in the past) to provide the auditor with any information or explanation that may be needed, and can require a meeting with such persons. Where a document is stored electronically, the auditor can require assistance from the relevant person at the connected entity or relevant authority in accessing the document. The connected entity must provide the auditor with such facilities and information as are reasonably required to carry out the audit functions. ■ The right to information and explanation, or to require a meeting, extends in relation to connected entities to: – any persons elected or appointed to an entity; – any employee of the entity; and – an auditor of the accounts of the entity. Many of the provisions on PIRs and written recommendations in Schedule 7 apply to connected entities. Accordingly, auditors must consider whether a PIR should be made on any matter coming to their attention during the audit and relating to the authority and/or a connected entity. Similarly, an auditor may make a written recommendation to a relevant authority relating to a connected entity.	***The Committee need to be aware of the provisions that are in place from 1 April 2015***

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Area	Level of Impact	Comments	KPMG perspective
Local Audit and Accountability Act 2014 – provisions affecting auditors' work from 1 April 2015 (continued)	● **Low**	***4) Power to call for information: exception for legally professionally privileged information*** Section 22(12) LAAA 2014 clarifies that the auditor's right to information and documents cannot be used to compel disclosure of legally privileged information. If a person would be entitled to refuse to produce documents in legal proceedings in reliance on the doctrine of legal professional privilege, they are equally entitled to refuse to provide the relevant information or documents to the auditor. This is a notable new provision and auditors will need to bear this in mind in requesting sight of an audited body's own legal advice. Any provision of such will be voluntary and cannot be compelled.	***The Committee need to be aware of the provisions that are in place from 1 April 2015***

Technical update

Area	Level of Impact	Comments	KPMG perspective
NAO report – Local Government New Burdens	● **Low**	This report from the NAO considers how well central government has applied the New Burdens Doctrine. This sets out how the government would ensure that new requirements that increased local authorities' spending did not lead to excessive council tax increases. The focus of this report is more on central government but includes findings that may also be of interest to local government bodies. The report is available from the NAO website at www.nao.org.uk/report/local-government-new-burdens/	***The Committee may wish to review the report to understand what impact this could have at the local government level***

Technical update

Area	Level of Impact	Comments	KPMG perspective
NAO report – Care Act first-phase reforms 130	● Low	The NAO's report examines the first phase of the Department of Health's new approach to adult social care, finding that it has been implemented well, but places new responsibilities on local authorities whose core funding is being significantly reduced. This could result in their having to delay or reduce services in the short term if demand for care exceeds expectations, presenting a risk to VFM which needs to be managed. Key findings within the report include: ■ The *Care Act* will increase demand for assessments and services at a time when local authority provision has been falling and the number of people in need is rising. ■ The Department's innovative joint governance with the sector has provided support to implement this challenging legislation. It has provided guidance materials and will give extra support to local authorities. ■ The Department's tight time frame for the sector to act on final guidance and funding allocations has inhibited local implementation planning in some areas. ■ Despite the challenging timetable, of local authorities with adult social care responsibilities, 99% were confident that they would be able to carry out the Care Act reforms from April 2015. However, it will take longer to change the culture. ■ The Department might have underestimated the demand for assessments and services for carers. ■ The Department has learned from the problems it encountered in modelling the cost of Phase 1 and has improved its approach for Phase 2. ■ There is variation in the extent to which individual councils might have been over or underfunded. ■ A significant proportion of the funding which the Department is providing for the Care Act's new burdens is not new money. The Department assumes that £174 million (40%) of Care Act funding will come through the Better Care Fund, from money previously allocated to clinical commissioning group budgets and existing local authority capital grants. ■ If costs exceed expectations, pressures will fall first on individual local authorities. The Department may not have sufficient information and does not have a contingency fund to avoid impacts on services. The full report is available from the NAO website at www.nao.org.uk/report/care-act-first-phase-reforms/	***The Committee may wish to seek assurances that the issues raised in the report are understood and there are plans in place to address the likely impact at their Authority.***

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Appendix

Appendix 1 – 2015/16 Audit deliverables

Deliverable	Purpose	Timing	Status
Planning			
Fee letter	Communicate indicative fee for the audit year	April 2015	Done
External audit plan	Outline our audit strategy and planned approach Identify areas of audit focus and planned procedures	Draft to officers - January 2016 Final to Audit and Risk Committee – April 2016	TBC
Interim			
Interim report	Details and resolution of control and process issues. Identify improvements required prior to the issue of the draft financial statements and the year-end audit. Initial VFM assessment on the Council's arrangements for securing value for money in the use of its resources.	Audit visit – March 2016 Final report - May 2016	TBC
Substantive procedures			
Report to those charged with governance (ISA+260 report)	Details the resolution of key audit issues. Communication of adjusted and unadjusted audit differences. Performance improvement recommendations identified during our audit. Commentary on the Council's value for money arrangements.	September 2016	TBC
Completion			
Auditor's report	Providing an opinion on your accounts (including the Annual Governance Statement). Concluding on the arrangements in place for securing economy, efficiency and effectiveness in your use of resources (the VFM conclusion).	September 2016	TBC
WGA	Concluding on the Whole of Government Accounts consolidation pack in accordance with guidance issued by the National Audit Office.	September 2016	TBC
Annual audit letter	Summarise the outcomes and the key issues arising from our audit work for the year.	November 2016	TBC
Certification of claims and returns			
Certification of claims and returns report	Certification of Housing Benefit Claim and Teacher's Pensions Return Report summarising the outcomes of certification work on your claims and returns for Government departments.	November 2016 December 2016	TBC

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Appendix 2

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KPMG Annual Report on grants and returns work 2014/15

Rutland County Council

January 2016

Contents

The contacts at KPMG in connection with this report are:

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Headlines

Introduction and background	This report summarises the results of work we have carried out on the Council's 2014/15 grant claims and returns. This includes the work we have completed under the Public Sector Audit Appointment certification arrangements, as well as the work we have completed on other grants/returns under separate engagement terms. The work completed in 2014/15 is: ■ Under the Public Sector Audit Appointment arrangements we certified one claim – the Council's 2014/15 Housing Benefit Subsidy claim. This had a value of £5,738,937 ■ Under separate assurance engagements we provided a Reporting Accountant's report on the Council's 2014/15 Teachers' Pensions return. This had a value of £649,468.	-
Certification results	We gave an unqualified certificate on the Council's Housing Benefit Subsidy claim, and an unqualified Accountant's Report on the Teachers' Pension return.	Page 3
Audit adjustments	No adjustments were necessary to the Council's grant claim or return as a result of our work this year.	Page 3
Fees	The indicative fee for our work on the Council's 2014/15 Housing Benefit Subsidy was set by Public Sector Audit Appointments at £7,180. The actual fee for this work was £7,180. Our fee for the Teachers' Pension assurance engagement was subject to agreement directly with the Council and was £2,500.	Page 3

Summary of reporting outcomes and fees

Overall, we carried out work on 2 grants and returns:

All were unqualified with no amendments required as a result of our audit work.

The fees we charged were consistent with the indicative fee set by PSAA and the fee agreed directly with you.

We have made no recommendations as a result of the work carried out this year.

Reporting outcomes

Detailed below is a summary of the reporting outcomes from our work on the Council's 2014/15 grants and returns, showing where either audit amendments were made as a result of our work or where we had to qualify our audit certificate or assurance report.

A qualification means that issues were identified concerning the Council's compliance with a scheme's requirements that could not be resolved through adjustment. In these circumstances, it is likely that the relevant grant paying body will require further information from the Council to satisfy itself that the full amounts of grant claimed are appropriate.

	Qualified	Significant adjustment	Minor adjustment	Unqualified
Public Sector Audit Appointments arrangements				
■ Housing Benefit Subsidy				●
Other assurance engagements				
■ Teachers' Pension Return				●

No adjustments needed to be made to either of the grants/returns as a result of our audit work.

Fees charged

Public Sector Audit Appointments (PSAA) certification arrangements - PSAA set an indicative fee for our work on the Council's Housing Benefit Subsidy claim in 2014/15 of £7,180. Our actual fee was the same as the indicative fee, and this compares to the 2013/14 fee for this claim of £6,466.

Grants subject to other assurance engagements - The fee for our assurance work on the Teachers' Pension Return was agreed directly with the Council. Our fee for 2014/15 was £2,500 (2013/14 £2,000).

Recommendations

We have made no recommendations as a result of the work carried out this year. There are no recommendations from last year's work that needed to be followed up.

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Report No: 20/2016
PUBLIC REPORT

AUDIT AND RISK COMMITTEE

26 January 2016

ACCOUNTS CLOSURE PLANNING 2015/16

Report of the Director for Resources

Strategic Aim:	Delivering Services within the Medium Term Financial Plan	
Exempt Information	No	
Cabinet Member(s) Responsible:	Mr T C King, Deputy Leader and Portfolio Holder for Places (Development and Economy) and Resources	
Contact Officer(s):	Saverio Della Rocca, Assistant Director (Finance)	01572 758159 sdrocca@rutland.gov.uk
	Andrew Merry, Finance Manager	01572 758152 amerry@rutland.gov.uk
Ward Councillors	Not Applicable	

DECISION RECOMMENDATIONS

That the Committee:

1. Notes the contents of the report including the following key changes that impact the Statement of Accounts for 2015/16;
    - Implementation of the Transport Infrastructure Code;
    - Accounting for the Better Care Fund; and
    - Early closure 2017/18.

1 PURPOSE OF THE REPORT

1.1 To inform the Committee of the emerging changes that will have an impact on the production of the Statement of Accounts for 2015/16 and how the Council are planning on meeting the new requirements.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 Transport Infrastructure Code

2.1.1 The Chartered Institute for Public Finance and Accountancy (CIPFA) and the Local Authority (Scotland) Accounts Advisory Committee (LASAAC) have agreed

that the 2016/17 Code of Practice on Local Authority Accounting in the United Kingdom will adopt the measurement requirements of the CIPFA Code of Practice on Transport Infrastructure Assets (TIA).

2.1.2 The TIA was first published in 2010 and since that time has been used to provide information for the Whole of Government Accounts. The purpose of the Code is to support an asset management based approach to the provision of financial information about local authority transport infrastructure assets. The TIA Code classifies Transport Infrastructure Assets under the following headings:

- Carriageways;
- Footways and cycleways;
- Structures (e.g. bridges, subways, underpasses);
- Street lighting;
- Traffic management systems; and
- Street furniture.

2.1.3 Currently the Council accounts for these assets using a valuation method known as Depreciated Historic Cost (DHC). This valuation method is based on the amount the Council has spent on the asset and then this amount is reduced on an annual basis through depreciation.

2.1.4 Once adopted from 1 April 2016 the Council will be required to use a different valuation method called Depreciated Replacement Cost (DRC). This represents the current cost of replacing an asset less an allowance for the age of the asset (depreciation). This change in valuation is expected to increase the value of the assets to c£1.4 billion from c£34 million. There are a number of reasons for the change in valuations, these include:

- The valuation method DHC does not take into account the time value of money, for instance a road that the Council spent £500,000 on resurfacing 20 years ago would be valued at a significantly higher rate today;
- Roads transferred to the Council for £1 or peppercorn would now have a value based on the cost of re-building the road, whereas previously they would have had no value, this includes all adopted highways.
- Roads constructed by the Council would also have a valuation rather than be based on a cost to build.

2.1.5 The valuation is based on 4,657,986m^2 of road/footway network. In order to get a value an assumed build rate per square metre ranging from £136.04 to £74.87 (depending on road/footway type) is multiplied by the m^2 plus the land value either £410 per m^2 for urban or £2.10 per m^2 for Rural.

2.1.6 The change in valuation basis is to be applied retrospectively and will, therefore, require valuations as at 1st April 2015 and comparative values for 2015/16 as well as for 2016/17.

2.1.7 The key question that Members of the Audit Committee might ask is how confident Officers are that the new requirements can be met. Officers believe the requirement will be met because:

- The Council has purchased the relevant guidance notes and codes issued by CIPFA and understands the requirements.
- The Accounts Team have been working closely with Highway colleagues and have all the information of the Assets required for valuation and will be able to provide this information to the contractor (Yotta Professional Services) for Valuation.
- The Council completed the CIPFA toolkit in 2014/15 to complete the Whole of Government Accounts (we have been providing indicative valuations on TIA to Government as part of this return) which further evidences the Council has the data on which to base valuations.
- The accounts team are expecting to produce comparative figures for 2015/16 accounts process.
- The Council has engaged with the external auditors (KPMG LLP) and completed progress questions and they are supportive of our approach.

2.2 Better Care Fund (BCF)

2.2.1 The Government has set up the BCF – this is a pooled 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 BCF aims to drive forward health and social care integration so that people receive the right care and support at the right time, in the right place. The main aims of the BCF include:

- Improving services even though there is greater demand and less money;
- Getting people cared for in their own homes, avoiding admission to hospital and residential care;
- Providing help for people to better manage their health conditions; and
- Spending money on supporting people to live well in their communities, to prevent them needing costly health or social care services later.

2.2.2 The Council is the host authority for the BCF fund between Rutland County Council and the East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG).

2.2.3 The accounting standards for pooled budgets changed from the 1 April 2014 and rather than apply a simple standard, the Council has to understand the underlying arrangement and how it works in practice to determine how to account correctly for the transactions associated with it.

2.2.4 Healthcare Financial Management Association (HFMA), with the support of CIPFA, has produced some guidance that allows us to assess how our BCF should be accounted for.

2.2.5 In applying this guidance it is considered that our BCF scheme is classed as one with Joint Control. IFRS 11 defines joint control as

'…the contractually agreed sharing of control of an arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control'.

2.2.6 Joint control requires that all the parties, or a group of the parties, must act together to direct the activities that significantly affect the returns of the arrangement – the relevant activities. This means that:

- No single party controls the arrangement on its own; and
- Any one of the parties in the arrangement can prevent any of the other parties from controlling the arrangement.

2.2.7 Our BCF fund is governed by a Section 75 legal agreement, a Partnership Board and works to an approved BCF plan. The legal agreement and actual working arrangements require consensus over how the funds are used.

2.2.8 Under a joint control arrangement there are two possible options:

- Joint Operation – A joint arrangement whereby the parties that have joint control of the arrangement have rights to the assets, and obligations for the liabilities, relating to the arrangement; or
- Joint Venture - A joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement, normally through a joint vehicle (a company that is set up for a specific purpose).

2.2.9 As our BCF is hosted by the Council and no separate vehicle has been created, our BCF will take the form of a Joint Operation. We will be discussing our provisional view with external audit for their view.

2.2.10 Based on our view of the BCF being a Joint Operation IFRS 11 states that a joint operation should be accounted for in the following way:

a) Each joint operator to the joint operation will recognise (in relation to its interest in that joint operation):

   i) Its assets, including its share of any assets held jointly;

   ii) Its liabilities, including its share of any liabilities incurred jointly;

   iii) Its revenue from the sale of its share of the output arising from the joint operation;

   iv) Its share of the revenue from the sale of the output by the joint operation; and

   v) Its expenses, including its share of any expenses incurred jointly.

b) Each joint operator shall account for the assets, liabilities, revenues and expenses relating to its interest in a joint operation in accordance with IFRSs applicable to the assets, liabilities, revenues and expenses (IFRS 11, para 22)

c) When accounting for transactions such as the sale, contribution or purchase of assets between an entity and a joint operation in which it is a joint operator, the entity will recognise the gains and losses resulting from such a transaction only to the extent of the other parties' interests in the joint operation (IFRS 11, paras B34-B37).

2.2.11 Regardless of which arrangement the BCF falls under the Council will have to make the following disclosures as set out in IFRS 12. This is to enable users of its financial statements to evaluate the nature, extent and financial effects of interests in joint operations including the nature and effects of its contractual relationship with the other investors with joint control. For material joint operations, the following will need to be disclosed:

- The name of the joint arrangement;
- The nature of the Councils relationship with the joint arrangement (could include description of the nature of activities);
- The principal place of business of the joint arrangement; and
- The proportion of ownership interest or participating share held by the entity and, if different, the proportion of voting rights held (if applicable).

2.3 Early Closure 2017/18

2.3.1 The Council currently has to publish a draft Statement of Accounts (SoA) signed by the Chief Finance Officer by the 30 June. These accounts are then required to be audited, approved by the Audit and Risk Committee and published by the 30 September.

2.3.2 From 2017/18 these dates are going to be brought forward with the draft SoA published by the 31 May and then audited, approved by the Audit and Risk Committee and published by the 31 July. In order to meet this deadline changes to the Audit and Risk Committee timetable will be required.

2.3.3 As part of the plans to achieve these dates the accounts team are planning on producing a statement of accounts by the 31 May 2015. In order to achieve this a number of key tasks will be completed earlier, including:

- Accounting for the valuation of Fixed Assets;
- Financial Instruments (cash, evidence of an ownership interest in an entity, or a contractual right to receive or deliver cash);
- Many notes to the accounts e.g. Senior Officer Remuneration; and
- Preparation of working papers e.g. revaluation of Fixed Assets.

2.3.4 The outcome will be monitored and risk areas identified to ensure improvements

can be made to processes to ensure the Council is compliant.

3 CONSULTATION

3.1 Formal external consultation is not required for any decisions being sought in this report

4 ALTERNATIVE OPTIONS

4.1 The Council could choose not to apply relevant accounting practice, however, in doing so the Council would be in breach of the Code of Practice and could potentially have the accounts qualified by the external auditors.

5 FINANCIAL IMPLICATIONS

5.1 The costs of the changes highlighted in the report will be met from within existing budgets. This includes any costs related to the valuation of the infrastructure assets as we already produce the majority of the information for the Whole of Government Accounts.

6 LEGAL AND GOVERNANCE CONSIDERATIONS

6.1 The Council must adhere to the code of practice setting out the proper accounting practices required by section 21(2) of the Local Government Act 2003.

6.2 To ensure the Councils accounts are prepared in accordance with the statutory framework established for England by the Accounts and Audit (England) Regulations 2011.

6.3 On 30 January 2014, the Local Audit and Accountability Act 2014 received Royal Assent. The implications of this act relate to early closure and publication of the SoA as discussed in 2.3.

7 EQUALITY IMPACT ASSESSMENT

7.1 An Equality Impact Assessment (EqIA) has not been completed because the report does not represent the introduction of a new policy or service or a change / review to an existing policy or service.

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

11 To ensure the Committee is aware of plans in place to ensure effective and timely closure of accounts.

12 BACKGROUND PAPERS

12.1 There are no additional background papers to the report.

13 APPENDICES

13.1 No appendices.

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